

Army Regulation 40–3

Medical Services

Medical, Dental, and Veterinary Care

**Headquarters
Department of the Army
Washington, DC
23 April 2013**

UNCLASSIFIED

SUMMARY of CHANGE

AR 40-3

Medical, Dental, and Veterinary Care

This major revision, dated 23 April 2013--

- o Requires that The Surgeon General appoint the Consultant, Blood Program and Director, Army Blood Program (para 5-2a(6)).
- o Adds qualifications for the Director, Army Blood Program (para 5-2d(1)).
- o Adds qualifications for the Chief, Blood Services and for Blood Donor Center officers in charge (para 5-2f(2)).
- o Clarifies that the regional medical command blood manager has overall responsibility for managing credits throughout their respective region (para 5-2f(15)).
- o Requires commanders to ensure that reservists mobilized in support of the Army Blood Program are used in the appropriate blood program position (para 5-2f(16)).
- o Provides guidance on establishing or terminating an Army Medical Department library property account (para 7-10).
- o Revises the mission of the nutrition care division (para 8-2).
- o Expands duties of the nutrition care divisions' noncommissioned officers in charge (para 8-4c).
- o Adds military treatment facility staff to those authorized to eat in a military treatment facility's nutrition care division (para 8-5a).
- o Revises nutrition care division documentation requirements (paras 8-5c, 8-9e, and 8-16).
- o Requires DD Form 1544 (Cash Meal Payment Book) for use with manual cash collections (para 8-6c).
- o Revises payment requirements for ambulatory patients (para 8-20).
- o Authorizes foreign national embassy staff to be listed for transplantation through the Army-Navy Transplant Service (para 9-1b(7)).
- o Updates medical and administrative living donor requirements (paras 9-1b(4) and 9-1c(1)).
- o Defines and separates from kidney donation requirements the provisions for living hepatic donation (para 9-2d(5)(b)).
- o Revises guidance on recording and reporting medication errors (para 11-9b).

- o Revises guidance on controlled substances (para 11-10 and app B).
- o Adds guidance relevant to dispensing procedures (para 11-14e).
- o Revises guidance on refill prescriptions from other medical treatment facilities (para 11-14g).
- o Specifies the age at which an accompanied child can pick up prescriptions (para 11-14h).
- o Updates guidance on pharmacy support to mobilizing and deploying personnel (para 11-26).
- o Revamps pharmacy and medication automation procedures (para 11-28).
- o Clarifies cardiac life support training requirements for boarded emergency medicine physicians (tables 13-1 and 13-2).
- o Incorporates the Laboratory Response Network into medical laboratory management (chap 14).
- o Adds food defense to veterinary services (para 15-2).
- o Makes administrative revisions (throughout).

Medical Services

Medical, Dental, and Veterinary Care

By Order of the Secretary of the Army:

RAYMOND T. ODIERNO
General, United States Army
Chief of Staff

Official:


JOYCE E. MORROW
Administrative Assistant to the
Secretary of the Army

History. This publication is a major revision.

Summary. This regulation, addressing multiple medical programs, has been revised to update policy on the Army Blood Programs, medical libraries, nutrition care management, The Army Organ Transplant and Organ/Tissue Donation Programs, pharmacy and medication management, emergency medical services, medical laboratory management, veterinary care, and air ambulance vehicles.

Applicability. This regulation applies to the Active Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve, unless otherwise stated. It also applies to medical department activities, medical centers, dental activities, veterinary activities, and other Army Medical Department organizations. This publication is applicable during mobilization.

Proponent and exception authority.

The proponent of this regulation is The Surgeon General. The proponent has the authority to approve exceptions or waivers to this regulation that are consistent with controlling law and regulations. The proponent may delegate this approval authority, in writing, to a division chief within the proponent agency or its direct reporting unit or field operating agency, in the grade of colonel or the civilian equivalent. Activities may request a waiver to this regulation by providing justification that includes a full analysis of the expected benefits and must include formal review by the activity's senior legal officer. All waiver requests will be endorsed by the commander or senior leader of the requesting activity and forwarded through their higher headquarters to the policy proponent. Refer to AR 25–30 for specific guidance.

Army internal control process. This regulation contains internal control provisions and provides an Internal Control Evaluation for use in evaluating key internal controls (see appendix C).

Supplementation. Supplementation of this regulation and establishment of command and local forms is prohibited without prior approval from The Surgeon General of the Army, 7700 Arlington Boulevard, Falls Church, VA 22042–5142.

Suggested improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and

Blank Forms) directly to The Surgeon General of the Army, 7700 Arlington Boulevard, Falls Church, VA 22042–5142.

Committee management. AR 15-1 requires the proponent to justify establishing/continuing committee(s), coordinate draft publications, and coordinate changes in committee status with the U.S. Army Resources and Programs Agency, Department of the Army Committee Management Office (AARP-ZA), 9301 Chapek Road, Building 1458, Fort Belvoir, VA 22060-5527. Further, if it is determined that an established “group” identified within this regulation, later takes on the characteristics of a committee, as found in the AR 15-1, then the proponent will follow all AR 15-1 requirements for establishing and continuing the group as a committee.

Distribution. This publication is available in electronic media only and is intended for command levels A, B, C, D, and E for the Active Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve.

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Glossary

Chapter 1 Introduction

1–1. Purpose

This regulation establishes policies, procedures, and responsibilities pertaining to selected Army Medical Department (AMEDD) programs and initiatives. Since policies and procedures contained in this regulation may change conditions of employment of bargaining unit members, the responsible commander or manager should be aware of and comply with bargaining obligations based on law, regulation, or relevant collective bargaining agreements.

1–2. References

Required and related publications and prescribed and referenced forms are listed in appendix A.

1–3. Explanation of abbreviations and terms

Abbreviations and special terms used in this regulation are explained in the glossary.

1–4. Responsibilities

a. Responsibilities specific to subject areas addressed in this regulation are delineated in individual chapters and pertain only to policies and procedures described in that chapter.

b. Heads of Headquarters, Department of the Army agencies and commanders of Army commands, installations, and activities will have knowledge of Army Regulation (AR) 340–21 and AR 25–55.

Chapter 2 Advance Directives, Do-Not-Resuscitate, and Withhold/Withdraw Orders

2–1. Introduction

This chapter sets policy and procedures for the implementation of advance directives and for the initiation of orders to suspend cardiopulmonary resuscitation (commonly referred to as do-not-resuscitate (DNR) or DNR orders) or to withhold or withdraw life-sustaining treatment.

2–2. Responsibilities

a. The military treatment facility (MTF) commander will provide operational guidance for implementation of the policies in this chapter.

b. The entire healthcare team (physicians, nursing personnel, administrators, attorneys, chaplains, social workers, and patient representatives) will assist patients and/or surrogate, if the patient is incapable, with healthcare decisions. The physician primarily responsible for the patient's care is responsible for ensuring that the patient has adequate information on which to base his or her decision and that the patient's wishes are honored so far as possible.

2–3. Policy

a. A patient with decisionmaking capacity has the legal and moral right to participate in medical care decisions, including the right to refuse medical treatment at any time even if the treatment is lifesaving.

b. Upon admission, all adult patients (as defined in the glossary) will be informed in writing of their right to participate in their healthcare decisions, including the right to accept or refuse medical or surgical treatment, and of their right to prepare advance directives.

c. The standing order is to resuscitate; resuscitation will be initiated unless there is a written DNR order to the contrary.

d. When a patient will not benefit from treatment, a decision to withhold or withdraw that modality, with the concurrence of the patient or appropriate surrogate decisionmaker, may be justified and will be fully and accurately documented.

e. An abatement order (see glossary) or an advance directive will not affect other treatment decisions. Specific attention will be paid to making respectful, responsive, and competent care available for patients who choose to forego life-sustaining treatment. Therefore, orders for supportive care will be written separately. All efforts to provide comfort and relief from pain will be provided.

f. Only privileged physicians who are members of the medical staff may write an abatement order. Physicians in a graduate medical education status can transcribe a verbal order from a privileged physician.

g. Physicians will promptly inform others who are responsible for the patient's care, particularly the nursing staff, about the abatement decision. All who are responsible for the patient's care will clearly understand the order, its scope, its rationale, and its implications.

2-4. Documentation

a. Advance directives.

(1) The presence or absence of an advance directive and/or the opportunity for the patient to formulate an advance directive will be documented as part of the admission process. Documentation will be included in the admission clerk's checklist, the nurse's intake assessment, and in the progress notes.

(2) A copy of the advance directive, if any, will be placed in the inpatient chart (see AR 40-66).

(3) A patient will not be coerced into formulating an advance directive.

b. Abatement orders.

(1) Documentation of the progress notes will explain the medical rationale for the order. It will also show the patient's decisionmaking capacity and the concurrence of the patient or surrogate. Any review and consultation by an ethics committee will also be documented. (Note: If an ethics committee exists, notify the U.S. Army Medical Command (USAMEDCOM) at: Commander, U.S. Army Medical Command (MCHO-CL-C), 2748 Worth Road, Fort Sam Houston, TX 78234-6010. The notification will include complete contact information for the committee chairperson and committee membership requirements. If no ethics committee exists, the ethics committee function will be performed as determined by the MTF commander; this information will also be provided to the USAMEDCOM at the address above. USAMEDCOM reporting requirements apply only to the existence of an ethics committee or, in its absence, the means by which abatement decisions are reached; there are no USAMEDCOM reporting requirements relevant to a specific decision to enter, or not enter, an abatement order.)

(2) Any discussion with the patient or appropriate surrogate will be summarized in the progress notes. In no instance will the patient or surrogate be asked to sign any type of "release."

(3) The order will be written on the doctor's orders sheet and will be dated and signed.

2-5. Review

Advance directives and abatement orders will be reviewed routinely on rounds and whenever there is a significant change in the patient's condition. If the patient is being considered for major invasive procedures (such as surgery), the indications for the procedure and the rationale behind the intervention and the patient's wishes will be reviewed. Abatement orders will stand unless rescinded either by the attending physician (oral orders will be accepted), or at any time when a patient with decisionmaking capacity or the surrogate makes this request known to any healthcare provider responsible for the patient's care. Rescission of the order will be documented as outlined in paragraph 2-4.

2-6. Abatement decisions for patients with decisionmaking capacity

a. The voluntary choice of a capable and informed patient will determine whether life-sustaining treatment will be undertaken.

b. In an attempt to respect their wishes, patients will be given the opportunity to formulate advance directives covering their preferences for end-of-life decisions. The attending physician will discuss advance directives with the patient, preferably in advance of a critical situation.

c. If a patient requests an abatement order after full discussion and assessment of risks and benefits, the attending physician will enter the order in the patient's medical record. When the physician finds the patient's preference to be morally unacceptable and is unwilling to participate in carrying out the request, he or she will transfer responsibility for the patient to another physician.

d. The patient will be asked if his or her Family may be informed of the advance directive or abatement order. If consent is granted, the Family will be informed but will not be permitted to override the patient's decision. Where the capable patient requests that Family members not be involved in or informed of his or her decision, the patient's decision and request for confidentiality will be honored and documented in the medical record. This documentation will be made by a person who is not a member of the treatment team.

2-7. Abatement decision for incapable patients

a. While capable of making decisions, patients may envision their later incapacity and deteriorating medical condition. Such patients may have made firm and explicit verbal or written directives regarding their wishes. Such directives will be discussed with the surrogate and will be honored.

b. An incapable patient may have no surrogate, and the treating staff may feel that an abatement order is proper. If so, documented consultation will be undertaken with the ethics committee, if available, and the supporting judge advocate.

c. Determining the patient's decisionmaking capacity, informing the surrogate, and helping the surrogate to decide may require time that is not available in an emergency. In general, therefore, because of its grave nature and consequences, abatement decisions will only be made under conditions which permit consultation and reasoned thought process. In an emergency, treatment will ordinarily be given if no prior decision has been made to forego life-sustaining treatment.

d. After assessment of the benefits and risks, if there is agreement between the attending physician and the patient's surrogate, an abatement order will be entered in the patient's medical record. When a patient's surrogate disagrees, the

case will be carefully reviewed by an ethics committee or other mechanism as defined by the local MTF commander. Every effort will be made to build consensus between the healthcare team and the surrogate.

2–8. Education

The education of healthcare professionals will include training on the patient's right to make an advance directive as well as to assist the patient and/or surrogate in making ethically supportable end-of-life decisions.

2–9. Active duty patients

While active duty (AD) patients usually determine their own care, occasionally the requirements of the Service will override their decision. These situations are unusual but when questions concerning mandatory medical or surgical procedures on AD Soldiers arise, the procedures in AR 600–20 will be followed. Because of the unusual nature of such situations involving AD patients, physicians may wish to additionally consult with their institutional medical ethics committee.

2–10. Additional guidance

Questions concerning implementation of this policy will be directed to Commander, U.S. Army Medical Command (MCHO–CL–C), 2748 Worth Road, Fort Sam Houston, TX 78234–6010.

Chapter 3

Army Aviation Medicine Program and Medical Care of Aviation Personnel

3–1. Program concept

The Aviation Medicine (AVMED) Program is designed to promote and maintain the aviation fighting force through health promotion and sustainment of the mental and physical well-being of aviation personnel. Flight surgeons (military occupational specialty (MOS) 61N9D) are graduates of the Army Flight Surgeon Primary Course and perform routine AVMED duties. They are generally assigned to the battalion or squadron level. Specialists in AVMED (61N9C, B, A) are residency-trained in aerospace medicine. This training includes earning a master's degree in public health plus additional study in preventive, occupational, and environmental medicine factors as they apply to the aviation environment. They are generally assigned to brigade or regiment level and above, according to their seniority, and perform additional supervisory functions in the AVMED Program.

3–2. Responsibilities

a. The Surgeon General (TSG) is responsible for training, development, fiscal planning, and oversight of Department of the Army (DA) policies and programs for the AVMED Program.

b. All Army command (ACOM), Army service component command (ASCC), and direct reporting unit (DRU) commanders are responsible for enforcing the regulatory aspects of AVMED within their commands.

c. The AVMED consultant (to TSG) will assist TSG in policy formulation and provide technical supervision of all aspects of the AVMED Program.

d. Regional medical command (RMC) commanders will—

(1) Ensure implementation of the AVMED Program.

(2) Assign a residency-trained specialist in aerospace medicine as RMC chief, AVMED. When a specialist is not available, an experienced flight surgeon (FS) will be temporarily assigned until a specialist is made available.

e. The RMC chief, AVMED will oversee the RMC AVMED Program and act as the RMC advisor for aeromedical policies and issues such as FS deployments, aeromedical evacuation policy, and regional review and disposition of flight physicals.

f. The Director, Aeromedical Proponency, will—

(1) Direct and supervise the U.S. Army Aeromedical Activity in order to provide worldwide support of Army AVMED programs through consultations, supportive services, and training in the areas of aviation and military occupational disease prevention, surveillance, and evaluation.

(2) Review and recommend dispositions of flying duty medical examinations (FDMEs) and medical waiver requests for continued flying duty according to AR 40–501 (see DA Form 4186 (Medical Recommendation for Flying Duty) as prescribed in AR 40–501).

(3) Develop and update FDME practices and policies through the publication of aeromedical policy letters and aeromedical technical bulletins (according to AR 40–501).

(4) Develop and maintain the Aeromedical Epidemiological Data Repository to support research and clinical studies for aircrew medical standards and policy.

g. The Commander, U.S. Army Combat Readiness Center (see Department of the Army General Order (DAGO)

2005–05) will direct the safety center surgeon to investigate human factors in aviation safety, aircraft design, and aviation mishaps.

h. The Commander, U.S. Army Aeromedical Research Laboratory, will—

- (1) Conduct research and development of aviation life-support equipment and aircrew protection.
- (2) Conduct research in the effects of exogenous aeromedical factors in the aviation operational environment.

i. The Dean, U.S. Army School of AVMED, will—

- (1) Oversee all aspects of AMEDD and U.S. Army Training and Doctrine Command aeromedical education and training, including developing advanced aviation medicine qualification training and conducting the Army aerospace medicine residency and the annual professional short course (Combined Operational Aeromedical Problems Course).
- (2) Supervise the aeromedical portion of the aviation resources management survey.

j. The installation medical authority (MTF commander) of installations hosting both Active Army and reserve component (RC) aviation assets will—

- (1) Establish, supervise, administer, and support the AVMED Program.
- (2) Appoint a senior installation FS or aeromedical physician assistant as chief, AVMED.
- (3) Ensure that the AVMED Program is included in the MTF's specific organizational performance improvement (PI) structure.

k. The chief of AVMED will oversee the installation AVMED Program and coordinate the efforts of the aviation medicine team consisting of aviation psychology, dentistry, and optometry.

l. Unit-level FS responsibilities are described in paragraphs 3–5 and 3–6.

3–3. Aeromedical physician assistants

Aeromedical physician assistants will be under the supervision of an FS, and their duties will be as prescribed by AR 40–68.

3–4. Flight medical aidman

The flight medical aidman is trained and supervised to provide—

- a.* Medical aidman crew duties for air ambulance operations.
- b.* The basics of emergency medical care.
- c.* Administrative support of the AVMED clinic.

3–5. Flight surgeon clinical duties

a. Primary care. The FS will—

- (1) Provide routine primary medical care to all unit aviation and aviation support personnel.
- (2) Ensure appropriate maintenance of medical records on all aviation personnel, including air crewmembers in nonoperational assignments, even if not on active flying duty (on flight status). He or she will maintain a tracking mechanism to ensure aeromedical documents (such as FDMs, DA Forms 4186, and so forth) arrive at their proper destinations. He or she will also ensure aviation medical records are included in all supervising MTF service treatment record (STR) quality assurance (QA) programs.

(3) Provide an AVMED primary care program, including health promotion and preventive medicine, for aviation personnel Family members when mission requirements, staffing, and facilities can support such a program.

(4) Within the constraints of the local MTF, monitor and support the mental and physical well-being of aviation personnel, Family members, and support personnel.

(5) Review care provided by other healthcare providers for impact on the flight status of aviation personnel.

b. Preventive medicine and occupational health. The FS will—

(1) Promote the health and safety of aviation personnel by instituting a health education program and monitoring the conditions and hazards present in the work environment. The FS will advise the command about issues that could impact safety through participation in the unit's quarterly command safety council meetings (per AR 385–10).

(2) Monitor aviation occupational hazards in accordance with established Army programs such as the Hearing Conservation Program and the Vision Conservation and Readiness Program, as described in AR 40–5.

(3) Assist the unit aircrew life support equipment shop with Class VIII support and survival education.

c. Flying duty medical examinations. The FS will—

(1) Conduct FDMs as prescribed by AR 40–501 and applicable aeromedical policy letters and technical bulletins, as well as other special medical examinations when indicated.

(2) Review and monitor all FDMs performed by other healthcare providers.

d. Aeromedical consultation. The FS will—

(1) Ensure that an on-call service for aeromedical emergencies and aeromedical evacuation consultations is in place during all hours of flight operations.

(2) Interview newly assigned aviation personnel and review their medical records before granting a medical clearance to fly.

(3) Establish procedures whereby air crewmembers are automatically grounded when treated in the emergency department or specialty clinic. Protocols will then require grounded air crewmembers to report to the FS as soon as reasonably possible.

(4) Medically clear air crewmembers for further flight duty, following temporary medical disqualification or aircraft mishap.

(5) Ensure timely evaluation of aviation personnel who are medically disqualified.

3-6. Flight surgeon nonclinical duties

a. Liaison. The FS will—

(1) Serve as a liaison between the medical and aviation elements and act as an advocate for the AVMED Program.

(2) Act as a special staff member on the aviation commander's staff.

(3) Serve as a member of, or a medical consultant to, flight evaluation boards, according to AR 600-105.

b. Readiness and mobility support planning. The FS will—

(1) Assist in medical staff planning activities associated with tactical aviation operations.

(2) Review aviation operations plans, including individual aviation training, team training, and tactical field exercises to determine whether aeromedical factors that may adversely affect unit operations exist, and ensure that these factors are considered in future operations plans revisions.

(3) Monitor aircrew, and advise the commander of physiological and psychological factors affecting aviation operations.

(4) Recommend policies and procedures pertaining to exposure and decontamination of aviation personnel operating in the vicinity of hazardous agents.

(5) Support the aviation commander's Fighter Management (air crewmember endurance) Program.

c. Air crewmember aeromedical training program. The FS will assist unit commanders in developing an air crewmember aeromedical training program to meet specific operational needs of the unit. He or she will also help conduct unit mission analyses to determine special aeromedical training requirements, as described in Training Circular (TC) 3-04.93.

d. Air ambulance operations. The FS will—

(1) Function as a medical technical advisor to local air ambulance unit commanders and MTF commanders. This includes, but is not limited to, instructing medical evacuation personnel, reviewing reports of medical evacuations (run sheets) for appropriateness of the mission and the care given, and evaluating equipment taken aboard medical evacuation aircraft.

(2) Participate in actual air evacuation missions as appropriate.

e. Accident investigation board. The FS will—

(1) Serve as a member of, or medical consultant to, any accident investigation boards as determined by the commander and per AR 385-10 and Department of the Army Pamphlet (DA Pam) 385-90.

(2) Participate actively in the board proceedings, including deliberations and drafting findings and recommendations.

(3) Organize and report on special medical consultations as required by the accident investigation board when human factors or medical laboratory findings are involved in the proceedings.

f. Flight line operations. The FS will—

(1) Assist in aeromedical occupational inspections.

(2) Conduct aeromedical briefings held for both officer and enlisted personnel at unit-level training or aviation safety meetings.

(3) Participate in aircraft mishap exercises and observe the effectiveness of response, equipment, and communication of fire rescue, air ambulance, and medical teams. The FS will develop and periodically review the medical portion of the unit's pre-accident plan as described in AR 385-10, AR 40-21, and DA Pam 385-90.

(4) Observe flight operations in order to monitor physical and psychological stresses that contribute to fatigue and human error in the flight environment.

(5) Participate in unit field training exercises and unit day-to-day flight activities.

(6) Participate in an operational capacity as an air crewmember, in flight, in each type of aircraft assigned to supported units. An FS's operational capacity will include observing flight crewmembers, monitoring patients, and so forth. Flight will be in all flight environments—including emergency procedures—and mission profiles (for example, nap of the earth, night vision goggles, and so on) according to AR 95-1 and AR 600-105. Flight simulators may be used to broaden FS exposure to various flight environments and mission profiles. The purpose of this simulator time is to ensure that FSs understand the mission profiles and stresses of the aviators that they support. Flight simulator time does not count toward the aviation, career incentive pay, flying hour requirement.

3-7. Supervising medical care for aviation personnel

All aviation personnel will be provided ambulatory care by, or under the direct supervision of, an FS. If such care is not available locally, an FS may be placed on temporary additional duty orders to supervise remotely AVMED

operations provided by local, non-FS healthcare providers. The arrangement must be approved and monitored by the RMC chief of AVMED (see para 3–2*d*). The shortage condition must be rectified as soon as possible and may not be seen as a lasting solution. Non-FS providers will not be authorized to provide the full spectrum of AVMED required by AR 385–10 or AR 95–1. The supervising FS and the non-FS healthcare providers will ensure adherence to the requirements in paragraph 3–8*a* and *b*.

3–8. Fitness for flying duty

a. When Army aviators and other personnel are on flight status, their fitness for flying duty must be determined according to AR 40–501 and AR 40–8. Admission to an MTF or being placed on “quarters” status, dental treatment requiring agents with systemic effects, and conditions specified in the above regulations are causes for removal from flight status (see AR 600–105). The MTF will notify the person’s commander by means of DA Form 4186 as prescribed in AR 40–501. For aviators in nonoperational flying jobs, there is no requirement to notify commanders, but all other procedures stated above apply.

b. Medical personnel administering or prescribing any type of treatment or evaluating any health-related condition of aviation personnel will ensure that proper entries are made in their patient’s STR. They will also refer their patients (with records) to an FS for further evaluation. However, aviators in nonoperational flying jobs who have minor temporary conditions need not be referred to an FS.

3–9. Federal Aviation Administration medical examinations and certificates

a. General.

(1) This paragraph establishes procedures by which Army FSs become designated Federal Aviation Administration (FAA) aviation medical examiners (AMEs). It also establishes procedures by which personnel listed in paragraph 3–9*b* may be given a medical examination for the issuance of a second-class or third-class FAA medical certificate.

(2) The following personnel may be given FAA medical examinations:

(a) Commissioned officers and warrant officers on AD with the Army who are designated Army aviators.

(b) Army personnel who are performing or may perform military air traffic control duties and who desire FAA certification, or for whom such certification is desired.

(c) Designated Army aviators of the Army National Guard and designated Army aviators in the Army Reserve Aviation Officer Training Program.

(d) Civilian flight instructors and test pilots employed by DA.

(e) Nonrated Army personnel who currently hold valid second- or third-class FAA medical certificates or who desire to obtain such certificates.

(f) Other personnel eligible under Department of Defense (DOD) or DA medical programs.

b. Designated Army aviation medical examiners.

(1) TSG, through the consultant for AVMED, may ask the Manager, FAA Aeromedical Education Division to assign an Army FS a designation number. This would be done to issue second- and third-class FAA airman medical certificates and combined medical/student pilot certificates and to authorize certification examinations at specified military clinics. The procedures for application, notification, and conditions of appointment are described in U.S. Department of Transportation FAA Order 8520.2E, in the FAA Guide for Aviation Medical Examiners (FAA AME Guide). (Also see para 3–9*f*(1).)

(2) It is FAA policy to assess the performance of designated FSs and to terminate their designation, if appropriate. Designation of a military FS to conduct FAA examinations as an AME will terminate when he or she leaves Government service. Reports of AME performance and notification of changes in designation status will be provided by the Manager, FAA Aeromedical Education Division, to the designated FS and to the consultant for AVMED, if applicable. It is the responsibility of the military AME to report changes in his or her status or location to the FAA.

c. Examinations. Designated military AMEs will conduct medical examinations for personnel coming within the scope of this section, subject to availability of time, personnel, and facilities as determined by the commander. Military AMEs are prohibited from using their designation number to conduct FAA examinations outside of the military such as while performing off-duty employment or, in the case of RC physicians, in their civilian practice.

d. Authority to issue certificates. By agreement with the FAA, authority to issue class 2 or class 3 medical certificates is delegated to the certified military AME. Upon successful qualification, applicants will be issued class 2 or class 3 FAA medical certificates in accordance with the provisions of the FAA Guide for Aviation Medical Examiners.

e. Disposition of examination reports. Upon completion of the examination, whether or not the candidate is qualified, the completed FAA Form 8500–8 (Application for Airman Medical Certificate or Airman Medical and Student Pilot Certificate) will be sent directly to the FAA using either the FAA’s encrypted Internet Web site or the return, self-addressed envelope supplied for this purpose. Personnel may also transmit the exam via the Internet to the FAA. There is a link to the FAA Aeromedical Certification Subsystem support page on the Civil Aeromedical Institute home page at <http://www.hf.faa.gov> that contains useful information regarding the Internet transmission of FAA physical exams.

f. Supply of Federal Aviation Administration forms. Miscellaneous required forms will be distributed by the FAA directly to facilities concerned. FAA 8500–8 forms are serially numbered and assigned to individual military AMEs, and they must be treated as controlled forms.

Chapter 4

Auditory Evaluation and Hearing Aids

4–1. Auditory evaluation and treatment facilities

This chapter establishes policy for audiologic evaluations and hearing loss treatment services for eligible beneficiaries. Patients will be referred for these services to the facilities listed in paragraphs 4–1*a* through *c*. Referrals will be based on professional considerations, mission requirements of the MTF, organizations supported by the MTF, travel economy, and the time required to obtain evaluation, diagnosis, and treatment. AR 40–400 (chap 3 and app B) further describes personnel eligible to receive hearing aids provided by Army MTFs.

a. Basic hearing test clinics.

(1) *Designation.* Any MTF capable of administering pure-tone audiometry may be considered a basic hearing test clinic (BHTC).

(2) *Services provided.* BHTCs will conduct audiometry for physical examinations, hearing readiness, and hearing conservation. Persons with hearing levels poorer than H–1 standards (as defined in AR 40–501) will be retested to confirm the hearing loss. Persons with confirmed or suspected hearing loss compatible with an H–2, H–3, or H–4 profile will be referred by the BHTC for further evaluations, profiling, or treatment. These would be conducted at the nearest MTF, with an audiologist holding privileges to provide independent clinical services, as noted in paragraph 4–1*b*(2).

b. Auditory diagnostic clinics.

(1) *Designation.* Any MTF with an assigned audiologist holding privileges to provide independent clinical services noted in paragraph 4–1*b*(2) may be considered as having an auditory diagnostic clinic.

(2) *Services provided.* Auditory diagnostic clinics provide comprehensive audiology assessments to determine the site of lesion and etiology of hearing loss and appropriate treatment strategy. Diagnostic services include pure-tone air and bone conduction, speech reception threshold, word recognition in quiet and noise, acoustic immittance, electrophysiologic tests, vestibular tests, other diagnostic tests as needed, and treatment services (hearing aid evaluations, hearing aid fitting, and counseling for individuals with hearing loss or parents of children with hearing loss).

(3) *Special auditory and vestibular services.* The RMC commanders will determine requirements for additional special auditory and vestibular services at individual MTFs within their command, based on recommendations from the RMC audiology consultant.

c. U.S. Army Audiology and Speech Center. The U.S. Army Audiology and Speech Center (AASC) represents the highest echelon of auditory evaluation and treatment in the AMEDD and sets clinical practice guidelines for audiology and speech services provided across the AMEDD. The AASC coordinates Army clinical audiology programs, conducts basic and applied research, and provides consultation for treatment programs and clinical audiology services. The AASC also provides the full spectrum of available audiologic care and services as an auditory diagnostic clinic.

4–2. Disposition of patients with hearing impairment

a. Active duty personnel examined for separation or retirement and found to have hearing compatible with H–3 and H–4 profiles may be evaluated at any auditory diagnostic clinic or the AASC, according to AR 40–501 and AR 635–40.

b. Patients with temporary hearing loss (for example, middle ear disease) will receive medical treatment according to local policy before a hearing profile is issued.

4–3. Procurement of hearing aids

The prescription of hearing aids for AD personnel will be limited to those instruments approved by the Department of Veterans Affairs (VA) and included on the VA purchasing contract unless the hearing aid required for a patient (based on the audiologist’s recommendation) is not on the VA contract. Procurement will be made by the medical supply officer (MSO) based on specifications from the MTF audiologist.

4–4. Records of hearing aid issue

When a hearing aid is issued, the following information will be entered in the patient’s STR or outpatient treatment record (OTR): make, model, and serial number of the hearing aid issued and date of issue. This record will be used to support subsequent hearing aid repairs and followup services.

4–5. Repair and replacement of hearing aids

a. Individuals will report any hearing aid malfunction or loss to the MTF audiologist or designated representative.

b. Hearing aid repairs will be provided worldwide through the nearest MTF with applicable services. The audiologist, audiology support staff, or authorized representative will check the batteries and electrical or mechanical contacts of a malfunctioning or defective hearing aid.

(1) Inoperable hearing aids covered by manufacturer's warranty will be repaired in house or sent by the MTF directly to the manufacturer for repair.

(2) Inoperable hearing aids no longer covered by the manufacturer's warranty will be sent for repair through local service contracts. When local service contracts are not feasible, the hearing aid may be shipped to the AASC, Walter Reed Army Medical Center, Washington, DC 20307 with the following information: user's name, rank, social security number (SSN), home address, telephone number, date of issue, location of MTF issuing the hearing aid, and a full description of the defect or complaint. The sender should contact the Hearing Aid Lab at the AASC for shipping instructions prior to sending the hearing aid(s). The contact phone number is (202) 782-8593/4.

c. When a hearing aid cannot be repaired, the AASC or MTF will notify the user and recommend a hearing reevaluation and new hearing aid prescription at the nearest MTF with applicable services.

d. A back-up hearing aid may be issued for AD users if, at the MTF audiologist's discretion, the hearing impairment is sufficiently handicapping as to render the wearer markedly disadvantaged during the time the primary hearing aid is undergoing repair. Multiple factors will be taken into consideration in determining if a back-up hearing aid is needed to include (but not limited to) the severity of hearing loss, the hearing impairment, and whether the wearer is to be deployed. The type and style of the backup hearing aid will also be at the discretion of the MTF audiologist, MSO, or designated representative.

e. Two packs of hearing aid batteries will be provided with each hearing aid at the time of initial issue unless, at the discretion of the dispensing audiologist, additional batteries are warranted. A reasonable stock of batteries will be maintained for and issued to AD hearing aid users by their MTFs. Consideration will be given to maintaining a small stock of batteries for mobilization missions supported by an MTF. Hearing aid batteries can be obtained from the Department of Veterans Affairs' Denver Acquisition and Logistics Center (DALC). Hearing aid batteries can also be provided by the Denver Distribution Center directly to AD Army personnel who are assigned to remote locations (more than 50 miles from an MTF), provided the Soldier's hearing aid is registered in the VA Remote Order Entry System (ROES). In order to register a Soldier's hearing aid in the ROES, the Soldier's name, grade, SSN, and the name of the MTF that has confirmed the Soldier is still on AD and eligible for care must be submitted to the RMC's primary audiology clinic (usually at the medical center level). The RMC's primary audiology clinic has access to and will register the hearing aid in the ROES. The AASC will coordinate this program and funding support for hearing aid batteries procured from the DALC for Soldiers assigned to remote locations.

4-6. Accountability and responsibility

Individuals are accountable for proper care of their hearing aids, consistent with instructions received at the time of hearing aid fitting. If loss, damage, or destruction of a hearing aid is due to the user's misconduct, pecuniary liability will be determined. If indicated, a reimbursement will be made to the Government for such loss, damage, or destruction.

Chapter 5 Army Blood Programs

5-1. General

This chapter, which applies to all Army blood donor centers and transfusion services—

a. Addresses the Army Blood Program and its relationships with the Armed Services Blood Program, other uniformed Services blood programs, and civilian blood programs;

b. Emphasizes the responsibilities of commanders and leaders to support the Army Blood Program.

c. Implements Department of Defense Directive (DODD) 6000.12E and Department of Defense Instruction (DODI) 6480.4.

5-2. Responsibilities

a. The Surgeon General will—

(1) As executive agent, manage the Armed Services Blood Program Office (ASBPO) and provide administrative support for its internal administration and operation according to the multi-Service regulation AR 10-64/OPNAVINST 6700.2/AFR 160-29/MCO 5420.18A.

(2) Program, budget, and finance all ASBPO operating costs. This does not include pay, allowances, and permanent-change-of-station travel of military personnel members and assigned staff, which are the responsibility of the military department providing the military personnel.

(3) Upon mobilization, fund for blood procurement from civilian sources including the costs of transportation to the

appropriate Armed Services Whole Blood Processing Laboratory (ASWBPL) when overall military requirements exceed the organic capability of the military Services. However, nothing will preclude a Service from obtaining local purchases of blood in an emergency, due to time or other constraints.

(4) Conduct research and develop programs devoted to progress and improvement in the areas of blood, blood derivatives, and plasma volume expanders including related techniques, facilities, and material according to policy guidance from the Assistant Secretary of Defense for Health Affairs (ASD (HA)) and the Under Secretary of Defense for Research and Engineering.

(5) Appoint the holder of the DA establishment and product licenses as specified in the memorandum of agreement (MOA) between the Food and Drug Administration (FDA) and the DOD.

(6) Appoint the Consultant, Blood Program and Director, Army Blood Program/Alternate Responsible Person for the Army's FDA establishment and product licenses.

b. Commanders, U.S. Army Training and Doctrine Command, Installation Management Command, and U.S. Army Forces Command will—

(1) Formally establish a donor blood program.

(2) Use their own units, subordinate units, and tenant units to provide volunteer donors at the frequency and in sufficient quantity to enable Army MTFs to maintain a working inventory of blood for treatment needs, and meet the blood product requirements as established by the Director, Army Blood Program.

(3) Provide maximum support, resources, and Soldiers to meet critical blood quotas assigned to the USAMEDCOM blood donor centers during contingencies and/or mobilization periods.

c. The Commander, USAMEDCOM will—

(1) Serve as FDA responsible person for the DA's FDA blood establishment, and blood product licenses and registrations, and provide oversight of the Army Blood Program.

(2) Provide the necessary blood donor centers, medical staff, and technical personnel in support of the Army Blood Program.

(3) Provide and operate, in compliance with terms of the FDA license, designated donor centers, manufacturing locations, and specifically designated products.

(4) Ensure that unlicensed (registered only) USAMEDCOM treatment facilities operate within the standards promulgated in Current Good Manufacturing Practices for Blood and Blood Components in Title 21, Code of Federal Regulation, parts 210, 211, and 600–680 (21 CFR 210, 211, 600–680). Those facilities must also operate within standards set forth by the American Association of Blood Banks (AABB) according to the multi-Service publication TM 8–227–3/NAVMED P–5101/AFMAN 41–119.

(5) Provide the requisite blood donor collection and manufacturing services from AMEDD resources or arrange for these services from other approved sources.

d. The Director, Army Blood Program will—

(1) Be educationally qualified, board certified by the American Society of Clinical Pathologists as a specialist in blood banking, and possess the 8T additional skill identifier (ASI).

(2) Provide technical oversight and policy guidance to Army blood establishments to ensure compliance with blood establishment regulatory or accrediting agencies and higher headquarters policies and directives.

(3) Act as the alternate responsible person of the DA FDA blood establishment and blood product licenses by—

(a) Serving as the sole point of contact between the Army facilities and FDA on licensing and operational issues.

(b) Standardizing blood donor center and transfusion services practices within the Army's FDA licensed and registered establishments.

(c) Processing all correspondence pertaining to the FDA license and registration, to include but not limited to, error and accident reports, inspection findings and responses, license applications, license amendments, license supplements, and so on.

(d) Overseeing the QA program for the Army Blood Program according to FDA requirements.

(4) Coordinate blood program operations with the RMC blood managers, with Air Force and Navy blood program directors (as appropriate), and with other government and civilian agencies having blood programs.

(5) Coordinate and establish procedures and guidelines for USAMEDCOM activities related to—

(a) The procurement and exchange (resource sharing) of in-date blood and blood products.

(b) The disposal of outdated blood and/or blood products.

(6) Establish blood product quotas at USAMEDCOM activities—

(a) For routine, peacetime support of Army MTFs, in order to maintain a working inventory for treatment needs.

(b) To meet requirements during readiness and mobilization, according to the USAMEDCOM Base Mobilization Plan (Unclassified).

(7) Establish accounting procedures with civilian agencies that handle the resource sharing of blood, blood products, and/or blood credits.

(8) Establish periodic operational reports and reporting procedures.

(9) Provide recommendations to TSG on research and development requirements that ensure continued progress and

improvement of blood products and donor center and transfusion service techniques, procedures, equipment, and material.

(10) Provide guidance and approval of locally negotiated MOAs with civilian blood collection agencies on DA installations. (A sample template for such an MOA is available on request from the Army Blood Program Office.)

(11) Oversee, perform, and maintain data for the U.S. Army Human Immunodeficiency Virus Look-Back Program as required by Federal and DOD policy.

e. RMC commanders will—

(1) Appoint, on orders, the senior or most qualified Blood Bank Officer (71E8T) to serve as the RMC blood manager, with the endorsement of the Director, Army Blood Program. The RMC blood manager will serve as consultant to the RMC commander.

(2) Develop and monitor the U.S. Army Blood Program at a regional level.

(3) Provide and/or arrange for consultation services and mutual blood support agreements among military hospitals within the region.

(4) Program periodic staff visits to member hospitals of the region to assist in licensing and accrediting of their blood donor centers and transfusion services by the FDA and AABB, respectively.

(5) Ensure that RMC blood managers conduct at least one evaluation visit biannually to all FDA registered transfusion services and licensed blood donor centers within their region. The purpose of the visit is to comply with FDA guidelines to ensure management is exercising control over all blood program activities within the Army's U.S. license.

(6) Ensure that all evaluations and audits performed are reported through normal channels to the Director, Army Blood Program, U.S. Army Medical Command (MCHO-CL-R), 2748 Worth Road, Fort Sam Houston, TX 78234-6010, as the alternate responsible person for the FDA license. Staff assistance visit reports must be submitted through the RMC headquarters to the Army Blood Program Office.

(7) Monitor and recommend movement of blood inventories among hospitals within the region to—

(a) Reduce outdating of blood and products.

(b) Provide for individual MTF shortfalls in blood inventories and emergencies.

(8) Maximize the use of the regional donor resources to meet regional MTF requirements and current operational support requirements, as assigned by the Director, Army Blood Program.

(9) Provide for the AABB national blood exchange services for member hospitals of the region.

(10) Appoint a national blood exchange participant within their regions to assist the medical department activity (MEDDAC) installation blood program by providing for the transfer of blood credits on behalf of the MEDDAC as required.

f. Commanders, USAMEDCOM installations and activities having an assigned blood program mission will—

(1) Operate blood donor centers and transfusion services to support the U.S. Army Blood Program as approved by the Army Blood Program Office.

(2) Ensure that Chiefs, Blood Services and Blood Donor Center officers in charge be educationally qualified, certified by the American Society of Clinical Pathologists as specialists in blood banking, and possess 8T ASI, or be selected or approved by the Director, Army Blood Program.

(3) Affect coordination with and provide support for designated USAMEDCOM activities not having blood donor center capability to ensure—

(a) An adequate supply of blood and blood products is provided by the most practical and efficient means, making every effort to minimize outdating of blood or blood products.

(b) Blood donor resources are used to the maximum extent possible. This may include joint blood donor operations conducted by USAMEDCOM activities, operations in coordination with other uniformed Services, and/or operations conducted in coordination with civilian blood agencies.

(4) Coordinate and assist the installation in the planning of all military blood donor drives and offer assistance and support to hospital commanders on installations not having a blood donor center.

(5) Ensure that all blood drives are coordinated with the commander of the installation, organization, or agency who controls the donor population to ensure blood donor operations do not conflict with appropriate operational and training missions.

(6) Promote an installation blood program regulation to include the designation of a committee consisting of key members from organizations scheduled to donate blood for the purpose of assisting the responsible commander in planning and conducting routine blood drives, assigning quotas, and responding to emergency requirements.

(7) Publicize all favorable results of donor drives to ensure that donors and their organizations are aware of the success of their participation in the U.S. Army Blood Program.

(8) Publish administrative directives addressing those actions necessary to—

(a) Transfer blood or blood products between regional activities or through appropriate civilian programs.

(b) Provide for emergencies requiring blood or blood products.

(9) Coordinate negotiations with civilian agencies for the procurement, sale, and exchange of blood and blood products with final approval of such written agreements by the Army Blood Program Manager.

(10) Oversee the RMC facilities to ensure the timely completion of monthly operational data reports through the Operational Data Reporting System and the submission of monthly metrics reports to the Army Blood Program Office.

(11) Maintain an ongoing donor recruitment and educational program on the host installation and, if requested, assist similar programs on other installations.

(12) Establish and implement U.S. Army Blood Program standardized policies and procedures as well as operating procedures which may be unique to each site. These will include but are not limited to—

(a) Donor selection, blood production, processing, and quality control procedures.

(b) Maintenance of donor, patient, compatibility, and transfusion records which clearly establish an audit trail. Such records will be maintained for the time period mandated by 21 CFR Part 606, and the current AABB “Standards for Blood Banks and Transfusion Services.”

(c) Mutual support arrangements to include copies of written agreements.

(d) Provision for an adequate inventory to meet operational requirements.

(e) Resource sharing MOA for both in-date and expiring products.

(13) Provide facilities, staffing, and funding of their blood program elements commensurate with mission and regulatory requirements.

(14) Designate in writing a QA coordinator for each transfusion service and blood donor center within the region.

(15) Ensure appropriate MOAs with civilian blood collection agencies are in force as required by DOD policy. The RMC blood manager has overall responsibility for managing credits throughout their respective region.

(16) Ensure the appropriate use of Reserve personnel ordered to active duty in support of the Army Blood Program in the assigned duty position.

g. Unit commanders will—

(1) Develop and maintain a program of donor motivation and education. The award of time off for “exceptional performance of duty” to military personnel who donate blood is encouraged. Additionally, all DOD healthcare beneficiaries will be encouraged to donate (see para 5–3d(5)).

(2) Be responsible for ensuring that the organization issuing the Common Access Card and identification tag is informed of the correct blood group and type so that they may be properly recorded on the Soldier’s identification card and tag.

(3) After coordinating with the responsible blood donor center, ensure that student and trainee groups located within a blood donor center’s collection area include time for blood donations in their training schedules.

h. The MTF commander will ensure that personnel working in the blood donor centers and transfusion services are properly trained, competency assessed, and supervised. All procedures will be in accordance with Clinical Laboratory Improvement Program (CLIP) standards, AABB standards, FDA regulations, and Army Blood Program policies.

i. Installation commanders of other ACOMs, ASCCs, and DRUs must establish an installation blood program and provide blood donors to MTFs conducting blood donor center operations. Blood donor resources will be made available to blood donor centers operating in support of installation, area, or regional missions.

5–3. Policy

a. The U.S. Army Surgeon General will—

(1) Operate an Army Blood Program.

(2) For all patients receiving care in Army MTFs, provide blood and blood component requirements from the Army’s own resources without adverse impact on blood programs in civilian communities.

(3) Restrict DOD blood donor center blood collections to military installations, activities, and Federal property, according to ASD (HA) policy #15545–07 (see app A).

b. The Director, U.S. Army Blood Program will—

(1) Provide for the blood requirements of USAMEDCOM facilities by the most efficient and cost effective means possible, consistent with established Federal regulations and approved blood donor center and transfusion service principles and practices (for example, 21 CFR Part 210–211, Part 600–660, Part 820 and TM 8–227–3/NAV MED P–5101/AFMAN 41–119).

(2) Provide for the most effective use of blood donor resources and blood inventories at U.S. Army installations supported by the USAMEDCOM with an outdate rate goal of less than 5 percent for red blood cells for continental United States (CONUS) facilities. Facilities outside CONUS may have outdate rates slightly higher due to readiness concerns.

(3) Provide the capability to rapidly expand to meet readiness and mobilization blood requirements established for the program by the ASBPO and Army leadership.

(4) Ensure the integration of the U.S. Army Blood Program with the blood programs of the other Services under lead agent initiatives.

- (5) Ensure that all USAMEDCOM blood donor centers and transfusion services meet or exceed the highest accepted standards for the operation of such services and are accredited by the AABB.
 - (6) Comply with requirements of the DOD CLIP.
 - (7) Obtain and maintain FDA registration for transfusion services and licensure for blood collecting and manufacturing facilities under procedures established by the DOD, Office of The Surgeon General (OTSG), and the USAMEDCOM in coordination with the FDA.
 - (8) Operate in a current good manufacturing practices environment as required by the FDA.
 - (9) Interact with civilian regional and community blood programs when it does not adversely affect the U.S. Army Blood Program. MOAs will be established within current guidelines to delineate current local relationships with civilian blood programs. MOAs with civilian blood collection agencies will be reviewed biannually and copies provided to the Commander, U.S. Army Medical Command (MCHO-CL-R), 2748 Worth Road, Fort Sam Houston, TX 78234-6010. MOAs must meet all requirements of ASD (HA) policies and directives.
 - (10) Fulfill contingency blood requirements to the ASWBPLs as required by DOD and the Army Blood Program Office.
 - (11) Be prepared to support with blood a national emergency anywhere in the world in a rapid, efficient, and adequate manner.
 - (12) Ensure the Army Blood Program supports DOD-directed requirements.
 - (13) Encourage resource sharing with civilian blood programs after service and other governmental requirements are met.
 - (14) Maintain a PI program which meets the requirements of the licensing and accrediting agencies (for example, FDA, AABB, The Joint Commission (TJC), and CLIP). This includes the timely submission of error or accident reports as mandated by the FDA.
- c.* The following policies apply to the operation of the U.S. Army Blood Program.
- (1) Army blood donor centers and transfusion services will not correspond directly with the FDA. All correspondence involving interaction with the FDA must be directed through the Director, Army Blood Program, U.S. Army Medical Command (MCHO-CL-R), 2748 Worth Road, Fort Sam Houston, TX 78234-6010.
 - (2) Operation of the program will be decentralized to the maximum extent possible, consistent with proper management and control. RMC blood program officers will communicate directly with and receive operational direction or policy guidance from the Director, Army Blood Program according to requirements of the FDA, thus demonstrating central control of the Army FDA license. RMC blood program officers will be appointed in writing by each RMC.
 - (3) The U.S. Army Blood Program will cooperate and integrate with similar programs of other uniformed Services and/or Federal services while maintaining the best interests of the U.S. Army Blood Program.
 - (4) The U.S. Army Blood Program will cooperate and integrate with civilian blood programs at the regional or community level while maintaining the best interests of the U.S. Army Blood Program and ensuring consistency with DOD and DA policies.
 - (5) Blood resources that exceed the needs of a USAMEDCOM facility will be distributed in the following order of priority:
 - (a) DOD ASWBPL quotas in peace and war.
 - (b) Other USAMEDCOM facilities within the same RMC.
 - (c) Other RMCs.
 - (d) Other uniformed Services facilities.
 - (e) VA facilities.
 - (f) Civilian blood establishments for predetermined credits or fees.
- d.* Policy addressing donors includes the following.
- (1) Priority of blood collections on any Army installation or leased property will be in support of the Armed Services Blood Program. Commanders will only permit civilian blood establishments to conduct blood collections on Army installations or leased property when all of the ASBP's blood collection requirements have been met. Prior to civilian blood establishments collecting blood on Army installations or leased property, they must enter into a formal agreement (that is an MOA) outlining the responsibilities of the installation, civilian blood establishment, and shared responsibilities. This MOA must be signed by the installation or garrison commander; MTF commander; Director, Army Blood Program; and representative(s) of the civilian blood establishment.
 - (2) ARNG and Army Reserve facilities and units should support the Army Blood Program blood donor centers as much as possible. If civilian agencies conduct blood drives with any ARNG or Reserve units, they should first establish an MOA with the civilian agency which would address, among other things, donor notification and credits to the Army Blood Program. The Director, Army Blood Program must be included on the signatory page.
 - (3) Donor nourishments will be provided to assist in preventing minor donor reactions and for other medical reasons. Provision of these nourishments is an authorized Army expense from local funds. Nourishment in connection with blood collections accomplished by civilian organizations will be furnished by those organizations.
 - (4) All donations under the auspices of the unified or specified command blood programs will be voluntary in

compliance with current FDA and AABB requirements. When standards are not identical, the more stringent will be followed.

(5) The voluntary blood donor is a person who meets patients' blood and component needs by donating without receiving compensation from the collecting facility, sponsor, or other external sources. Each Soldier will be afforded the opportunity to donate voluntarily.

(6) Commanders will support and encourage Soldiers and civilian personnel to voluntarily donate. Although donors may not be forced or coerced to donate, reasonable incentives, inducements, and recognition may be offered to encourage donations. Pressure exerted by the chain of command to donate is not appropriate. A commander's policy of time off in order to donate blood will not be considered payment or inducement. It is permissible to use lesser value incentives that would not motivate a potential donor to conceal detrimental medical background made available to all potential donors. Recognition items for donation milestones (for example, gallon donor awards, special donor recognition letters, and so on) are not considered inducements.

(7) Donors give blood with a full expectation that their donation will be used for maintaining the life or improving the health of another human. In keeping this donor trust, extraordinary attention and effort must be used in avoiding waste (outdating) when at all possible. Managerial actions are a primary influence.

e. RMC blood managers have regional responsibility for providing inventory control and regional blood and blood product support as directed by the Army Blood Program Office.

f. Army collection centers will provide continuing training opportunities for technical services and skill development. They will also maintain blood collection equipment for mobilization and emergency requirements.

g. Each MTF that uses or expects to use blood for patient care will establish a sound business plan to support its blood and blood component needs. Each facility operating a blood collection facility will be FDA licensed. Contingency plans for mass casualty and mobilization must be in place.

h. When requirements exceed local supplies, other uniformed Services blood programs may be used. As a secondary alternative, activate exchange arrangements with local civilian blood establishments. When blood or blood products cannot be obtained from the above sources, they may be purchased from licensed blood centers. Costs may not exceed the current established local rate. Conversely, excess blood or blood product stocks will be made available in accordance with paragraph 5-3c(5).

i. Recovered Plasma Exchange Program agreements with commercial firms are authorized and encouraged. This maximizes use of a valuable resource.

j. A records system will be developed and maintained to account for the manufacturing, acquisition, utilization, and disposition of all blood products to include recovered plasma assets in the medical blood programs as well as identifying all transient, acute, or chronic problems related to blood collection, transfusion, or other dispositions. Records retention will be according to FDA and AABB requirements.

k. Transfusion medicine programs related to the therapeutic use of blood and blood products, and the establishment and operation of transfusion services is beyond the scope of this chapter and will not be addressed.

5-4. Organization

a. Army blood donor centers and transfusion services will remain under the command and control of the appropriate MTF commander.

b. The Director, Army Blood Program, by virtue of being the Alternate Responsible Person for the DA FDA blood establishment, the product licenses, and the registrations, must have access and reporting authority to local QA coordinators. Therefore, some QA activities and requirements will be directed by the Director, Army Blood Program and reporting requirements may be mandated.

c. The QA coordinator will report to the management of the blood donor center or laboratory, as appropriate. This individual is part of the management team and will not be directly involved with the work he or she reviews. In smaller facilities, it may prove impossible to have a separate individual from the testing work force fulfill this requirement. If the transfusion services supervisor, for instance, is designated as the transfusion services QA coordinator, that supervisor cannot review his or her own work. The reporting authority for the local QA coordinator is to local management which has the authority to make changes and enforce requirements.

5-5. Individual blood group and type

a. All AD Soldiers will have their blood group determined by both cell and serum grouping tests and their blood type determined by the use of Anti-Rho (D) serum.

b. The results of the grouping tests will be recorded using the international (Landsteiner) classifications of "A," "B," "O," and "AB." This blood typing will be noted on the standard form (SF) 600 (Medical Record—Chronological Record of Medical Care) overprint and filed in each Soldier's STR as a blood type for record. The results of the Rh typing test will be recorded as "POS" or "NEG." The individual blood group and type is used primarily for identification purposes, but can serve as a convenience in donor prescreening when only selected bloods are needed.

c. Blood group and type determination will be made for all individuals processed through reception stations, training divisions, or similar organizations before transfer to other organizations. Blood group and type determinations for

individuals not processed through such organizations ordinarily will be made at the initial Army installation or organization where the Soldier reports for duty provided appropriate facilities are available.

5–6. Disposition of blood products

a. Surplus blood products.

(1) Blood is donated to the military in anticipation that it will be used to fulfill a medical need. There is a moral obligation to ensure that the donated product is used. Blood is in short supply within the U.S. and resource sharing is essential in order to meet the blood needs of the military and civilian healthcare systems.

(2) Blood and blood products have a short shelf life that ranges from 4 hours to 10 years depending on how the product was collected, manufactured, processed, and stored. Frequently, Army blood donor centers and transfusion services have extra blood and blood products on hand or have an ABO/Rh mix available in surplus of current requirements. To optimize the use of a product in short supply, sharing, exchanging, selling, or buying blood products is an important factor in doing business. The following guidelines are provided for local use.

(a) After satisfying the requirements of paragraph 5–3c(5), blood may be declared excess and offered on the open market.

(b) Blood or blood products licensed by the FDA may be exchanged or moved across State lines according to Federal regulations. In the District of Columbia, all commerce within the District is considered Interstate. Intrastate movement of blood or blood products does not require the facility or product to be licensed.

(c) Any recovery of expenses will be credited to the appropriation supporting the maintenance and operation of the local facility according to Title 10, United States Code, Section 1095 (10 USC 1095).

b. Disposition of outdated blood products.

(1) General.

(a) Stored blood products have a short shelf life and on occasion disposal of outdated products is required. Outdated products may include recovered plasma, platelets, red blood cells, and many other products. These blood products frequently have value for the further manufacture into non-injectable products used for treatment of medical conditions, diseases, or laboratory reagents.

(b) Since these outdated products frequently have residual value, it is recommended that such products be sold, traded, or exchanged in such a manner that the residual value may be recovered by the local MTF. This is authorized under 10 USC 1095.

(2) *Records.* Records tracing each blood product from collection to disposition must be strictly maintained allowing any inspector or auditor to establish a complete audit trail. FDA also requires strict manufacturing records maintenance and retention.

(3) Labeling and shipment.

(a) Products so disposed of will be labeled “FOR USE IN MANUFACTURE OF NONINJECTABLE PRODUCTS ONLY” according to FDA labeling guidelines. A short supply agreement for the manufacture of injectable products is **NOT** authorized.

(b) The label will meet current regulatory and accrediting requirements and contain all information required by law.

(c) For the purpose of uniformity and clarity in labeling, all labels used for this product must be approved by the Director, Army Blood Program.

5–7. Exchange or sale of outdated blood plasma

U.S. Army medical center (MEDCEN)/MEDDAC commanders will ensure that purchasing officers establish an exchange or sale agreement with a commercial processor of blood products whereby outdated blood products may be exchanged, sold, or otherwise capture the product’s value. According to 10 USC 1095, any revenue generated by such an agreement may be retained at the local MTF.

Chapter 6 Dental Care

6–1. General

This chapter provides guidance for the delivery of oral health services within the Army Dental Care System (ADCS). AR 40–400 addresses dental care for AD personnel not assigned to an Army installation. The dental commander is responsible for delivery of effective and efficient dental care. Dental care provided will be consistent with accepted professional standards.

6-2. Authorization of care

All AD personnel are entitled to comprehensive dental care. Care to other-than-active-duty beneficiaries is authorized depending on space availability and according to statutory requirements.

6-3. Dental care priority

Dental commanders will determine how to employ available resources to improve oral health and dental readiness of supported personnel, taking into consideration the following factors:

a. Acuteness of the condition. Dental emergencies have the highest priority for care. The provision of all other dental care will be left to the professional judgment of the attending clinician consistent with the use of available resources as determined by the dental commander.

b. Impact on the Army's mission effectiveness. The major impact of oral disease on mission effectiveness occurs when military personnel develop acute oral conditions. The extent of this impact depends on the accessibility of dental care. Potential areas of concern are as follows:

(1) Army personnel being assigned or likely to be assigned to combat areas or deployed in support of operations other than war.

(2) Army personnel being assigned to isolated or remote areas.

c. Entitlement of care. The basis for degree of entitlement to care at a military dental treatment facility (DTF) is as stated in AR 40-400.

6-4. Dental examinations and screenings

a. Dental examinations. A dental examination must be performed by a dental officer or a privileged dentist (general schedule (GS) or contract). The examination will include: a review of DA Form 5570 (Health Questionnaire for Dental Treatment); a thorough intraoral and perioral soft and hard tissue clinical evaluation; the Periodontal Screening and Recording; and the use of any necessary diagnostic radiographs to allow the dentist to determine the absence or presence of any disease process as well as its severity. Radiographs (for example, bitewings) will be taken according to FDA guidelines and the clinical judgment of the examining dentist.

(1) Personnel entering initial AD will have a panoramic x ray taken during initial dental processing as indicated. There are no specific time-related guidelines for retaking panoramic x rays. Panoramic x rays will be taken when—

(a) There is a diagnostic requirement.

(b) There have been significant changes to the oral cavity and the existing x ray no longer reflects the current oral condition of the patient.

(2) A dental examination is required each year for AD Army personnel and selected Reserve personnel. Periodic dental examinations may be suspended for Soldiers serving in a deployed status outside continental United States (OCONUS). Deferred examinations will be performed within 90 days of the return from the OCONUS deployment. Requests for deferment of dental examinations will be forwarded to The Surgeon General of the Army, 7700 Arlington Boulevard, Falls Church, VA 22042-5142.

(3) Dental examinations for persons evaluated under various medical fitness standards will be conducted under the provisions of AR 40-501. Appropriate diagnostic aids will be used as required.

(4) The findings of dental examinations will be recorded consistent with the instructions contained in Technical Bulletin, Medical (TB MED) 250.

b. Dental screenings. A screening of the oral cavity is used to detect gross pathology and to identify patients requiring treatment of potentially emergent conditions. Screening examinations may be performed by a trained technician under the supervision of a dentist. Dental screenings will not be used, in lieu of dental examinations, to determine dental readiness classification.

6-5. Dental readiness classification

a. Recording. Recording dental classification in dental STRs is useful in patient scheduling and dental care management.

b. Dental readiness profile. The primary measure of unit dental readiness is the dental readiness profile, defined as the percent of the unit in each class. Using summaries of the percent in each class to profile supported units, dental commanders can describe the oral health status to unit commanders. The classification will be entered where indicated on SF 603 (Health Record—Dental) and SF 603A (Health Record—Dental—Continuation). See AR 40-66 for instructions on the use of these forms. The oral health status of personnel will be classified based upon the DOD Oral Health and Readiness Classification System (see Health Affairs Policy #02-011 or superseding policy).

(1) Class 1 are patients with a current dental examination, who do not require dental treatment or reevaluation. Class 1 patients are worldwide deployable.

(2) Class 2 are patients with a current dental examination, who require nonurgent dental treatment or reevaluation for oral conditions which are unlikely to result in dental emergencies within 12 months. Class 2 patients are worldwide deployable.

(3) Class 3 patients who require urgent or emergent dental treatment. Class 3 patients are normally not considered to be worldwide deployable.

(4) Class 4 are patients who require dental examinations. This includes patients who require annual or other required dental examinations and patients whose dental classifications are unknown.

6-6. Dental appointments

a. Whenever possible, DTFs will schedule appointments based upon the dental readiness status and the mission essential duties of the patient. The patient and/or unit commanders will be notified when scheduled appointments must be changed or canceled.

b. Unit commanders are responsible for the dental readiness of their personnel and for their personnel reporting for appointments promptly. The DTF will be notified as soon as possible when appointments must be canceled.

c. In coordination with responsible unit commanders, dental commanders will reduce broken and canceled appointments to minimum levels. Management techniques will be used to fill open appointments to the maximum extent possible.

d. Flexible appointment scheduling, determined by the type and extent of treatment planned, is essential for an efficient operation of a DTF.

e. Whenever possible, patients will be provided a written record of their scheduled appointments.

f. Dental commanders will collect and analyze data on broken and canceled appointments. Time lost because of unfilled appointments will be analyzed and corrective actions taken as necessary.

6-7. Audit system

Dental commanders will implement a functional audit system. This system will ensure that electronically generated dental workload reports are correct and the daily treatment entry on the SF 603/603A accurately represents the care provided. A standard-of-care evaluation of the treatment provided will be part of the audit system.

6-8. Preventive dentistry

a. The prevalence of oral disease and injury among Army beneficiaries is so great that cure and restoration of these conditions exceed the capability of the ADCS. The costs associated with providing direct care or dental insurance programs can be reduced by the avoidance of preventable diseases and injuries. To reduce the prevalence of oral disease and injury, the ADCS will conduct a preventive dentistry program with three components: the Oral Health Fitness Program, the Clinical Preventive Dentistry Program, and the Community Preventive Dentistry Program. AR 40-35 explains these programs.

b. The community director of dental services (DDS) will conduct preventive dentistry programs for the military population within his or her area of responsibility. The highest priority will be given to services that improve the dental readiness of Soldiers in support of military operations.

c. All dental treatment plans will include measures to promote oral health and prevent dental disease and injury.

d. General health promotion and disease prevention (for example, hypertension screening, tobacco intervention, and nutrition education) will be integrated into dental programs. The DDS will also seek ways to integrate oral health promotion and disease prevention into AMEDD and community programs (for example, nutrition, neonatal education, community health visits, school programs, physical examinations, and outpatient and troop medical clinic visits).

e. Installation water fluoride adjustment is important for the maintenance of adult dental health as well as child dental health. The DDS will establish procedures to assist in periodic fluoride surveillance and educate the community.

Chapter 7 Medical Libraries

7-1. Purpose

This chapter prescribes policies, responsibilities, standards, procedures, and provides guidance for the Army Medical Library Program, the AMEDD Medical Library and Information Network (AMEDD MEDLI-NET). It prescribes a command and control concept based on centralized administration and support and decentralized mission execution to maximize the network's effectiveness.

7-2. Applicability

This chapter applies to all libraries, library systems, information centers, and library programs within the AMEDD. Specifically included are the USAMEDCOM libraries, U.S. Army Medical Research and Materiel Command (USAMRMC) libraries, Stimson Library at the AMEDD Center and School (AMEDD C&S), and the U.S. Army Public Health Command (USAPHC) library. Specifically excluded are the Armed Forces Medical Library (see AR 10-64/

OPNAVINST 6700.2/AFR 160-29/MCO 5420.18A), patient libraries under monitorship of the USAMEDCOM, and other general library collections and services offering diverse self-developmental reading.

7-3. Objectives

The objectives of the Army Medical Library Program are to—

- a. Organize all AMEDD libraries into an integrated library and information network providing the level and degree of information services required by all elements of the AMEDD.
- b. Make the latest library and information science techniques and network technologies available to AMEDD libraries and information centers and their clientele through the AMEDD MEDLI-NET and other electronic gateways.
- c. Ensure the highest quality library and information services are provided to all echelons of the AMEDD.
- d. Promote and facilitate efficiencies through consortia, networks, and consolidations to optimize resource sharing and cooperative partnerships.

7-4. Responsibilities

a. The Assistant Chief of Staff for Health Policy and Services, USAMEDCOM, is the executive agent responsible for developing policies and procedures for the Army Medical Library Program.

b. USAMEDCOM, USAMRMC, AMEDD C&S, and USAPHC commanders at all levels will ensure compliance with this regulation.

c. The USAMEDCOM Library Program Director (ACOM, ASCC, or DRU librarian) will—

(1) Advise the Assistant Chief of Staff for Health Policy and Services, on all matters concerning the command's library program including facilities, design guides, space criteria, equipment, disaster planning, programs, staffing, and automation.

(2) Serve as Deputy Career Program Manager for medical librarians in the Army Civilian Librarian Career Program and represent the command on its panels, task forces, and meetings.

(3) Serve as principal spokesperson for the USAMEDCOM on medical library matters.

(4) Serve as the commander's representative to Federal, non-Federal, civilian, and Army library groups or committees. Functions as the AMEDD medical library representative and liaison with DA, DOD, other Federal agencies, academia, industry, professional associations, information management, or knowledge management committees, work groups, and task forces.

(5) Establish the vision, mission, and supporting goals and objectives for the Army Medical Library Program.

(6) Establish and implement policies, procedures, and standards that govern the mission accomplishment of the Army Medical Library Program consistent with applicable DOD and DA policies and professional standards.

(7) Ensure the USAMEDCOM Emergency Management Plan includes contingency planning and continuity of operations plans for the organization's medical library services.

(8) Serve as the USAMEDCOM library focal point on knowledge management and digitization.

(9) Assess the library program and individual library activities through consultation and onsite visits to CONUS and overseas USAMEDCOM medical library facilities with coordination of key Army personnel.

(10) Consolidate AMEDD libraries requirements for consortium group licensing of electronic access to a select group of knowledge-based biomedical information resources to support the AMEDD medical readiness mission.

(11) Serve as Web master administrator for the USAMEDCOM Library System's AMEDD Virtual Library, maintaining its currency and expanding coverage of Web-based, knowledge-based resources and databases.

(12) Advise, coordinate, and support professional development and training for the command's library personnel.

(13) Provide guidance on Army competitive sourcing and other business initiatives.

(14) Review, analyze, and consolidate the AMEDD libraries' management reports submitted to the Department of Army Library Program (see para 7-9).

d. The USAMRMC Command Librarian, AMEDD C&S Library Director, USAPHC Library Director, and RMC/MEDCEN library directors will—

(1) Advise the USAMEDCOM major subordinate command (MSC) and RMC commanders on all matters concerning MSC and regional libraries, knowledge management, and information services.

(2) Establish the vision, mission, and supporting goals and objectives for the MSC/RMC library program, consistent with the Army Medical Library Program.

(3) Establish and implement policies, procedures, and standards that govern mission accomplishment of the MSC libraries consistent with applicable DOD, DA, and USAMEDCOM policies and professional standards.

(4) Conduct staff visits and provide professional consultative support on library services and systems, coordinating with key Army personnel to review, evaluate, and analyze the MSC/RMC/MTF libraries.

(5) Provide support, as needed and feasible, to any USAMEDCOM consortium member library requiring assistance in the event of emergency and contingency operations, including loss of electronic access to knowledge-based information resources.

(6) Advise, coordinate, and support professional development and training for library personnel.

e. The librarian or technical information specialist will be responsible for all aspects of the library program to include at least the following:

(1) Develop programs and services in support of the AMEDD that are customer oriented, demand driven, and knowledge based.

(2) Plan, budget, and manage resources for facilities, personnel, information technology, library materials, equipment, supplies, and other resources needed to operate libraries in accordance with the mission and recognized standards.

(3) Provide program planning and direction and recruit, select, train, and supervise staff.

(4) Provide expert retrieval and evaluation of information in support of knowledge- and evidence-based clinical, research, and administrative decision making.

(5) With the approval by the commander or a designee, develop local policies and regulations governing the use of an AMEDD library consistent with the Army's Medical Library Program policies, procedures, and recognized standards.

(6) Initiate and implement efficiencies through consortia, networks, and consolidations to optimize resource sharing and cooperative partnerships.

(7) Apply rapidly changing information technologies and knowledge management principles in the acquisition, storage, management, and dissemination of knowledge-based information.

(8) Develop an effective marketing plan to promote the library collection, products, and services.

(9) Evaluate the performance and continuous improvement of AMEDD libraries through the use of formal and informal needs assessment surveys.

7-5. Directives

a. *Medical Library Association Standards for Hospital Libraries 2007 (or current edition)*. AMEDD libraries will use these standards to assess and meet the knowledge-based information resource and service needs to the organization and the library's physical space and staffing requirements.

b. *The Joint Commission standards*. AMEDD libraries will comply with TJC standards to ensure the library's services support clinical, service, and management decision making; educational and research needs; patient and Family information; performance improvement and patient safety; and a plan to provide access to information when electronic systems are unavailable.

c. *Department of Defense guidance on space allocations*. Space allocated for medical library facilities will conform to appropriate DOD guidance. The space will be planned to meet the separate and distinct functions of providing service space for users and workspace for the library staff. Medical libraries will be planned according to the Office of the Secretary of Defense (HA) DOD Space Planning Criteria for Health Facilities, with command or agency library staff guidance. Medical library facilities will not be used for office, work, storage space, or other functions not specifically related to library services, with the exception of conference rooms that may be used for nonlibrary meetings.

d. *Privacy Act*. A general privacy act notice for Library Borrowers' and Users' Profile Files is located at the DOD Privacy Act Systems of Records Notices Web site (<http://www.defenselink.mil/privacy/notices>) (see Administrative Order 215-1 DAPE). Library circulation records are for internal use only. Release of information on circulation records will occur only after a review of the request by the appropriate official. Records are destroyed when no longer needed to obtain and/or control library materials.

e. *Copyright*. AMEDD libraries will comply with and inform their clientele of the requirements of copyrights (17 USC). The Army point of contact on copyright law issues is the Intellectual Property Division, U.S. Army Legal Services Agency.

f. *Mailing of library material*. AMEDD libraries may use registered, insured, and express mail services to meet mission requirements according to AR 25-51.

g. *Class determination and findings authorizing Army Libraries to use the Federal Library and Information Network (FEDLINK)*. This Determination and Findings, executed by the Army Senior Procurement Executive, authorizes the Library of Congress FEDLINK Program, under the authority of the Economy Act, to procure commercial information; publications in any format; library support; related accounting, education, and information; and support services on behalf of participating Federal libraries.

h. *Multiyear subscriptions for publications*. Subscriptions for periodicals, newspapers, and other publications for which it is known in advance that a continuing requirement exists and funding is available, may be for multiple years rather than for a single year to take advantage of lower multiyear subscription rates. Under 31 USC 3324(d)(2), advance payment is authorized for "charges for a publication printed or recorded in any way for the auditory or visual use of the agency."

i. *Network security*. AMEDD libraries will comply with AR 25-2 information assurance requirements.

j. *Networks*. AMEDD libraries will participate in both Federal and non-Federal library networks, including the

FEDLINK (see 2 USC 182(c)). Memberships may be determined by geographical region, library consortia, or functional area.

7-6. Policy

a. Staffed medical libraries (see para 7-7*a*) will be established at all MEDCENs and MEDDACs and may be established at other healthcare facilities to include Army health centers and clinics, subject to the approval of the Commander, U.S. Army Medical Command (MCHO-CL), 2748 Worth Road, Fort Sam Houston, TX 78234-6010.

b. Libraries established at the AMEDD C&S, USAPHC, and USAMRMC are subject to approval by the responsible major subordinate commander.

c. Medical libraries will comply with TJC standards for knowledge-based information ensuring the MTF has the resources and services required to effectively meet their knowledge-based information needs.

d. MEDCEN and MEDDAC medical libraries will use Medical Library Association (MLA) hospital library standards to develop and evaluate services and/or policies.

e. At graduate medical education program sites, the level of services and onsite accessibility to the library will comply with the accrediting requirements of the Accreditation Council for Graduate Medical Education and the residency review committees for the various specialties.

f. A medical library committee representing a cross section of the professional staff will be established to serve in an advisory capacity to the medical librarian.

g. All AMEDD libraries will participate in the AMEDD MEDLI-NET consortium.

h. AMEDD libraries will share their collective resources through the following services: interlibrary loan and document delivery; bibliographic access to journals, monographs, technical reports, and audiovisual information via the designated AMEDD MEDLI-NET integrated online library system; duplicate and excess journals exchange; and cooperative technical processing.

i. AMEDD libraries will use commercial search services and networks to ensure AMEDD staffs have access to the required multimedia bibliographic and online services. Consortium group licensing will be used for electronic access to a select group of knowledge-based biomedical information resources.

j. Libraries will provide reference and bibliographic services to all authorized users and to personnel who are on temporary duty (TDY) to the facility.

k. The library staff will conduct a continuous program of orientation and instruction for the AMEDD staff in the use of the library and managing knowledge-based information.

l. The library's circulation system records will ensure the proper lending, safeguarding, and return of library materials. There will be an organized plan for the systematic follow-up and return of overdue library materials.

m. Indefinite loan collections will be kept to a minimum and will include only items used daily.

n. Library personnel will ensure that interlibrary loan (ILL) policies—

(1) Conform to the ILL codes of the National Library of Medicine (NLM), the American Library Association, and the guidelines of the Commission on New Technological Uses of Copyrighted Works.

(2) Comply with the AMEDD MEDLI-NET's designated automated interlibrary loan and referral system, NLM's DOCLINE®.

(3) Comply with the NLM's Serial Holdings annual update requirement.

(4) Promote using the most expeditious, cost-effective interlibrary loan and commercial document delivery services for obtaining the loan, or photocopy of materials required by staff in connection with their official duties. Libraries may enter into agreements with local, regional, national, or international ILL networks. Libraries reserve the right to terminate ILL agreements with any Government or non-Government institution for misuse or violation of established ILL practices or policy, such as reciprocity agreements.

(5) Address payment for ILLs and document delivery by establishing accounts with the Federal Library and Information Network and non-Federal institutions.

(6) Comply with the provisions of 17 USC 107 et seq. On-demand systematic copy services staffed by Government employees are not authorized; such a service is in violation of the copyright law. Libraries may make photocopies for interlibrary loan within the guidelines of the law. Libraries will transfer electronic documents according to licensing agreements established between libraries and the database vendors. Paper copies obtained from electronic sources will also be subject to licensing agreements.

(7) Authorize the use of appropriate telecommunications, capabilities, technologies, and services (for example, telephone, facsimile, e-mail, digital scanner, electronic document delivery, tagged image file format, portable document format, Ariel® document delivery software, and so forth) to participate fully in ILL systems and essential library networks.

(8) Authorize the use of registered, insured, and express mail services when necessary to meet mission requirements.

o. When feasible, technical services functions of acquisitions, cataloging, and shelf-ready processing may be consolidated for AMEDD libraries collocated on the same installation.

p. The NLM Classification Scheme and NLM Subject Headings will be used for cataloging and classifying books.

Library of Congress (LC) classification and subject headings will be used for nonmedical titles. Cataloging digital resources and collections will use accepted taxonomies and metadata standards.

q. Libraries without online access to the Online Computer Library Center will order cards from commercial sources that use the standard machine-readable cataloging format and provide cataloging from the NLM and the LC. Original cataloging will not be done locally unless Online Computer Library Center access is available on site.

r. Membership in the MLA is recommended for all AMEDD libraries.

s. Each medical librarian will obtain copies of the U.S. edition of the North Atlantic Treaty Organization (NATO) Handbook of Emergency War Surgery (CMH Pub 83-3) (see app A) in sufficient quantity to allow issuance by commanders to each medical, dental, and veterinary corps officer upon entry into AD. These handbooks become the personal property of the officer and are not accountable.

t. The medical library committee may advise on the selection of those materials that will be housed in the library or exist on the library inventory. The librarian or technical information specialist will serve as reviewer for the acquisition of library materials in various formats for the organization. The librarian or information specialist is not authorized to make credit card purchases of materials not housed in the library or existing on the library inventory.

u. The AMEDD libraries and information centers will be staffed during the facility's regular duty hours. After hours, key-card access is authorized in compliance with appropriate TJC standards and standards of other accrediting agencies.

v. According to MLA standards, physical facilities will be readily accessible to the staff and will be large enough to house the collection and have space for services provided without encroaching on reading and study areas. Reading and study areas will be reserved for library users (see para 7-5a).

w. The AMEDD libraries will have the appropriate equipment to most cost effectively accomplish the facility's mission. Photocopiers and digital scanners will be maintained for all AMEDD libraries to ensure maximum use of the collection and minimize losses of collection materials.

7-7. Personnel

a. The AMEDD libraries will be staffed by individuals in the following series according to the provisions of Job Qualification System for Trades and Labor Occupations (formerly Handbook X-118) and the Qualification Standards for General Schedule Positions Operating Manual:

(1) GS-1410, Professional Librarian. Libraries without an individual in the GS-1410 series will request periodic consultations from the command medical librarian or their regional MEDCEN.

(2) GS-1411, Library Technician.

(3) GS-1412, Technical Information Specialist.

b. Appointments or placements for GS-1410 vacancies in which another librarian is not in the supervisory chain at the activity require prior approval of the recommended applicant's qualifications by the USAMEDCOM Library Program Director/Civilian Career Program-34 Manager Librarian track.

c. The AMEDD libraries staffed by a professional librarian in the GS-1410 series will place the librarian on orders as the accountable property officer (APO) for the library according to AR 735-17. If a library technician (GS 1411), technical information specialist (GS 1412), or Government contractor is in charge of the library, a DOD commissioned officer will be put on orders as the APO. A copy of the library's property account appointment orders will be sent to the Commander, U.S. Army Medical Command (MCHO-CL), 2748 Worth Road, Fort Sam Houston, TX 78234-6010. Requests for an exception will be forwarded through the USAMEDCOM Library Program Office (MCHO-CL) to the U.S. Army Community and Family Support Center (CFSC-CR-L), Alexandria, VA 22302-4418.

d. The APO may not also serve as the Government credit card holder.

e. Clinical and research libraries will, whenever feasible, be directed by a qualified medical librarian holding a graduate degree in library and information science from an American Library Association accredited library school. A medical librarian supervises or performs work that requires a full professional knowledge of the theories, objectives, principles, and techniques of librarianship for the selection, organization, preservation, access, and dissemination of knowledge-based information. Reliance on commercial electronic resources to meet the clinical and research information needs of the organization cannot substitute for a qualified medical librarian.

f. All library activities will have adequate clerical support for the performance of routine medical library functions.

g. Mission essential training and continuing education courses are required for AMEDD library staffs to develop skills and specializations required by the continually evolving disciplines of library and information science. MLA certification is desirable and recommended. The MLA credentialing program, the Academy of Health Information Professionals, demonstrates initiative in completing an approved educational program for professional development.

h. The AMEDD library staffs are encouraged to join and participate in local consortia and additional professional library organizations.

i. At clinical libraries adequately staffed by individuals in the GS-1410 or GS-1412 series, specialized services (such as a Clinical Medical Librarianship Program or Literature Attached to Charts Program) may be established, as required.

j. Librarians will coordinate the use of volunteer services with the local judge advocate, the activity volunteer program coordinator, and the servicing personnel office.

7–8. Collection development

a. Collections will support the patient care, healthcare administration, education, training, readiness, and research needs of the organization.

b. Regional cooperative collection development policies for AMEDD libraries will be developed to eliminate unnecessary duplication.

c. Development of the AMEDD library collection will be based on the collection development guidelines determined by the library staff. Collections will include print and electronic access to material in the following categories as determined by the librarian or technical information specialist and recommended by the medical library committee, as appropriate:

- (1) Journal subscriptions.
- (2) Monographs and textbooks.
- (3) Reference materials.
- (4) Reprints of staff and other source publications.
- (5) Patient education and consumer health.

d. Reliance on commercial electronic resources to meet all of the organization's clinical and research information needs cannot substitute for a locally held physical library collection. TJC requires hospitals to have a backup to electronic resources when systems are unavailable.

e. The AMEDD libraries will, where feasible, retain first copies of all texts in the library's collection and will not sign them out on indefinite loan. Second and successive copies may be purchased for indefinite loan libraries pending the review by the librarian and the availability of funds.

f. The AMEDD libraries will establish a local policy for providing access to consumer health and patient library resources to support the needs of patients and their families.

g. A local policy for binding and/or acquiring backfiles of journals in microform will be formulated in clinical libraries; priority will be given to those journals indexed in standard indexing services such as NLM's List of Journals Indexed in *Index Medicus*, *Psychological Abstracts*, and so forth.

h. If local policy dictates, audiovisual and visual information units will be cataloged and incorporated into the library's collection.

i. The AMEDD libraries will develop a local policy for withdrawing outdated or unused materials from the library collection. This policy will identify any mission-related requirements impacting the retention of these materials.

j. In keeping with mission requirements, AMEDD libraries will use preservation and conservation measures, including digital archiving, either in house or by contract services. The librarian or technical information specialist will coordinate with the chief information officer to develop procedures and acquire storage media for digital resources.

k. Increased demand for access to electronic information in the collection requires the availability of hardware and software to support customer needs. Services and technologies will conform to the appropriate industry technical standards and specifications to ensure interoperability. As a minimum standard, AMEDD libraries will have the technology to use CD-ROMs and DVDs, and to access automated services such as online bibliographic and cataloging services, the AMEDD MEDLI-NET, the Internet, and other electronic information sources.

7–9. Management reporting

Each AMEDD library will complete and submit the DA Library Program's Web-based statistical report by 31 December. This collection and resource usage statistical reporting tool, the Measurement, Tracking, and Information Collection System, is available at the Digital Army Library Service, <https://www.libraries.army.mil>.

7–10. Accountability

a. *Library property accounts.* Policies addressing accountability, inventory, establishing, or terminating an account will be according to AR 735–17.

b. *DOD activity address code.* AMEDD libraries will be issued a DOD activity address code to identify the library's property account (see AR 725–50).

c. *Establishing or terminating an AMEDD library property account.* The activity commander will submit a request for assignment or termination of a medical library's property account through command channels to the USAMEDCOM Assistant Chief of Staff for Health Policy and Services, who is the Executive Agent of the Army Medical Library Program.

(1) Each request for establishing an AMEDD library property account will include a description of the proposed content of the library, how the library will be supported, and the projected number by media types (for example, books, journals, and so forth) of accountable materials. It will also include justification for establishing a new medical library property account and indicate whether a professional librarian, GS–1410 series, will supervise the account.

(2) Each request to terminate an AMEDD library property account will contain a description of the collection to

include the collection size, physical condition, subjects, and the media types. The request will also state the reason for closing the library and how the organization will continue to receive library support for its mission. Examples of how library support may be continued include initiating—

- (a) A memorandum of understanding with another AMEDD library;
- (b) An operation order issued by the regional medical command directing an AMEDD library to provide support; or
- (c) A contract with another MTF library providing professionally directed reference and research, interlibrary loan, document delivery, access to the providing library's online catalog, and commercial information services.

7-11. Procurement

The AMEDD libraries and information centers will use the most cost-effective and responsive means of acquiring materials in support of the facility's mission. AMEDD MEDLI-NET member libraries are encouraged to use the Library of Congress FEDLINK program for procuring library publications and library support services. Benefits include availability of Federal and/or consortium discounts, contracts written and competed by FEDLINK, and litigation or corrective action for vendor failure to perform provided by FEDLINK at no added cost to the library.

Chapter 8 Nutrition Care Management

8-1. Purpose and scope

This chapter prescribes regulatory policies for the operation of nutrition care divisions (NCDs) in fixed MTFs. For operational policies and procedures for food service in nonfixed MTFs, refer to AR 30-22, DA Pam 30-22, and Field Manual (FM) 4-02.56.

8-2. Mission

The mission of the NCD is to provide—

- a. Comprehensive nutritional care and assessment.
- b. Safe, wholesome foods including modified diets, as required, to patients and personnel authorized to subsist in the MTF.
- c. Medical nutrition therapy, intervention, and monitoring.
- d. Nutrition education, disease prevention, performance optimization, and health promotion in support of patient care mission.
- e. Nutrition education for the military community.
- f. Nutrition education and awareness programs in support of the Army Weight Control Program and health and total fitness initiatives.
- g. Nutrition care in support of detainee, humanitarian, and stability operations.
- h. Supervised practice requirements for the nationally accredited Military Dietetic Internship Program.
- i. Graduate level education in nutrition.
- j. Consultation and support to commanders on the nutritional aspect of Army policy and programs including the Army Weight Control Program, field training exercises, joint training exercises, garrison dining facilities, installation child care facilities, and nutrition-related force health protection issues such as performance nutrition and Soldier use of dietary supplements.
- k. Applied research.

8-3. Organization and functions

The organization and functions of the NCD will be as prescribed by the medical command with jurisdiction over the MTF.

8-4. Responsibilities

- a. MTF commanders will—
 - (1) Ensure the provision of nutritionally adequate meals within the value of the basic daily food allowance (BDFA) for patients and dining facility patrons according to the multi-Service publication AR 40-25/BUMEDINST 10110.6/AFI 44-141.
 - (2) Ensure that the hospital meal charge policy is implemented according to DOD 7000.14-R, volume 12, chapter 19, and DA guidance. However, when changing meal charge policies, servicing civilian personnel offices will be consulted regarding any bargaining obligations to recognized unions under appropriate labor relation statutes. NCD may establish subsistence-in-kind (SIK) meal guidelines based on the monthly BDFA.
 - (3) Ensure implementation of policies and procedures to review the ongoing competence of all nutrition care personnel to include use of clinical privileges according to AR 40-68 as appropriate.

- (4) Ensure proper use of dietitians and nutrition care specialists according to AR 40–1 and DA Pam 611–21.
- (5) Ensure that adequate internal controls exist according to AR 11–2 for procurement of safe and wholesome subsistence and prevention of waste, fraud, and abuse of subsistence and supplies.

b. The chief, NCD, will—

- (1) Be responsible to the commander for operating all NCD activities.
- (2) Provide the vision, leadership, motivation, and guidance in accomplishing the NCD mission.
- (3) Initiate internal controls for the efficient and effective use of personnel, equipment, subsistence, supplies, and funds.
- (4) Maintain standards established by TB MED 530, TJC, and local hospital regulations.
- (5) Integrate a locally approved performance improvement plan into the MTF’s organizational performance improvement structure according to AR 40–68 and the TJC.
- (6) Ensure dietitians (65C) and nutrition care specialists (68M) Professional Filler System positions are filled and trained.
- (7) Maintain a viable annex to the MTF’s emergency management plan according to USAMEDCOM guidance. The annex will address food safety and food security, and establish alternate feeding plans and procedures for patients, staff, and dining facility patrons for mass casualty events.

(8) Support established training programs and research including the Graduate Program in Nutrition and the Military Dietetic Internship Program where applicable.

c. The noncommissioned officer-in-charge will—

- (1) Assist and serve as an adviser to the chief on all matters related to NCD management.
- (2) Oversee daily operations and ensure compliance with established policies and procedures.
- (3) Establish and conduct an NCD physical training program.
- (4) Enforce standing operating procedures for cashiers and cash accountability to the medical services accountable officer (MSAO) according to USAMEDCOM guidance.
- (5) Serve as hand receipt holder for NCD facilities and equipment and ensure both are properly maintained and safeguarded.
- (6) Serve as subject matter expert (SME) for automated management systems or manual management systems and point of sale (POS) cash register systems, ensure operability of such systems, and coordinate related training.
- (7) Provide overall supervision and training of all enlisted personnel, including all required 68M skill sets and a medical proficiency training program with the local table of organization and equipment (TOE) unit and training with RC personnel.

8–5. Persons authorized to eat in the military treatment facility’s nutrition care division

a. The primary purpose of NCD food service operations is to feed inpatients, enlisted personnel entitled SIK rations, and MTF staff. The MTF commander may authorize other personnel to eat in the dining facility on a regular or occasional basis according to NCD capabilities and manpower resources.

b. Meal rates charged to authorized personnel using the MTF dining facility are based on guidance contained in DOD 7000.14–R, volume 12, chapter 19 and DA guidance.

c. The MTF must establish a method of identifying categories of authorized personnel that is consistent with MSAO requirements and document NCD use by category.

8–6. Cash collections

a. Nutrition care cash collection and control procedures established by the USAMEDCOM (MCHO–CL–R) will govern the entire NCD cash control process including proper accountability of dining facility cash collection and change funds. These procedures establish internal controls to ensure proper handling of Government funds.

b. When used to collect cash reimbursements for meals, POS systems will—

- (1) Provide a paper receipt to each patron that indicates the diner category and the total value of the transaction.
- (2) Maintain—electronically or on paper tape—a retrievable detailed record of all entries into the cash register.
- (3) Provide access to the cash drawer when power is not available.

c. Manual cash collections of meal reimbursements will use DD Form 1544 (Cash Meal Payment Book) and DA Form 3032 (Signature Headcount Sheet) for SIK personnel.

d. An electronically generated form will be used to show accountability and collections for each meal period.

e. Change fund policies and procedures are established locally to support cash collection functions and are maintained by the NCD staff.

8–7. Personnel management

a. An established training and orientation program is required for optimal work performance and staff competence. At a minimum, training will include the topics identified by the TJC, DOD, and the chief, NCD based on established requirements and the needs of NCD staff. Registered dietitians and registered dietetic technicians will earn sufficient

continuing education credits to maintain registration, credentials, and state licensure according to AR 351–3 and AR 40–68.

b. The NCD Training Program and medical proficiency training program for nutrition care specialists (68M) will emphasize career development and MOS proficiency. Training programs to support RC units will emphasize clinical training for deployment as well as support the NCD mission. Both unit and individual needs will be addressed as appropriate. Overall training also must address common Soldier tasks for tables of distribution and allowances (TDA) and TOE MTFs.

8–8. Standard hospital diets

The most current Academy of Nutrition and Dietetics (AND) manual is the only authorized diet manual for use in Army MTFs.

8–9. Clinical dietetics management

a. The patient’s medical nutritional therapy will be planned and will include collaborative nutritional screening, assessment, nutritional diagnosis, intervention, and monitoring to enhance recovery, promote optimum nutritional status, decrease health risks, and enhance the effectiveness of drug therapy. Dietitians, dietetic technicians, diet aides, and nutrition care specialists (68M) perform the professional tasks and supportive duties required to ensure prescribed diets are served.

b. Standard diet orders are found in the most current AND manual. The physician or other individual with appropriate clinical privileges will order the diet before any food or other nutrient is administered to the patient. Diet orders will be transmitted to the clinical dietetics branch using appropriate patient information systems or with other approved technologies or procedures.

c. All patients treated at the MTF will be screened for nutritional risk that will define priority of care. The online AND Evidence Analysis Library will be used to supplement nutrition care plans and evidence-based nutrition-practice guidelines. The screening criteria will be locally developed and implemented. For patients at nutritional risk, a treatment plan will be determined and routinely updated. Patients not at nutritional risk will be rescreened at intervals determined locally based on patient acuity levels and average length of stay.

d. The mechanism for identifying patients who need dietary intervention will be locally developed and implemented. Patients will receive instruction on nutrition, on modified diets, and on potential drug-nutrient interactions. When a patient is discharged to another healthcare organization, a description or copy of the diet information will be forwarded to the receiving facility according to PL 104–191 (Health Insurance Portability and Accountability Act (HIPAA)) standards.

e. Nutrition care will be documented in the patient’s medical record. This includes pertinent nutrition-assessment-related information such as dietary history, biochemical data, anthropometric measurements, nutrition-focused physical findings and pertinent patient history; a nutrition diagnostic statement following the AND’s standardized language recommendations; the intervention strategies to resolve or improve the nutrition issue identified through the nutrition assessment; and the measures for nutrition monitoring and how they will be evaluated. Inpatient medical care documentation is recorded in the electronic health record or using SF 509 (Medical Record-Progress Note), and outpatient nutrition care is documented in the electronic health record or on the SF 600 (Medical Record-Chronological Record of Medical Care).

f. SF 513 (Medical Record—Consultation Sheet) is used to document response to consultations. Dietetic consultations will be reported to the requesting practitioner by entry on SF 513 or on an automated equivalent. A dietetic consultation is not required for nutrition assessment and general nutrition education.

g. Registered dietitians with advanced training and certifications in clinical nutrition and nutrition assessment will be members of the nutrition support or other specialized medical teams.

h. Procedures for service of food to patients will be determined by organizational policy and will be coordinated with the chief, clinical dietetics branch and with the nursing service. Tray service will be limited to inpatient feeding. Duty personnel are prohibited from eating food intended for patients. Exception to policy may apply to tray service for security personnel while guarding a patient or Family members in an extreme situation when appropriate payment or signature is obtained.

(1) Each tray served will be identified with the patient’s name, ward, room and bed number, date meal served, and diet prescription.

(2) Isolation procedures will be established within each MTF and will be reviewed and approved in writing by the local MTF infection control committee.

(3) DA Form 1829 (Hospital Food Service Ward—Diet Roster) or equivalent automated documentation will be maintained by the clinical dietetics branch to ensure accurate transmission of diet order and tray delivery information.

(4) The NCD will deliver nourishments and supplemental fluids to the wards at locally established times. Nursing personnel are responsible for nourishment receipt, storage, and distribution.

i. Nutrition education will be provided in support of health promotion and wellness programs, the Army Weight

Control Program (AR 600–9), child development services, the Army Substance Abuse Program, and the military community to the extent that resources permit.

j. The chief, clinical dietetics branch, is responsible for recommending medical nutritional products for inclusion in the MTF formulary. A local policy with written approval by the pharmacy and therapeutics (P&T) committee will direct the procedures involved with dispensing medical nutritional products to patients.

k. Clinical dietitians will participate in locally established peer review committees that use the patient's medical record as the basis for determining the quality and appropriateness of nutritional care.

8–10. The military treatment facility menu

The MTF menu will be planned to provide nutritionally adequate meals within established monetary limitations. All menus for regular and modified diets will be preplanned, approved, and signed by a registered dietitian. The chief, NCD will incorporate the provisions of AR 40–25/BUMEDINST 10110.6/AFI 44–141 into the MTF menu.

8–11. Subsistence and supply management

Efficient operation of the NCD is largely dependent upon adequate control over purchase, inspection, receipt, storage, and issue of food items and supplies. Losses and discrepancies will be immediately investigated and the chief, NCD will initiate appropriate follow-up action. Subsistence procured with appropriated funds will not be used to support meetings, conferences, staff calls, boards, visits of dignitaries, or social functions unless appropriate reimbursement is provided. Procedures for support of social functions are outlined in AR 215–1.

a. Food requisitions. All subsistence items for a fixed MTF, including special patient feeding items, will be supplied by the VA, Defense Supply Center Philadelphia (DSCP), or other contracted prime vendor (according to DSCP and regional contracting office policies), troop issue subsistence activity (TISA) (according to AR 30–22), and/or the installation commissary (according to Defense Commissary Agency Directive (DECA) 70–6).

b. Receipt of food.

(1) The prime vendor contractor, TISA, and commissary store will issue subsistence only to persons with proper identification and authorized by the chief, NCD. The receipt copy of the food requisition or vendor invoice serves as the basis for food receipt entries into the nutrition automated food service management accounting system.

(2) All food items not required for immediate use will be stored in a temperature controlled, secure food supply storeroom. Secure refrigerated storerooms will be used. All nonfood supplies will be stored in secure nonfood storage areas and designated as nonfood storage.

c. Physical inventory. All subsistence items on hand will be physically counted on the last working day of each month. The chief, NCD will appoint personnel to assist in the physical inventory. Two teams will be used. The reconciliation of counts between the teams will not take place until the entire inventory is completed. The MTF commander or designee will appoint a disinterested officer or noncommissioned officer (staff sergeant and above) to at least one inventory team to verify procedures semiannually. Inventory value is determined by multiplying the number of issue units on hand by the most recent price of the item received (current costing).

(1) *Inventory control.* Optimally, NCDs will maintain a just-in-time inventory with no more than 96 hours' worth of subsistence on hand. The NCD Emergency Preparedness Plan will be considered when determining the correct value of food inventory items maintained. As a guideline, the value of the food inventory will normally not exceed 10 percent of the previous fiscal year (FY) authorized monetary value allowed for subsistence. Differences greater than one half of one percent or 0.005 of the total value for all items under perpetual inventory will be investigated, explained, and corrected.

(2) *Perpetual inventory.* The automated food service management inventory system will provide a perpetual inventory on all subsistence items. A 10 percent sample of total inventory line items will be selected monthly for review.

d. Operational rations. Operational rations required to support medical field training will not be charged against the MTF subsistence account. The Defense Finance and Accounting Service Indianapolis Center Manual 37–100 - FY permits the MTF budget officer to charge field rations for both officer and enlisted personnel against the Military Personnel Appropriation Project 1321–0. DD Form 1544 and DA Form 3032 will not be used for field training exercises. Ration accountability will be according to DA Pam 30–22 for all field training that incorporates overnight field billeting. The accounts of the field feeding operation will not be combined with that of the fixed facility. Accountability is the responsibility of the commander conducting the exercise.

e. Issuing subsistence. Written procedures for processing and issuing subsistence will be developed and enforced. Procedures will ensure that all food issued is recorded on inventory/withdrawal and requisition lists, in an automated food service management system, or manually prepared on individually serial numbered DA Form 2930 (Hospital Food Service—Kitchen Requisition). Facilities will adhere to the guidelines provided in TC 8–502.

8–12. Food management

a. Control measures will be established to ensure all production planning reports and therapeutic worksheets are completed, and food products are prepared according to standardized recipes. The NCD will comply with TB MED 530 and applicable TJC standards.

b. Prepackaged meals may be offered to those personnel authorized to subsist in the NCD. The standard meal rate is applicable for prepackaged meals, carry-out meals, and meals consumed in the dining facility. A night meal may be served to support night-duty personnel and patients admitted after the scheduled dinner meal if economically feasible and if permitted by manpower resources.

8-13. A la carte meal service

a. MTFs are authorized to provide a la carte meal service in lieu of the traditional meal service. The traditional meal pricing system charges a fixed price for a complete meal, while the a la carte meal pricing system charges for individual menu items. A la carte meal service will be used only when the following are present:

- (1) An automated food service management recipe costing system is used.
- (2) The physical layout controls access to the serving line and places the cash register at the end of the food serving area.
- (3) POS cash register appropriate for the a la carte meal pricing system is used.

b. Workload calculations and authorized monetary value for a la carte subsistence operations are as follows:

- (1) Patient and SIK meal days are computed by multiplying meals by the appropriate conversion factor in table 8-1.
- (2) Each dining facility patron counts as a “meal” regardless of the amount of food consumed. Meals are converted to meal days by multiplying by the appropriate conversion factor in table 8-1.

**Table 8-1
Meal conversion factors (weights)**

Meal	Factor
breakfast	0.2
lunch	0.4
dinner	0.4
brunch	0.45
supper	0.55 ¹
night meal	0.20 or 0.40 ^{2, 3}
holiday	0.65 ⁴

Notes:

¹ If a brunch meal is served, a supper meal must also be served.

² Depends on whether breakfast or dinner menu is served.

³ Patients receiving three meals, plus a night meal, per doctor’s order, may have weighted totals exceeding the factor of 1.

⁴ The sum of 0.40 lunch plus 0.25 percent of BDFA.

(3) To determine the authorized monetary value allowed for subsistence (earnings), SIK meal days are multiplied by the MTF BDFA, and patient meal days are multiplied by the patient BDFA (MTF BDFA times 15 percent or 1.15). To determine earnings from cash patrons, the operating costs are subtracted from the total cash collected.

c. Commanders may authorize use of fixed meal prices for special occasions such as Thanksgiving or Christmas meals. The price charged may be either the DOD established holiday rate or a rate established by a weighted average of individual meal component prices. Additional funds are not authorized if the DOD rate is used and it is less than the cost of the food.

8-14. Ration accounting

a. The BDFA is computed by the Army Center of Excellence, Subsistence and found on its BDFA Web page. It will be obtained and updated monthly by the NCD cost accountant prior to the beginning of each accounting period. The NCD cost accountant will maintain accurate records of meals served and meal days (rations) served to provide cost and earnings data for management and reporting purposes.

b. The daily facility summary (generated by the automated food service management accounting system) will be completed for each dining facility.

c. The monthly monetary record (generated by the automated food service management accounting system) is used to manage and control food costs for an a la carte operation. Weighted meal days and earned income, by category and total, are reported along with subsistence purchases and issue information. When closing inventory is entered, account status and other management ratios are displayed.

d. For the traditional Thanksgiving, Christmas, and Army birthday special meals, an increased holiday allowance of 25 percent is authorized for these meals only.

8-15. Food cost management

a. The chief, NCD is responsible for maintaining proper security measures and adequate control over supplies. The chief, NCD is responsible for maintaining the total value of subsistence between plus 3 percent overspent and minus 10 percent underspent of the total authorized monetary value allowed for subsistence during the FY. The primary goal of the NCD is to conclude the FY at zero or underspent in the year-to-date status.

b. When the authorized monetary value allowed for subsistence is insufficient to provide adequate subsistence, commanders may request authority through their RMC to Commander, U.S. Army Medical Command (MCRM), 2748 Worth Road, Fort Sam Houston, TX, 78234-6010, to use a higher MTF subsistence allowance rate. Normally, requests will be submitted only when less than 100 meal days per day are being served. Requests will include the following:

(1) Average number of meal days served per day for each of the 3 preceding calendar months and the authorized MTF BDFFA for each of the 3 months.

(2) Forecast of the average number of meal days to be served per day for the current month and each of the succeeding 3 months and the MTF BDFFA for the current month.

(3) Statement of the conditions necessitating an increased allowance.

(4) Recommendation as to the amount of increased allowance needed, expressed as a percentage (for example, a 10 percent increase) over the MTF BDFFA.

(5) Ability of the MTF to finance the increased allowance.

(6) A statement indicating that costs will not be increased as a result of providing items or services to nonpatient personnel when such items or services are not provided in installation troop feeding facilities. (The intent is that nonpatient personnel subsisting in the NCD are provided subsistence at a comparable level with troop feeding facilities.)

8-16. The nutrition care division activities report

The NCD activities report and significant activity report will be submitted to the appropriate regional NCD chief by the 10th calendar day following the end of the reporting month. These reports are published and are available from the USAMEDCOM (see MCHO-CL-R address, below). Regional personnel will consolidate the report and send by email to the USAMEDCOM Chief Dietitian with copy furnished to the 68M Senior Enlisted Advisor. Hard copies can be mailed to Commander, U.S. Army Medical Command (MCHO-CL-R), 2748 Worth Road, Fort Sam Houston, TX 78234-6010, by the 20th calendar day following the end of the reporting month.

8-17. Nutrition care division contracts

Where food service and/or labor contracts exist, the NCD contract officers' representative, contract officers' technical representative, and/or the designated government representative are responsible for ensuring contract requirements are met. They will be familiar with all aspects of the contract, act as liaison between the contracting officer and the contractor, evaluate contract performance, and report findings to the contracting officer. Contractor personnel will not be included in the personnel strength totals on the NCD activities report.

8-18. Termination of military treatment facility nutrition care operations

a. During the inactivation period of an MTF, the reduction of food inventory and food procurement will be commensurate with diminishing feeding requirements. Surplus items will be returned to the commissary, prime vendor, or appropriate contracted vendor for reimbursement to Army medical activities funds. To the extent practicable, economical use of subsistence supplies on hand will take precedence over additional food procurement.

b. When NCD operations terminate, subsistence items (including special patient feeding items), expendable supplies, and equipment items that are not returnable for reimbursement will be made available to another Army MTF (usually the nearest facility) as directed by the RMC concerned. Perishable subsistence that cannot be returned for reimbursement or absorbed in inventory by another nearby Army MTF will be laterally transferred to the installation food advisor. The food will be distributed to the garrison dining facilities on or near that installation, to prevent loss to the Government due to spoilage. Transfers will be conducted according to AR 710-2.

8-19. Other food service support

a. The a la carte meal pricing system is a customer-oriented system that allows for the sale and appropriate reimbursement of food items provided for purposes other than meals, including official functions. This service is limited to those MTFs that use an a la carte meal pricing system and have adequate manpower and other resources to ensure that patient and staff feeding are not compromised. Providing this support is not intended to become a significant part of the NCD workload.

b. NCD resources are provided to support the primary mission of feeding patients and authorized patrons. Other food service support will not be considered an additional mission, but rather a value-added enhancement. If the primary

mission changes, the provision of other food service support may be curtailed or eliminated if additional resources are not available.

c. MTF commanders will establish local written policies to clearly define implementation procedures for other food service support. Policies will include measures to prevent actual or perceived misuse of Government facilities, equipment, food, and personnel; and to provide specific guidance on internal control measures, reimbursement, and accountability of funds, food, and supplies.

d. Additional information and specific guidance for implementation of the a la carte meal pricing system is available from the U.S. Army Medical Command (MCHO-CL-R), 2748 Worth Road, Fort Sam Houston, TX 78234-6010.

8-20. Subsistence for ambulatory patients on observation or receiving care in the emergency department, speech pathology, gastroenterology, or other special clinics

a. Observation patients are those nonadmitted patients on hospital premises using a bed who, by order of a physician, are periodically monitored by nursing or other staff. Nourishment is authorized when provided incidental to observation-care services, as an oral challenge, to evaluate the patient's reestablishment of normal physiological response or functioning as a precondition of release.

b. Observation and other patients receiving care in these clinics are classified as ambulatory procedure visit (APV) patients and are not considered inpatients. In certain circumstances, food and beverage items can be provided to these patients when they are considered an essential part of the medical treatment.

c. To determine when food and beverages consumed by these patients require payment from beneficiaries, the following guidance will be used:

(1) Payment is not required when food items are used to evaluate physiological response or function (for example, food required to determine if the gastrointestinal tract is functioning).

(2) Payment may not be required when the patient's immediate need for food or beverage significantly compromises their medical condition, determination of diagnosis, or medical treatment; extends their use of costly medical resources; or is caused by a lengthy delay in required medical services and/or available bed space.

(3) Payment is required when food and beverage is not an essential component of medical treatment and is provided solely to relieve hunger.

d. All observation and APV meals will be entered into the automated food service management accounting system, and an audit trail of meals served and associated costs will be maintained. Each MTF will establish local procedures for reimbursement from the MTF budget to pay for subsistence provided to these patients.

8-21. Food service support during mass casualty

The NCD annex to the MTF Emergency Preparedness Plan will state what subsistence will be provided during a mass casualty. The purpose of the annex is to establish procedures ensuring responsive, appropriate, and necessary nutritional support to MTF staff, patients, and patients' families. While developing the Emergency Preparedness Plan, the NCD should coordinate with other activities on post that have a role in supporting Soldiers and Families affected by mass casualty events (for example, Army Community Services and the Garrison Chaplain). The NCD will keep records of all written requests for food and related services, a list of food items provided, and associated costs.

8-22. Food service support for military training exercises

The MTF commander may request that the NCD provide warming or cooling beverages to Soldiers for unit training events such as sergeant's time training, weapons ranges, or common task tests. Items such as soup, coffee, and fruit punch may be requested and will be provided as long as adequate reimbursement is obtained for all subsistence items provided. NCD must keep a record of all written requests for food and related services, a list of food items provided, and associated costs.

a. Soldiers in an SIK status will sign DA Form 3032 and the cost of subsistence provided will be entered into the a la carte meal pricing system for reimbursement.

b. All other categories of diners will pay for food consumed.

Chapter 9

The Army Organ Transplant and Organ/Tissue Donation Programs

9-1. The Army-Navy Organ Transplant Service

a. *Objective.* The Army-Navy Organ Transplant Service is established to perform organ transplantation in DOD MTFs for patients who have statutory entitlement to care or are covered by VA-DOD healthcare resource sharing agreements (38 USC 8111) and require this service.

b. *Policy.*

(1) Organ procurement and distribution will use the established national system of Organ Procurement Organizations

(OPOs) and listing program of the Organ Procurement and Transplantation Network except as noted in paragraph (2), below.

(2) The Army-Navy Organ Transplant Service establishes voluntary MOAs with MTFs and their local OPOs, to implement the Military Organ Donor Program that allows use of organs procured from DOD beneficiaries preferentially in DOD recipients.

(3) Cadaveric organ and tissue donation will be promoted in all Army MTFs. The Chief, Army-Navy Organ Transplant Service, will collaborate as needed with MTF commanders to ensure education of their personnel regarding organ donation, but use of the local OPO will be the standard for this function.

(4) Living-related and living-unrelated organ donors may be used from informed, voluntary adults who are competent, emotionally stable, and in good health. Potential donors will be evaluated initially by qualified, organ-specific specialists not part of the potential recipient's healthcare team, to assure objective evaluation.

(5) The Army-Navy Organ Transplant Service may provide transplant services applicable to all organs for which the surgical team meets established training and experience criteria, as established by the National Organ Procurement and Transplantation Network, the transplant community, and as approved by The Surgeon General of the Army, 7700 Arlington Boulevard, Falls Church, VA 22042-5142.

(6) Patients may be accepted to the service from military or civilian referrals.

(7) DOD healthcare-eligible foreign nationals—to include embassy staff and Secretary of the Army Designees—are eligible for transplant services through The Army-Navy Organ Transplant Service.

c. Special consideration affecting volunteer donors.

(1) Living donors who are not DOD beneficiaries may be used as donors for DOD recipients subject to approval of the Secretary of the Army and receipt of designee status. A statement of good health and basic laboratories will be obtained initially by the donor's civilian physician to screen potential for candidacy. The Army-Navy Organ Transplant Service will perform the pre-transplant evaluation and provide operative and post-operative care for a period determined by the Secretary of the Army for those services provided by the Army-Navy Organ Transplant Service at Army MTFs. Requests will be made in writing (through the Army-Navy Organ Transplant Service) to The Surgeon General of the Army, 7700 Arlington Boulevard, Falls Church, VA 22042-5142.

(2) The Army assumes no liability in the case of a non-DOD beneficiary donor whose donation results in mortality. Exceptions will apply only under circumstances giving rise to a claim or action under the Federal Tort Claims Act, the Military Claims Act, and/or the Foreign Claims Act.

(3) AD members may serve as living donors in the Army-Navy Organ Transplant Service subject to requirements listed in paragraph 9-2.

d. Disposition of active duty recipients.

(1) All organ transplant recipients who are AD members of the uniformed Services will be referred for a medical evaluation board before disposition from the MTF.

(2) Except under special circumstances, these patients will be considered not worldwide deployable in physical evaluation board determinations.

e. Exclusions. Recipients with failed transplants and who have since lost entitlement to care and beneficiaries who lose entitlement while awaiting a cadaveric organ have no status under the Army-Navy Organ Transplant Service. Exceptions may be considered under the Secretary of the Army Designee Program on a case-by-case basis (see AR 40-400).

9-2. The Army Organ and Tissue Donation Program

a. Objective. To establish Army policies and procedures for promoting organ and tissue donations.

b. Policy.

(1) All beneficiaries of the Army healthcare system will be encouraged to make organ and tissue donations. Coercion, or the appearance of coercion, of donors or their next of kin (NOK) will be avoided at all times. Donations from minors will be accepted only with appropriate informed consent of NOK.

(2) Army MTFs will establish reasonable methods for DOD beneficiaries to complete and carry DD Form 2731 (Organ and Tissue Donor Card).

(3) Army MTFs will participate in the Congressionally established National Organ and Tissue Procurement Network that facilitates and coordinates organ and tissue donation, the recovery of donated organs and tissues, and the matching of donors and recipients through MOAs with the local OPO. The MOAs will include participation in donation-after-cardiac-death (DCD) programs if practiced by the local OPO.

(4) All Army inpatient facilities will establish MOAs with the Army-Navy Organ Transplant Service and local OPOs that grant DOD-eligible recipients access to organs and tissues from DOD donors (also known as the Military Share Program).

(5) Army inpatient MTFs will maintain MOAs with the Army-Navy Organ Transplant Service and the local OPO to provide organ and tissue recovery services as well as assistance with education of personnel and beneficiaries regarding organ and tissue donation. All MOAs will be subject to legal review before enactment.

(6) Each USAMEDCOM RMC will ensure compliance by their MTFs with this chapter. MOAs with MTFs, the Army-Navy Organ Transplant Service, and OPOs will be considered open and require review only at the request of one of the parties or when changes occur in code, Army or DOD policy, or standards of organ and tissue donation practice. Tri-annual review of the MOA at the time of TJC review is encouraged.

c. Procedures.

(1) An affirmative organ or tissue donation election shown on a DOD-issued card, DOD-maintained database, driver's license, living will, or advance directive will be considered by the DOD medical system to be guidance to the NOK. The decision of the NOK will be honored. A negative organ or tissue donation election on these documents will be honored.

(2) In cases in which State law provides that an organ or tissue donation election is irrevocable and may not be countermanded by the NOK, and the donor made such an election in a manner specified by State law (considering such matters as signature and witnesses) and such action is documented as provided by State law (such as on a driver's license, if so provided by State law), DOD medical system personnel may follow the State law, donor election, and donation documentation, rather than the policy of paragraph (1), above.

(3) MTF personnel will provide the OPO with timely notification of *all* cardiac deaths (controlled or uncontrolled) and brain deaths—

(a) Timely notification is defined as within one hour of the time of a patient's untimely cardiac death or within one half hour of determining death is imminent as defined in paragraph (b), below.

(b) A patient meeting imminent-death criteria is one who is severely brain injured, on a ventilator with a Glasgow Coma Scale less than or equal to 5, all cases involving a severely brain-injured patient, prior to the withdrawal of ventilator support, initiation of brain death examination(s), or de-escalation medical care.

(4) Organ and tissue donation will be discussed with the NOK in every MTF death unless the potential donor is determined to be medically unsuitable by the OPO, or if the patient previously elected not to participate as a donor. The discussion of donation with NOK will only be initiated by the OPO and subsequent consent obtained by OPO personnel.

(5) An MOA with the local OPO will require that the OPO maintain a listing of patients who die in the MTF and record the results of action taken to secure the donation of organs or tissues from each patient who dies. Death chart review statistics will be made available to the MTF command to determine level of compliance with this regulation.

(6) The granting of privileges to local OPO physicians to recover organs or tissues is not required but may be covered in the MOA (see AR 40-68).

(7) After notification that a potential organ and/or tissue donor exists and subsequent confirmation of brain death or suitability for DCD participation, the OPO will notify the Army-Navy Transplant Service of potential organs and/or tissues available from DOD donors. (Note: As stated in paragraph (10), below, in OCONUS MTFs, the MTF personnel (not the OPO) will notify the Army-Navy Organ Transplant Service.)

(8) DOD-incurred retrieval costs for organs or tissues accepted for transplantation to non-DOD beneficiaries will be paid by either the civilian OPO or the transplanting institution. Reimbursement for these costs will be made payable to the MTF in which the organ and/or tissue donation occurred.

(9) The MTF will notify the NOK that death has been declared. The hospital will contact the Casualty Area Command for deceased DOD donor beneficiaries if the primary NOK is not already available at the MTF or civilian treatment facility where the deceased is located. This ensures that the primary NOK who was not present at the hospital at the time of death is notified properly by a representative of the Casualty Area Command before organ or tissue donation is solicited by the OPO. The Casualty Area Command will not discuss organ donation but may inform the NOK that they will be contacted by the OPO. The primary NOK will then be contacted telephonically by a member of the local OPO to request approval of organ or tissue donation from the deceased patient. A primary NOK's authorization of an organ or tissue gift from the deceased patient is required; telephonic consent is acceptable.

(10) Gifts of organs and tissues in CONUS will be made in accordance with the laws of the State where the gift is made. If the gift is made in a foreign country, such gift will be in accordance with 42 USC 1320b-8 (The Uniform Anatomical Gift Act), unless in violation with an international agreement or host nation law, in which case the latter will apply. MTFs in foreign countries will develop MOAs that address organ recovery services with the local foreign transplant agencies. The local agencies' name will be substituted for OPO as the term, "OPO" applies only to CONUS MTFs. The MOA will include discussion of military shares with DOD beneficiaries as in paragraphs b(4) and (5), above, and (7), above. OCONUS MTF personnel will directly notify the Army-Navy Organ Transplant Service/Military Transplant Center (MTC) of potential organ and tissue donors. The MTC will be given the option of performing the OCONUS organ recovery if practical.

(11) Opportunities for a DOD beneficiary to make organ and tissue donation pledges will be made available with arrival at the first duty station, at regular physical examinations, during identification card issuance and reissuance, in all MTFs, at military unit meetings, and during Soldier readiness processing prior to mobilization or deployment

(12) Informational materials to explain organ and tissue donation and blank donor cards will be provided by MTFs. DD Form 2731 will be used as the organ donor card.

d. Active duty members as donors.

- (1) There is no objection to an AD Army member executing a declaration of intent to donate organs or tissues after death, under the Uniform Anatomical Gift Act.
- (2) Active duty members may serve as living-related or living-unrelated organ donors in the absence of better matched volunteer donors.
- (3) The AD member must be counseled in writing by the immediate commander with follow-on counseling by a medical officer—preferably internal medicine—who can also review preliminary results. The counseling sessions must ensure that the AD member understands before donation of an organ that his or her qualification for continued service will be contingent upon favorable medical evaluation results following organ donation.
- (4) Any disability or mortality resulting from organ donation made by an AD Army member in accordance with this chapter will be considered “in line of duty.” Otherwise, line-of-duty determinations will be made according to applicable provisions of AR 600–8–4.
- (5) Prior OTSG approval is required when living organ donation by an AD Army member is to be performed in a transplant facility other than the Army-Navy Organ Transplant Service. Requests for such approval will be submitted through the individual’s unit commander to the local MTF patient administration division (PAD) and forwarded to The Surgeon General of the Army, 7700 Arlington Boulevard, Falls Church, VA 22042–5142. Circumstances requiring more immediate response may be approved electronically by OTSG. All requests to serve as an AD live organ donor other than in the Army Organ Transplant Service must contain the following information:
 - (a) Screening policy for live renal donation for AD Service members:
 1. A written request from the Soldier to be a living organ donor in a civilian hospital, stating that he or she has been counseled and accepts the risks of donation.
 2. The prospective donor’s name, rank, social security number, home and work phone, and the unit’s address, phone, and facsimile numbers.
 3. A statement, signed by the Soldier, acknowledging that the Army is not responsible for any costs associated with a transplant performed in a civilian institution, except when the recipient is a TRICARE beneficiary. In this case, TRICARE assumes fiscal responsibility of both donor and recipient.
 4. A statement by the Soldier that follow-up medical evaluation by a military medical internist will be completed between 6 and 12 months after the donation.
 5. A letter from the Soldier’s commander approving the request to donate.
 6. The intended recipient’s name and relationship to the donor.
 7. A signed statement from the attending physician associated with the transplant facility, which provides the recipient’s diagnosis, prognosis, and verifies that no other donor is available.
 8. The name, office address, and telephone number of the attending physician(s) for both the donor and recipient.
 9. The name and address of the intended operative facility.
 10. A statement from a military medical officer that establishes the Soldier’s competency, emotional stability, bona fide volunteer status, and satisfactory health for donation. Evaluation should be based on personal interview, record review, and objective clinical data.
 11. One copy each of DD 2807–1 (Report of Medical History) and DD 2808 (Report of Medical Examination), completed within 90 days preceding the request to donate.
 12. Official reports of the following medical tests: ABO typing and crossmatch result of the donor and recipient, the donor’s serum basic metabolic panel, fasting blood glucose, and urinalysis result, donor’s 5-day blood pressure readings, height and weight, and imaging study of the donor’s kidneys, laterality of donation, and typing results (that is, ABO typing, HLA typing, and cross-match).
 13. If the donor is over 45 years of age, a copy of the cardiac risk assessment should be provided, if clinically indicated based on family history or high risk factors as deemed by the evaluating military physician.
 14. If both donor and recipient are TRICARE eligible, the recipient *must* be interviewed at the Army-Navy Organ Transplant Service clinic at Walter Reed National Military Medical Center, Washington, DC *prior* to scheduling an evaluation at a non-DOD transplant center.
 - (b) Screening policy for live hepatic donation for AD Service members:
 1. A written request from the Soldier to be a living organ donor in a civilian hospital, stating that he or she has been counseled and accepts the risks of donation.
 2. The prospective donor’s name, rank, social security number, home and work phone, and the unit address, phone, and facsimile numbers.
 3. A statement, signed by the Soldier, acknowledging that the Army is not responsible for any costs associated with a transplant performed in a civilian institution except when the recipient is a TRICARE beneficiary. In this case, TRICARE assumes fiscal responsibility of both donor and recipient.
 4. A statement by the Soldier that follow-up medical evaluation, by a military medical internist, will be completed between 6 and 12 months after the donation.
 5. A letter from the Soldier’s commander approving the request to donate.
 6. The intended recipient’s name and relationship to the donor.

7. A signed statement from the attending physician associated with the transplant facility, which provides the recipient's diagnosis, prognosis, and verifies that no other donor is available.
 8. The name, office address, and telephone number of the attending physician(s) for both the donor and recipient.
 9. The name and address of the intended operative facility.
 10. A statement from a military medical officer that establishes the Soldier's competency, emotional stability, bona fide volunteer status, and satisfactory health for donation. Evaluation should be based on personal interview, record review, and objective clinical data.
 11. One copy each of DD 2807-1 and DD 2808, completed within 90 days preceding the request to donate.
 12. Official reports of the following medical tests: ABO typing of the donor and recipient, the donor's serum liver panel (total bilirubin, alkaline phosphatase, alanine transaminase, aspartate transaminase) and Infectious Hepatitis panel (Qualitative: HepB surface antibody, HepB core antibody, HepA antibody, HepC antibody), donor's liver magnetic-resonance-imaging report with calculated right and left lobe volumes, the donor's height and weight, and laterality of donation.
 13. If the donor is over 45 years of age, a copy of the cardiac risk assessment should be provided.
- (6) Active duty Army members approved under this paragraph for organ donation will be placed in an absent sick status at the time of admission to a non-Army treatment facility through discharge. Convalescent leave must be approved by an Army MTF. Administrative responsibility will be assumed by the appropriate Army hospital according to AR 40-400. Any absence from duty before hospital admission will be charged as ordinary leave.
 - (7) An AD Army member in a non-Army treatment facility for the purpose of donating an organ will be transferred to an Army MTF, at the point in his or her hospital course when he or she would normally be discharged. This transfer is not to be used as a means of transferring to the Army the responsibility for treatment or expenses associated with the transplant. Rather, it is to ensure that the Army member is medically evaluated after the organ donation to determine his or her future profile, assignments, and qualification for continued service.
 - (8) Requests for live organ donation to be performed through the Army-Navy Organ Transplant Service may be sent directly to the Chief, Army-Navy Organ Transplant Service, Walter Reed National Military Medical Center, Bethesda, MD, 20889-5600.
 - (9) In the case of a TRICARE or DOD medical beneficiary donating to another TRICARE or DOD medical beneficiary, the recipient *must* be interviewed at the Army-Navy Organ Transplant Service clinic at Walter Reed National Military Medical Center, Washington, DC prior to scheduling an evaluation at a non-DOD transplant center in order to apply for OTSG approval.

Chapter 10

Orthopedic Footwear

10-1. Persons eligible for orthopedic footwear

- a. Questions concerning eligibility for the orthopedic footwear will be referred to the PAD at the local MTF. Categories of personnel eligible for orthopedic footwear are (see AR 40-400, table B-1):
- (1) Members of the U.S. Army, U.S. Navy, U.S. Air Force, and U.S. Marine Corps (including initial entry training) serving on active duty or active duty for training.
 - (2) NATO International Military Education and Training Program trainees, both military and civilian.
 - (3) Foreign military sales trainees.
 - (4) Cadets and midshipmen of the U.S. Army, U.S. Navy, and U.S. Air Force Academies.
 - (5) Senior Reserve Officers' Training Corps members with line-of-duty conditions incurred during required field training (see AR 40-400, table B-1).
 - (6) Members of other uniformed Services (U.S. Coast Guard and the commissioned corps of the Public Health Service and the National Oceanic and Atmospheric Administration) serving on active duty, active duty for training, and inactive duty training, including cadets at the U.S. Coast Guard Academy (see AR 40-400, table B-1).
 - (7) Retired officers and retired enlisted members.
 - (8) Foreign military members of NATO nations in the United States, including NATO international military education training, foreign military members in the United States under DOD sponsorship, Partnership for Peace, and foreign military members in the United States in a status officially recognized by the DA.
 - (9) Special nationals and Korean Augmentation to the U.S. Army.
 - (10) Liaison personnel from NATO Army force OCONUS.
 - (11) Office of Workers Compensation Program beneficiaries.
 - (12) VA beneficiaries (see AR 40-400, table B-1).
 - (13) Persons in military custody and nonmilitary Federal prisoners (prisoners of war in time of war, retained

personnel and internees, and military prisoners whose punitive discharge has been executed but whose sentence has not expired).

(14) Secretary of the Army designees (if approved, consult with PAD).

b. TRICARE Prime enrollees will receive their orthopedic footwear through the facility at which they are enrolled. If a beneficiary is not a TRICARE Prime enrollee, the MTF at which the beneficiary receives care will be responsible for procuring orthopedic footwear. The beneficiary's branch of service has no bearing on where a non-TRICARE Prime enrollee can procure orthopedic footwear.

10-2. Number of pairs of orthopedic footwear furnished

a. Persons requiring orthopedic footwear will initially be furnished one pair of the type(s) determined by the orthopedic physician or podiatrist to best meet the patient's needs based upon the evaluation of the foot. Not every patient will require each type of footwear available. For active duty personnel, the type of footwear (boots, low quarters, and so forth) furnished will depend on the nature of the duties to be performed.

b. A second pair of the specified shoes will be ordered once the fitting of the first pair has been determined as acceptable.

c. See paragraph 10-5 for guidance on replacement orders.

10-3. Types of orthopedic footwear available

a. For active duty personnel—

- (1) Men's dress shoe, oxford (low quarter).
- (2) Men's shoes, 3/4 chukka.
- (3) Men's shoes, 3/4 "George" with strap and buckle.
- (4) Men's shoes, safety, oxford (low quarter).
- (5) Men's shoes, dress, 5 inch (in).
- (6) Women's shoes, oxford.
- (7) Women's shoes, dress, oxford, leather, type I.
- (8) Shoes, molders, safety.
- (9) Shoes, women's, 3/4 safety fleet (chukka).
- (10) Boots, combat, black leather (cattle hide).
- (11) Boots, Wellington style with zipper.
- (12) Boots, hot weather, black (tropical) type I.
- (13) Boots, hot weather, tan (desert).
- (14) Boots, flyers, FWU-3/P (insulated).
- (15) Boots, flyers, FWU-8/P (summer).
- (16) Boots, combat, safety.

b. For retirees and other categories of beneficiaries—

- (1) Men's dress shoe, oxford (low quarter).
- (2) Men's shoes, dress, 5 in.
- (3) Women's shoes, oxford.
- (4) Women's shoes, dress, oxford, leather, type I.

10-4. Procedures for obtaining orthopedic footwear

The Defense Orthopedic Footwear Clinic, Boston, MA, relinquished the responsibility for processing requisitions for orthopedic footwear in 2001. This responsibility has been transferred to the Department of Veterans Affairs (Veterans Integrated Service Network 3 (VISN3)), New York, NY 10010.

a. When a person requires orthopedic footwear, a DD Form 150 (Special Measurements Blank for Special Measurements/Orthopedic Boots and Shoes) must be prepared and signed by an appropriate medical officer.

(1) Evaluations for orthopedic footwear must be performed by an orthopedic physician or a podiatrist. (MEDCEN/MEDDAC commanders, in order to meet access standards, may determine that personnel in clinical specialties other than orthopedics and podiatry—based on appropriate training and in conjunction with the granting of appropriate privileges—may also evaluate for and prescribe orthopedic footwear.)

(2) When the person's foot cannot be clearly and fully described, a cast may be prepared for one or both feet. This will enable the VA to construct the proper footwear cast. At installations where plaster casts cannot be made, they may be obtained locally from VA or commercial sources with local operating funds. Casts will be properly packaged and forwarded to the designated medical supply officer with the completed DD Form 150.

b. The completed DD Form 150 is then sent to the designated MTF orthotics lab or designated medical supply officer where a requisition on DD Form 1348 (DOD Single Line Item Requisition System Document (Manual)) or DD Form 1348M (DOD Single Line Item Requisition System Document (Mechanical)) will be prepared.

(1) The statement, “Orthopedic initial requirement for a trial pair of orthopedic footwear,” will be entered in the remarks block.

(2) The patient’s name, rank, SSN, size, and type of footwear for each foot will also be entered in the remarks block.

(3) A point of contact name and commercial telephone number will be listed on each DD Form 1348.

c. Orthopedic footwear must be ordered through the DSCP Directorate of Clothing and Textiles Web site’s “Special Footwear Store.”

(1) The designated medical supply officer, or designated orthotics lab staff member, must register to become an authorized user before ordering orthopedic footwear directly from the Web site. Typically, validation of the information provided at the time of registration may take up to 1 week. Once the information provided by the designated medical supply officer has been validated, online orders may be placed by the approved medical supply officer or orthotics lab staff member.

(2) A Government credit card may be used for billing purposes (preferred method), or a DOD activity address code account can be used for payment. Each RMC has been allocated funds for this purpose; invoices will not be sent to the USAMEDCOM for payment (see para 10–11).

(3) The DSCP will maintain files on each patient for whom orthopedic footwear is ordered. The DSCP will ensure that cross checks are performed to avoid abuses in the requisitioning of orthopedic footwear.

d. The designated medical supply officer or designated orthotics lab staff member will forward the original requisition (DD Form 1348) with two copies of the completed DD Form 150, any prescriptions, drawings, tracings, molds, or casts via facsimile to (212) 951–3247 (Attention: VISN3) or mail to: Veterans Integrated Service Network 3, Attention: VISN3, Department of Veterans Affairs Medical Center, 423 East 23rd Street, New York, NY 10010. Important: Any drawings being forwarded in order to determine shoe size must either be mailed or sent by courier to the VA Medical Center (address in preceding sentence) since facsimile machines distort the original dimensions of the drawing.

e. Upon receipt of the requested footwear, it will be test-fitted by an appropriate medical officer, pedorthist, or other orthopedic or podiatric technician before issue to the user. This ensures the footwear meets prescribed specifications for correcting the disability. A medical officer will complete the documentation received with the footwear and return the form to the designated medical supply officer or orthotics lab. If a pedorthist or other orthopedic or podiatric technician completes the documentation, it must bear the countersignature of an appropriate medical officer.

f. When the footwear is issued, entry will be made on the SF 600 per AR 40–66. Additionally, for active duty enlisted personnel, an entry will be made on DA Form 3078 (Personal Clothing Request) according to AR 700–84 for personal footwear or AR 710–2 for organizational footwear, depending on the type of issue.

10–5. Replacement orders

a. Requests for replacements of footwear due to “wear and tear” will be assessed by an orthotic lab technician, an orthopedic physician, or a podiatrist to verify that the footwear is unusable and requires replacement. For one pair assessed as being unusable, only one pair will be ordered as a replacement.

b. Before ordering replacement orthopedic footwear, a review of the Defense Enrollment Eligibility Reporting System (or other authorizing document) will be performed to verify patient eligibility.

c. A medical officer will then perform a physical examination to establish that the type of footwear previously prescribed remains satisfactory.

(1) If no changes are required, DD Form 150 will be marked by an appropriate medical officer as “Orthopedic replacement requirement.”

(2) The prescribing medical officer will indicate any new required changes on a new DD Form 150 conspicuously marked “REVISED.”

d. The designated medical supply officer or orthotics lab will then prepare a requisition for the replacement footwear according to the administrative procedures for ordering orthopedic footwear.

e. A Soldier with satisfactory previously prescribed footwear may be located in an area where no medical officer is available. If so, a request for replacement will be sent directly to the designated medical supply officer without a medical examination.

10–6. Delivering footwear after patient transfer

a. When orthopedic footwear is delivered for an active duty patient who has been transferred, it will be shipped to the designated medical supply officer at the patient’s current duty station. Appropriate personnel from the supporting MTF’s orthopedic clinic, podiatry clinic, or orthotics lab will assist in fitting the footwear.

b. If the patient has been transferred to a VA treatment facility, the footwear, fitting report, and any other pertinent data will be sent to the VA treatment facility director.

c. If the transfer makes the patient no longer eligible for orthopedic footwear under AR 40–400, table B–1, the footwear and all pertinent data will be returned to the VA Network Prosthetics Center.

d. If the patient has been discharged (not retired) from the military service, the footwear and all pertinent data will be returned to the VA Network Prosthetics Center.

e. If the patient retired from the military service and has relocated, send the shoes to the MTF closest to where the retiree now resides (or to the MTF where the retiree is enrolled as a TRICARE Prime enrollee). The retiree will be notified of the transfer of the shoes to that location.

10-7. Orthopedic adjustments to standard footwear

Orthopedic adjustments to standard footwear may be furnished without charge to the beneficiary eligible for military medical care when prescribed by a medical officer. However, the patient will procure the standard footwear to which the orthopedic adjustment is to be made (for example, athletic shoes, and so forth). Adjustments may be made by military shoe repair shops or by commercial repair shops using local operating funds.

10-8. Repairing orthopedic footwear

a. Footwear that requires more than minor repairs will be sent to the Veterans Integrated Service Network 3, Department of Veterans Affairs Medical Center, 423 East 23rd Street, New York, NY 10010. Based on information furnished by a medical officer, the designated medical supply officer or orthotics lab will prepare a DD Form 1348 or 1348M (according to guidelines in para 10-4) indicating the required repairs. The requisition will be sent with the footwear to the VISN3 at the address given earlier in this paragraph.

b. Minor repairs (excluding maintenance repairs such as normal soling and heeling) are authorized without charge to the eligible beneficiary who received his or her footwear through the orthopedic footwear channels. Repairs may be made by military shoe repair shops or by commercial repair shops using local operating funds.

10-9. Orthopedic lasts and patterns

Special lasts and patterns required in making orthopedic footwear for authorized personnel will be kept on file at the VA Network Prosthetics Center.

10-10. Moving active duty military members to the Department of Veterans Affairs Network Prosthetics Center

Active duty patients will be moved to the VA Network Prosthetics Center when casts cannot be properly prepared locally or the military member's presence is otherwise required. These military members may be moved in a duty or patient status. Movement will be by Government transportation when available. Advance arrangements for the required services will be made with the VA Network Prosthetics Center.

Chapter 11 Pharmacy and Medication Management

11-1. Purpose and applicability

The purpose of this chapter is to provide overarching guidance on the Army's Medication Management System while articulating key quality management components that are consistent with the requirements of AR 40-68. This chapter applies to Army pharmacy management services worldwide and is applicable in peacetime (in garrison) as well as during deployments and mobilizations.

11-2. Responsibilities

a. The MTF commander, who also routinely serves as the Army installation (in garrison) Director of Health Services, will operate the pharmacy and all aspects of medication management, and appropriate and safe drug therapy, and will exercise careful supervision over all phases of pharmacy operations and medication management throughout the command. This includes employment of recognized professional procedures, and establishment and aggressive pursuit of those policies, that ensure conformity with the highest standards of the pharmaceutical profession. The commander will ensure that—

(1) Supervision is exercised directly by—

(a) A pharmacy officer or civilian pharmacist who is a graduate of a recognized school or college of pharmacy and licensed to practice pharmacy in one of the States of the United States, Puerto Rico, or the District of Columbia.

(b) A Medical Corps or civilian physician acting as officer in charge or equivalent status when no pharmacist is on duty at the facility.

(2) Policies will be established to ensure—

(a) Rational prescribing, taking into consideration pharmacoeconomic aspects of various medication alternatives so that healthcare providers use the most cost-effective therapies at the MTF.

(b) Quantities of drugs prescribed do not exceed amounts required to provide sound medical treatment.

(c) Drug dispensing is based on a formulary system.

(d) MTF compliance with guidance from the DOD Pharmacy Board of Directors and decisions made by the DOD P&T committee to ensure the provision of pharmaceutical care and the application of a uniform, consistent, and cost effective pharmacy benefit available to all eligible beneficiaries.

(e) Adherence to appropriate credentialing and privileging procedures, guidelines, and mandates according to Federal laws, ARs, DODDs and/or DODIs, accrediting bodies (for example, TJC or other), and other regulatory agency requirements for dispensing medication.

b. The chief, pharmacy services (note: exact title of the chief of pharmacy varies depending on local designation) will be charged with the duties of recognizing, identifying, selecting, ordering, preparing, safeguarding, evaluating, and dispensing all pharmaceutical substances (of whatever kind and combination) used in preventive, curative, and diagnostic medicine. The chief and his or her staff will be responsible for keeping abreast of new developments in the field of pharmacy and for operating the pharmacy in compliance with Federal laws, accreditation standards defined by the current accrediting body (for example, TJC or other), and standards of pharmaceutical care within the community. In doing so, the chief will—

(1) Assist and advise healthcare providers in the writing of prescriptions, medication orders, and other matters involving the use or misuse of medications.

(2) Conduct and document inspections of all medication storage areas.

(3) Maintain adequate reference material for use by pharmacy personnel and other professional staff served by the pharmacy.

(4) Disseminate information to the professional staff concerning advances in the field of pharmacy and related matters.

(5) Assist the P&T committee in developing a policy for local management and control of pharmaceutical industry activities. In the event that a USAMEDCOM policy is implemented, the local MTF policy will support the USAMEDCOM policy.

(6) Disseminate appropriate pharmacy information on drug items and preparations available for use, prescribing policies, and items of interest to the medical staff.

(7) Maintain and dispense investigational drugs according to AR 40–7.

(8) Operate a pharmacy sterile-products program within the hospital, to include the preparation and delivery of pharmaceutical sterile products to patient care areas.

(9) Operate a unit dose or other point-of-use drug distribution system to ensure a safe, efficient, and economical method of drug distribution.

(10) Operate an ambulatory pharmacy service that fills and dispenses prescriptions to outpatients.

(11) Counsel and advise patients and the professional staff on the appropriate use of medications, including interactions and cautions related to the use of alternative forms of medicines such as dietary supplements and herbal remedies.

(12) Conduct staff assistance visits to outlying clinic pharmacies.

(13) Participate in the MTF medication use evaluation program.

(14) Represent the pharmacy service on various committees used by the MTF to improve information management, utilization management, and patient outcomes.

(15) Ensure competency assessment of pharmacy staff is documented and filed, including tech-check-tech functions.

11–3. Monetary collections for medicine

The pharmacy will not serve as a monetary collection agency for drugs or pharmaceutical services. However, the pharmacy will assist the command's Third Party Collection Program (TPCP) office in billing third party insurers for medications as authorized under the TPCP.

11–4. Personnel

a. The chief, pharmacy services will ensure that only qualified persons compound and/or dispense pharmaceutical preparations. Only graduates of accredited civilian pharmacy schools will be assigned professional duties in the pharmacy. Technicians who have successfully completed a course of instruction at a pharmacy specialist course of the Armed Forces, a civilian course of equivalent scope, or on-the-job experience may be assigned technical duties in the pharmacy. Local, onsite training of civilian personnel to fill technician positions is permitted. Military and civilian pharmacy technicians are encouraged to meet all requirements for the civilian-based Pharmacy Technician Certification Board and local State licenses when appropriate. Documentation of training will be maintained on file within the pharmacy.

b. One or more licensed pharmacists will be assigned primary duty at all full-service military pharmacies (those that dispense other than prepackaged medications to Soldiers or other beneficiaries) to supervise the prescription-dispensing process. At installations that do not have a pharmacist assigned, the pharmacy may be operated—

(1) By part-time licensed pharmacy officers who are assigned other primary duties.

(2) By part-time civilian licensed pharmacists.

(3) By dispensing physicians or dentists.

c. Trained pharmacy technicians, either enlisted or civilian, may be used in pharmacies provided they function under the direct supervision of licensed pharmacists or dispensing physicians or dentists and that the individual providing the direct supervision checks all prescriptions before they are dispensed. The MTF commander will ensure that a medication dispensing protocol is in place to facilitate this process. Tech-Check-Tech locally certified technicians will be used when possible to support refill processing and dispensing.

d. Troop medical clinic pharmacies may be operated by trained pharmacy technicians working independently provided only prescriptions for AD Soldiers are filled from a limited list of drugs. The licensed pharmacist or the MTF commander's designee, who has oversight responsibility for the troop medical clinic pharmacy, will provide leadership and guidance.

11-5. Pharmacy benefits

a. The three managed pharmacy points of service accessible to eligible DOD beneficiaries include—

- (1) MTF pharmacy.
- (2) Mail order pharmacy (MOP).
- (3) TRICARE retail network pharmacy.

b. Additionally, under certain circumstances, patients can be partially reimbursed for using a non-network retail pharmacy.

11-6. Basic core formulary and committed use requirement contracts

a. All MTFs will implement the DOD Basic Core Formulary (BCF) with the Uniform Formulary Concept, in accordance with current ASD(HA) policies. All BCF medications will be available to all beneficiaries. The BCF may be supplemented by the local P&T committee as approved by the MTF commander based on the facility's scope and level of care.

b. MTF commanders will actively ensure compliance with contracts for pharmaceuticals established by Defense Supply Center Philadelphia, in conjunction with the Pharmacoeconomic Center and the DOD P&T committee. Additionally, MTF commanders will not permit local prescribers or pharmacy industry initiatives to supplant or circumvent contract requirements.

11-7. Pharmacy and therapeutics committee

a. *Establishment.* The MTF commander will appoint the P&T committee.

b. *Composition.* The committee will include a mixture of clinical and administrative staff, so that all specialties are represented to the maximum extent possible.

c. *Objective.* The primary objectives of the P&T committee are—

(1) *Advisory.* The committee recommends the adoption of and assists in the formulation of broad professional policies regarding the Medication Management System to include evaluation, selection, procurement, distribution, use, safe practices, and other matters related to therapeutic agents.

(2) *Educational.* The committee recommends or assists in the formulation of programs designated to meet the needs of the professional staff for current knowledge on matters related to therapeutic agents and their use for patient care.

d. *Functions.* The functions of the P&T committee are to—

(1) Advise the commander and the professional staff in all matters pertaining to the use of therapeutic and diagnostic agents.

(2) Advise the commander and the professional staff in the selection of therapeutic agents that are the most efficacious and cost effective.

(3) Recommend local prescribing policies based on professional, economic, and other appropriate administrative considerations.

(4) Evaluate clinical data regarding new therapeutic agents proposed for use in the hospital.

(5) Prevent unnecessary duplication in stockage and use of the same basic therapeutic agent or its combinations.

(6) Establish a formulary of therapeutic agents and provide for its continual review and revision.

(7) Establish an approved policy and procedure for obtaining approval for use of nonformulary drugs in a timely manner. This process will include the generation of information on the use of nonformulary drugs to enable the P&T committee to review trends in nonformulary drug use, which may influence formulary addition or deletion decisions.

(8) Propose educational programs for the professional staff on particular matters related to therapeutic agents and their use.

(9) Review a summary of the quality control messages furnished by the chief, pharmacy service and disseminate all pertinent information to members of the professional staff.

(10) Monitor all adverse drug events and make recommendations to prevent their occurrence.

(11) Determine which adverse drug events are reportable, and forward reports to the MTF's patient safety committee, the FDA, and manufacturer as appropriate.

- (12) Monitor the medication use evaluation program, and make recommendations to optimize drug use.
- (13) Monitor the use of controlled substances.
- (14) Develop a standard list of chemical symbols and abbreviations for use in prescribing medications.
- (15) Develop a list of “DO NOT USE” abbreviations, acronyms, or symbols unique to each MTF that must not be used in any written medication management-related documents.
- (16) Develop a list of “look alike sound alike” medications unique to each MTF, as appropriate.
- (17) Recommend policies to govern the access, conduct, and activities of pharmaceutical industry representatives within the MTF.
- (18) Coordinate with, and be represented on, the MTF patient safety committee.
 - e. New therapeutic agents.* Requests for new therapeutic agents will be submitted to the P&T committee on DD Form 2081 (New Drug Request) or an alternate, locally approved form.
 - f. Meetings.* The P&T committee will meet as often as required, but no less frequently than quarterly. Patient safety throughout the medication use process will be a P&T committee agenda item.
 - g. Records.* The MTF commander will ensure documentation of all P&T committee meetings.

11–8. Therapeutic dietary supplements

- a.* Therapeutic dietary supplements are specially manufactured formulas used in many instances as the sole source of nutrition for patients and are considered therapeutic agents subject to review by the P&T committee and approval by the MTF commander.
- b.* Inpatients will be provided therapeutic dietary supplements consistent with appropriate professional care, as directed by a privileged practitioner. The NCD will be responsible for preparing and distributing these items. However, if any medication is to be added, the final preparation will be compounded and labeled by the pharmacy service.
- c.* Outpatient use of dietary supplements will be reviewed on an individual basis for each patient by the P&T committee and approved by the MTF commander. These items will be dispensed by the MTF pharmacy service, or NCD, as appropriate.
- d.* Patients with aminoacidopathies consisting of phenylketonuria, maple syrup urine disease, homocystinuria, histidinemia, and tyrosinemia will be provided special amino acid modified nutrient preparations by the pharmacy or dietary service upon presentation of a valid prescription from either a military or civilian healthcare provider.

11–9. Performance improvement

- a. Performance improvement process.* The chief, pharmacy services will implement an internal process that will demonstrate improvement in pharmacy services. This process will be integrated with the MTF’s organizational performance improvement structure, and documentation will provide evidence of ongoing improvement according to AR 40–68.
- b. Recording and reporting medication errors.* The recording and analysis of all MTF adverse events and medication errors will be according to AR 40–68 and current USAMEDCOM guidance and will use the standardized or automated DOD medication error reporting system. (For example, the Joint Medication Error Reporting Tool (that is, JAMRS), Patient Safety Reporting Tool, or other will be used.)
 - (1) The implementation of medication error documentation will be done via a multi-disciplinary approach. The patient safety manager and the chief, pharmacy service will work together to assume leadership and coordination of the local program.
 - (2) MTFs will track and organize medication-error data, identify trends, pinpoint problem areas, and develop mitigating strategies.
 - (3) MTF patient safety managers will analyze aggregate data related to medication-use errors, or near misses, locally and report information to the P&T committee.
 - (4) MTF patient safety managers will ensure that medication-error data are entered in the standardized or automated DOD medication-error reporting system.
 - (5) The USAMEDCOM patient safety manager will use the data gathered to identify and provide feedback on systemic patterns and practices that place patients at risk in the AMEDD, and will report AMEDD data to the DOD Patient Safety Center for further analysis.
 - (6) The DOD Patient Safety Center will use the data gathered to identify and provide feedback on systemic patterns and practices that place patients at risk across all three Services, and thereby stimulate, initiate, and support local interventions designed to reduce risk of errors and to protect patients from inadvertent harm.
 - (7) The event harm scale, listed in (a) through (f), below, was developed by the Agency for Healthcare Research and Quality. The scale will be used by all USAMEDCOM pharmacy services to identify medication errors. Using these categories helps ensure standardization with the civilian community, as they are compatible with the Web-based medication-error reporting program currently available.
 - (a) “Death” is death at the time of the assessment.

(b) “Severe Permanent Harm” is severe, lifelong, bodily or psychological injury or disfigurement that interferes significantly with the functional ability or quality of life. Prognosis from time of assessment.

(c) “Permanent Harm” is lifelong, bodily or psychological injury or increased susceptibility to disease. Prognosis at the time of assessment.

(d) “Temporary Harm” is bodily or psychological injury, but likely not permanent. Prognosis at the time of assessment.

(e) “Additional Treatment” is injury limited to additional intervention during admission or encounter and/or increased length of stay, but no other injury. Treatment since discovery, and/or expected treatment in future as a direct result of event.

(f) “Emotional Distress or Inconvenience” is mild and transient anxiety or pain, or physical discomfort, but without the need for additional treatment other than monitoring (such as by observation; physical examination; laboratory testing, including phlebotomy; and/or imaging studies). Distress or inconvenience since discovery, and/or expected in the future as a direct result of event.

11–10. Controlled substances

a. General.

(1) Controlled substances are drugs so designated by the Drug Enforcement Administration (DEA). The DEA assigns controlled substances to one of five schedules according to the abuse potential and degree of control required. A list of controlled substances in each schedule and changes are published in the Federal Register and in the supply bulletin 8–75S1 series.

(2) MTF commanders may designate items as locally controlled if they deem them subject to potential abuse or diversion. The method of accountability for such items will be as either Schedule II or Schedule III–V, as determined by the commander.

(3) The use of methadone for drug dependency withdrawal or maintenance of narcotic addiction is not authorized in Army MTFs. Methadone may be used for extreme, uncontrolled discomfort of rapid withdrawal or for the temporary maintenance of patients hospitalized for the treatment of conditions other than narcotic addiction, in accordance with the 21 USC 301 and the 21 CFR 290 and 291. There is no restriction on the use of methadone when it is used for analgesia.

(4) Amphetamines and methamphetamines will not be prescribed as anorexic agents. Also, any medication used solely for its anorexic activity is prohibited from use in Army MTFs.

b. Accounting for controlled substances used in the manufacture of pharmaceutical preparations. DD Form 1289 (DOD Prescription) or an equivalent automated record will be used to account for all controlled substances used in the manufacture of pharmaceutical preparations. Such orders will be authenticated and signed by a pharmacist and will be filed in the appropriate prescription file (also see app B).

c. Procedures regarding controlled drugs.

(1) The AMEDD currently has in effect regulatory guidance that exceeds requirements of Federal law and standards of accrediting bodies (for example, TJC or other). Specific guidance for inventory, control, and accountability of controlled substances is included in appendix B. It is essential that commanders place emphasis on the audit and inventory procedures outlined in appendix B.

(2) Periodic reviews to detect overuse and/or abuse of controlled substances will be conducted and findings reported to the MTF commander via the P&T committee.

(3) Controlled substance histories recorded in patient medication profiles for prescriptions from civilian practitioners will be made available to MTF prescribers upon their request.

(4) 21 USC 801 et seq (The Controlled Substances Act) requires facilities that maintain controlled substances to conduct an inventory of all controlled substances every 2 years. The inventory can be accomplished without performing an additional inventory if the MTF designates the first monthly inventory every other FY as the biennial inventory.

11–11. Individuals authorized to write prescriptions

a. The following categories of personnel are authorized to write prescriptions:

(1) Uniformed and civilian physicians, dentists, veterinarians, and podiatrists engaged in professional practice at uniformed Services MTFs.

(2) Civilian physicians, dentists, and podiatrists not assigned to a uniformed Services MTF but licensed in the jurisdiction of their practice and treating personnel eligible for care in the Military Health System (MHS).

b. The following personnel are authorized to write prescriptions as established under the provisions of AR 40–68:

(1) Uniformed and civilian optometrists, certified nurse midwives, certified registered nurse anesthetists, nurse practitioners (NPs), physician assistants (PAs), physical therapists, occupational therapists, and clinical pharmacists engaged in professional practice at uniformed Services’ MTFs and privileged to prescribe medications.

(2) Civilian personnel not assigned to a uniformed Service’s MTF but licensed in the jurisdiction of their practice and treating personnel eligible for care in the MHS will prescribe to the extent authorized by State law and by policies for equivalent staff nonphysician healthcare providers.

(3) Other nonphysician healthcare providers not listed above but assigned to a uniformed Service's MTF and granted limited prescribing privileges.

(4) Retired uniformed practitioners not in a professional practice but with a valid State license may prescribe only noncontrolled substances for themselves or their Family. Retired medical personnel not in a professional practice and not having a valid State license will not prescribe medications.

c. Prescriptions written by licensed civilian practitioners not assigned to a uniformed Service's MTF for personnel eligible for care in the MHS will be honored at Army MTFs if the prescribed medication is on the MTF's formulary and meets local dispensing policies.

(1) Filling a prescription written by a civilian practitioner does not imply knowledge of or responsibility for a patient's medical condition. Under no circumstances will civilian prescriptions be countersigned or rewritten by military practitioners.

(2) Special or nonformulary drug requests will not be submitted by military providers on behalf of prescriptions from civilian providers that are written for nonformulary medications.

d. A distance factor or geographic boundary limitation will not be a basis for denying prescription services. MTF pharmacists will adhere to all applicable Federal and State laws when filling prescriptions originating from outside the State.

e. Individuals with prescribing privileges are not authorized to prescribe controlled substances for themselves or members of their families.

f. Personnel assigned to a uniformed Service's MTF will use the Composite Health Care System (CHCS), AHLTA, or other officially designated computer systems physician order entry (POE) menus for prescribing inpatient physician order entry (IPOE) and outpatient medications on the MTF formulary. IPOE may vary depending on location and scope of practice.

g. The approval of prescriptive authority and the access to and use of CHCS POE menus will coincide with the completion, approval, and annual reassessment of the credentialing and privileging process.

11-12. Signatures

a. With the exception of POE via the CHCS, no prescription or order will be filled in the pharmacy unless it bears the signature of an individual authorized to write prescriptions. Signature stamps are not authorized for prescriptions. The pharmacy service will maintain a system that allows their staff to validate the signature of individuals privileged to write prescriptions within their MTF.

b. Subject to such restrictions as may be imposed by the local commander, the pharmacy will honor bulk orders for drugs other than controlled substances when signed by a designated representative of the officer in charge of the patient care area. The name and signature of each designee must be provided to the pharmacy in advance.

c. Orders for controlled substances will be signed by individuals authorized to write prescriptions or by a registered nurse.

d. MTFs with electronic ordering capability may use electronic signatures if security measures are provided.

11-13. Prescription writing

a. Prescriptions will be stamped, typed, or written in ink and signed in ink by an authorized prescriber. As an exception to this rule—

(1) Electronic prescriptions generated through the CHCS, to include prescriptions for Schedules II through V controlled substances, may be filled by the pharmacy contingent upon guidelines established in ASD (HA) Memorandum dated 31 May 1990 and letter dated 26 Mar 1990. Otherwise, prescriptions for Schedule II substances require an original prescription.

(2) MTFs may accept prescriptions electronically or via facsimile from civilian prescribers outside the facility according to appropriate State laws. Controlled substance prescriptions will not be accepted by facsimile.

(3) A carbon, facsimile, or electronic copy of prescription orders noted for a patient at the time of discharge in the nursing notes, to include prescriptions for Schedules II through V controlled substances, may be filled by the pharmacy.

(4) In the event that a multiple prescription (military or civilian) is presented to the pharmacy and the pharmacy does not stock all the medications ordered, the pharmacy will make a copy of the prescription for the pharmacy's files. The original prescription will be annotated as to which items were filled and returned to the patient. An original prescription must be on file for controlled substances.

b. Prescriptions will be dated and signed on the day when written and bear the full name, address, and telephone number of the patient and SSN of the sponsor. When patients present more than one prescription for other than controlled substances, the full name must be on all with the above-required information on at least one of the prescriptions. DD Form 1289 will contain only one item per form.

c. In accordance with current policies, authorized military and DOD providers who are authorized to prescribe, dispense, and administer controlled substances will record their DEA number or national provider identifier (NPI) on all prescriptions written for controlled substances in the course of their official duties. The prescriber will place his or

her signature; branch of service; DEA number or NPI; and name (stamped, typed, or hand printed) on each controlled substance prescription. When working in other than their official capacity (that is, off-duty employment), military and DOD civilian MTF providers will be required to have their own personal DEA number. Contract prescribers working in MTFs are not officials of the Armed Forces and, therefore, must have a DEA number to prescribe controlled substances within the MTF.

d. Prescriptions written for children 12 years of age and under will include the child's age and weight.

e. Prescriptions originating in Army MTFs will be written using the metric system.

f. Prescriptions for controlled substances written at Army MTFs will have the amount prescribed shown both in numerals and spelled out in words.

g. Healthcare providers are encouraged to include the indication for each medication on the face of the prescription and on inpatient medication orders.

h. Prescriptions written by civilian or military veterinarians for government-owned animals (GOAs) will be honored at Army MTFs. Prescriptions for privately owned animals (POAs) will not be filled.

i. Prescriptions written by foreign licensed practitioners and brought into MTFs located within the United States may be filled according to the appropriate State law. In MTFs located outside the United States, the laws of the foreign country and the terms of the applicable treaty and/or administrative agreement between the United States and the foreign country concerned will be followed.

j. A system designed to ensure eligibility of outpatients will be established. Local policies and procedures will address actions the pharmacy will take when they encounter noneligible patients. Also, a system to ensure accurate identification of outpatients at the time they receive prescribed medications will be established.

k. The pharmacy data transaction service automatically screens all patients' outpatient medications against the patient's total drug profile (MTF, TRICARE retail network, and MOP) for drug interactions, drug overlaps, drug dosage, and patient compliance.

l. Prescriptions written by civilian healthcare providers will comply with their respective State law (that is, if the State requires controlled substance, class 2 prescriptions to be written on a triplicate form, then the MTF will not accept a prescription written on a single form).

m. Prescriptions for noncontrolled medications, to include legend and over-the-counter (OTC) medications, are valid for 365 days. Refills will not exceed 1 year.

11–14. Dispensing

a. General. The MTF commander will ensure adherence to the DOD tri-Service pharmacy policy guidance for dispensing medications. Wards, clinics, and other activities within the MEDCEN/MEDDAC will use the pharmacy as the source of supply for drugs administered within the MTF. In addition, the pharmacy dispenses such preparations, as may be authorized and required, directly to inpatients and outpatients.

b. Prescription forms.

(1) DD Form 1289 is the standard form. Prescription forms provided by or preprinted by a commercial company will not be used in Army MTFs. The CHCS automated equivalent is acceptable.

(2) The MTF commander may authorize use of other official forms for prescribing medications (for example, SF 600, SF 558 (Medical Record–Emergency Care and Treatment), or DA Form 4256 (Clinical Record - Doctor's Orders)).

c. Logs. A log or automated documentation will be maintained of all medications placed in storage-counting cells. Information documented will include drug name, manufacturer, lot number, expiration date, and quantity filled. A double check system will be used showing the initials of the pharmacist or technician filling and checking the filled cell. Disposition of these logs will be according to paragraph 11–24.

d. Bulk drug orders. DA Form 3875 (Bulk Drug Order), a local form, or an automated system will be used for ordering all noncontrolled drugs or preparations in bulk quantities for use in wards, clinics, or other activities. Items requiring maintenance of a stock record card will be issued only upon receipt of a properly written and authenticated prescription blank or locally approved form. The chief, pharmacy service will establish mechanisms to review and approve medications for stockage in these areas. At least annually, the appropriateness of these items as well as their stock levels will be reviewed and approved.

e. Dispensing procedures.

(1) All legend drugs will be dispensed only upon receipt of a properly written or automated prescription and recorded in the patient's CHCS medication profile.

(2) A policy relative to filling civilian prescriptions will be established and announced by the commander. The policy will coincide with those regulating staff prescribers except in those MTFs located in a State where the law limits product substitution by the pharmacist. In such areas, the generic equivalent will not be substituted for a brand name drug on a civilian prescription without prior approval of the prescriber.

(3) The MTF commander will ensure that written procedures for dispensing controlled medications comply with Federal laws and Army regulations.

(4) A policy will be established that allows prescribers to order up to a 90-day supply of maintenance medications.

The prescriber will maintain the flexibility to determine dispensing quantities for individual patients. Prescriptions will be filled as written up to the 90-day supply.

(5) Prescriptions of up to 180 days or an amount specified for current operations may be dispensed to deploying Soldiers according to paragraph 11–28.

(6) All items provided to outpatients will be dispensed in accordance with the Poison Prevention Packaging Act of 1974 and in accordance with policies prescribed by the commander and will be labeled to include the legend “KEEP OUT OF THE REACH OF CHILDREN.”

(7) During the hours that the pharmacy is closed, amounts of drugs sufficient to provide treatment until pharmacy services are available or to complete a therapeutic regimen may be dispensed directly from an after-hours walk-in clinic or from the emergency department or service. The use of automated dispensing equipment that uses a bidirectional CHCS interface is acceptable. The prescriber must check all prescription medications before they are given to the patient. All prescription containers will be labeled to show the identity of the facility, date filled, directions to the patient, name of drug, quantity issued, and the name of the patient and prescriber. Repackaged medications will include a lot number and expiration date. Documentation of all medications dispensed after hours will be entered into the patient’s medication profile, which must include the CHCS medication profile to the greatest extent possible.

(8) A coordinated system for after-hours dispensing of medications will be established and will include the consideration for a pharmacist or pharmacy technician on call to answer questions and/or provide medications beyond those accessible by nonpharmacy staff.

(9) A policy will be established whereby a pharmacist will conduct a retrospective review of all orders filled during the hours the pharmacy was closed. This review will occur within the next duty day.

(10) To ensure eligibility of care and patient safety, the MTF pharmacy will require the patient or designated individual picking up the prescription(s) to show the patient’s uniformed Services photo identification card or facsimile of the patient’s uniformed Services photo identification card upon receiving the prescription(s). In the absence of a uniformed Services photo identification card, MTF pharmacy personnel will verify eligibility and ask for the two MTF-recognized patient identifiers.

f. Self-care programs.

(1) At the discretion of the commander, individual MTFs are permitted to establish self-care programs using OTC nonprescription medications. The programs will be strictly defined and controlled to include a patient educational component, medications, and quantities included in the program. Unstructured medication hand-out programs are not authorized.

(2) A self-care program includes a pharmacist who authorizes dispensing selected OTC medications.

(3) Items dispensed will be limited to OTC medications and packaging will comply with Federal law.

(4) Items dispensed will be documented in the patient’s CHCS medication profile.

(5) Self-care certificates or cards originally obtained from one MTF will be honored by another MTF, provided that the MTF has an established self-care program.

g. Refill prescriptions from other medical treatment facilities. Refilling a prescription from other MTFs is considered transferring the prescription. See paragraph 11–16 for procedures for prescription transfers. Exceptions to this are when multiple MTFs share a server. These prescriptions may be refilled without transfer.

h. Prescription pick up by a child. The age at which a child may pick up his or her prescription from the pharmacy without being accompanied by a parent or guardian is 12 years old. Pharmacists may use discretion if the patient appears unable to understand information about the medications.

11–15. Mailing prescriptions

The routine mailing of prescriptions to patients who are authorized to use either the MOP or the TRICARE retail network pharmacy is discouraged, but not prohibited. Exceptions are limited to cases of individual patients with exceptional need or hardship. If prescriptions are mailed, they must be in compliance with appropriate Federal and State law.

11–16. Prescription transfers

The MTF pharmacies are authorized to transfer prescriptions to and from DOD MTF pharmacies and retail pharmacies. All prescriptions except Schedule II medications may be transferred and filled provided the medication is routinely available on the outpatient pharmacy formulary and the patient is not in the Sole Provider Program. Prescription transfers must be communicated between two licensed pharmacists or certified pharmacy technicians provided that one of the individuals transferring or receiving the prescription is a pharmacist as required by the State Boards of Pharmacy. To transfer these prescriptions, Army pharmacies must follow all applicable regulations and Federal law. As a courtesy, MTF pharmacies will provide and accept any requested information from or to civilian pharmacies as required by that State. The MTF pharmacy will develop a local standing operating procedure (SOP) to facilitate beneficiary prescription refill transfers and to accommodate available resources and staffing.

11-17. Labeling

a. A label will be prepared for each prescription dispensed to individuals and will be securely affixed to the container prior to dispensing. The information on the label will be consistent with Federal law and the HIPAA.

b. Supplemental labels will be affixed to prescription containers as dictated by the pharmacist's professional judgment and the current standard of pharmacy practice. Such labels will be used to warn individuals of potential interactions or side effects, special handling or storage requirements, or poison considerations.

c. Labeling requirements for drugs issued in bulk to wards, clinics, and other authorized agencies will be as prescribed by the commander. The container label will include the generic name and strength, manufacturer, lot number (or locally assigned lot number), and expiration date.

d. OTC medications dispensed through a self-care program will be dispensed in the manufacturer's original package without additional labels attached.

e. Labels for intravenous admixture solutions prepared by the pharmacy service will comply with Federal law and appropriate standards of practice.

f. Labels for legend prescriptions dispensed by nonpharmacy personnel (clinic re-issue or after-hours clinic) will comply with Federal law.

g. During periods of computer down time, the product labeling requirements for prescriptions and intravenous admixtures remain unchanged.

11-18. Numbering and filing

All hard copy prescriptions and orders filled by the pharmacy will be placed in files established and maintained in the pharmacy. Prescriptions will be numbered serially and initialed by the individual who checked them. Three or more series of numbers will be used; one series for Schedule II controlled substances, alcohol, and alcoholic liquors; one series for Schedules III, IV, and V controlled substances; and one series for all others. A corresponding file will be established for each series of numbers. Pharmacies using CHCS or any other designated computer system will develop a suitable alternative method to number, check, and file prescriptions.

11-19. Stock record

The pharmacy will maintain a record of receipts and expenditures of all controlled substances, ethyl alcohol and alcoholic liquors, and of such other drugs as may be designated by the commander. A separate record will be maintained on DA Form 3862 (Controlled Substances Stock Record) for each dosage form in which the item is supplied except where an equivalent locally approved automated accounting record is used.

11-20. Disposition of drugs collected from patients

a. Nursing personnel will collect all drugs brought in by patients admitted to the wards. When possible, these drugs will be given to a member of the patient's Family. Drugs not given to a Family member will be turned in to the pharmacy for disposition as follows. A record will be maintained by the pharmacy of all medications turned in by patients or their Family members.

(1) If the medication is carried in stock by the hospital, the pharmacy has the option of either discarding the medication or storing the medication until the patient is discharged. If the patient has the same medication prescribed upon discharge and the retained medication is suitable for re-issue, then it may be returned to the patient with appropriate labeling. Medications not reissued will be turned in for destruction using an authorized and contracted pharmaceutical reverse distribution company.

(2) If the medication is not stocked by the hospital and the prescription came from a military pharmacy, it will be stored until the patient is discharged. It may be returned to the patient upon discharge if approved by the attending physician.

(3) If the medication was purchased by the patient from a civilian pharmacy, it will be stored until the patient is discharged. If requested by the patient or authorized Family members on behalf of the patient, it will be returned to the patient at time of discharge.

(4) The turn-in of controlled substances will be performed with a physical count and receipt system.

(5) Any medications held for more than 30 days after the patient is discharged, or not reissued upon discharge, will be turned in for further destruction as outlined in subparagraph (1), above.

b. Except as noted below, drugs collected from inpatients and stored at the pharmacy will not be used for treatment. All medications to be administered to inpatients will originate from pharmacy stocks. Patients may be allowed to use their personal medications when alternative drugs stocked in the pharmacy are not acceptable. Pharmacy personnel must positively identify the personal medications, and there must be a written order (describes medication, dose, route, and frequency) from a responsible practitioner. Blanket authorization is not appropriate. This information must be documented in CHCS as part of the permanent medication profile.

11-21. Pharmacy supply and support functions

a. *Noncontrolled drug inventory management.* To monitor for diversion of noncontrolled medication, the chief,

pharmacy service (or his or her representative) will implement policies and procedures to minimize the theft of Government property. The following procedures are required for use:

(1) Conduct quarterly reviews of selected medications to compare and reconcile with pharmacy financial records (for example, select the top twenty high dollar medications, the top twenty prescriptions prescribed, and twenty randomly selected medications to compare with the previous year's selections and reconcile with CHCS medication profiles).

(2) Report reviews through the pharmacy's PI structure.

(3) Conduct a 100 percent inventory on all pharmaceutical items once a year.

(4) Five medications will be added to the monthly noncontrolled inventory (see para B-12a).

b. Pharmaceutical returns management.

(1) A local policy will be developed for the return and/or destruction of drugs, biologicals, and reagents. The policy will be in compliance with appropriate DOD, Army, USAMEDCOM, and Federal regulatory guidance.

(2) When using a contracted reverse distributor, the following apply:

(a) The chief, pharmacy service will maintain oversight throughout the entire process. All inventory, disposal, and credit documentation will be reconciled and stored separately.

(b) Accurate accountability will be ensured using a verifiable audit trail. Inventory documents will be reconciled against follow-on processing documents such as waste reports, returnable for credit with anticipated return value reports, in-date material with anticipated return value reports, manufacturer credit memos or checks. Additionally, periodic follow-up will be done to ensure credits are received and processed within 90 days.

11-22. Inspection and disposition of prescription files and records

a. Inspection. Prescription files and medication logs will be subject to examination by inspectors and higher echelon commanders.

b. Disposition. Prescription files, controlled substance records, and other records maintained in pharmacy will be retained and disposed of according to AR 25-400-2 and HIPAA. The MTF records management officer must approve any alternative method of storage and disposal.

11-23. Investigational drugs

a. Within the FDA's jurisdiction, only FDA-approved medications will be procured for use in Army MTFs except when investigational drugs (see glossary) are used according to AR 40-7 and AR 40-38. The procedures outlined in AR 40-7 will be applied to the one-time emergency use of an investigational drug.

b. Outside the FDA's jurisdiction, every possible effort will be made to procure FDA-licensed pharmaceuticals. Some regional products, like selected antivenoms, are not procurable from FDA-licensed sources. AR 40-7 outlines procedures for documenting and reporting use of these products. The deployed medical authority must report any intended or actual purchases of non-FDA licensed pharmaceuticals.

11-24. Patient counseling

a. Pharmacists will conduct prospective drug use reviews and offer counseling to all patients receiving a new prescription. Counseling on refill prescriptions will be performed when appropriate.

b. Dispensing pharmacists will provide printed patient information sheets for new medications dispensed to supplement verbal counseling.

c. MTF pharmacy personnel will be sufficiently versed on the use, potential side effects, and drug interactions associated with herbal preparations, vitamin or mineral supplements, or other dietary supplements commonly used by DOD beneficiaries. Appropriate references will be readily available to answer questions from both patients and medical staff regarding these products. Mechanisms will be in place within the MTF to screen patients taking these supplements whenever medical histories are taken. Healthcare providers will document in AHLTA adverse events believed to be due to the use of dietary supplements and will notify the P&T committee. When appropriate, providers or the P&T committee will report these events to the FDA.

d. All counseling will be conducted in compliance with the HIPAA.

11-25. Drug samples

Drugs samples are generally prohibited from use in the MTF. However, if drug samples are needed to treat an individual patient, the chief, pharmacy service will control and maintain them in the pharmacy.

11-26. Pharmacy support to mobilizing and deploying personnel

a. Pharmacy services at each installation will provide medication screening and initial maintenance medication supply for all deploying Soldiers. The provision of the initial supply of maintenance medications and the establishment of the refill process for deploying Soldiers will receive the highest possible priority of pharmacy personnel at all Soldier readiness process (SRP) locations.

b. SRP is a term used to describe the process of screening and preparing Soldiers and units for deployment. SRP is

commonly completed at an SRP Center, Soldier Readiness Center, CONUS Replacement Center, or other location involved in deployment preparation of Soldiers. Pre-SRP screening is often done at the reserve unit level prior to mobilization.

c. During SRP, all Soldiers will be initially screened for medication needs using the Prescription Medication Analysis Reporting Tool (PMART). To request a PMART for the deploying unit, contact the Pharmacy Operations Center or for more information, enter <http://pec.ha.osd.mil/PMART/default.php> into the Web browser. The personnel deployment policy from the command responsible for the deployed area (for example, United States Central Command (USCENTCOM)) will determine specific medication guidelines or exceptions to quantities of medications dispensed. Generally, a minimum of 180-day supply of maintenance medications will be dispensed. Personnel needing malaria prophylaxis will deploy with enough medication to last the entire deployment and follow current guidelines for appropriate medication (for example, doxycycline, chloroquine, mefloquine, and so forth). Each Soldier's medications will be entered into the Soldier's CHCS medication profile to document drug therapy and to screen for potential drug-drug interactions or duplicate drug therapy. Each Soldier will be enrolled in MOP and provided contact information for updating address once at deployed site. Pharmacy personnel will review refill prescription forms for accuracy and forward completed MOP prescription forms to the Pharmacy Operations Center, for processing. The Joint Deployment Formulary, USCENTCOM formulary, current USCENTCOM deployment policy, and MOP contact information are available on the Pharmacoeconomic Center Web site: <http://pec.ha.osd.mil/PMART/deployment.php/>.

d. Individuals taking maintenance medications that require special handling, special monitoring, or not available in the deployed theater will be screened by the SRP medical officer for further evaluation and suitability of deployment.

e. A medication information sheet will be provided to each Soldier, DOD or DA civilian, and eligible contract employee upon the initial filling of all prescriptions in CHCS. Additionally, deploying personnel will receive Deployment Medication Information Sheets for vaccines and specified deployment-related medications which can be downloaded from the following Web site: <http://phc.amedd.army.mil/>.

11–27. Field pharmacy operational considerations

a. Pharmacy operations in a field environment will be organized to ensure the safe and effective use of medications throughout the hospital or other medical unit.

b. The commander is responsible for all aspects of medication use within the deployed medical unit and must develop and execute policies and procedures that ensure the safe and effective use of drugs for the prevention, diagnosis, or treatment of diseases and ensure medication use conforms to the highest standards of medical care.

c. The deployed medical unit chief, pharmacy service—in collaboration with the commander of the medical staff—will develop pharmacy and medication management policies and procedures and implement hospital-wide programs to ensure safe and appropriate drug therapy in the mobilized and deployed environment.

11–28. Pharmacy and medication automation

a. *Purpose.* Automated pharmacy and medication systems are designed for centralized filling of individual outpatient medications (prescriptions), unit dose medications, point-of-use systems, decentralized after-hours and remote site clinic dispensing cabinets, and other purposes. Any Army MTF that implements pharmacy automation will ensure that the technology interfaces with existing medical information systems. Further, the technology must enhance the facility's ability to meet current medication use standards of TJC and applicable Army physical security requirements.

b. *Safety checks.*

(1) All elements of the automated system require periodic checking, including, as applicable, patient information and medication profiles, computer controls for access, operations of drawers and bins, and transaction records.

(2) Each MTF that uses an automated system will have a written plan for safe and effective use of the system. The pharmacy will develop the plan with input from nursing, medicine, and other disciplines that may be affected by the system.

(3) Each MTF will have a written contingency plan for maintaining timely medication distribution, security, and documentation when system interruptions occur.

c. *Monitoring and surveillance.*

(1) The pharmacy will ensure that drug supplies are adequately controlled and that medication use is documented within the healthcare organization.

(2) The MTF will have a written plan for the monitoring and surveillance of medications accessed through automated systems. The pharmacy will develop the plan in collaboration with nurses, physicians, and others who interface in any way with the medication use process.

d. *Storage and inventory.* The pharmacy will develop criteria for determining the drug products and quantities that will be stored under different levels of access. Patient safety will be the primary concern in establishing criteria.

e. *Security and responsibility.*

(1) The pharmacy and other MTF stakeholders will ensure the integrity of the facility pharmaceutical supply chain. This includes the development and coordination of policies and procedures that reduce the risk of patient medication harm and economic loss through medication misuse, pilferage, counterfeit drugs, and drug diversion.

(2) The MTF will have a written plan that assigns responsibility and addresses security issues. The pharmacy will develop the plan with input from nursing, medicine, and other disciplines that may be affected by the system. The plan will clearly identify that the chief, pharmacy service has general responsibility for the automated system. The specific responsibilities of all personnel involved in operating or using the automated system will be defined in written policies and procedures.

Chapter 12

Use and Control of Psychological Test Materials

12-1. Purpose and scope

This chapter prescribes policies on the use and control of psychological test materials. This policy is applicable at all levels within the DA where psychological test materials are used.

12-2. Objective

The objective of this chapter is to identify a class of specialized professional materials and to provide guidance in the proper management of services using psychological test procedures.

12-3. Policy

a. All qualified psychologists as defined in the glossary section of this regulation are responsible for advising professional and staff personnel in the appropriate use of psychological tests. This includes direct responsibility for the use, security, and control of psychological test instruments in the functions of patient care, clinical investigations, personnel screening, and community and command consultation.

b. Psychological test results include sensitive, private, and confidential information. Every effort will be made to ensure that the procedures used in obtaining, recording, and reporting of psychological test results are appropriate, and that the test results are not misused. The use of psychological testing techniques by unqualified, nonprivileged persons is prohibited. To ensure the privacy rights of individuals are maintained, the Army Privacy Program (AR 340-21) provides overall guidance on information protection. The Army health promotion policy (AR 600-63) provides health promotion guidance. The health promotion, risk reduction, suicide prevention pamphlet (DA Pam 600-24) provides more details on information sharing.

c. Only qualified psychologists are authorized to supervise the administration, scoring, and interpretation of psychological testing.

d. Other users of psychological tests must be able to document formal, supervised training in the use of psychological tests, or use psychological tests under the direct supervision of a qualified psychologist. In addition, these individuals must possess a working knowledge of the principles of test measurement and be familiar with the literature pertaining to the psychological tests employed. Healthcare professionals who demonstrate and can document appropriate training, skill, and knowledge in the use of psychological tests, and who are granted clinical privileges to do so, may use psychological tests.

e. Users of psychological test procedures will adhere to the professional requirements set forth in the publications of the American Psychological Association that provide guidelines and standards for education and psychological testing, ethical principles for psychologists, and specialty services by psychologists.

f. Nonadherence to the policies and procedures of this regulation may jeopardize medical, legal, and administrative actions based on or supported by psychological test results. In addition, nonadherence could raise issues such as professional misrepresentation or misconduct, unlawful invasion of privacy, negligence in the safeguard of private information, or discriminatory healthcare practice.

g. Monitoring of psychological test use must be included in the PI structure.

h. The use of computerized psychological test administration, scoring, and interpretation services requires the direct supervision of a qualified psychologist.

i. Psychological test interpretation and reporting will be performed only by individuals who are qualified and granted privileges to do so by the MEDCEN/MEDDAC credentials committee, according to AR 40-68.

12-4. Supplemental conditions of psychological test use

The following conditions supplement the basic guidance on the use and control of psychological test material, equipment, data, and reports:

- a.* Test instruments, methodology, materials, and equipment—
- (1) Will be accessed only by those persons with professional interests who safeguard their use and security.
 - (2) Will be secured under locked storage when not in use.
 - (3) May not be removed from the physical premises of the professional agency unless under the direct supervision of a qualified psychologist.

- (4) Will not be reproduced in any fashion.
 - (5) Will not be described or displayed to others in ways that might invalidate their use.
 - (6) Will not be administered to, or practiced on, the general public, including Family members or friends. (It is acknowledged that practice subjects may be used in approved training programs.)
 - (7) Will be used only in situations having established formal and local referral procedures to either a qualified psychologist or to other behavioral health professionals as outlined in paragraphs 12–5*b* through *d*.
 - (8) Are subject to control, recall, and use under the direction of the responsible qualified psychologist.
 - (9) Are disposed of by locally appropriate destruction means when they are no longer usable due to obsolescence, defacement, or state of disrepair.
- b.* Acquired raw test data, test scores, and user aid documents (that is, test answer sheets, profile sheets, score summaries, or inference notes) will be—
- (1) Released only to persons who are qualified to interpret and use them properly. Such release requires the consent of the patient and must be closely supervised by a qualified psychologist.
 - (2) Subject to access and disclosure procedures of AR 340–21, AR 40–66, and the HIPAA if a patient or client requests copies of documents that result from psychological testing. Decisions of release, access, and inter-professional transmittal will include—
 - (*a*) The judgment of adverse affects on the individual’s behavioral health.
 - (*b*) The disposition advice of the senior qualified psychologist.
 - (3) Reported in official medical records or administrative or legal correspondence only with technical guidance, review, and approval of a qualified psychologist.
 - (4) Maintained and disposed of according to AR 25–400–2. When and if documents (acquired raw test data, test scores, user aid documents) are found in inpatient treatment records, OTRs, STRs, consultation service case files, or photograph and duplicate medical files (file number 40–66y), they will be removed and given to the psychology organizational element for proper filing in the clinical psychology individual case file.
- c.* Reports of psychological test evaluation or assessment (that is, written statements of test data analyses to include summaries, interpretations, diagnostic formulations, dispositions, and consultation request responses) will conform to the requirements of paragraphs 12–3*b* and *c*. Requests for release and disclosure of psychological testing evaluation reports will be processed according to AR 40–66, AR 340–21, and the HIPAA. Refer to paragraph 12–4*b*(2) for requests from patients.
- d.* According to AR 40–66, a review of clinical psychology entries in medical records (that is, inpatient treatment records (ITRs), OTRs, and STRs) will be an integral part of the “documentation review” activity in the PI structure.

12–5. Qualifications of occupations and specialties in psychological testing

The following is a list of qualification guidelines for personnel who are typically involved in the use (administration, scoring, interpretation, and reporting) of psychological tests:

- a.* Military, DA, and Government contract civilian psychologists who are eligible candidates for full professional responsibility in psychological testing include—
 - (1) Military officer personnel possessing the specialty skill identifier of psychologists, Medical Functional Area 73B67.
 - (2) DA and Government contract personnel who function in and have been appraised as qualifying to perform psychological evaluations in positions of—
 - (*a*) Clinical psychologist (series 180, GS–11 and above).
 - (*b*) Counseling psychologist (series 180, GS–11 and above).
- b.* Military officer and civilian personnel who are in training under the Clinical Psychology Internship Program may be involved.
- c.* Department of the Army or Government contract civilian personnel who function in psychologist positions (series 180, GS–09) and who qualify may be involved in the testing activities below only in consultation with a psychologist supervisor having professional accountability responsibilities. These personnel may—
 - (1) Administer and score psychological tests.
 - (2) Make preliminary interpretations of the validity and significance of test data.
 - (3) Evaluate overall patterns revealed by some psychological tests.
- d.* The following military and civilian personnel may be used for psychological test administration and scoring only under the supervision of a qualified psychologist. These individuals are not permitted to make test interpretations or accomplish other test usage activities:
 - (1) Military enlisted personnel awarded the MOS of mental health technician (68X).

(2) DA civilian personnel who qualify to function in psychology aid positions (series 181, GS-04) or psychology technician positions (series 181, GS-05 through GS-09).

Chapter 13

Emergency Medical Services

13-1. Applicability

This chapter establishes policy, prescribes procedures, and assigns responsibilities for the administration and management of emergency medical services (EMS) in nondeployed Army MTFs. This includes MTFs with inpatient capabilities as well as facilities that provide emergency ambulance services and advertise the provision of emergency care. Deployed MTFs set up on or near hospital grounds for training purposes are also subject to this regulation. Medical units deployed off post will meet these standards to the best of their ability in line with their overall mission. Policies also apply to U.S. Army (AD and RC) and civilian (civil services, foreign national hire, and contract) healthcare personnel.

13-2. Scope

Policies cover all aspects of EMS including those provided in both the prehospital and hospital settings. Policies do not address off-site deployed facilities.

13-3. Policy

a. Emergency medical services patients.

(1) Any eligible beneficiary with a stated or apparent patient care emergency arriving at a medical treatment facility will be evaluated, treated, and/or referred. It will be the responsibility of a designated EMS healthcare provider or the medical commander's designated representative to determine which patients have a patient care emergency and to refer the patient to the appropriate resources for care. If referral to another medical treatment facility (military or civilian) is necessary, the patient will be evaluated by the most appropriate senior and experienced provider and stabilized before transfer. If a physician is not available then the most senior and experienced authorized medical individual will make transfer decisions.

(2) Patients who are ineligible for military healthcare services, but come to an MTF seeking emergency care will be evaluated by a provider and will be treated as appropriate if the provider determines that a patient care emergency exists. Referral or transport to an appropriate civilian treatment facility will follow the written guidelines for transport and referral after appropriate provider evaluation.

(3) All MTFs will, during routine hours of operation, have the capability to determine if a patient care emergency exists and to initiate life and limb saving measures before providing definitive treatment or transporting the patient for definitive treatment.

(4) When a facility is not open for care, arrangements will be made to provide emergency assistance utilizing military or civilian resources. Such arrangements will provide an EMS level of care that meets or exceeds community standards and is consistent with the facility's mission, patient requirements, and medical assets.

b. Emergency medical services-level capability.

(1) The MTF commander will designate EMS capability at level I, II, III according to paragraphs (2), (3), and (4), below. Each MTF will be responsive to the healthcare needs of the population served but the designated EMS level will not exceed the personnel and equipment resources of the MTF. When the needs of a patient exceed the capability of available resources, then the patient should be referred to the closest appropriate facility.

(2) Level I emergency department or service—

(a) Offers comprehensive emergency care 24 hours a day with at least one physician experienced in emergency care (as defined in tables 13-1 and 13-2) on duty in the EC area.

(b) Has in-hospital physician coverage by members of the medical staff or by senior-level residents.

(c) Has specialty consultation available in the facility within approximately 30 minutes; initial consultation through two-way voice communication is acceptable.

(d) Additional physicians providing care must meet the criteria outlined in table 13-2.

(3) Level II emergency department or service offers emergency care 24 hours a day, with at least one physician experienced in emergency care (as defined in table 13-2) on duty in the EC area, and with specialty consultation available within approximately 30 minutes by members of the medical staff or by senior-level residents. Additional physicians providing care must meet the criteria outlined in table 13-2.

Table 13–1
Chief, emergency medical services—experience, training, and certification requirements¹

EMS level: Level I

Requirements: Successfully completed an accredited emergency-medicine residency and applied for, or successfully achieved, board certification in emergency medicine.

EMS level: Level II

Requirements: Successfully completed an accredited emergency-medicine residency and applied for, or successfully achieved, board certification in emergency medicine. One may substitute a physician who has successfully completed a primary-care residency and has 2 years' experience working in emergency medicine (working at least 20 hours per week) within the last 5 years. This substituted physician must also hold current certifications in ATLS, ACLS, and Pediatric Advanced Life Support (PALS)/Advanced Pediatric Life Support (APLS).

EMS level: Level III

Requirements: Successfully completed an accredited emergency-medicine residency and applied for, or successfully achieved, board certification in emergency medicine. As an alternative, one may substitute a physician who has successfully completed an accredited primary-care residency and has 6 months' clinical experience in emergency medicine (working at least 20 hours per week) in the past 2 years. This substituted physician must also hold current certifications in ATLS, ACLS, and PALS/APLS.

Note. ¹A physician who has successfully completed an accredited, emergency-medicine residency and applied for, or successfully achieved, board certification in emergency medicine is not required to have current certifications in ATLS, ACLS, and PALS/APLS. Any physician working in emergency medical services who does not meet the above criteria must have current certification in ATLS, ACLS, and PALS/APLS.

Table 13–2
Emergency medical services staff physicians—experience, training, and certification requirements¹

EMS level: Level I

Requirements: There must be at least one full-time physician physically present in the EC area 24 hours a day who has successfully completed an accredited emergency-medicine residency. As a substitution, that physician must be fully residency trained or board certified in a primary-care specialty, with current experience in emergency medicine. The physician must also hold current certifications in ATLS, ACLS, and PALS/APLS. Additional physicians on duty must have current certifications in ATLS, ACLS, and PALS/APLS.

EMS level: Level II

Requirements: Same as for Level I.

EMS level: Level III

Requirements: There must be at least one full-time physician physically present in the EC 24 hours a day who meets the same requirements as for Level I or Level II. As a substitution, that physician must be fully residency trained in any clinical specialty and have extensive, current, emergency-medicine experience (working more than 20 hours per week for the past 12 months) in similar or higher level emergency-care institutions. That substituted physician must also hold current certifications in ATLS, ACLS, and PALS/APLS. Additional physicians on duty must have current certifications in ATLS, ACLS, and PALS/APLS.

Note. ¹A physician who has successfully completed an accredited emergency-medicine residency and applied for, or successfully achieved, board certification in emergency medicine is not required to have current certifications in ATLS, ACLS, and PALS/APLS. Any physician working in emergency-medical services who does not meet the above criteria must have current certification in ATLS, ACLS, and PALS/APLS.

(4) Level III emergency department or service offers emergency care 24 hours a day, with at least one physician available in the EC. Specialty consultants for admission or referral must be available within a reasonable time. Procedures for transfer of stabilized patients must be prearranged and available. Additional physicians providing care must meet the criteria outlined in table 13–2.

(5) A facility that does not meet levels I through III should not be classified as an emergency facility and should not advertise itself as providing any level of emergency medical care. An MTF that does not provide 24-hour, in-house EMS will not use the word “emergency” to advertise its medical service capability. Signs indicating an EC or EMS capability will be restricted to those MTFs that offer EMS 24 hours per day.

(6) Facilities categorized at appropriate levels must have appropriately trained and certified staff, equipment, and supplies consistent with the national standard of the specialty of emergency medicine and contingency arrangements for practically dealing with unexpected situations (such as mass casualties and disaster preparedness).

c. Emergency medical services personnel.

(1) The Chief, EMS and the EMS staff physicians will fulfill the experience, training, and certification requirements as defined in tables 13–1 and 13–2.

(2) Clinical privileges granted to healthcare providers for EMS practice will be based on specific education, training, and experience requirements as stated in AR 40–68. The EMS clinical privileges for EMS healthcare providers will

define those patient care activities and procedures that providers can perform independently, those requiring consultation or supervision, and, as appropriate, those that cannot be provided. Experience and training requirements for civilian or contract physicians employed as EMS staff will be the same as AD military EMS physicians.

(3) The EMS facility will be staffed with EMS healthcare providers who have current life support training according to specified levels of this regulation. All EMS healthcare personnel must have current basic life support (BLS). Any exceptions will be made according to AR 40–68. PAs, NPs, and emergency nurses will have as a minimum, current Advanced Cardiac Life Support (ACLS) training. All PAs and NPs practicing in the EMS area without immediate physician supervision must also have current Advanced Trauma Life Support (ATLS)/Trauma Nurse Corps Course and Pediatric Advanced Live Support (PALS)/Advanced Pediatric Life Support (APLS)/Emergency Nursing Pediatric Course certification

(4) Training of emergency medical technician (EMT) personnel will be according to the Department of Transportation EMT National Standard Curriculum, or its equivalent, and accepted by the National Registry for Emergency Medical Technicians (NREMT). EMTs working in prehospital EMS, to include both ground and air ambulance, will possess and maintain current certification through the NREMT commensurate with the requirements of the positions to which currently assigned. Those positions include: emergency medical technician-basic (EMT–B), emergency medical technician-intermediate (EMT–I), and emergency medical technician-paramedic (EMT–P). Newly appointed civilian EMTs who are not NREMT-certified must, as a minimum, possess EMT certification from the State in which the employing MTF is located and any neighboring State(s) in which emergency responses are required. These employees, who do not have the NREMT certification, will be given up to 1 year to obtain national certification. There must be a process for monitoring NREMT status and validating that the NREMT certification remains current.

(5) Clinical privileges for providing patient care in an EC is required for appropriately qualified physicians, dentists, psychologists, social workers, NPs, and PAs. Physician supervision and accountability will be required when NPs and PAs are diagnosing and treating patients in an EC. Physician supervision, responsibility, and accountability are also required when EMT personnel are treating patients at the scene of an emergency, during emergency transport, or in the EC. Supervision of EMT personnel treating patients at the scene of an emergency, or en route, may be by two-way voice communications. EMT personnel will provide treatment only according to guidelines approved by the EMS physician supervisor who will be assigned oversight responsibility for all phases of prehospital care and standards.

(6) NPs, PAs, emergency nurses, EMTs, and other healthcare personnel may be used to augment physician services when appropriately privileged or certified and supervised. The records of emergency patients treated by NPs, PAs, and general medical officers providing care in the EC will be reviewed within a locally defined acceptable time of the treatment.

(7) All healthcare personnel will receive orientation training (including current BLS) before assignment in the EMS. Specific training in use of ambulance attendants in the EC, dispatch, medical control, EMT protocols, and organizational PI activities are encouraged.

(8) In a level I, II, or III EMS facility using NPs or PAs, the EMS physician will be present in the EC with the nonphysician providers. If the physician supervisor must leave the area for brief periods of time, he or she must be immediately available by two-way communications and be physically present in the hospital.

(9) When technical staff (91W, 91WM6, EMT, and nursing assistant) are used within the EC, their duties will be defined in writing. Supervision will be the responsibility of the EMS physician or charge nurse, as appropriate.

d. Physician referral. Any patient having a problem beyond the scope of the NP's or PA's clinical privileges or clinical judgment will be referred to an EMS physician. Common sense and good judgment should be used for referral of patients to supervising physicians by non-physician providers. Local guidelines should be developed for types of patients requiring physician referral. Examples of patients that may need referral include but are not limited to—

- (1) Any patient having a life threatening problem.
- (2) Any patient requesting to see a physician.
- (3) Any patient having a major trauma, multisystem injury.
- (4) Any patient having an unscheduled repeat visit within 72 hours for the same complaint or returning more than twice for an acute problem over a 1-month time period.
- (5) When the NP or PA determines the need for referral.
- (6) When patient transport or referral to another facility is necessary.
- (7) Alleged sexual assault.

e. Prehospital emergency services.

(1) Pre-hospital EMT services must be defined by the MTF commander as EMT–B, EMT–I, or EMT–P. Such services must be mission focused and meet the requirements of this regulation.

(2) Two healthcare personnel will accompany each ground ambulance when dispatched on an emergency. A minimum of one healthcare staff member will accompany each air ambulance when dispatched on an emergency. This may include any combination of qualified healthcare personnel who can provide for the emergency care of the patient. This individual is generally a member of the aircraft crew, although this does not preclude the use of other appropriately trained personnel. If the healthcare personnel are nonphysicians or do not have clinical privileges to provide emergency patient care, these individuals will be under the direction of an EMS physician. All treatment

during ambulance or helicopter transport—other than that rendered by an EMS physician—will be in accordance with guidelines approved by the EMS physician supervisor. (Health care for a patient should not be passed from a more experienced or higher level of care to a less experienced or lower level of care unless specifically approved by a responsible supervising physician who is accepting responsibility for the transfer.)

(3) All treatment in the prehospital setting will be appropriately documented at the scene, during transport, and finalized at the termination of the prehospital mission (for inclusion in the patient's ITR, STR, or OTR) according to the highest recognized local and national standards for EMS. A designated EMS physician supervisor will review all care provided by healthcare personnel during ambulance or helicopter transport.

(4) Each EMS will meet State and Federal requirements for ambulance vehicles and other emergency medical support equipment, unless specifically excluded for valid medical reasons by the responsible supervising EMS physician staff.

f. Written diagnostic and treatment guidelines.

(1) Written diagnostic and treatment guidelines for initial patient care in ECs will be available in each EMS. Guidelines will be developed or adopted and used to reflect nationally standardized guidelines or the equivalent. Guidelines may be supplemented locally but will be concise and convey the essential diagnostic and therapeutic measures that may be rendered quickly by EMS healthcare providers whose primary expertise may not be emergency medicine.

(2) Written diagnostic and treatment guidelines will be provided as aids for augmenting clinical judgment in prehospital patient care and to help avoid errors of omission. These guidelines should be developed and modified according to local resources and logical, acceptable standards. Flow chart or checklist-type guidelines in prehospital EMS also serve as educational aids and provide a quick review for EMS healthcare providers. EMS healthcare providers may responsibly deviate from established guidelines when clinical judgment so dictates, but such deviations should not exceed a provider's scope of practice.

g. Performance improvement. The EMS will actively participate in organizational PI activities as described in the MTF program. Occurrence screens specific to the EMS will be a part of the EMS PI process.

h. Patient transfer. A written plan will exist at each MTF for transporting or referring emergency patients for definitive treatment. The plan will establish responsibility for the patient during transfer and set forth procedures for conveying pertinent patient care documents, which will accompany the patient being transferred. The patient will be transferred only on order of the physician in charge (or designated representative) and after a physician at the receiving hospital has consented to accept the patient.

i. Community agreements. MTFs, as appropriate, will initiate written working agreements with the surrounding civilian MTFs. The working agreements will specify the requirements for prehospital response, patient referral and transfer, mutual support disaster plans, and the means of communication among facilities. EMS standards will meet or exceed surrounding community standards.

Chapter 14 Medical Laboratory Management

14-1. General

a. This chapter further defines CLIP implementation within the U.S. Army in accordance with policies and procedures contained in Armed Forces Institute of Pathology (AFIP) Pamphlet 40-24, published separately.

b. Specific CLIP technical standards and the minimal certification requirements for laboratories to perform testing on human specimens are contained in AFIP Pam 40-24.

c. This chapter defines the requirements for the Laboratory Response Network (LRN) mission within the Army Medical Department.

14-2. Applicability

This chapter applies to all fixed Army MTFs worldwide that operate a clinical laboratory. This chapter applies to AD, Reserve, and National Guard components and to clinical laboratories operated under the executive agency of the U.S. Army (U.S. Military Entrance Processing Command and the U.S. Army Corps of Engineers). This chapter does not apply to facilities that perform testing only for forensic purposes; research laboratories that test human specimens but do not report patient-specific laboratory results for the diagnosis, prevention, or treatment of any disease, or the assessment of health for individual patients; or laboratories that perform solely substance abuse testing under DODD 1010.1 and AR 600-85.

14-3. Responsibilities

a. The Commander, USAMEDCOM will—

- (1) Establish corrective action procedures for clinical laboratory facilities whose proficiency testing or performance criteria fall outside tri-Service CLIP regulations and standards.
 - (2) Establish standards and promulgate policy for implementation of quality clinical laboratory testing within all units assigned to the USAMEDCOM.
 - (3) Establish roles and capabilities of clinical laboratories for the LRN mission.
 - (4) Assign an Army LRN biopreparedness coordinator to ensure program objectives and goals are met.
- b. RMC commanders will—
- (1) Provide medical laboratory, LRN, blood bank, and pathology staff assistance visits and technical consultation to subordinate hospitals, occupational and health clinics, decentralized laboratories, blood donor centers, and departments of pathology throughout their region. Each subordinate hospital department of pathology will be provided a staff assistance visit by a regional consultant listed in paragraph (2) below a minimum of once a year. The RMC will fund the staff assistance visit.
 - (2) Appoint regional laboratory consultant(s) to provide oversight of proficiency testing and technical consultation throughout the region concerning laboratory standards, laboratory accreditation, and laboratory business practices. Personnel will be appointed as regional consultants for the following specialties: RMC pathology consultant (board certified pathologist), RMC laboratory consultant (laboratory manager–MOS 71E), RMC chemistry consultant (clinical chemist–MOS 71B), RMC microbiology and LRN consultant (microbiologist–MOS 71A), RMC blood manager/consultant (MOS 71E8T), RMC transfusion medicine consultant (MOS 61U), and RMC senior enlisted laboratory consultant (MOS 91K40/50).
 - (3) Analyze the use of laboratory resources and assess laboratory performance indicators throughout the RMC region. Develop regional laboratory business plans that optimize use of laboratory resources, consolidate commercial reference laboratory testing contracts, and regionalize the purchase or lease of laboratory reagents or equipment.
 - (4) Ensure maximum use of blood resources within the RMC by ensuring that blood and blood product inventories are kept at an acceptable medically indicated level, and cross-leveled throughout the region, as appropriate, to reduce outdated and wastage of a valuable resource.
 - (5) Support the laboratory readiness requirements of the Total Force throughout the RMC. Coordinate and take an active role in ensuring that readiness blood quotas for the ASWBPLs are met as directed from the USAMEDCOM. Coordinate a laboratory-related professional filler system or medical filler system and individual mobilization augmentee training of personnel in the region.
 - (6) Assign qualified pathologists to act as consultants, and, as required, the laboratory director of all medical laboratories in the region without director-qualified assigned medical personnel or director-qualified civilian contract personnel.
 - (7) Provide technical expertise and guidance, onsite monitoring as necessary, and reference laboratory support for laboratories in the region that fail regulatory laboratory proficiency testing. Under a plan of corrective action, approve the decision to resume patient testing for failed analytes or subspecialties in all medical laboratories located within the region.
 - (8) Ensure adequacy of services as follows. The regional pathology consultant will ensure that each subordinate hospital with a pathologist(s) maintains anatomic pathology support as required by the subordinate hospital mission. Where a subordinate hospital has only one pathologist, the RMC will ensure anatomic pathology does not lose current capability during the pathologist's absence, for whatever reason. The preferred method is to have cases requiring pathologist interpretation, excluding autopsies and frozen sections, sent to the regional MEDCEN. The regional pathology consultant will ensure that a back-fill or a mutually agreed upon alternative plan is provided when requested by the subordinate hospital commander. The RMC will provide the TDY funding for the back-fill.
- c. The MTF commander will—
- (1) Ensure the operation and CLIP registration of all medical laboratories within the MTF and all assigned clinics. CLIP registration is accomplished in accordance with AFIP Pam 40–24. This includes centralized laboratories (such as the Department of Pathology), but also includes all decentralized medical laboratories including all places in the facility where medical laboratory tests are performed. Examples of common decentralized medical laboratories in MTFs include the following: medical laboratory tests performed in the intensive care unit, critical care unit, EC, or other medical clinics, such as the physical examination clinic, or the occupational health clinic; in vitro medical laboratory tests performed by respiratory therapy or nuclear medicine; medical laboratory tests performed by nursing or other non-laboratory staff on patient wards; and medical laboratory tests performed by preventive medicine personnel as part of medical screening programs or health fairs.
 - (2) Determine the requirement and operational need for each decentralized laboratory assigned to the organization and register all medical laboratories (minimal, moderate, or high complexity laboratories, or provider-performed microscopy (PPM) laboratories) with the CLIP office.
 - (3) Ensure that each clinical microbiology laboratory is able to successfully meet the LRN-biopreparedness mission assigned to that laboratory. The clinical laboratory facilities will be classified as either a(n)—
 - (a) Basic sentinel LRN laboratory, which either has no, or minimal, clinical microbiology capabilities. These laboratories generally do not perform tissue, body fluid, or blood cultures. These laboratories will—

1. Have policies and procedures for referral of diagnostic specimens to either an advanced sentinel LRN laboratory or to an LRN reference laboratory.

2. Have policies and procedures for direct referral of suspicious cultures or specimens to the nearest LRN reference laboratory in its jurisdiction.

(b) Advanced sentinel LRN laboratory, which is a typical MEDDAC clinical microbiology laboratory with the ability to do tissue, body fluids, and blood cultures. These laboratories will—

1. Meet all criteria established for basic sentinel LRN laboratories, and;

2. Have policies and procedures that include the LRN sentinel level clinical microbiology laboratory guidelines detailing the presumptive identification of potential biothreat isolates from clinical specimens.

d. The chief, laboratory services or chief, department of pathology, depending upon the local designation, is charged with the duties of laboratory director as defined by the CLIP. The chief and his or her staff will ensure quality medical laboratory services throughout the organization, keeping abreast of new or modern developments in the medical laboratory field, and operation of the MTF medical laboratories in compliance with Federal laws; accreditation standards defined by TJC, the College of American Pathologists (CAP), the CLIP; and standards of practice within the community. In doing so, the chief will—

(1) Assist and advise healthcare providers on the cost-effective use of timely, quality medical laboratory services to aid in the medical screening, prevention, and diagnosis or treatment of disease, including monitoring of therapy.

(2) Conduct and document inspections and assistance visits for all medical laboratories within the MTF, including medical laboratories in all outlying clinics assigned to the MTF and all troop medical clinics supported by the MTF. Recurring problems and trends not corrected by department or service chiefs will be referred to the appropriate person or group within the MTF's specific organizational PI structure.

(3) Maintain adequate reference material (books, periodicals, atlases, computer-assisted instructional material, and so forth) and knowledge-based information systems for use by laboratory personnel and other professional staff served by the laboratory.

(4) Provide technical expertise and guidance, onsite monitoring as necessary, and centralized laboratory support for MTF laboratories that fail regulatory laboratory proficiency testing. Under the plan of action, approve the decision to resume patient testing in the MTF medical laboratory for analytes or subspecialties that scored as a two-time proficiency testing failure.

(5) Disseminate information to the professional staff concerning advances in laboratory medicine, use of the laboratory services, laboratory input to clinical practice guidelines adopted by the MTF, and related matters. Appropriate media (for example, CHCS, electronic mail, memorandums, and so on) will be used to disseminate information concerning available laboratory services, acceptable specimen requirements, methods of obtaining service, the cost of each laboratory test ordered, the reference ranges for all laboratory tests provided, and items of interest to the medical staff.

(6) Represent the laboratory services on various committees used by the MTF to improve information management, utilization management, and patient outcomes.

(7) Provide an adequate number of qualified, competent staff to perform the laboratory workload and to provide technical consultation and supervisory duties. The laboratory director also provides for orientation, in-service training, and continuing education for all personnel assigned to the clinical laboratory.

e. The reference LRN laboratory possesses assays available from the Centers for Disease Control and Prevention (CDC) LRN that can confirm the identity of significant biothreat organisms from natural or criminal events. These laboratories will—

(1) Meet all criteria established for advanced sentinel LRN laboratories, plus;

(2) Meet enrollment criteria established by the CDC LRN;

(3) Perform reference-level identifications using BSL3 biocontainment per procedure SOP;

(4) Adhere to all conditions of the LRN laboratory qualification agreement, and will not perform any procedure outside of established CDC LRN protocol;

(5) Coordinate with the USAMEDCOM LRN biopreparedness coordinator for any requests to increase or decrease LRN capabilities;

(6) Report any significant results, events, or challenges to the USAMEDCOM LRN biopreparedness coordinator.

f. Due to the potential impact of epidemic surges of seasonal or novel influenza, MTF laboratories will provide weekly respiratory viral workload data to the Laboratory Program Manager office weekly during each respiratory viral season, 1 October through 1 May.

14-4. Accreditation policies

a. All eligible U.S. Army hospital clinical laboratories (department of pathology or laboratory service) located in fixed MTFs in the United States, Europe, or Korea will be accredited by the Commission on Inspection and Accreditation of the CAP. Onsite accreditation inspections are required at least biennially.

b. All fixed MTFs, ambulatory care clinics, and troop medical clinics, including their assigned laboratories, will be

accredited by and follow the laboratory guidelines of the TJC. The required biennial TJC survey of laboratories by a qualified medical technologist inspector will be waived if all laboratories (non-waived testing) assigned to the MTF have been inspected and accredited by the CAP.

c. Decentralized laboratories (point-of-care testing, separate health clinics or troop medical clinics, or military entrance processing stations, and so forth) will be inspected biennially and accredited by the CAP, TJC, or the Commission on Office Laboratory Accreditation.

14-5. Laboratory personnel

a. The chief, laboratory service or chief, department of pathology will ensure that only properly qualified personnel whose competency has been assessed will perform and report the results of laboratory testing. Qualifications for testing personnel will be based on laboratory test complexity (minimal, moderate, or high complexity) and will meet the requirements of AFIP Pam 40-24.

b. Local, onsite training of military or civilian personnel to perform limited minimal or moderate complexity laboratory testing is permitted. In these cases, prior to analyzing patient specimens and reporting patient results, personnel must be trained appropriately for the laboratory testing performed with a formal training program, not solely limited to on-the-job training. Documentation of training, skills, and competency assessment for these individuals will be maintained in a competency assessment file per AR 40-68.

c. PPM, a special subset of moderately complex laboratory analyses, may be performed by privileged providers when authorized by the MTF commander and competency assessed. In such cases, the PPM lab must be registered with CLIP and approved procedures for PPM tests must be instituted.

d. At MTFs that do not have an assigned pathologist, a qualified licensed physician according to AFIP Pam 40-24, will be assigned as the director of the laboratory and competency assessed. At inpatient facilities without an assigned pathologist, the commander will ensure that appropriate and timely professional pathology services are available to the staff and patients of the facility.

e. At all MTFs without an assigned civilian or military pathologist or without an equivalent contracted pathologist, the commander of the facility will appoint an appropriate regional military pathologist as a consultant to the medical staff of the MTF.

14-6. Quality control

a. Sound quality-control systems in all MTF clinical laboratories, including decentralized laboratories, are essential to providing excellent services. Quality control systems must be designed to ensure medical reliability and timeliness of laboratory data. The goal of quality control is to achieve the most accurate test results and outcomes.

b. Each laboratory must have a written, defined, and approved quality-control program that meets the standards of the CLIP and any applicable accrediting body. The quality-control system must address pre-analytical, analytical, and post-analytical phases of laboratory testing and results reporting.

c. For the subspecialty of cytopathology, a written quality-control program must be in place to measure, assess, and improve quality in cytology addressing the accuracy of both positive and negative findings. Each cytopathology service will be directed by a pathologist or other physician qualified in cytology who will maintain the quality of the service through direct supervision and adequate oversight. Cytology service personnel will be assessed in accordance with cytopathology competency requirements in AFIP Pam 40-24.

14-7. Monetary collections for laboratory services

The laboratory will not serve as a monetary collection agency for medical laboratory test services. However, laboratory personnel will assist the command's third party collection office in billing third party insurers for laboratory tests authorized under the TPCP.

14-8. Improving organizational performance

a. A laboratory's performance of important healthcare functions significantly affects the outcomes of the patients it serves, the costs to achieve these outcomes, and the patient's or customer's perceptions or satisfaction. The goal of organizational PI is to continuously improve the laboratory services that affect patient health outcomes.

b. The chief, laboratory services will implement a collaborative and interdisciplinary performance improvement process that will demonstrate improvement in laboratory services. This process will be integrated with the MTF's organizational PI structure, and documentation will provide evidence of ongoing improvement processes.

c. Data will be collected on important laboratory processes and outcomes, including as a minimum patient preparation; handling of specimens; communication processes; appropriateness of laboratory tests offered (utilization management); and the needs, expectations, and satisfaction of patients and other customers. Data on important processes and outcomes are also collected from risk-management and quality-control activities.

d. Data for the defined RMC metrics will be collected and reported electronically using the USAMEDCOM Laboratory Program Office automated tool for assessment.

14–9. Individuals authorized to order laboratory tests

a. The following categories of personnel are authorized to order laboratory tests:

(1) Uniformed and civilian physicians, dentists, veterinarians, optometrists, and podiatrists engaged in professional practice at uniformed Services' MTFs.

(2) Other uniformed and civilian providers with privileges at the MTF which allow them to do so. Providers include, but are not limited to: certified nurse midwives, NPs, PAs, chiropractors, dietitians, clinical pharmacists, and psychologists.

(3) Civilian physicians, dentists, optometrists, and podiatrists not assigned to a uniformed Service's MTF, but licensed in the jurisdiction of their practice and treating personnel eligible for care within the MHS.

(4) Civilian nonphysician healthcare providers not assigned to a uniformed Service's MTF, but licensed within the jurisdiction of their practice and treating personnel eligible for care in the MHS, to the extent authorized by State law and by policies for equivalent staff nonphysician healthcare providers.

b. Requests for medical laboratory tests written by licensed civilian practitioners not assigned to a uniformed Services MTF for personnel eligible for care in the MHS will be honored at Army MTFs according to AR 40–400 subject to the availability of space, facilities, the capabilities of the professional staff, and the following considerations.

(1) A policy relative to performing and reporting laboratory tests ordered by civilian practitioners will be established and announced by the local commander. This policy will coincide with policies regulating staff ordering of laboratory tests. This policy also must include policies on reporting emergency or alert (panic) value laboratory results to civilian practitioners.

(2) Performing a laboratory test requested by a civilian practitioner does not imply knowledge of, or responsibility for, a patient's medical condition. Under no circumstances will civilian laboratory test requests be countersigned or rewritten by military practitioners.

(3) A distance factor or geographic boundary limitation will not be the basis for denying laboratory testing services. MTFs may accept orders for laboratory tests electronically or in writing from civilian practitioners outside the MTF. Oral orders will not be accepted from civilian practitioners outside the MTF.

(4) Orders for laboratory tests written by foreign licensed practitioners and brought into MTFs located within the United States may be honored in accordance with appropriate State law. In MTFs located outside the United States, the laws of the foreign country and the terms of the applicable treaty and/or administrative or status of forces agreement between the United States and the foreign country concerned will be followed.

(5) The Internet will only be used for transmittal of encrypted laboratory results or patient demographic data which is subject to the Privacy Act and to the HIPAA. Unencrypted laboratory results or patient demographic data can only be sent using direct modem communications, such as a fax machine.

14–10. Self-performance of laboratory tests

a. Patients will not be required to self-perform laboratory tests within the MTF. When current medical practice indicates that a patient may routinely monitor their condition or treatment using an FDA-approved laboratory test for home use, healthcare providers assigned to the MTF may train the patients on the use and interpretation of the FDA-approved home laboratory test.

b. Only qualified personnel will perform laboratory tests within the MTF. The results of all laboratory tests performed in the MTF will be entered into clinical information system (that is, Essentris) or laboratory information system (that is, CHCS) and in the appropriate patient medical record according to AR 40–66.

14–11. Inspection and disposition of laboratory files and records

a. Inspection. Laboratory files and records will be subject to inspection (by personnel from accreditation organizations, other Government entities, and the CLIP) and higher echelon commanders at all times.

b. Disposition. Laboratory files, testing results, and other records maintained by the laboratory will be retained and disposed of according to AR 25–400–2.

Chapter 15 Veterinary Care

15–1. General

This chapter provides guidance for the delivery of veterinary medical care within the U.S. Army. The multi-Service publication AR 40–905/SECNAVINST 6401.A/AFI 48–135 addresses veterinary responsibilities and functions to all DOD agencies and the services. Public health and veterinary commanders are responsible for delivery of effective and efficient veterinary care. Veterinary medical care provided will be consistent with accepted professional standards.

15-2. Veterinary services

The Secretary of the Army has been appointed the DOD Executive Agent for veterinary services in accordance with DODD 6400.4 and provides veterinary services to all branches of the DOD. Veterinary services include, but are not limited to—

- a. Veterinary medical care for GOAs.
- b. Control of zoonotic diseases.
- c. Food safety, food defense, and QA programs.
- d. Veterinary medical care for POAs.

15-3. Authorizing care

The public health or veterinary commander will establish the extent and priority to which veterinary medical care is provided to GOAs and POAs within the area of the commander's scope of responsibility.

15-4. Providing veterinary medical care

Public health or veterinary commanders will determine how best to employ available resources to provide authorized veterinary medical care taking into consideration the following factors:

a. *Animal categories.* The population and health needs of the different categories of animals provided veterinary care—

- (1) Military working dogs (see AR 190-12), military working horses, and GOA and POA health assistance animals (seeing-eye dog, and so forth).
- (2) Non-appropriated fund (NAF) animals (rental horses and so forth).
- (3) Unit mascots authorized by appropriate orders.
- (4) Noncommercial POAs for authorized care.
- (5) Other GOAs in confinement (buffalo, deer, strays, and so forth).
- (6) Free-ranging wild or feral animals (game animals, horses, and so forth).

b. *Acuteness of the condition.* The presentation of any animal with an acute, life-threatening condition is the highest priority for care. The provision of all other veterinary care is left to the professional judgment of the attending veterinarian consistent with the use of available resources and other factors as determined by the commander.

c. *Civilian veterinary care for military working dogs and military working horses.* In certain circumstances, a military or NAF veterinarian may not be available to provide needed care for a GOA. In these cases, AR 40-905 provides for payment of civilian veterinary care if the following circumstances are met.

- (1) The care is authorized by AR 40-1.
- (2) The care needed is for an emergency or is requested at a time when an Army or NAF veterinarian is not available. The caretaker of the animal needing the care must have permission to use a civilian veterinarian. This permission can be obtained by—

(a) Calling the responsible military veterinarian or a delegated animal technician. This necessitates providing all veterinary customers with current emergency telephone and pager numbers and being available to answer calls.

(b) Using a roster of participating local veterinarians that has been previously distributed by the responsible military veterinarian who has specifically noted when he or she will not be available.

(3) Prior written agreements with one or more local civilian veterinarians to accept these types of cases at the time of need with charges being at or below their normal rate of reimbursement for services and supplies.

d. *Impact on the Army's mission effectiveness.* Potential areas of concern are as follows:

- (1) Deployability of military working dogs being assigned or likely to be assigned to combat, humanitarian relief, or other areas of intense Army concern.
- (2) The POAs likely to be moved because of military actions, political unrest, or natural catastrophes such as noncombatant evacuation operations.
- (3) The POAs belonging to Army personnel assigned to isolated areas where veterinary care is not available from civilian sources.
- (4) Disease status of indigenous feral and wildlife and local POAs, for example, an outbreak of rabies, leptospirosis, Lyme disease, or other major zoonotic disease could influence military plans.

15-5. Veterinary training assistance team

a. *Purpose.* The veterinary training assistance team (VTAT) will perform onsite technical demonstrations and training on veterinary preventive medicine, clinical veterinary medicine, food safety, and QA. VTAT visits may be performed as a cost-effective training measure or when such training cannot be obtained practically through other means.

b. *Staffing.* The AMEDD C&S will form VTATs in coordination with public health or veterinary unit commanders and senior staff elements of ACOMs, ASCCs, and DRUs. Staff personnel to form a VTAT may come from the following sources:

- (1) AMEDD C&S.
- (2) U.S. Army Public Health Command.
- (3) Other DOD agencies.
- (4) Other qualified persons.

c. Availability. The VTAT is available on request to public health commanders, TOE veterinary unit commanders, major overseas commanders, and commanders of military advisory groups or teams. Commanders wanting the help of a VTAT will send a written request to the Commander, AMEDD C&S (MCCS–HV), 3630 Stanley Road, Fort Sam Houston, TX 78234–6100. The requesting commander will ensure all requests are coordinated in accordance with their command policy. The AMEDD C&S will coordinate time and location of training with requesting agency.

d. Funding. The VTAT may be funded by the AMEDD C&S, the requesting commander, or a combination of sources subject to availability of funds.

Chapter 16

Air Ambulance Vehicles

16–1. Purpose

This chapter describes Army air ambulances, prescribes the use of these vehicles, establishes policy pertaining to use of special equipment, and specifies requirement authorization for these aircraft.

16–2. General

a. The Army recognizes the strategic value of the medical evacuation (MEDEVAC) mission and has implemented the aeromedical evacuation standard of a one-hour mission completion time for urgent and urgent surgical missions (time from mission request to delivery of the patient to the appropriate medical care).

b. In DAGO 2002–03, as amended by DAGO 2009–03, the Secretary of the Army assigns The Surgeon General responsibility for development, policy direction, organization, and overall management of Armywide health services.

c. Army air ambulance companies are medical units (special requirements code 08 versus 01 aviation) designed to transport patients and medical department personnel. Army air ambulance use is restricted to—

- (1) Transporting sick, wounded, or injured persons who are eligible, by law or regulations, to receive medical care.
- (2) Transporting medical department personnel.
- (3) Transporting supplies and equipment used in the care and treatment of the sick, wounded, or injured.
- (4) Instructing personnel required to use air ambulances.
- (5) Operating solely as dedicated evacuation platforms in support of the fundamental mission set and corresponding training requirements as described in Army Training and Evaluation Program (ARTEP) 1–118–MTP, FM 4–02.2, FM 4–02.10, and the appropriate aircrew training manual or training circulars.
- (6) Operating according to AR 95–1.
- (7) Operating in support of humanitarian assistance missions.

16–3. Authorization

Air ambulances are authorized for use in accordance with the allowances in TDAs, TOEs, or DA special authorization documents. Air ambulance use and marking will be in accordance with this regulation and AR 95–1. Waiver authority will be in accordance with AR 95–1. National Guard Bureau requests for exceptions to the authorized operational uses (while in Title 10, Title 32, or State active duty status) must comply with the operations and safety chapter in AR 95–1 and National Guard (NG) Pamphlet 95–5.

16–4. Operational control

a. The Medical Evacuation System consists of ground and air medical evacuation platforms, which work in concert to clear the battlefield. Air ambulances are under the command and control of combat aviation brigades and general support aviation battalions, which are responsible for the execution of the Health Services Support Plan and/or the Joint Service Support Plan. The AMEDD will influence the use of these assets through doctrine, training, laws, regulations, and the orders process to ensure aeromedical evacuation missions are executed in accordance with the Health Services Support Plan and/or the Joint Service Support Plan.

b. The aeromedical evacuation standard of a 1-hour mission completion time for urgent mission and urgent surgical missions is consistent with Army guidance and objectives outlined in this regulation and in AR 95–1.

(1) The primary focus of the MEDEVAC mission is patient care. The effort to save human life warrants accepting additional risk when there is a reasonable expectation of success. Commanders must not be overly focused on meeting the 1-hour standard as patient needs may dictate longer flight legs to reach appropriate care.

(2) Commanders should establish and enforce procedures according to AR 95–1 that authorize prebriefed and

preapproved MEDEVAC missions to launch immediately upon request without rebriefing and reapproval. This requires decentralized medical and aviation processes that place the execution decision at the lowest practical level.

(3) Commanders should incorporate MEDEVAC procedures according to AR 95–1 that authorize single-ship MEDEVAC aircraft missions as well as en route linkups with escort or security, when acceptance of this risk is tactically feasible.

(4) Aviation brigade commanders are authorized to delegate high-risk approval authority to battalion commanders and moderate-risk approval authority to field grade MEDEVAC company commanders for urgent and urgent surgical missions according to AR 95–1. This delegation of authority is reasonable, appropriate, and necessary to provide maximum flexibility to brigade commanders and facilitate rapid response. This authority may not be delegated.

(5) The Army has designed MEDEVAC companies to be commanded by 67–J field grade commanders (O–4) because of the unique mission. These commanders possess the technical and tactical understanding of both medical and aviation missions necessary to ensure that proper experience, training, and authority is resident at the unit level for successful mission execution.

16–5. Equipment

Air ambulances will—

- a. Contain supplies for the care and treatment of patients.
- b. Contain the essential patient movement items and equipment listed in appendix D. Additional patient movement items and equipment may be added at the discretion of the commander or, as dictated by the mission.
- c. Be equipped as indicated in the appropriate AR, TOE, TDA, or special DA authorization document.
- d. Have both an approved airworthiness release from Aviation and Missile Command (in accordance with AR 70–62 and AR 40–61) and an approved medical certification from Medical Research Materiel Command, for each patient-movement item or equipment used on board the aircraft.
- e. Not use medical equipment unless determined through Airworthiness Certification and Evaluation testing by the USAMRMC to be suitable for air ambulance use in order to meet requirements of paragraph 16–5d, above. Contact them at: U.S. Army Aeromedical Research Laboratory, Attention: ACE Program Manager (MCMR–UAX–FS), Fort Rucker, AL 36362. Phone numbers: commercial 334-255-6957/6820 or DSN 558. Email them at: awr@se.amedd.army.mil/.
- f. Not carry on board or install crew-served weapons on aeromedical evacuation aircraft at any time, even if mounting brackets are present.
- g. Clearly mark all aeromedical evacuation aircraft on the nose, lower, upper, and lateral surfaces according to TM 55–1500–345–23. Red Cross markings will not be removed, painted over, or obscured.

Chapter 17

Placement and Use of Automatic External Defibrillators on Army Installations and Within Army Facilities

17–1. Overview

This chapter provides regulatory guidance regarding responsibilities for public access defibrillator programs as well as the placement of automated external defibrillators (AEDs) at strategic locations on Army installations and within Army facilities.

17–2. Authority and guidance

Title 42, United States Code, Chapter 238p requires the Secretary of Health and Human Services to establish guidelines with respect to placing AEDs in Federal buildings. These guidelines are available at the Department of Health and Human Services Web site (<http://www.foh.dhhs.gov/public/whatwedo/AED/HHSAED.asp>). Under the provisions of DODI 6055.06, the Secretary of the Army is responsible for executing emergency services programs on Army installations.

17–3. Responsibilities

a. *Installation and garrison commanders.* Overall responsibility for the public access defibrillator program rests with the installation commander. Responsibility for program execution rests with the garrison commander who will delegate day-to-day responsibility for the program to the garrison director of emergency services (DES) or to an equivalent position at installations without a DES.

b. *Director of emergency services.* The DES will determine— how many AEDs the garrison requires for all buildings and other areas under garrison control, the purchasing procedures necessary to acquire them, where they will be placed, who should be trained in their use, and who will be responsible for ensuring adequate training and training recordkeeping. Tenant units will be responsible for similar actions for buildings or areas under their direct control.

c. Military treatment facility commander or director of health services. The MTF commanders will provide subject matter expertise to the installation or garrison commanders they support and will specifically work with the garrison DES to help ensure a high quality program that complies with all laws and regulations and that meets the medical needs of the community served. As a tenant unit commander, the MTF commander bears responsibility for all AEDs deployed within the MTF. The director of health services will designate a physician as the public access defibrillator program SME, who will assume medical oversight responsibilities. At installations with no director of health services, the supporting MTF commander will designate such a physician. At installations with neither a director of health services nor an MTF, the first higher level command with physician-level medical support will designate such a physician to provide AED program oversight for the installation.

d. Public access defibrillator program subject matter expert. The physician designated as the SME will advise the command on development of the public access defibrillator plan and protocols, and will be involved as a consultant in all aspects of the program, not only as the program's prescribing physician, but also as an active participant in all phases. The SME will ensure the installation's public access defibrillator plan and established protocols comply with all DOD regulations applicable for prescriptive devices and must approve the installation plan prior to implementation. The SME will conduct an assessment of the public access defibrillator system's performance after the use of an AED, including review of the AED data and the electrocardiograph tracing of the victim. The SME will assist the garrison leadership to publicize and explain their public access defibrillator programs to the local community and to appropriate EMS and hospital systems.

e. Tenant agencies, organizations, or units. Individual agency, organization, or unit responsibility for AEDs rests with the tenant unit commander or tenant agency's or organization's director. The director or commander of each tenant agency, organization, or unit is responsible for ensuring compliance with the standards published by the garrison commander; for coordinating with the DES; and for ensuring that agency, organization, or unit personnel are trained in the use of an AED.

f. Staff or command judge advocate. The servicing staff or command judge advocate or command counsel will review the installation public access defibrillator program to ensure compliance with applicable Federal, State, local, and/or host-nation laws and DOD and Army regulations. The servicing staff or command judge advocate or command counsel will ensure that all personnel involved in developing the public access defibrillator program or trained in the use of AEDs understand applicable Federal, State, or host-nation "Good Samaritan" laws.

17-4. Operational control

a. An installation public access defibrillator program will include the following major elements:

- (1) Support of the program by the installation, agency, organization, or unit leadership.
- (2) Personnel training or certifying and retraining in cardiopulmonary resuscitation and use of AEDs and accessories.
- (3) Medical direction and medical oversight.
- (4) Understanding of legal considerations.
- (5) Development and regular review of the public access defibrillator program and operational protocols.
- (6) Development of an emergency response plan and protocols, including a notification system to activate responders.
- (7) Integration with other installation or area EMS systems.
- (8) Maintenance of hardware and support equipment on a regular basis and after each use.
- (9) Development of quality assurance and data- or information-management plans.
- (10) Development of measurable performance criteria, documentation, and periodic program review.
- (11) Review of new technologies.

b. Each installation or garrison will develop a master plan that coordinates the procurement of all AEDs on the installation. The plan will attempt to standardize the type or brand of AED and should include a funded maintenance program. Tenant units, agencies, or organizations must coordinate with the installation DES if they will be responsible for the purchase of desired AEDs. This will ensure the tenant plan is synchronous with the installation master plan and will address cost sharing for any garrison or installation-wide maintenance programs. Many AED manufacturers provide a maintenance contract.

c. The Department of Health and Human Services guidelines recommend that AEDs be placed where large numbers of personnel are found, including locations with personnel at high risk of cardiac arrest. When determining where to place AEDs, the DES should consider response time, demographics, number of visitors, strenuousness of work areas, and uniformity throughout facilities. Automatic external defibrillators should be centrally located and easily accessible to trained personnel in case of an emergency (for example, in lobbies or near exits, elevators, telephones, and/or fire extinguishers).

d. Public access to AEDs does not mean that any member of the public who witnesses an event should be able to use an AED. Public access refers to the accessibility of the device itself. While AEDs are reasonably uncomplicated to use, AEDs should be used only by persons who have received proper training and education and who have been certified by a competent authority. Persons without these basic credentials should not use AEDs.

e. Medical (and physician) oversight of installation public access defibrillator programs does not mean that a physician is required to be present on a day-to-day basis to manage the program. Unit and agency or organization leadership should develop management and oversight protocols for non-medical personnel overseeing the unit's or agency's or organization's AEDs to ensure that quality is consistently maintained.

f. Subject to the availability of funds and resources, the MTF will provide training opportunities for AED use. Each tenant unit or activity, however, retains the responsibility for ensuring AED training for all assigned personnel.

17-5. Procurement of automatic external defibrillators

a. The actual selection and procurement of AEDs will be one of the last steps in the public access defibrillator program design and will be completed under the guidance and written authorization of the public access defibrillator program's supervising physician.

b. Any tenant agency, organization, or unit that acquires an AED for its facility is responsible for all costs associated with the operation and maintenance of the AED, unless an agreement otherwise has been reached between the tenant and the garrison DES as outlined in the installation's public access defibrillator program (that is, possible shared maintenance costs, and so forth). For example, if a commissary desires an AED, the commissary must purchase the AED and the commissary leadership is responsible for ensuring that the AED is maintained and that commissary personnel are properly trained.

17-6. Legal considerations for the use of automatic external defibrillators

Public access defibrillator programs establish procedures for dealing with emergency medical situations that present an appreciable risk of serious bodily injury or death regardless of the degree of care exercised by those responding to the situation. Federal, State, local, and host-nation laws may regulate these emergency medical situations. The risk of civil liability for failing to follow applicable regulations and for acts or omissions that result in harm, are important and ever-present concerns that must be addressed in public access defibrillator programs. The garrison or installation leadership must ensure that all personnel involved in the public access defibrillator program or trained on the use of AEDs are aware of the legal considerations surrounding their use.

17-7. Additional guidance

Questions about implementing this policy will be directed to Commander, U.S. Army Medical Command (MCHO-CL-C), 2748 Worth Road, Fort Sam Houston, TX 78234-6010. For garrison-specific guidance unrelated to medical oversight, contact the DES in the responsible command.

Chapter 18 Nursing Administrative Forms

18-1. Purpose

This chapter implements the following four administrative forms used by the Department of Nursing/Nursing Services:

- a. DA Form 3872 (Nursing Service Personnel Time Schedule).
- b. DA Form 3887 (Nursing Department - Army Nurse Corps Data).
- c. DA Form 3889 (Nursing Unit 24-Hour Report).
- d. DA Form 3889-1 (Nursing Unit 24-Hour Report Continuation Sheet).

18-2. Form description and use

a. *DA Form 3872.* This form is used as a time schedule and should be prepared and posted in advance to relay schedule information. Abbreviations will be used as listed on the form and as established by the Chief, Department of Nursing/Nursing Services. Schedules will be retained as references for the current year and the previous year.

b. *DA Form 3887.* This form is maintained by the Office of the Chief, Department of Nursing/Nursing Services. It is used as a source of professional and personal information on Army Nurse Corps officers and assists in their assignment and responsibilities within the activity. Individual officers will ensure that data on the card are current, and that necessary changes or new information are reported to the Chief, Department of Nursing/Nursing Services.

c. *DA Forms 3889 and 3889-1.*

(1) *General.* The nurse in charge or other designated by the Chief, Department of Nursing/Nursing Services, is responsible for the report. The manner of its preparation and submission will be established locally.

(2) *Purpose.* This report is used to inform the Chief, Department of Nursing on the status of patients. This information provides administrative personnel with a substantive report of patient care activities within the Department

of Nursing. The report will give a concise and accurate portrayal of ward activities during each period covered. It should furnish the Chief, Department of Nursing with data required to manage resources and disseminate patient care information.

(3) *Content.* Patients to be reported will include those who are on the very serious or seriously ill list and those designated locally as command interest. Information includes census and patient movement figures. Unusual occurrences or accidents, and other matters which would be of interest to the Chief, Department of Nursing/Nursing Services and the commander should also be documented.

Appendix A References

Section I

Required Publications

There are no entries in this section.

Section II

Related Publications

A related publication is a source of additional information. The user does not have to read a related reference to understand this publication. Unless otherwise stated, all publications are available at: <http://www.apd.army.mil/>. Department of Defense regulations are available at: <http://www.dtic.mil/>. The U.S. Code, the Code of Federal Regulations, and the Federal Register are available at: <http://www.gpo.gov/fdsys/>.

AR 10-64/OPNAVINST 6700.2/AFR 160-29/MCO 5420.18A

Joint Field Operating Agencies of the Office of the Surgeon General of the Army

AR 11-2

Managers' Internal Control Program

AR 25-2

Information Assurance

AR 25-51

Official Mail and Distribution Management

AR 25-55

The Department of the Army Freedom of Information Act Program

AR 25-400-2

The Army Records Information Management System (ARIMS)

AR 30-22

The Army Food Program

AR 32-4/DLAR 4235.18/AFR 67-125/NAVSUPINST 4400.70C/MCO 4400.137A

Special Measurement Clothing and Footwear, Orthopedic Footwear, Guidons, Streamers, and Flags

AR 40-1

Composition, Mission, and Functions of the Army Medical Department

AR 40-5

Preventive Medicine

AR 40-7

Use of U.S. Food and Drug Administration-Regulated Investigational Products in Humans Including Schedule I Controlled Substances

AR 40-8

Temporary Flying Restrictions Due to Exogenous Factors Affecting Aircrew Efficiency

AR 40-21

Medical Aspects of Army Aircraft Accident Investigation

AR 40-25/BUMEDINST 10110.6/AFI 44-141

Nutritional Standards and Education

AR 40-35

Dental Readiness and Community Oral Health Protection

AR 40-38

Clinical Investigation Program

AR 40-61

Medical Logistics Policies

AR 40-66

Medical Record Administration and Healthcare Documentation

AR 40-68

Clinical Quality Management

AR 40-400

Patient Administration

AR 40-501

Standards of Medical Fitness

AR 40-905/SECNAVINST 6401.1B/AFI 48-131

Veterinary Health Services

AR 70-62

Airworthiness Qualification of Aircraft Systems

AR 95-1

Flight Regulations

AR 190-12

Military Working Dog Program

AR 190-13

The Army Physical Security Program

AR 190-45

Law Enforcement Reporting

AR 190-51

Security of Unclassified Army Property (Sensitive and Nonsensitive)

AR 215-1

Military Morale, Welfare, and Recreation Programs and Nonappropriated Fund Instrumentalities

AR 340-21

The Army Privacy Program

AR 351-3

Professional Education and Training Programs of the Army Medical Department

AR 385-10

The Army Safety Program

AR 600-8-4

Line of Duty Policy, Procedures, and Investigations

AR 600-9

The Army Weight Control Program

AR 600-20

Army Command Policy

AR 600–63

Army Health Promotion

AR 600–85

The Army Substance Abuse Program (ASAP)

AR 600–105

Aviation Service of Rated Army Officers

AR 635–40

Physical Evaluation for Retention, Retirement or Separation

AR 700–84

Issue and Sale of Personal Clothing

AR 710–2

Supply Policy Below the National Level

AR 725–50

Requisition, Receipt, and Issue System

AR 735–17

Accounting for Library Materials

CMH Publication 83–3

North Atlantic Treaty Organization (NATO) Handbook of Emergency War Surgery (Available at [http://www.bordeninstitute.army.mil/other_pub/ews.html/.](http://www.bordeninstitute.army.mil/other_pub/ews.html/))

DAGO 2002–03

Assignment of Functions and Responsibilities Within Headquarters, Department of the Army, 9 July 2002, as amended by DAGO 2009–03, dated 18 March 2009

DAGO 2005–05

Redesignation of the U.S. Army Safety Center

DA Pam 30–22

Operating Procedures for the Army Food Program

DA Pam 385–90

Army Aviation Accident Prevention Program

DA Pam 600–24

Health Promotion, Risk Reduction, and Suicide Prevention

DA Pam 611–21

Military Occupational Classification and Structure

FM 4–02.2

Medical Evacuation

FM 4–02.10

Theater Hospitalization

FM 4–02.56

Army Medical Field Feeding Operations

Integrated Pharmacy System

DOD Pharmacoeconomic Center Pharmacy Data Transaction Service Business Rules for Direct Care System, Version 7.9 (Available at [http://pec.ha.osd.mil/.](http://pec.ha.osd.mil/))

NG Pam 95-5

Use of Army National Guard Aircraft

SB 8-75-S1 series

Department of the Army Supply Bulletin Army Medical (Available at <http://www.usamma.army.mil/>.)

TB MED 250

Dental Record Administration, Recording and Appointment Control

TB MED 530

Food Service Sanitation

TC 3-04.93

Aeromedical Training for Flight Personnel

TC 8-502

Nutrition Care Operations

TM 8-227-3/NAVMED P-5101/AFMAN 41-119 (I)

The Technical Manual of the American Association of Blood Banks (Available in print only from the St. Louis Army Depot ordering system, at <http://www.apd.army.mil/>, under the “order/subscriptions” tab.)

TM 55-1500-345-23

Painting and Marking of Army Aircraft (Available at <https://www.logsa.army.mil/etms/online.htm/>.)

Administrative Order 215-1 DAPE

Library Borrowers’/Users’ Profile Files (Available at <http://www.defenselink.mil/privacy/notices/>.)

Agency for Healthcare Research and Quality

Event harm scale (Available at <http://www.ahrq.gov/>.)

AFIP Pamphlet 40-24

Armed Forces Institute of Pathology: Technical Instructions for the DOD Clinical Laboratory Improvement Program (Available at <http://www.tricare.mil/tma/ocmo/DocumentsForms.aspx/>.)

ARTEP 1-118-MTP

General Support Aviation Battalion (Available at <http://emilitarymanuals.com/artepmanuals.html/>.)

DeCA Directive 70-6

Financial Procedures for the Accounts Control Section and the Office of the Commissary Officer (Available at https://www.commissaries.com/inside_deca/publications/directives/directives_index.cfm/.)

DFAS-IN Manual 37-100-FY

Defense Finance and Accounting Service: The Army Management Structure Fiscal Year (Available at <https://dfas4dod.dfas.mil/centers/dfasin/library/regs.htm/>.)

DOD 7000.14-R, Volume 12

DOD Financial Management Regulation: Special Accounts, Funds and Programs

DODD 1010.1

Military Personnel Drug Abuse Testing Program

DODD 6000.12E

Health Services Support

DODD 6400.4

DOD Veterinary Services Program

DODI 6055.06

DOD Fire and Emergency Services (F&ES) Program, 21 December 2006

DODI 6480.04

Armed Services Blood Program (ASBP) Operational Procedures

Health Affairs Guidance

Guidelines for Public Access Defibrillation Programs in DOD Facilities, 12 August 2003 (Available at [http://www.health.mil/About_MHS/HA_Policies_Guidelines.aspx?policyYear=2002/.](http://www.health.mil/About_MHS/HA_Policies_Guidelines.aspx?policyYear=2002/))

Health Affairs Policy #02-011

Policy on Standardization of Oral Health and Readiness Classifications (Available at [http://www.health.mil/About_MHS/HA_Policies_Guidelines.aspx?policyYear=2002/.](http://www.health.mil/About_MHS/HA_Policies_Guidelines.aspx?policyYear=2002/))

Health Affairs Policy #15545-07

Policy on Blood Donations by Non-Department of Defense Individuals to the Armed Services Blood Program (Available at [http://www.militaryblood.dod.mil/press/ha_policy.aspx/.](http://www.militaryblood.dod.mil/press/ha_policy.aspx/))

Military Health System (MHS):

DOD Space Planning Criteria for Health Facilities (Available at [http://www.wbdg.org/ccb/DOD/MHSSC/spaceplanning_healthfac_22.pdf/.](http://www.wbdg.org/ccb/DOD/MHSSC/spaceplanning_healthfac_22.pdf/))

AME Guide

Federal Aviation Administration Guide for Aviation Medical Examiners (Available at [http://www.faa.gov/.](http://www.faa.gov/))

EMT

Emergency Medical Technician: National Standard Curriculum (Available at [http://www.nhtsa.gov/.](http://www.nhtsa.gov/))

FAA Order 8520.2E

Federal Aviation Administration: Aviation Medical Examiner System (Available at [http://www.faa.gov/.](http://www.faa.gov/))

21 CFR 210

Current Good Manufacturing Practice in Manufacturing, Processing, Packing, or Holding of Drugs; General

21 CFR 211

Current Good Manufacturing Practice for Finished Pharmaceuticals

21 CFR 290

Controlled Substances

21 CFR 291

Drugs Used for Treatment of Narcotic Addicts

21 CFR 600-800

Biological Products

21 CFR 606

Current Good Manufacturing Practice for Blood and Blood Components

21 CFR 820

Quality System Regulation

66 FR 28495 through 28511

Guidelines for Public Access Defibrillation Programs in Federal Facilities (Federal Register 23 May 2001, Volume 66, Number 100, pages 28495 through 2851, Department of Health and Human Services.)

OPM Operating Manual

Job Qualification System for Trades and Labor Occupations (Available at <http://www.opm.gov/qualifications/x-118c/index.htm>.)

OPM Operating Manual

Qualification Standards for General Schedule Positions (Available at [http://www.opm.gov/qualifications/.](http://www.opm.gov/qualifications/))

PL 104-191

Health Insurance Portability and Accountability Act (Available at www.ncbi.nlm.nih.gov/pubmed/10167156/.)

2 USC 182c

Revolving Fund for FEDLINK Program and Federal Research Program

10 USC 1095

Health care services incurred on behalf of covered beneficiaries: collection from third-party payers

17 USC

Copyrights

17 USC 107

Copyrights: Limitations on exclusive rights: Fair use

21 USC 801, et seq.

Congressional findings and declarations: controlled substances

31 USC 3324(d)(2)

Charges for a publication printed or recorded in any way for the auditory or visual use of the agency

38 USC 8111

Sharing of Department of Veterans Affairs and Department of Defense health care resources

42 USC 238p

Recommendations and guidelines regarding automated external defibrillators for Federal buildings

42 USC 1320b-8

Hospital protocols for organ procurement and standards for organ procurement agencies

Academy of Managed Care Pharmacy

Concepts in Managed Care Pharmacy Series (Available at <http://www.amcp.org/Sec.aspx?id=5399/>.)

Academy of Nutrition and Dietetics

Nutrition Care Manual (Available at <http://www.nutritioncaremanual.org/>.)

American Psychological Association

Ethical Principles of Psychologists, 1992 (Available from American Psychological Association, Book Order Department, Dept. KK, P.O. Box 92984, Washington, DC 20090-2984.)

American Psychological Association

Specialty guidelines for the delivery of services by clinical, counseling, industrial/organizational, and school psychologists, 1981 (Available from American Psychological Association, Book Order Department, Dept. KK, P.O. Box 92984, Washington, DC 20090-2984.)

American Psychological Association

Standards for Educational and Psychological Testing, 1995 (Available from American Psychological Association, Book Order Department, Dept. KK, P.O. Box 92984, Washington, DC 20090-2984.)

TJC publication

The Joint Commission (Available at <http://www.jointcommission.org/>.)

Section III**Prescribed Forms**

The following forms are available on the APD Web site (<http://www.apd.army.mil>) unless otherwise stated. DD forms are available from the Office of the Secretary of Defense Web site (<http://www.dtic.mil/whs/directives/infomgt/forms/formsprogram.htm>).

DA Form 3862

Controlled Substances Stock Record (Prescribed in paras 11-19, B-11, B-13.)

DA Form 3872

Nursing Service Personnel Time Schedule (Prescribed in para 18-1 and 18-2.)

DA Form 3875

Bulk Drug Order (Prescribed in para 11-14.)

DA Form 3887

Nursing Department-Army Nurse Corps Data (Prescribed in para 18-1 and 18-2.)

DA Form 3889

Nursing Unit 24-Hour Report (Prescribed in para 18-1 and 18-2.)

DA Form 3889-1

Nursing Unit 24-Hour Report Continuation Sheet (Prescribed in para 18-1 and 18-2.)

DA Form 3949

Controlled Substances Record (Prescribed in paras B-5, B-7, B-8, B-9, B-11, and B-13.)

DA Form 3949-1

Controlled Substances Inventory (Prescribed in paras B-5, B-7, B-11, and B-13.)

DD Form 1289

DOD Prescription (Prescribed in paras 11-10, 11-13, 11-14, B-8, and, B-9.)

DD Form 2081

New Drug Request (Prescribed in para 11-7.)

DD Form 2731

Organ and Tissue Donor Card (Prescribed in para 9-2.)

Section IV**Referenced Forms**

DA Forms are available on the Army Publishing Directorate Web site (www.apd.army.mil/). DD Forms are available from the OSD Web site (<http://www.dtic.mil/whs/directives/infomgt/forms/formsprogram.htm/>). SFs and OFs are available from the GSA Web site (<http://www.gsa.gov/>).

DA Form 11-2

Internal Control Evaluation Certification

DA Form 1296

Stock Accounting Record

DA Form 1829

Hospital Food Service-Ward Diet Roster

DA Form 2028

Recommended Changes to Publications and Blank Forms

DA Form 2930

Hospital Food Service-Kitchen Requisition

DA Form 3032

Signature Headcount Sheet

DA Form 3078

Personal Clothing Request

DA Form 3161

Request for Issue or Turn-In

DA Form 4186

Recommendations for Flying Duty

DA Form 4256

Clinical Record–Doctor’s Orders

DA Form 5570

Health Questionnaire for Dental Treatment

DD Form 150

Special Measurements Blank for Special Measurement/Orthopedic Boots and Shoes

DD Form 1348

DOD Single Line Item Requisition System Document (Manual)

DD Form 1348M

DOD Single Line Item Requisition System Document (Mechanical)

DD Form 1380

U.S. Field Medical Card

DD Form 1544

Cash Meal Payment Book

DD Form 2807–1

Report of Medical History

DD Form 2808

Report of Medical Examination

SF 509

Medical Record–Progress Notes

SF 513

Medical Record–Consultation Sheet

SF 558

Medical Record–Emergency Care and Treatment

SF 600

Medical Record–Chronological Record of Medical Care

SF 603

Health Record–Dental

SF 603A

Health Record–Dental-Continuation

FAA Form 8500–8

Application for Airman Medical Certificate or Airman Medical and Student Pilot Certificate (This form is a controlled item and is distributed by the FAA. Available at: [http://www.faa.gov/licenses_certificates/medical_certification/.](http://www.faa.gov/licenses_certificates/medical_certification/))

Appendix B Inventory, Control, and Accountability of Controlled Substances, Select Noncontrolled Medications, and Diagnostic Agents

B-1. Purpose

The purpose of this appendix is to provide guidance for the accounting, control, and physical security of controlled substances, select noncontrolled medications, and diagnostic agents.

B-2. Responsibilities

AR 40-61 provides overall responsibilities for the control of medical items or select noncontrolled medications. The following paragraphs delineate additional responsibilities as applicable to pharmaceuticals classified as controlled substances.

a. The chief, pharmacy services will safeguard and account for all controlled substances; noncontrolled medications; and diagnostic agents received, issued, and dispensed by the hospital pharmacy and will—

(1) Maintain a current listing of all activities authorized to receive controlled substances as determined by the P&T committee.

(2) Conduct periodic controlled medication reviews to detect overuse and/or abuse of controlled drugs, select noncontrolled medications, and diagnostic agents. Any significant trends or findings will be reported to the P&T committee as appropriate.

b. Department and service chiefs are responsible for safeguarding and accounting for all controlled substances issued for use within their activities.

c. Officers in charge of patient care areas are responsible for the maintenance of the controlled substances register and will ensure the correct storage of controlled substances under this regulation.

d. The chief, logistics is responsible for the care, preservation, and surveillance of installation controlled substances stocks, noncontrolled medications, and diagnostic agents.

e. The inventory officer(s) is responsible to the MTF commander for complying with the instructions contained in this regulation and those otherwise provided.

f. The chiefs of all areas inventoried will scrutinize all findings in their respective areas to detect any significant trend indicating increased use of any controlled substances and take immediate action to determine the reasons for increased use.

g. The commanders of medical logistics units and other medical supply operations are responsible for the care, preservation, and surveillance of installation-controlled substances stocks.

B-3. General policy

a. At least annually, the MSO will request the local provost marshal to evaluate the security of controlled medical items at all medical materiel storage areas to include logistics and the pharmacy. This survey will be documented, and installation engineer support will be obtained to accomplish any facility adaptation required for improvement of security.

b. Controlled substances are drugs so designated by the DEA and assigned to one of five schedules according to the abuse potential and degree of control required. A list of controlled substances and changes are published in the Federal Register and, annually, in the supply bulletin 8-75-S1 series. Any other items designated by the commander as controlled may be handled either as Schedule II or Schedules III-V with reference to the recordkeeping and physical security requirements according to this regulation and AR 40-61. See AR 190-45 for guidance on category 2 reportable serious incidents applicable to controlled substances.

c. Noncontrolled medications include legend drugs and nonprescription drugs.

d. Diagnostic agents are products for the diagnosis and monitoring of patients. Blood glucose monitors and test strips used for point-of-care or home testing are examples of diagnostic agents that may be dispensed by the pharmacy.

e. The chief, pharmacy services will ensure that only authorized activities receive controlled substances or noncontrolled medications from the pharmacy. Issue of controlled substances to these activities will be completed by proper entry into the controlled substances register of the receiving activity by responsible pharmacy personnel. Criteria for issue to the activity will be based on appropriate medical need and appropriate physical security during both transport and storage.

f. Wards, clinics, and other activities receiving controlled pharmaceuticals will manage them as indicated in this regulation. The use of unit-dose packaging of controlled substances will simplify this responsibility in patient care areas. The commercial reverse-numbered unit-dose package is considered the package of choice whenever available.

g. Use of automated dispensing equipment that satisfies the intent of this regulation without the manual use of controlled substance registers is authorized.

h. Stock levels of controlled substances should not exceed an anticipated 2-week supply for wards or clinics or a 30-day level for each pharmacy section, unless otherwise specified by the commander.

i. Controlled substances (unit package or broken lots) will be turned in to the pharmacy when no longer required, as outlined in paragraph B-9.

j. Controlled substances collected from patients will be handled, safeguarded, and accounted for in the same manner as regularly stocked controlled substances. However, returned drugs should be segregated from regular stocks to ensure that they are not reissued. Controlled substances collected from patients in patient care areas will be turned in to the pharmacy as soon as possible to prevent possible reissue or diversion. Procedures for turn-in are outlined in paragraph B-9.

k. A physical inventory will be conducted within the pharmacy on every administrative duty day. This inventory will include all controlled substances having an issue or receipt action since the last inventory. All controlled substances will be inventoried at least weekly, regardless of activity. MTF commanders will ensure that the inventory is conducted weekly and corrective action taken promptly when discrepancies not attributable to operational losses are discovered. Within the guidance established by the local commander, an adjustment for minor overages and shortages caused by operational handling or undiscoverable posting errors will be made by posting an inventory adjustment to the stock record. All adjustments will be given to the monthly inventory team to be included in their report and a copy will go to the security officer.

l. An inventory and audit of all controlled items throughout the facility and select noncontrolled medications and diagnostic agents within the pharmacy will be conducted monthly. The medical activity commander will appoint a disinterested officer, a noncommissioned officer (sergeant first class (or equivalent) or above), or DA civilian (GS-7 or above) to perform the duty. Commanders or a designee will change inventory officer assignments each month and ensure that the inventory officer(s) receives timely appointing orders, a briefing concerning the importance of this function and responsibilities, a current set of pertinent regulations, a list of activities and controlled substances to be inventoried, and rubber stamps required to accomplish the inventory. Paragraph B-11 provides instructions and procedures for conducting the controlled substances inventory. Also see AR 190-45 on reportable serious incidents.

m. The monthly inventory and audit of controlled substances, select noncontrolled medications, and diagnostic agents should be conducted between the first and tenth working day of the month and a typewritten report submitted to the MTF commander by the 15th working day of the month.

n. This guidance does not apply to clinical research activities.

B-4. Physical security

a. AR 190-51, chapter 4, establishes policy, procedures, and minimum physical security standards for the storage of controlled medical substances and medically sensitive items. Automated systems that secure, track, and monitor the replenishment of controlled substances may be used in place of GSA-approved safes. These systems must be physically secured in an appropriate area and do not replace required inventories, double counting, limited access, and other controls required to ensure accountability of all medications.

b. A physical security officer, appointed in writing by the MTF commander, will ensure appropriate protection of all controlled substances and sensitive items.

c. Facility commanders will ensure that an annual physical security inspection is conducted according to AR 190-13. In addition, commanders may request the U.S. Army Criminal Investigation Command to conduct crime prevention surveys for the purpose of detecting crime, evaluating the possibilities of easy criminal activity, and identifying procedures conducive to criminal activity. Theft, loss, recovery, or mismanagement of significant quantities of controlled substances and other medically sensitive items will be reported according to appropriate 190-series regulations.

B-5. Composition and maintenance of a controlled substances register for patient care areas not using automated dispensing equipment

a. *Arrangement of controlled substances register.* The controlled substances register will be maintained in a loose-leaf binder. The register will be divided into two major sections, one for Schedule II items and the other for Schedules III-V items. Each of these sections will contain two subsections as follows:

(1) Active files section.

(a) *DA Form 3949-1 (Controlled Substances Inventory).* An example of a completed DA Form 3949-1 is at figure B-1.

(b) *DA Form 3949 (Controlled Substances Record).* An example of a completed DA Form 3949 is at figure B-2.

CONTROLLED SUBSTANCES INVENTORY For use of this form see AR40-3; the proponent agency is OTSG											TO BE USED WITH DA FORM 3949		WARD	MONTH AND YEAR																											
NURSE'S SIGNATURE THIS IS A CORRECT INVENTORY OF CONTROLLED SUBSTANCES AT THE TIME OF TRANSFER OF POSSESSION.											CONTROLLED SUBSTANCES (Continued)																														
DAY OF THE MONTH	TOUR OF DUTY	NURSE'S SIGNATURE										CONTROLLED SUBSTANCES																													
a	b	c										e	f	g	h	i	j	k	l	m	n	o	p	q	r	s	t	u	v	w	x	y	z	aa	bb	cc	dd	ee	ff	gg	hh
		FIRST LINE - Signature of off-going nurse. SECOND LINE - Signature of on-coming nurse.										s. Morphine Sulfate 30mg/mL, 1mg Syr Dexamethasone 20mg Tab Fentanyl Tab Meperidine 200mg Tab Hydromorphone 30mg 30mg (Update 8/13)																													
2	DAY	Nurse 1 Signature										34	12	18	20	42																									
	EVE	Nurse 2 Signature										29	12	15	16	36																									
	NIGHT	Nurse 3 Signature										27	12	15	12	30																									
3	DAY	Nurse 1 Signature										25	12	15	13	26																									
	EVE	Nurse 2 Signature										21	12	15	23	51																									
	NIGHT	Nurse 3 Signature										46	12	15	23	49																									
4	DAY	Nurse 1 Signature										43	12	15	21	43																									
	EVE	Nurse 2 Signature																																							
	NIGHT																																								
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DA FORM 3949-1 OCT 79

EDITION OF 1 APR 73 WILL BE USED UNTIL EXHAUSTED.

Figure B-1. Example of a completed DA Form 3949-1

CONTROLLED SUBSTANCES RECORD			This form is to be used in conjunction with DA Form 3949-1			WARD/CLINIC		DATE INITIATED (YYYYMMDD)		
For use of this form, see AR 40-3; the proponent agency is OTSG.						WARD & EAST		20120601		
MONTH/YEAR		ITEM (Generic Nomenclature; may add trade name for additional clarity)		ACCOUNTABLE UNIT		FORM INITIATED (Sign and Print Name)			BALANCE FORWARDED (From the previous sheet)	
JUNE 2012		MORPHINE SULFATE 10MG/ML, 1ML SYRINGE		EACH ML		DOE, JANE			23	
DAY	HOOR	PATIENT NAME (Last Name, First Name)	ORDERED BY (Dr.'s Last Name)	ADMINISTERED BY (Sign on top line; Print name on bottom line)	WITNESS TO ANY WASTE (Sign on top line; Print name on bottom line)	ACTUAL DOSE ADMINISTERED TO PATIENT	AMOUNT OF MEDICATION WASTED	EXPENDITURES (Accountable units used)	RECEIPTS (Amount from pharmacy)	BALANCE (Accountable Units Remaining)
7	0200	DOE, JOHN	SMITH, B			1		1		22
				COBB, JOE						
7	0300	BURNS, WILLIAM	BEARDSKEY			1		1		21
				COBB, JOE						
7	0400	REX, RENEE	SIMS, S			4MG 0.4ML	0.6ML	1		20
				STEVENS, STU	COBB, JOE					
7	0600	TAYLOR, TRAVIS	BUSSY, J					10	JB	10
				STEVENS, STU						
7	1000	DOE, JOHN	SMITH, B					1		9
				COBB, JOE						
7	1030	BURNS, WILLIAM	BEARDSKEY					1		8
				JACKSON, M						
7	1100	PHARMACY ISSUE	R-1483					MJ	20	28
				LEWIS, CRAIG						
7	1500	INVENTORIED AND FOUND CORRECT								28
				GORDON, DAVID						
7	1800	BURNS, WILLIAM	BEARDSLEY					1		27
				JACKSON, M						
7	1900	TURN-IN TO PHARMACY	2159-0007					10	JB	17
				ELLIOT, JANE						

DA FORM 3949, SEP 2009 PREVIOUS EDITIONS ARE OBSOLETE. APD PE v1.00

Figure B-2. Example of a completed DA Form 3949

(2) *Inactive files section.* This includes any DA Form 3949 that has been audited and has a zero balance but may be used at a later date.

b. Use of forms as the centralized filing method. DA Forms 3949 and 3949-1 will be used as the centralized filing method for records pertaining to receipts, issues, balances, and audits of controlled substances for which appropriate personnel are responsible. Records will be kept in a controlled area of the patient care area and will be available only to authorized personnel.

c. Preparation of DA Form 3949-1. DA Form 3949-1 will be maintained in the controlled substance register for all patient care areas operating multiple shifts. This form will be completed as outlined in paragraph B-7.

d. Preparation of DA Form 3949. (Also see paras e, f, and g, below.) Separate DA Forms 3949 will be prepared for each controlled substance line item stocked. Forms will be arranged in sequence to correspond with the order in which the drugs are listed on DA Form 3949-1, appropriately marked to denote the controlled substance, and filed behind indexed divider sheets. The box heading of each DA Form 3949 will be completed to reflect the ward number or clinic, date initiated, correct name and strength of the drug to include nomenclature and generic name, accountable unit of measure, signature and printed name of the person initiating the form, and balance on hand. Common trade names such as Demorol™ for meperidine hydrochloride injection may be inserted immediately following the nomenclature for ease in identifying the controlled substance. All entries will be recorded in ink or typewritten.

e. Controlled substances expenditure entries.

(1) Each time a controlled substance is administered in a patient care area, complete information will be recorded on the DA Form 3949 as to the disposition of the substance. The day, hour, patient's name, last name of the healthcare provider who ordered the medication, signature and printed name of the individual administering the substance, and the accountable unit of the substance dispensed will be entered in the "expenditures" column. The amount expended will then be subtracted from the amount shown in the "balance" column and the new balance will be recorded in the

“balance” column. All amounts will be recorded in Arabic numbers. (Roman numerals are not acceptable.) In cases where the accountable unit is designated in milliliters (ml), any fractional amount used will be recorded as a decimal fraction.

(2) In cases where the dose administered is a fraction of the accountable unit for the drug, the actual dose administered will be placed in the “actual dose administered to patient” column of DA Form 3949 and the amount wasted will be placed in the “amount of medication wasted” column. The wasting of partial doses of controlled substances must be witnessed by a second party. Persons witnessing the wasting of partial doses will place their signature and printed name in the “witness to any waste” column, verifying the drug and amount wasted.

f. Entries in cases of accidental destruction, damage, or contamination. If any dose(s) of a controlled substance is accidentally destroyed, damaged, or contaminated during the preparation for administration, a record of the fact will be made on DA Form 3949, including the date, amount of the drug, a brief statement of the circumstances, the new balance, the signature and printed name of the person making the entry in the “administered by” column, and the signature and printed name of a second individual for verification in the “witness to any waste” column.

g. Controlled substances receipt entries. When controlled substances are issued to a patient care area, the pharmacy representative will record on the appropriate DA Form 3949 the following: the day and hour delivered in the columns indicated; the words, “pharmacy issue” in the “patient’s name” column; the document number in the “ordered by” column; the amount of the drug issued in the “receipts” column; and the new balance in the “balance” column. The pharmacy representative will enter his or her signature and printed name in the “administered by” column. The person authorized to receive the controlled substance will acknowledge receipt of the drug by placing his or her initials in the “expenditures” column on the same line as the entry made by the pharmacy representative. That person receiving the controlled substance will then sign the reverse side of the document used to request the drug and print their name, grade or rank, SSN, date, hour, and the name and quantity of the controlled substance received.

h. Correction of errors. Erasures and eradications invalidate records and such methods will not be used to correct errors in the DA Form 3949 register. Errors will be corrected by drawing a single line in ink through the erroneous entry and adding the initials of the person making the correction and the date the correction was made. The correct entry will be recorded in the same block, adjacent to the erroneous entry. If the entire line is erroneous or the corrected entry cannot be placed in the same block, draw a line through the entire entry and date and initial it. Make the correct entry on the next available line.

B-6. Composition and maintenance of a controlled substances register for patient care areas using automated dispensing equipment

Controlled substance inventory registers are not required in patient care areas using automated dispensing equipment. Reports should be run periodically to ensure appropriate change-of-shift inventories are being completed and discrepancies are appropriately resolved.

B-7. Tour-of-duty inventory

a. In all patient care areas operating multiple shifts, transfer of the possession of controlled substances will be affected by completing a joint inventory of such items and comparing the amounts on hand with the balances shown on DA Form 3949.

b. If the inventoried amount does not match the balance shown on the corresponding DA Form 3949, the staff will try to rectify the discrepancy. If the discrepancy cannot be corrected, the amount inventoried will be entered in the appropriate column and the discrepancy reported immediately to the next higher authority.

c. Those patient care areas operating one shift per 24 hours will not be required to maintain DA Form 3949-1. DA Form 3949 will be maintained and completed according to paragraphs B-5d through g.

B-8. Issuance of controlled substances to patient care areas

a. Issuance of controlled substances will be made only upon the receipt of a properly written and authenticated DD Form 1289 or other locally approved form. An authorized prescriber or a registered nurse will sign the form requesting controlled substances for the patient care area.

b. Routine bulk transfer of controlled substances between patient care areas is not authorized. Emergency transfers, when necessary, will be recorded on the appropriate DA Form 3949 by an individual authorized access to the controlled substances. Corresponding entries must be made on the DA Forms 3949 for both the patient care area providing the medication and the patient care area receiving the medication. The entries must show a credit for the receiving area and a debit for the transferring area.

B-9. Disposition of surplus, contaminated, or deteriorated controlled substances by patient care areas

Controlled substances that are in excess of current requirements, contaminated, or deteriorated will be returned to the pharmacy using DD Form 1289, DA Form 3161 (Request for Issue or Turn-in), or another locally approved form. A pharmacy representative will record the turn-in transaction on the DA Form 3949 as follows.

a. Enter the day, the hour, and write “turn-in” in the “patient’s name” column.

- b. Enter the document number in the “ordered by” column.
- c. The patient care area representative will sign and print his or her name in the “administered by” column.
- d. The quantity of medication turned in will be entered in the “expenditures” column.
- e. The pharmacy representative receiving the controlled substance will acknowledge the turn-in by entering his or her initials in the “receipts” column.
- f. The new balance will be entered in the “balance” column.
- g. The pharmacy representative will then sign the document and print his or her name, rank or grade, SSN, the date, and the hour. The original document will be filed in the pharmacy. A copy of the turn-in document will be provided to the patient care area.

B-10. Disposition by pharmacies of contaminated or deteriorated controlled substances

a. Whenever controlled substances have deteriorated or have been contaminated and are not usable for the purpose originally intended, are of questionable potency, or have had their identity compromised, personnel will report such items to the MTF commander or designated representative for a determination of disposition.

b. Whenever controlled substances are to be destroyed, destruction is accomplished in the presence of a destruction officer and according to the requirements of AR 40-61. A record of such destruction, signed by the destruction officer and two witnesses, is filed in the controlled substances file as authority for dropping the items from the records of the accounts. Full and partial units of issue are turned in to the MSO for destruction as appropriate.

B-11. Instructions for monthly inventory and audit of controlled substances

a. Preliminary actions.

(1) If the inventory cannot be completed within the specified period in the appointing orders, it will be reported to the appointing authority and approval obtained for a new suspense date.

(2) The inventory officer(s) will coordinate with the chief, logistics division for inventory and audit of installation stocks and the chief, pharmacy service for inventory and audit of MTF stocks. The list of activities to be inventoried will be verified through the logistics division and pharmacy service. Direct coordination with custodians of controlled substances is authorized and encouraged so as to preclude any disruption to normal activities.

b. Documentation of inventory.

(1) *Annotation.* Entries found to be correct will be annotated “inventoried and found correct” with the date, signature, and rank or grade of the inspecting officer recorded on the line immediately below the last entry.

(2) Documentation of discrepancies.

(a) In the event a quantity other than that indicated on accounting records is actually on hand and no discrepancies are found in the “balance” column, the quantity found will be recorded as the new balance with the notation, “per inventory,” and the date, signature, and rank or grade of the inspecting officer recorded on the line immediately below the last entry.

(b) Every attempt will be made to resolve all discrepancies at the time of inventory. If overages or shortages cannot be resolved, the area supervisor and chief, pharmacy service is notified. Discrepancies will also be reported in the final report to the MTF commander with identifying data and recommendations. The commander will take appropriate action.

(c) If no discrepancies were found upon completion of the required inventory and audit, a statement to that fact will be reported in the final report to the MTF commander.

c. Procedures for the logistics division.

(1) The purpose of the monthly audit of logistics division vault records is to ensure that records on vault items are accurate and that there is an audit trail of all receipts, issues, and adjustments on vault items. This will be accomplished by—

(a) Ensuring that balances on the DA Forms 1296 (Stock Accounting Record) in the vault match the physical quantity of the item on hand in the vault. Figures B-3 and B-4, below, show a sample of a completed DA Form 1296, front and back.

(b) Ensuring that the balances on the DA Form 1296 in the vault match the quantity on hand on the stock control record in the inventory management section.

(c) Ensuring that every vault item reported as shipped by a supplier was recorded on the vault records.

(d) Ensuring that every item that was issued to customers of the logistics division was picked up on the customer's controlled substance records.

(e) Validating that all other transactions (destruction, inventory adjustments, transfers out) that decreased the on-hand balance have supporting vouchers in the vault.

(2) The chief, logistics division will furnish the following documents to the inventory officer:

(a) Inventory count list.

(b) List of vault items reported shipped from that activity's supplier(s) during the previous month.

(c) The last monthly transaction register for vault items (automated accounts only).

(d) A list (preferably automated) of all issues of vault items to customers during the past month.

(3) The ACOMs, ASCCs, and DRUs will publish detailed procedures for the monthly audit of controlled substances for each of their automated medical supply systems. These uniform procedures will be used by each of the medical activities within the ACOMs, ASCCs, and DRUs to ensure that there is no abuse in the management of controlled substances. These procedures will be established to further the purposes for the audit contained in paragraph c(1), above, and will include as a minimum—

(a) Physical inventory of all controlled substances.

(b) Reconciliation of the physical inventory count with the balance on DA Forms 1296 located in the vault.

(c) Reconciliation of DA Forms 1296 balances with the stock control record balances.

(d) Proper inventory entries on the vault DA Forms 1296.

(e) Reconciliation of shipping reports from suppliers with vault DA Forms 1296 to ensure all items were received and posted.

(f) Reconciliation of DEA order forms with vault DA Forms 1296 to ensure that all local purchase items were received and posted.

(g) Reconciliation of all transactions other than issue transactions that decrease on-hand balances on the DA Forms 1296 with supporting vouchers (that is, destruction, transfers out, and inventory adjustments).

(h) Reconciliation of automated issue or listings or issue documents with customer-controlled substances records to ensure that all items reported as issued were reflected on customer records.

(4) See AR 40–61 for additional procedures on the management of controlled medical items and AR 190–45 for reportable serious incidents.

d. Procedures for pharmacies.

(1) Request from the custodian of controlled substances the following records:

(a) All DA Forms 3862 or approved automated accounting record (AAAR) printouts. These forms are used to record all transactions affecting the status and accountability of controlled substances. Figure B–5 shows an example of a completed DA Form 3862.

CONTROLLED SUBSTANCES STOCK RECORD

For use of this form, see AR 40-3; the proponent agency is Office of The Surgeon General

STOCK NUMBER 6505-01-251-6895					DESCRIPTION ACETAMINOPHEN/CODEINE 325/30MG (TYLENOL #3)				
UNIT AS RECEIVED EACH BOTTLE			CONVERSION FACTOR 1 BOTTLE=100 TABLETS			ACCOUNTABLE UNIT EACH TABLET			
DATE	DEBIT (Receipts)	DEBIT (VO.) OR CREDIT (RX) NO	CREDIT (Expenditures)	BALANCE ON HAND	DATE	DEBIT (Receipts)	DEBIT (VO.) OR CREDIT (RX) NO	CREDIT (Expenditures)	BALANCE ON HAND
7 JUNE 2012	Balance	Brought	Forward	300					
7 JUNE 2012	WARD 7 EAST	Q-7485	50	250					
7 JUNE 2012	INVENTORIED AND	FOUND CORRECT	(inventory officer name and signature)	250					
7 JUNE 2012	WARD 2 WEST	Q-7503	25	225					
7 JUNE 2012	25	Q7515	WARD 7 EAST	250					
7 JUNE 2012	Patient Name	RX 1234567	60	190					

DA FORM 3862, JUN 1972

REPLACES DA FORM 8-235, 1 AUG 51, WHICH WILL BE USED

APD PE v1.00

Figure B-5. Example of a completed DA Form 3862, front

column, the quantity found is recorded as the new balance with the notation “per inventory” and the date, the signature, and rank or grade of the individual conducting the inventory recorded on the line immediately below the last entry.

(7) After verification of records, the inventory officer will tabulate all issues and turn-ins of controlled substances for activities supported by the pharmacy or obtain the AAAR listing for each activity. Tabulations will be included in a report made to the MTF commander.

e. Procedures for patient care areas such as wards and clinics without automated dispensing equipment.

(1) The inventory officer will request from the representative in charge of the controlled substances in the ward, clinic, or other activity the following records:

(a) *DA Form 3949.* One form for each controlled substance line item stocked.

(b) *DA Form 3949-1.* All forms completed since the previous inventory.

(2) Verify that all DA Forms 3949 and/or DA Forms 3949-1 were properly reconciled the preceding month and that an appropriate entry was made on each form.

(3) Verify all of the issues and turn-ins have been properly entered on the applicable DA Form 3949.

(4) Without referring to the amount shown on the “balance” column of DA Form 3949, conduct a physical inventory of all controlled substances in the storage cabinet.

(a) If no discrepancies are found as a result of the above checks, proceed to certify each DA Form 3949 by entering on the next available line, the date; the hour; the statement, “inventoried and found correct”; the signature and rank or grade of the individual conducting the inventory; and the balance on hand as determined by the inventory.

(b) If a quantity other than that indicated is actually on hand and no discrepancies are found in the “balance” column, the quantity found will be recorded as the new balance with the notation “per inventory.” The date, the hour, the signature, and rank or grade of the inventory officer is recorded on the line immediately below the last entry.

(5) If a DA Form 3949-1 is maintained, enter on the far right of the last used line the applicable date, the shift when the inventory was conducted (for example, if the inventory was conducted at 1000 hours, it would be the day shift; if it was conducted at 1600 hours, it would be the evening shift), and the signature and rank or grade of the individual conducting the inventory.

(6) Upon completion of the inventory, all forms that are no longer required or were previously inventoried and filled will be withdrawn from the active controlled substances register, tagged, and turned in to the MTF headquarters or responsible section for retirement action per AR 25-400-2.

f. Procedures for patient care areas such as wards and clinics with automated dispensing equipment.

(1) The inventory officer will be issued a temporary user name and password for his assigned areas.

(2) Without referring to the amount on hand, conduct a physical count of all controlled substances in the automated cabinet.

(3) Random comparison checks of controlled substance withdrawals to a healthcare provider’s medication orders will be done to account for order amount and if waste is annotated

g. Other activities such as laboratories and veterinary clinics. The procedure to be followed will be determined by the type of form the activity uses to account for controlled substances. DA Form 3862 will be used by activities drawing controlled substances directly from the logistics division, and the procedures are the same as used for pharmacies. All other activities will use the DA Form 3949, and the procedure is the same as the one used for wards and clinics.

B-12. Instructions for monthly inventory and audit of select noncontrolled medications and diagnostic agents

a. Preliminary actions.

(1) If the inventory cannot be completed within the specified period in the appointing orders, it should be reported to the appointing authority and approval obtained for a new suspense date.

(2) The inventory officer(s) must coordinate with the chief, pharmacy service to produce an audit list of the top twenty-five (25) dispensed medications and diagnostic agents, by cost, for the month prior to the audit.

(3) The inventory officer(s) will select five (5) of these medications and diagnostic agents at random for further analysis and inventorying.

(4) The chief, pharmacy service will provide the records (to include credit card transactions) documenting the volume of medications or diagnostic agents dispensed as well as the records showing the volume of medications or diagnostic agents received from supply sources (medical logistics, prime vendor, or alternate source) for the selected noncontrolled substances and diagnostic agents.

(5) The inventory officer should request a tabulation of the selected noncontrolled medications and diagnostic agents issued by the logistics division for comparison, if applicable, to verify that all medications and diagnostic agents issued to the pharmacy have been properly accounted for as receipts (that is, verify there is no drug diversion between the logistics division and the pharmacy).

b. Documentation of inventory.

(1) Analysis and inventory.

- (a) Determine amounts dispensed and amounts received from all supply sources for each item.
 - (b) Inventory whole containers of each item. Subtract the quantities of inventory still on-hand from the amounts received.
 - (c) Compare amounts dispensed to the amounts calculated in (b), above, for each item. Amounts dispensed should be within 1 percent (in dollars) of the amount received minus inventory on-hand, as in: Amount Dispensed = (Amount Received – Amount Inventoried).
- (2) Documentation of discrepancies.
- (a) Every attempt should be made to resolve all discrepancies at the time of inventory. If overages or shortages cannot be resolved, the area supervisor and chief, pharmacy service are notified. Discrepancies must be reported in the final report to the MTF commander with identifying data and recommendations. The commander will take appropriate action.
 - (b) If no discrepancies were found (that is, the quantities of the select noncontrolled medications are within the permitted variance) upon completion of the required inventory and audit, a statement to that fact is included in the final report to the MTF commander.

B-13. Disposition of records

- a. *DA Forms 3949 and 3949-1.*
 - (1) Immediately following inspection and audit by the appointed inventory officer, retain in the active files section the individual DA Form 3949 and DA Form 3949-1 that show the results of this inspection and audit. Remove other previously audited forms that are no longer needed for historical purposes and were completed prior to the current inventory and turn them over to the inventory officer for disposition.
 - (2) DA Forms 3949 which show a zero balance at the time of the inventory may be placed in the inactive files section if stocks in the patient care area are to be replenished at a later date.
 - (3) The inventory officer will turn in to the MTF headquarters all DA Forms 3949 and 3949-1 for storage and proper retirement action according to AR 25-400-2.
- b. *DA Forms 1296 and 3862.* Each activity using these forms will maintain the most current inventory on file. Other completed forms will be disposed of as prescribed in AR 25-400-2.

Appendix C Internal Control Evaluation Checklist

C-1. Function

The function covered by this checklist is medical, dental, and veterinary care.

C-2. Purpose

The purpose of this checklist is to assist in evaluating the key internal controls listed below. It is not intended to address all controls.

C-3. Instructions

Answers must be based on the actual testing of key internal controls (for example, document analysis, direct observation, interviewing, sampling, or simulation). Answers that indicate deficiencies must be explained and corrective action indicated in supporting documentation. These key internal controls must be formally evaluated at least once every 5 years. Certification that this evaluation has been conducted must be accomplished on DA Form 11-2 (Internal Control Evaluation Certification).

C-4. Test questions

a. The Army Organ Transplant and Organ/Tissue Donation Programs. Processes for organ and tissue donation are reviewed at the triennial TJC review with the standards outlined in the current TJC manual.

- (1) Did the MTF commander ensure compliance with the DOD and Army policy on organ and tissue donation?
- (2) Did the MTF commander—in collaboration with the Chief, Army Organ Transplant Service—ensure that staff as well as patient education regarding organ donation was provided at each MTF?
- (3) Was an MOA established with the local OPO that ensured—
 - (a) Mandatory notification to the OPO of potential donors?
 - (b) The OPO will obtain consent?
 - (c) Recovery services are performed according to the 1986 update of the Uniform Anatomical Gift Act (as part of 42 USC 1320b-8 (the Omnibus Budget Reconciliation Act)) and this regulation?
 - (d) Efforts were made to include the local OPO in the education process of both staff and patients?
- (4) Were voluntary MOAs established with the MTCs and local OPOs to implement the military donor system?
- (5) Did all AD personnel that became living organ donors meet all criteria outlined and was approval obtained from the commanding officer and the OTSG?
- (6) Were MTF policies established that met the standards for the procuring and donation of organs and other tissue as outlined in current TJC standards?
- (7) Did each USAMEDCOM RMC ensure compliance by their subordinate MTFs by annual review of MOAs, the MTC, and the local OPO?
- (8) Were organ and tissue donations made according to the laws of the State where the donation was made? The Uniform Anatomical Gift Act of 1968 and its update in 1986, as part of 42 USC Section 1320b-8 (The Omnibus Budget Reconciliation Act), outlines the hospital's obligations and this has been accepted by a majority of States?
- (9) Is there a mechanism in place to ensure that potential donors are recognized and that Family or NOK are given the opportunity to consent? MOAs may address death chart reviews by the local OPO as one way to meet this requirement.

b. Medical laboratory management. The CAP and/or the TJC review will be the evaluation process used to evaluate the key internal controls. The local medical laboratory will coordinate with the internal control administrator to ensure that the laboratory schedules the CAP and/or TJC review on the 5-year internal control plan. In addition, the local medical laboratory will coordinate with its QA office and the CAP and/or TJC review team to ensure the review of the key controls contained herein are included in the CAP and/or TJC review.

- (1) Does the MTF commander ensure that the DOD CLIP standards for all medical laboratories are implemented and followed and that all medical laboratories under their command and control are properly registered with the DOD CLIP Office?
- (2) At installations that do not have an assigned pathologist, did the commander assign a qualified licensed physician to be the director of the laboratory?
- (3) Have commanders of RMCs appointed regional medical laboratory consultants to provide oversight of proficiency testing and technical medical laboratory consultation throughout the region?
- (4) Did medical laboratories implement an internal performance improvement program that demonstrated improvement in clinical laboratory services?
- (5) Have procedures been implemented to ensure that laboratory-related DOD patient access and cytopathology turnaround time standards are met?
- (6) Did local procedures ensure that only authorized individuals ordered laboratory tests?

(7) Were all fixed U.S. Army hospital clinical laboratories accredited by the CAP or other acceptable accreditation body on a biennial basis? Were all MTF laboratories accredited by the TJC biennially?

(8) Was a written quality control program in place to measure, assess, and improve the quality of cytopathology services provided? Were annual statistical QA reports of cytopathology services provided according to CLIP and accreditation standards?

(9) Are annual statistical QA reports of cytopathology services published and provided at least yearly to the next higher headquarters?

c. The U.S. Army Blood Program. Blood Program elements at each MTF are inspected by several outside agencies every year to two years to determine compliance with required standards. The FDA and AABB conduct unannounced visit to each facility. FDA is the regulatory body that examines the manufacturing and blood storage and distribution process to determine compliance with standards and Federal Law. FDA investigators are Federal employees with the authority to recommend the revocation of an establishment's license for noncompliance with applicable law. The AABB makes biennial accreditation visits to donor centers and transfusion services. Their assessors are volunteers who, through a peer-review process and available guidelines of accepted blood bank practices, review the procedures and practices of a facility and recommend improvements. The CLIP reviews the operation of the entire laboratory with emphasis on how the blood bank or transfusion service fits into the integrated delivery of laboratory services. TJC inspects the entire MTF. A portion of the inspection reviews the operation of the laboratory and the transfusion services to determine its integration into the total delivery of service by the healthcare organization. Each MTF prepares and submits their Operational Data Report to the Blood Program Management Office for review using the electronic Operational Data Reporting System (DODI 6480.04). This report provides statistical data to the Director, Army Blood Program allowing a review of the operation of each MTF.

(1) Did the donor center and manufacturing locations operate in compliance with the terms of the FDA license?

(2) Did the MTF operate within the standards promulgated in Current Good Manufacturing Practices for Blood and Blood Components in 21 CFR 210, 211, 600–680?

(3) Did the MTF operate within the standards set forth by the AABB in TM 8–227–3/NAVMED P–5101/AFMAN 41–119? In addition, did blood banks and transfusion services receive accreditation by the AABB, and are they complying with requirements of the FDA, CLIP, and TJC?

(4) Did the blood banks and transfusion services implement a QA program to foster continuous improvement and to meet the requirements for the licensing and accreditation agencies (for example, FDA, AABB, CLIP, and TJC)?

(5) Did the MTF establish a sound business plan to support its blood and blood component needs? Did the plan include efforts to minimize waste (outdating) through exchange agreements with other uniformed Services and local civilian institutions? Does the plan include a fair market value for products exchanged to include red blood cell components and recovered plasma?

d. Pharmacy management. The TJC review will be the evaluation process used to evaluate the key management controls. The local pharmacy will coordinate with the internal control administrator to ensure that the pharmacy schedules the TJC review on the 5-year internal control plan. In addition, the local pharmacy will coordinate with their QA office and the TJC review team to ensure the review of the key controls contained herein are included in the TJC review.

(1) Did the MTF commander ensure compliance with the DOD Tri-Service pharmacy policy guidance for dispensing medications?

(2) Did pharmacy services ensure that only qualified persons compounded and/or dispensed pharmaceutical preparations?

(3) Did pharmacy services implement an internal performance improvement process that demonstrated improvement in pharmacy services?

(4) Did local procedures ensure that only authorized individuals wrote medication orders and/or prescriptions?

(5) Except for the physician order entry via the CHCS, did local procedures ensure that no prescription or order was filled in the pharmacy unless it bore the signature of an individual authorized to prescribe medications?

(6) Did local procedures ensure that the guidance for inventory, control, and accountability of controlled substances was accomplished in accordance with appendix B?

(7) Were local procedures implemented to minimize theft of noncontrolled drugs in accordance with paragraph B–12 of this regulation as well as current OTSG/USAMEDCOM policy regarding inventory management of noncontrolled medications?

e. Army Aviation Medicine Program.

(1) Has the RMC commander established procedures to ensure that the AVMED program is implemented?

(2) Has the Commander, U.S. Army Aeromedical Center established procedures to ensure worldwide support of Army AVMED programs through consultations, supportive services, and training in the areas of aviation and military occupational disease prevention, surveillance, and evaluation?

(3) Has the installation medical authority having aviation assets assigned to the installation established, supervised, administered, and supported the AVMED program?

f. Army Medical Department Libraries and Information Centers.

(1) Is the DA Library Web-based Program's Measurement, Tracking, and Information Collection System statistical report submitted electronically by 31 December?

(2) Is there compliance to the interlibrary loan standards established by the NLM and/or the American Library Association?

(3) Is an inventory record (manual or electronic) maintained as the official record of accountable library materials as required by AR 735-17?

(4) Is a physical count of the library collection conducted and documented every 3 years as required by AR 735-17?

C-5. Supersession

This checklist replaces the checklist for medical, dental, and veterinary care previously published in AR 40-3.

C-6. Comments

Help make this a better tool for evaluating the Medical, Dental, and Veterinary Care process. Comments regarding this checklist may be addressed to Commander, U.S. Army Medical Command (MCHO-CL), 2748 Worth Road, Suite 10, Fort Sam Houston, TX 78234-6010.

Appendix D Essential Equipment on Aerial Ambulance

D-1. Air ambulances

Air ambulances will contain supplies for the care and treatment of patients.

D-2. Listing of requirements

a. Additional equipment may be added to the list at paragraph D-2(*b*) at the discretion of the commander or as dictated by the mission.

b. The following equipment list represents minimal equipment on each aerial ambulance.

(1) Portable suction apparatus, with wide-bore tubing and pharyngeal tips in adult, child, and infant sizes; electric powered, acid, rechargeable battery or 115v.

(2) Bag—mask ventilation unit, hand-operated with clear adult, child, and infant size mask; valves operable in cold weather and unit capable of use with oxygen supply.

(3) Oropharyngeal airways, adult, child, and infant sizes.

(4) Portable oxygen equipment, with adequate tubing and semi-open, valveless, transparent masks in adult, child, and infant sizes; positive pressure (with capacity for 80 centimeter water pressure), demand, vaporization, and metered flow capability.

(5) Bite sticks.

(6) Sterile intravenous fluids, with administration kits; ringer's lactate and others as appropriate in plastic bag containers.

(7) Dressings, first aid, field, 113/4 square in.

(8) Bandages, soft roller, self-adhering type, assorted widths.

(9) Aluminum foils, sterilized and wrapped, 18 × 25 in.

(10) Adhesive tape, 3 in × 5 yards.

(11) Burn sheets, sterile.

(12) Traction splint, lower extremity, with ratchet device, hook and pile fasteners.

(13) Padded wooden splint, 4 1/2 × 3 in, 3 × 3 in, 15 × 3 in.

(14) Inflatable splints, for extremities.

(15) Spine boards, short and long, with accessories.

(16) Triangular bandages, 37 × 37 × 52 in.

(17) Safety pins, large.

(18) Scissors, bandage, angular, 7 1/4 in.

(19) Obstetrical kit, sterile.

(20) Poison kit.

(21) Blood pressure manometer, adult and pediatric cuffs, and stethoscope.

(22) Cold pack, chemical.

(23) Blanket, combat casualty.

(24) Otoscope and ophthalmoscope.

(25) Monitor, blood pressure, respiration, and pulse, digital display, aircraft interconnectable, and battery operated, noninterfering with avionics equipment.

(26) Infant transport incubator or isolette, with oxygen, air transportable.

(27) Laryngoscope.

(28) Cardioscope/recorded module and defibrillator.

(29) Butterfly intravenous infusion needles, 19, 21, 23 gauge.

(30) Litter straps.

(31) Scoop litter, contractable, with capability of operation with aircraft rescue hoist.

(32) Litter, semirigid.

(33) Bags, stabilizing.

(34) Catheter, nasogastric tube, suction.

(35) Applicator, wood, cotton-tipped.

(36) Type 2 military antishock trousers.

(37) Surgical clamps.

(38) Alcohol swabs.

(39) Razor blades.

(40) Air sickness bags.

(41) Thermometer, human, clinical, oral, low reading and regular scales.

- (42) Tourniquet, nonpneumatic.
- (43) Sterile gloves, assorted sizes.
- (44) Cervical collars, assorted sizes.
- (45) Saw, finger ring.
- (46) Surgical lubricant.
- (47) Litter pads.
- (48) Blanket set.
- (49) Drug administration kit, with drugs, protocol dependent.
- (50) Wire fabric.
- (51) Flashlight.
- (52) Ammonia inhalant ampules.
- (53) Amyl nitrite inhalant ampules.
- (54) Antidote, nerve agents, injector.
- (55) Aspirin tablets.
- (56) Bacitracin zinc ophthalmic ointment.
- (57) Detergent, surgical.
- (58) Diphenhydramine hydrochloride capsules.
- (59) Morphine injection.
- (60) Povidone-iodine solution.
- (61) Bandage, adhesive, $3/4 \times 3$ in.
- (62) Bandage, cotton, elastic.
- (63) Catheter and needle unit, iv, 16, 18, 20 gauge.
- (64) Dressing, first aid, field camouflaged, 4×7 in.
- (65) Dressing, first aid, field camouflaged, $7 \frac{1}{2} \times 8$ in.
- (66) Skin closure, adhesive, surgical, $1/4 \times 3$ in.
- (67) Sponge, surgical, 2×2 in.
- (68) Sponge, surgical, 4×4 in.
- (69) Airway, pharyngeal, rubber, small adult.
- (70) Blade, surgical knife, #11.
- (71) Depressor, tongue, wood.
- (72) Forceps, dressing, straight, $5 \frac{1}{2}$ in.
- (73) Handle, surgical knife, #3.
- (74) Scissors, general surgical straight, $5 \frac{1}{2}$ in.
- (75) Pencil, mechanical.
- (76) DD form 1380 (U.S. Field Medical Card).
- (77) Litter, folding, rigid pole.

Glossary

Section I Abbreviations

AAAR

approved automated accounting record

AABB

American Association of Blood Banks

AASC

U.S. Army Audiology and Speech Center

ACLS

Advanced Cardiac Life Support

ACOM

Army command

AD

active duty

ADCS

Army Dental Care System

AED

automated external defibrillators

AFI

Air Force Instruction

AFIP

Armed Forces Institute of Pathology

AFMAN

Air Force Manual

AFR

Air Force Regulation

AHLTA

(formerly known as the Armed Forces Health Longitudinal Technology Application)

AME

aviation medical examiner

AMEDD

Army Medical Department

AMEDD C&S

Army Medical Department Center and School

AMEDD MEDLI-NET

Army Medical Department Medical Library and Information Network

AND

Academy of Nutrition and Dietetics

APLS

Advanced Pediatric Life Support

APO

accountable property officer

APV

ambulatory procedure visit

AR

Army regulation

ARTEP

Army Training and Evaluation Program

ASBPO

Armed Services Blood Program Office

ASCC

Army service component command

ASD (HA)

Assistant Secretary of Defense, Health Affairs

ASI

additional skill identifier

ASWBPL

Armed Services Whole Blood Processing Laboratory

ATLS

Advanced Trauma Life Support

AVMED

aviation medicine

BCF

Basic Core Formulary

B DFA

basic daily food allowance

BHTC

basic hearing test clinic

BLS

basic life support

BUMEDINST

Bureau of Medicine and Surgery Instruction

CAP

College of American Pathologists

CDC

Centers for Disease Control and Prevention

CD-ROM

compact disk-read only memory

CFR

Code of Federal Regulations

CHCS

Composite Health Care System

CLIP

Clinical Laboratory Improvement Program

CONUS

continental United States

DA

Department of the Army

DA Pam

Department of the Army pamphlet

DAGO

Department of the Army general order

DALC

Denver Acquisition and Logistics Center

DCD

donation after cardiac death

DDS

director of dental services

DEA

Drug Enforcement Administration

DECA

Defense Commissary Agency

DES

director of emergency services

DNR

do not resuscitate

DOD

Department of Defense

DODD

Department of Defense directive

DODI

Department of Defense instruction

DRU

direct reporting unit

DSCP

Defense Supply Center Philadelphia

DTF

dental treatment facility

DVD

digital video disk

EC
emergency center

EMS
emergency medical services

EMT
emergency medical technician

EMT-B
emergency medical technician-basic

EMT-I
emergency medical technician-intermediate

EMT-P
emergency medical technician-paramedic

FAA
Federal Aviation Administration

FDA
Food and Drug Administration

FDME
flying duty medical examination

FEDLINK
Federal Library and Information Network

FM
field manual

FS
flight surgeon

FY
fiscal year

GOA
government-owned animals

GS
general schedule

HIPAA
Health Insurance Portability and Accountability Act

ILL
interlibrary loan

IPOE
inpatient physician order entry

ITR
inpatient treatment record

JAMRS
Joint Medication Error Reporting Tool

LC
Library of Congress

LRN
Laboratory Response Network

MCO
Marine Corps order

MEDCEN
medical center

MEDDAC
medical department activity

MEDEVAC
medical evacuation

MHS
Military Health System

ml
milliliter

MLA
Medical Library Association

MOA
memorandum of agreement

MOP
mail order pharmacy

MOS
military occupational specialty

MSAO
medical services accountable officer

MSC
major subordinate command

MSO
medical supply officer

MTC
Military Transplant Center

MTF
military treatment facility

NAF
nonappropriated fund

NATO
North Atlantic Treaty Organization

NAVMED
Navy Medical

NCD
nutrition care division

NG
national guard

NLM
National Library of Medicine

NOK
next of kin

NP
nurse practitioner

NPI
national provider identifier

NREMT
National Registry for Emergency Medical Technicians

OCONUS
outside continental United States

OPNAVINST
Operational Naval Instruction

OPO
Organ Procurement Organization

OTC
over-the-counter

OTR
outpatient treatment record

OTSG
Office of The Surgeon General

P&T
pharmacy and therapeutics

PA
physician assistant

PAD
patient administration division

PALS
Pediatric Advanced Life Support

PI
performance improvement

PMART
Prescription Medication Analysis Reporting Tool

POA
privately-owned animals

POE
physician order entry

POS
point of sale

PPM
provider-performed microscopy

QA
quality assurance

RC
reserve component

RMC
regional medical command

ROES
Remote Order Entry System

SECNAVINST
Secretary of the Navy Instruction

SF
standard form

SIK
subsistence in kind

SME
subject matter expert

SOP
standing operating procedure

SRP
Soldier readiness process

SSN
social security number

STR
service treatment record

TB MED
technical bulletin, medical

TC
training circular

TDA
table of distribution and allowances

TDY
temporary duty

TISA
troop issue subsistence activity

TJC

The Joint Commission

TM

technical manual

TOE

table of organization and equipment

TPCP

Third Party Collection Program

TRICARE

tri-service medical care

TSG

The Surgeon General

U.S.

United States

USCENTCOM

United States Central Command

USAMEDCOM

U.S. Army Medical Command

USAMRMC

U.S. Army Medical Research and Materiel Command

USAPHC

U.S. Army Public Health Command

USC

United States Code

VA

Veterans Affairs

VISN3

Veterans Integrated Service Network 3

VTAT

veterinary training assistance team

Section II**Terms****A la carte meal service**

A system in which a variety of food items are available and the individual selects those food items desired.

A la carte meal pricing system

Each menu item is priced separately, based on its food cost (including an applicable condiment percentage factor) plus a proportional charge for related operating costs determined annually by the DOD Comptroller.

Abatement order

A written order for DNR (or “no-code”) or to withdraw or withhold life-sustaining treatment.

Active duty

Full-time duty in the active military Service of the United States. It includes Federal duty on the active list (for

National Guard personnel), full-time training duty, annual training, and attendance, while in the active military Service, at a school designated as a Service school by law or the Secretary of the military department concerned.

Adult

A person 18 years or older, emancipated minors (as determined by State law), and members of the armed forces.

Advance directive

A written document defining a patient's wishes, should (s)he become incapable of participating in medical decisions. These include a "Durable Power of Attorney for Health Care" and a "Living Will." State law governs the validity of these documents.

Aeromedical physician assistant

Physician assistants who successfully complete the Army Flight Surgeon Primary Course.

AMEDD MEDLI-NET

The electronic network of AMEDD libraries and information centers that ensures timely and cost-effective access to biomedical information and services to all echelons of the AMEDD worldwide. The goal of the AMEDD MEDLI-NET is to provide the highest quality, customer-oriented, knowledge-based information programs and services in support of patient care, healthcare administration, research, education, training, and readiness.

Anthropometric

Concerned with comparative measurements of the human body and its parts.

Authorized monetary value allowed for subsistence

NCD earnings equal patient meal days multiplied by the patient BDFA plus non-patient meal days multiplied by the MTF BDFA. NCD earnings in an a la carte operation equals the patient meal days multiplied by the patient BDFA plus SIK meal days multiplied by the MTF BDFA plus cash collected (less operating costs). The authorized monetary value allowed for subsistence or earnings is calculated on a daily basis to provide a "yardstick " to compare with the monetary value of food purchases.

Aviation Medicine Program

An integrated, multi-disciplinary program of primary care, preventive medicine, and occupational health for aviation personnel.

Basic daily food allowance (BDFA)

The authorized monetary value of a meal day furnished by non-MTF dining facilities.

Box meal

Meal sold to personnel authorized to subsist in NCD who are unable to eat in the dining room.

Clinical laboratory

A facility for the biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body for the purposes of providing information for the prevention, diagnosis, or treatment of any disease or impairment of, or the assessment of the health of, human beings. These examinations also include procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body. Facilities only collecting or preparing specimens (or both) or only serving as a mailing service, and not performing testing, are not considered clinical laboratories.

Clinical specialty

Any medical specialty excluding pathology, psychiatry, nuclear medicine, preventive medicine, occupational medicine, physiatrics, and radiology.

Decision-making capacity

A patient with decision-making capacity is an adult who has the ability to communicate and understand information and the ability to reason and deliberate sufficiently well about the choices involved.

Donation after cardiac death

All patients with significant neurologic injury, Glasgow Coma scale of 5 or <, and who are ventilator dependent, are potential DCD donors. This type of donor should be covered in the MOA with the local OPO. Some OPOs use a Glasgow Coma Scale of 4 or < and this should be addressed in the MOA.

Donor card

A legal document signed by an individual properly witnessed under the rules of informed consent, and indicating a desire to have one or more organs and/or tissues removed at death for donation to another individual.

Do not resuscitate (DNR) order

A written order suspending the otherwise automatic initiation of cardiopulmonary resuscitation, that is, any means used to support ventilatory and/or circulatory function until spontaneously resumed or until artificial means are established or until the patient is pronounced dead.

Durable power of attorney for health care

A written document designating a surrogate. This is a type of advance directive.

Emergency

Situation that requires immediate intervention to prevent the loss of life, limb, sight, or body tissue, or to prevent undue suffering.

Emergency center

The designated area in a nondeployed MTF having the personnel and resources required to provide patient care emergency services at level I, II, or III of care as defined by this regulation.

Emergency medical services (EMS)

The resources—both personnel and facilities—that are available 24 hours a day to assess, treat, or refer for medical and/or dental treatment, an ill or injured person. The level of EMS at a fixed MTF will be classified as level I, II, III according to TJC standards and the requirements of this regulation. EMS refers to prehospital emergency services to include aeromedical evacuation—and fixed facility emergency services.

EMS healthcare providers

Physicians, dentists, NPs, and PAs granted clinical privileges to provide emergency patient care. This includes DOD military and civilian personnel as well as contractual personnel.

EMS nurse

A registered nurse who has (1) successfully completed the AMEDD C&S Emergency Nursing Course or (2) a minimum of 1500 hours experience in emergency nursing with at least 750 hours of this experience in the year preceding application. Clinical competencies must be documented in conjunction with validation of emergency nursing practice hours.

EMS physician

A physician who is assigned to the EC and fulfills the educational, training, and experience requirements of this regulation.

Emergency medical technician

Hospital medic, corpsmen, or technician (military or civilian) who is assigned to the EC and/or ambulance duty and is trained according to DOT curriculum or equivalent program approved by NREMT.

Ethics committee

A multidisciplinary committee that can assist in resolving ethical concerns pertaining to medical treatment decisions. This committee can assist all parties in identifying ethical issues, defining their positions, and resolving potential areas of conflict.

Federal Library and Information Network

An interagency cooperative program sponsored by the Library of Congress and the Federal Library and Information Center Committee. It offers any Federal library or information center service contracts directly from commercial vendors for information or operations support services including online reference databases, online cataloging and interlibrary loan services of bibliographic utilities, and ordering and publications control services of book jobbers and serials subscription agents. These contracts usually provide substantial discounts to the library or information center.

Fixed medical treatment facility

A permanently established, land-based medical treatment facility excluding ships, field units, and air-transportable hospitals.

Incapable patient

A minor or someone who does not have the ability to communicate or understand information or to reason and deliberate sufficiently well about the choices involved. Some exceptions have been created for “mature” minors between the ages of 14 and 17 years, because children sometimes have adequate capacity to make decisions. However, a minor below 14 years old will be considered to lack capacity for healthcare decisions, unless specifically so provided by applicable State law. This incapacity should be verified by clinical assessment of mental and emotional status.

Indefinite loan collections and libraries

Any size collection of library materials on loan to a department for use on a daily basis. The materials are part of the main library’s total collection and signed out to the department’s indefinite loan accountable officer on DA Form 3161. Materials on indefinite loan are subject to recall for use by other library users.

Investigational drug

A drug not yet approved by the FDA for routine use by the public as a safe and efficacious drug.

Knowledge-based information

Commonly referred to as “the literature,” knowledge-based information includes journal literature, reference information, and research data. It is authoritative and up-to-date. It supports clinical decision making, continuing education of staff, administrative planning and management, performance assessment and improvement, patient and family education, and research. Systems, resources, and services are necessary to effectively and efficiently manage knowledge-based information. Systems refer to the structures needed to identify, locate, and control knowledge-based information, that is, electronic and paper-based catalogs, networks, consortia, controlled vocabularies, and standard nomenclatures. TJC has identified knowledge-based information as vital to an organization’s ability to provide patient care.

Living will

A written document setting forth a person’s desires concerning medical care when (s)he is terminally ill or in a persistent vegetative state. This is a type of advance directive.

Lunch

The meal served during midday and considered the second meal of the day.

Meal day

The quantity of nutritionally adequate subsistence (food) furnished to one person during a 24 hour period (0001 to 2400 hours).

Meal days served

Meal days served is determined each day by multiplying meals served by the appropriate conversion factor (weight) for each meal period and then adding patient census.

Meals served

Aggregate number of meals furnished by NCD for all dining situations (for example, dining room, ward meals served, box meals) for a prescribed period of time.

Medical care

Unless otherwise specified, medical care includes, but is not limited to the following:

- a. Inpatient treatment.
- b. Outpatient treatment.
- c. Nursing care.
- d. Medical examinations.
- e. Immunizations.
- f. Drugs.
- g. Subsistence.
- h. Transportation.
- i. Other adjuncts such as prosthetic devices, spectacles, hearing aids, and orthopedic footwear. This includes appliances such as braces, walking irons, and elastic stockings.

Medical officer

Pertaining to orthopedic footwear, defined as an orthopedic physician or a podiatrist. MEDCEN/MEDDAC commanders, in order to meet access standards, may determine that personnel in clinical specialties other than orthopedics and

podiatry (based on appropriate training and in conjunction with the granting of appropriate privileges) may also evaluate for and prescribe orthopedic footwear.

Medical treatment facility

A civilian or uniformed Services medical center, hospital, clinic, or other facility that is authorized to provide medical, dental, or veterinary care.

Medication errors

Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient, or consumer. Such events may be related to professional practice, healthcare products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use.

Medical treatment facility basic daily food allowance (MTF BDFa)

The authorized monetary value of a meal day furnished by the MTF to a nonpatient.

Next of kin (primary)

The available interested party highest in the order of priority in *a* through *f*, below. The designated NOK may waive all referenced rights for organ disposition in favor of the next interested party in the order of priority. The spouse of the donor.

- a.* An adult son or daughter of the donor.
- b.* Either parent of the donor.
- c.* An adult brother or sister of the donor.
- d.* A grandparent of the donor.
- e.* A guardian of the donor at the time of death.

Non-Service treatment record

Chronology of outpatient medical, dental, and behavioral health care received by non-Service members and applies to anyone that does not meet the criteria for a Service treatment record.

Nutrition support team

An interdisciplinary team concerned with aggressive nutrition support of patients requiring enteral or parenteral nutrition.

Official functions

Functions which further the successful completion of the MTF mission or operation.

Organ

Includes heart, lung, liver, kidney, pancreas, or any other organ that is currently or in the future deemed suitable for transplantation.

Organ donor

An individual who makes a gift of all, or part, of his or her body, for use after death, for specific purposes.

Organ procurement organization

A formally constituted civilian organization created to coordinate and recover organs and tissues for a specific type of transplantation or a special geographic area.

Orthopedic footwear

Footwear designed to conform to the contour of abnormal feet that have been disabled or distorted. This footwear may contain specially molded innersoles or built-in appliances. Orthopedic footwear is medically prescribed when disabled or deformed feet cannot be fitted satisfactorily with a size and type of footwear available in regular supply channels.

Other food service support

Provision of food items for purposes over and above the traditional meals and nutrition support provided for patients and authorized patrons.

Other psychological test users

Individuals who choose tests, interpret scores, make decisions, make dispositions, render reports, or who conduct experimental studies, based on test scores or results.

Patient basic daily food allowance (BDFA)

The authorized monetary value of a meal day furnished by the MTF to an inpatient. The patient BDFA is determined by multiplying the MTF BDFA by 1.15 (an increase of 15 percent).

Patient with decision-making capacity

An adult (18 years of age or over or emancipated minor as determined by State law) who has the ability to communicate and understand information and the ability to reason and deliberate sufficiently well about the choices involved. Some exceptions have been created for “mature” minors in recognition that children sometimes have adequate capacity to make decisions. However, a minor below 14 years old will be considered not to have capacity for healthcare decisions, unless specifically so provided by applicable State law. Emancipated minors include 17 year old service members.

Pharmaceutical care (Academy of Managed Care Pharmacy’s Concepts in Managed Care Pharmacy series)

That component of the healthcare system that seeks, through the caring, collaborative efforts of a team of pharmacists, physicians, nurses, and other healthcare providers working with patients, to ensure that medications are used appropriately to improve patient health status.

Pharmacy data transaction service (PDTS) (from PDTS Business Rules)

Military Health System Integrated Pharmacy System business rules that identify issues and processes used by the pharmacists and providers in the direct care system when interacting with the PDTS. The integrated pharmacy system will operate with several Government systems to screen an eligible patient’s prescription against the patient’s total drug profile for drug interactions, drug overlaps, drug dosage, and patient compliance. Additionally, retrospective, concurrent, and prospective drug utilization reviews will be accomplished.

Protocols

Written procedures providing basic guidelines for the management (diagnosis and treatment) of specific types of medical and dental patient-care emergencies.

Pre-hospital EMS

Emergency services rendered between the onset of an emergent pre-hospital event (sudden illness or injury) and arrival at the EC.

Primary care specialty

Those medical specialties of emergency medicine, internal medicine, pediatrics, and family practice.

Psychological test

Any standardized assessment device, test or inventory, designed and used for understanding and diagnosing the nature and causes of, and for predicting and reducing the following effects of, mental disorder or disturbance and physical disease or disability: subjective distress, individual impairment, and psychological and emotional factors. Psychological tests focus on cognitive and intellectual abilities, aptitudes, emotions, motivations, personality characteristics, psychoneurologic functioning, academic skills and educational achievement, or other aspects of human experience and behavior.

- a. The criteria used to identify a procedure as being a psychological test include that the test has been—
- b. Involved in appellate decisions of the Courts of the United States, or in the decisions of their administrative agencies, both Federal and State, that define the admissibility of clinical, counseling, school, or industrial psychologists’ test results; or
- c. Developed by psychologists applying principles, methods, and procedures of the science of psychology in test construction; or
- d. Introduced to, or routinely evaluated in, professional psychological practice by publications authored by psychologists in recognized clinical, counseling, or consulting psychology or medical literature; or
- e. Listed or reviewed in authoritative references either of psychological testing and evaluation or of mental measurements classified as individual achievement, intelligence, aptitude, personality, psychology, or neuropsychology; or
- f. Obtained from vendors making known that sale is made in adherence to the ethical standards of the American Psychological Association.
- g. The following types of procedures are excluded from the definition of a psychological test, as defined by this regulation:
 - h. Surveys and questionnaires used in measuring group attitudes and interests.
 - i. Surveys and questionnaires administered for purposes of assessing an individual patient’s social relationships (that is, marital and family) or pediatric developmental milestones and schedules.

j. Instruments solely measuring occupational interest or choice, role or skill performance, and vocational adaptation or leisure.

Psychological test direction

The technical and operational management, control, supervision, instruction, and guidance of the actions of individuals, or of the operations of services, pertaining to psychological testing. Psychological test direction includes the legal, administrative, and professional accountability for such services.

Qualified psychologist

An individual who has earned a doctoral degree from a regionally accredited university or professional school providing an organized, sequential clinical or counseling psychology program in a psychology department or unit of a professional school. The person has acquired supervised training that is directly related to the functions to be performed and services to be provided. Doctoral education programs and other professional training and internship programs accredited by the American Psychological Association, or evaluated as acceptable by the OTSG, are recognized as meeting this definition. The individual possesses a current, valid, and unrestricted State license to practice psychology independently at the doctoral level.

Service treatment record

Chronology of medical, dental, and behavioral health care received by Service members during the course of their military career on an outpatient basis (that is, without admittance to a hospital, clinic, or any treatment facility). The STR is the official record used to support clinical care and the administrative, business-related, and evidentiary needs of the DOD, the VA, and the individual.

Special measurement footwear

That footwear which is required by reason of size alone for active duty personnel. Special measurement footwear guidance is covered in AR 32–4 and AR 700–84. These procedures should not be confused with those in AR 40–3 for the issue and fitting of orthopedic footwear. Special measurement footwear is not purchased through the MTF, but through the clothing sales store.

Surrogate

An agent, proxy, or surrogate decision maker who is designated to make medical decisions on behalf of a person who lacks decision making capacity. This surrogate has the authority to act fully on behalf of the patient and has priority over any other person to act. The identification of the surrogate may require reference to State law.

Test administration

Orally, manually, or electronically giving a test, or portion thereof, following standardized instructions.

Test scoring

The manual or electronic tabulation, compilation, or summation of derived test data in accordance with developed standards, criteria, norms, and methodology.

Tissue

Includes cornea, eye, skin, bone, bone marrow, peripheral blood stem, dura, blood vessels, fascia, or other tissue that is currently or in the future deemed suitable for transplantation.

Traditional meal pricing system

Fixed charge for a complete meal determined annually by the DOD Comptroller. Under this system, there are two meal rates for individual categories of personnel determined by the DOD Comptroller. Full (standard) meal rate. A fixed charge for a complete meal that includes the cost of the food and a proportional charge for related operating costs. Discount meal rate. A fixed charge for a complete meal that includes the cost of the food only.

Traditional meal service

A system in which a complete meal is served with few or no substitutions or selections available.

Withhold or withdraw order

A written order not to initiate or to discontinue specific therapeutic modality(ies), including life-sustaining modalities.

Section III

Special Abbreviations and Terms

This section contains no entries.

UNCLASSIFIED

PIN 000498-000