



## AEROMEDICAL EVACUATION OPERATIONS

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During support of operations, aeromedical evacuation (AE) employs its full capability, to include staging, AE aircrew members, specialty teams, specialized medical equipment, and integrated communications. During expeditionary operations, AE includes the movement of military casualties from forward operating sites to definitive care facilities. The AE system may also be tasked to provide patient movement for [noncombatant evacuation operations](#), injured US combat forces, repatriated American citizens, allied prisoners of war, detainees, coalition forces, and Department of Defense (DOD) civilian contractors.

### AE Laydown

The AE force provides time-sensitive mission critical en route care to patients to and between levels of care. This drives a requirement to provide continuity of care at the patient staging point and during transportation.

AE planners on the [Air Force forces \(AFFOR\) staff](#) are responsible for deployment, basing, sustainment, and redeployment of Air Force forces and develop plans and strategies to determine appropriate force laydown of AE ground forces and AE crews in support of the [joint force commander's](#) (JFC's) joint patient movement operations. The [aeromedical evacuation control team's](#) theater aeromedical evacuation system manager coordinates with the AFFOR staff and joint theater medical planners to integrate AE support into the theater patient movement plan and ensure theater AE system (TAES) specific issues are addressed that impact operations. The TAES manager collects situation reports and maintains real-time information on the status of TAES capabilities (equipment and personnel). The TAES manager also coordinates logistics support for and the movement of TAES equipment and personnel to ensure proper laydown, phasing, and sequencing of AE forces.

### Patient Validation

The theater validating flight surgeon and patient movement requirements center provides clinical and administrative oversight of patients requiring AE. Once validated, these movement requirements are sent and coordinated with the appropriate [air operations center](#) or other appropriate agency for obtaining space on AE airlift missions.

AE squadron operations are conducted through operational wing [command and control](#) channels.

AE begins once a validated patient movement request is passed to the Air Force component agency for execution. AE is not the only mechanism for movement of patients. Casualty evacuation refers to the movement of casualties aboard vehicles or aircraft (most often rotary wing aircraft). Medical evacuation traditionally refers to US Army, Navy, Marine Corps, or Coast Guard patient movement using pre-designated aircraft temporarily equipped and staffed for en route medical care. Patient evacuation from point of injury to initial treatment at a health care facility is the responsibility of each Service component.

## **En Route Care Transport Team**

En route critical care transport capabilities consist of several specialized medical teams who assist in carrying out the mission of the global patient movement system. These teams are limited, rapidly-deployable resources available in selected situations to maintain or enhance the standard of care provided to critically ill or injured patients who require continuous stabilization and highly advanced care during transport to the next level of medical treatment. En route critical care units include the critical care air transport team (CCATT), special operations surgical team, and special operations forces medical element. Pararescue jumper (PJ) teams may also provide limited critical care transport as a collateral mission. Other enabling capabilities include, but are not limited to, point of injury care, post-surgical critical care, acute lung emergency rescue teams, and neonatal intensive care unit teams. CCATTs provide intensive care, by themselves or in conjunction with AE crews, to evacuate critical patients requiring advanced care during transportation. These teams are medically responsible for their patients.

## **AE Aircraft Considerations**

Many considerations should be taken into account when selecting appropriate aircraft for AE missions. Altitude restrictions, configuration, patient load, airfield restrictions, aircraft range and potential [air refueling](#) are key factors. Additionally, AE crew members should be provided combat aircrew flight equipment on the same basis as other aircraft crew members.

## **Defense Support of Civil Authorities**

[Defense support of civil authorities](#) (DSCA) enables mutual assistance and support between DOD and any civil government agency. This includes planning and preparation for response to civil emergencies or attacks, including national security emergencies. Most DSCA situations are managed within the state. In a natural disaster, the state normally declares when the situation is beyond the state's response capability and then requests federal support for the state emergency management agency from the [Federal Emergency Management Agency](#) (FEMA). The director of patient stage operations is

the senior AE DOD representative responsible for coordinating AE efforts at the aerial port of embarkation (APOE) and coordinating resource requirements with DOD, state, and federal units and agencies at the APOE. This person is responsible for all aspects of patient care and operations affecting patient care at the APOE.

When the DOD provides support, most FEMA-requested patient evacuations requiring air transportation are accomplished by AE. [US Transportation Command](#) (USTRANSCOM) validates AE requirements in support of civilian authorities. Once patient movement is validated, the requirement is tasked to the appropriate air operations center for execution. [Air Mobility Command](#) (AMC) also provides trained AE coordinating officers and coordinating elements for DSCA from existing active and Reserve Component forces in execution of the [National Response Framework](#). AE assets required depend on the size and scope dictated by the disaster or contingency and may be supported by in-place AE infrastructure or the deployment of AE assets to the disaster area. For additional information on homeland operations, see AFDP 3-27, [Homeland Operations](#).

## **AE Interface with Special Operations and Personnel Recovery Operations**

Some expeditionary forward deployed forces, such as special operations forces (SOF), Marine expeditionary forces, and personnel recovery operations forces, do not possess organic patient evacuation capability and should identify requirements for, and obtain patient evacuation support at forward airbases. See AFDP 3-50, [Personnel Recovery](#), for more information about personnel recovery.

Evacuation of casualties within a joint special operations area can be particularly complex since SOF often operate with small, widely dispersed teams, and in locations not easily accessible. SOF are responsible for care and evacuation of casualties from the forward location to the secure airfield where AE forces may be prepositioned to support the operation. SOF conduct the evacuation of patients with their organic capabilities. At the secured airfield, patient evacuation and specialty care teams (e.g., CCATT) assume responsibility for the casualties, freeing special operations medical assets to return to forward locations. Patient evacuation assets provide the support required to move patients through the en route care system.

Normally, the interface point with special operations is the en route patient staging system (ERPSS). ERPSS personnel have contingency operations training and, in forward locations, should be ready to provide limited holding for patients who have been provided resuscitation and surgical intervention, when augmented by CCATT or similar capability. AE missions originating at secure forward airfields may require AE operations in low light conditions. When supporting these forces, AE crew members and CCATTs should be trained in low light and low noise operations, weapons use, and operations in austere locations to meet special mission requirements.

## **Detainee Missions and AE**

AE personnel are not normally used for providing care to detainees unless they require in-flight medical care. Security of detainees is not a responsibility of the en route care system. Strict adherence to detainee handling guidelines is required.

## **Inter-fly Agreements with Services and Coalition AE Support**

The Air Force employs aircraft for the movement of patients and uses AE crew members and specialty teams (e.g., CCATT) to provide in-flight patient care. Other Services and coalition forces use various ground transport and a variety of aircraft for patient movement. Air Force AE aircrew members may perform appropriate duties in non-Air Force aircraft in the interest of the US government and approved by the appropriate Air Force component, the affected geographic combatant commander (GCC), and the controlling aircraft authority. Conversely, coalition forces may also integrate with Air Force AE forces.

## **AE of Contaminated or Contagious Casualties**

Patients, personnel, or casualties with known or suspected contamination from chemical, biological, radiological, or nuclear agents are not normally transported within the aeromedical patient movement system. However, chemically or radiologically contaminated casualties, when approved for AE should be decontaminated before entering the AE system unless the Secretary of Defense (SecDef) directs otherwise. USTRANSCOM Surgeon General maintains a list of bioterrorism and Centers for Disease Control and Prevention critical list (CL) agents. The imminent concern is communicable person-to-person agents.

Patients with CL contamination should be quarantined and treated in-place and are not recommended for evacuation. For more information, see AFDP 3-40, [Counter Weapons of Mass Destruction \(WMD\) Operations](#).

Movement of highly contagious patients requires commander, USTRANSCOM, and GCC approval, as well as SecDef exception to policy.

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