

CDC A4N051

Aerospace Medical Service Journeyman

Volume 1. Introduction to the Aerospace Medical Service Career Field



**Air Force Career Development Academy
The Air University
Air Education and Training Command**

A4N051 01 1505, Edit Code 05

AFSC 4N051

Author: SMSgt Christopher D. Cole
383d Training Squadron
937 Training Group (AETC)
383 TRS/TRR
2931 Harney Rd.
Fort Sam Houston, Texas 78234
DSN: 420-5126
E-mail address: christopher.d.cole1.mil@mail.mil

Instructional Systems

Specialist: Evangeline K. Walmsley

Editor: Sherie A. Davis

Air Force Career Development Academy (AFCDA)
The Air University (AETC)
Maxwell-Gunter Air Force Base, Alabama 36118-5643

THE AEROSPACE MEDICAL SERVICE TECHNICIAN is an integral piece to the success of the Air Force Medical Service (AFMS). We are standing on the brink of military service that is undergoing tremendous changes in personnel, equipment, and technology. The most exciting part is that you are the future of the Air Force and will experience new opportunities and challenges that have never been encountered before. Seize this opportunity to learn; grow in your career field as well as a military professional and pass on your knowledge and experience to others. In order to provide the world's best medical care to the world's best soldiers, sailors, and Airmen, you must stay abreast of the latest developments in medical doctrine, career opportunities, required training, customer care techniques, and technical responsibilities. To do this effectively, you must have a strong foundation in the basics, including a sound understanding of basic human science and fundamentals of the medical technician duties and responsibilities.

This career development course (CDC) is designed to build on the information you learned in technical school to teach you not only how to perform a task, but when and why to do so. Faithful study of the material provided in this course CDC A4N051, *Aerospace Medical Service Journeyman*, and in the course that follows this one (B4N051) will help you become a more competent medical team member and enable you to provide your patients with the best medical care possible.

Volume 1 starts with an introduction to medical doctrine and how it applies to your career field and to you as a technician. It opens with an overview of Air Force doctrine and moves into medical doctrine. Also included in the first unit is information you will need to understand your career path, AFSC duties, requirements for upgrade training and maintenance of your training folder and documentation. Unit 2 discusses manpower and resources to introduce you to how manning needs are developed and gives you the basics to understand how you receive and maintain supplies and equipment necessary to complete your duties. Unit 3 looks at medical ethics, patient and staff relations and ways to develop and improve those relationships, as well as legal aspects of your job. Understanding and applying lessons learned in this volume will assist you in establishing yourself as a caring professional with an excellent understanding of your career field and how to deal with people. Lastly, the unit covers the future of our medical healthcare system through Population Health and Patient Centered Medical Home.

Volume 2 focuses on anatomy and physiology of the body. While you may remember some information that was taught in the resident course, the human body is amazingly complex and I challenge you to build on what you learned in technical school. Understanding the body and how it works is extremely important to providing patient care and identifying potential problems quickly. You can be a great help to your team by capturing a firm understanding of this volume!

After completing the 4N051A course, students in upgrade training will be required to enroll in and complete the 4N051B course before award of the 5-skill level.

Code numbers on figures are for preparing agency identification only.

A glossary is included for your use.

The use of a name of any specific manufacturer, commercial product, commodity, or service in this publication does not imply endorsement by the Air Force.

To get a response to your questions concerning subject matter in this course, or to point out technical errors in the text, unit review exercises, or course examination, call or write the author using the contact information on the inside front cover of this volume.

NOTE: Do not use the IDEA Program to submit corrections for printing or typographical errors.

If you have questions that your supervisor, training manager, or education/training office cannot answer regarding course enrollment, course material, or administrative issues, please contact Air University Educational Support Services at <http://www.aueducationsupport.com>. Be sure your

request includes your name, the last four digits of your social security number, address, and course/volume number.

This volume is valued at 24 hours and 8 points.

NOTE:

In this volume, the subject matter is divided into self-contained units. A unit menu begins each unit, identifying the lesson headings and numbers. After reading the unit menu page and unit introduction, study the section, answer the self-test questions, and compare your answers with those given at the end of the unit. Then complete the unit review exercises.

	<i>Page</i>
Unit 1. Aerospace Medical Services	1-1
1–1. United States Air Force Medical Service	1-2
1–2. Enlisted Specialty Training	1-15
1–3. Develop the Unit Training Program.....	1-23
1–4. Progression in the 4N0X1 Career Paths	1-52
Unit 2. Resource Management.....	2-1
2–1. Management of Personnel.....	2-1
2–2. Supervision.....	2-5
2–3. Management of Medical Logistic	2-22
Unit 3. Interpersonal Relations and Population Health.....	3-1
3–1. Ethical and Legal Standards	3-1
3–2. Professional Relationships	3-14
3–3. Patient Centered Medical Home	3-24
 <i>Glossary.....</i>	 <i>G-1</i>

Unit 1. Aerospace Medical Services

1-1. United States Air Force Medical Service.....	1-2
001. Basics of Air Force Medical Service doctrine	1-2
002. Medical role in air and space expeditionary force	1-3
003. Medical scope of practice	1-10
1-2. Enlisted Specialty Training	1-15
004. Functions of the Career Field Education and Training Plan	1-15
005. Purpose of the job inventory and Graduate Assessment Survey.....	1-18
006. Maintaining sustainment training programs	1-19
007. How to develop and present inservice training	1-20
1-3. Develop the Unit Training Program	1-23
008. Creating a workcenter master training plan	1-23
009. Creating a workcenter master task list	1-27
010. Creating a workcenter duty task list	1-30
011. Identify personnel training needs.....	1-36
012. 4N0XX training plan	1-37
013. Evaluate personnel in upgrade training.....	1-38
014. Career knowledge upgrade	1-41
015. Requirements of job proficiency upgrade.....	1-43
016. Maintaining on-the-job training tasks	1-45
017. Evaluate training effectiveness	1-46
1-4. Progression in the 4N0X1 Career Paths.....	1-52
018. Progression in 4N0X1 career path	1-52
019. Career path broadening	1-55
020. Components of your Air Force training record.....	1-58
021. Updating Profile I	1-61
022. Enrolling in AF Form 623 Part I/II/III.....	1-64
023. How to document training progress on AF 623a	1-68
024. Enroll users into AF Form 1098, Special Task Certification and Recurring Training	1-70
025. Enrolling users into the job qualification standard	1-75
026. Completing AF Form 797 and AF Form 803	1-78
027. Uploading documents into the training record user file.....	1-83

CONGRATULATIONS! YOU ARE ENROLLED in the Aerospace Medical Service Journeyman course, and that means you are well on your way to earning your 5-skill level. This course is your first step toward achieving the 5-skill level goal. The career knowledge you obtain from this course and the hands-on training provided by your supervisor will greatly enhance your abilities and skills. Both will help you serve as a team member in our diversified and ever-changing career field. You will soon see that the only constant in our career field is change! New people bring new ideas and improve upon the way we do things. This course is intended to provide training to develop your awareness of the duties and responsibilities you hold as a medical technician. As you read and study this material, keep in mind that this course is only as current as the information available at the time of writing.

Our recommendation to you is to stay familiar with the directives that govern your assigned duties. Throughout this course, you will see the terms aerospace medical service journeyman, aerospace

medical service specialist, aerospace medical service technician, medical service technician, medical service specialist, and medical technician. For the purpose of this career development course (CDC), these terms will be used interchangeably.

1-1. United States Air Force Medical Service

To understand the mission of the United States Air Force Medical Service (USAFMS) we must first answer this question: “*What are we here to do?*” Answering that question reveals our mission, vision, and goals. Without a clear mission, people spend time trying to accomplish “something” but have no real direction or purpose. Just like a football team’s game plan, a mission defines our direction and gives us a common goal.

So whose responsibility is it to establish and define our mission? Obviously, we can’t all be the ones responsible. In our system, we have an appointed leader who lays the foundation for the USAFMS and defines our direction as it relates to the overall mission of the entire Air Force. This person is the USAF Surgeon General (USAF/SG). The USAF/SG establishes our overall mission and must ensure that it supports the mission of the Air Force. Each organization within the USAFMS must establish mission statements that support the USAF/SG defined mission. Air Force Medical Service leaders rely on tried and true guidance to formulate and conduct their mission. This guidance is known as “*doctrine.*”

001. Basics of Air Force Medical Service doctrine

In order to understand Air Force Medical Service (AFMS) doctrine, it is important to understand first what doctrine is and where its guidance originates. Air Force Doctrine Document–1 (AFDD–1), *Air Force Basic Doctrine*, is established general guidance for the application of air and space forces in operations across the full range of military operations. AFDD Annex 4–02, *Medical Operations*, is the guide for all of the AFMS.

Doctrine is extremely valuable as it combines the lessons of Air Force history, technology, and insight to the future. To put it in basic terms, doctrine is a principal or teaching that governs certain operations. It is an accumulation of knowledge that is obtained from actual combat, contingency operations, and exercises and is designed to give us a common understanding that we then use to make decisions. Doctrine is authoritative but not directive, meaning it is a document that holds an enormous amount of guidance and experience, but does not state what or how you must complete a task or mission. AFMS doctrine applies to all active duty, Air Force Reserve, Air National Guard, and civilian Air Force personnel. AFMS commanders use AFDD Annex 4–02 to accomplish their missions.

You may be wondering how the commander does this. The commander uses Air Force assets, such as people, information, and support systems across the range of military operations. AFMS doctrine provides the guidance for the commander to make decisions and appropriately use assets. There are three levels of doctrine: basic, operational, and tactical.

Air Force Medical Service Doctrine	
Levels of Doctrine	Principles
Basic	Provides broad and continuing guidance on how Air Force forces are organized, employed, equipped, and sustained. Basic doctrine changes more slowly than other levels of doctrine.
Operational	Guides organization and employment of air and space forces within distinct objectives, force capabilities, broad functional areas, and operational environments. It provides the focus for developing the mission and task that will be executed through tactical doctrine. Operational doctrine changes quicker than basic doctrine but is usually discussed through an internal Service debate prior to change.

Air Force Medical Service Doctrine	
Levels of Doctrine	Principles
Tactical	Describes the proper employment of specific Air Force capabilities, individually or with other assets to accomplish a specific objective. Changes may occur faster than basic or operational doctrine and may be classified due to their sensitive nature.

Basic doctrine

Doctrine may seem a little hard to grasp, so let's break it down to something that might be more familiar. Cars are often an important purchase we make; try comparing car production to doctrine. Every car starts with an automotive designer that uses broad information on how cars have historically been designed, constructed, and used by the public. The designer may consider facts about size, weight, style, and gas mileage. Though new cars are produced each year, the basic structures are similar; drastic changes usually take a lot of time, effort, and debate to establish a design change. Basic doctrine is very similar in nature to the automotive designer.

Operational doctrine

Operational doctrine can be compared to an automobile manufacturer such as Ford, General Motors, or Dodge, to name a few. These manufacturers hire personnel with the skills to make products and parts and assemble the design using the basic plan of the automobile designer. The manufacturer must have a goal in mind for the target audience (you, the buyer) and ensure the cars are assembled to include broad functions and capabilities. This would be similar to standard options such as electric windows, air conditioning, and two-wheel drive that come with the car. Designs can change a bit more quickly if the automotive manufacturer decides to add, delete, or change a standard option. Perhaps leather seats could become a standard option in this case.

Tactical doctrine

The buyer (you) now become the tactical doctrine piece. If you are looking for the car that goes from 0 to 60 in four seconds flat, you will be looking to buy something completely different than a parent who is looking for the car with reinforced walls, side air bags, and a high-safety rating. Good gas mileage on either would be a bonus! You can see how the tactical piece looks for specific qualities, assets, and resources to complete your specific mission—to go fast or to be safe. Tactical doctrine enables commanders to use specific assets to accomplish specific missions. As life and missions can change rather quickly, tactical doctrine is easier to change than basic or operational doctrine. Sometimes, tactical doctrine is classified due to the nature or secrecy of the mission. For instance, telling the local policeman how fast your car can go could be considered “secret” information.

Among the three levels of doctrine, operational doctrine will most likely guide your daily practices as an aerospace medical technician. Operational doctrine for Air Force Medical Operations outlines the principles for helping Airmen maintain health and fitness by integrating prevention-oriented health, fitness, and medical intervention. Multiple forces are shaping national and global concepts of health and health care.

To meet the demands of this changing environment, Air Force Medical Operations and the USAFMS must balance operational demands in order to deliver world-class health care to Airmen, their families, and beneficiaries.

002. Medical role in air and space expeditionary force

Medical forces must have flexible organizations and trained people ready to perform their wartime tasks. They must be prepared to work in any area of the world, across the whole spectrum of conflict, from humanitarian aid to full-scale combat. As a medical technician, you are usually assigned to an air and space expeditionary force (AEF) to perform medical care any area of the world. Training to take care of someone else also means taking care of your own medical requirements. For example,

this means scheduling annual preventive health assessments, immunizations, and a whole range of activities designed to keep the force fit and ready. Readiness also entails teaching service members to not only protect themselves but also other Airmen in their duty sections. Equally important are efforts that address disease prevention before, during, and after deployment, including mental health counseling. Prevention is both a quality of life and a readiness issue.

Sickness and disease, historically, have been the cause of a great number of casualties in the field. This can and must be prevented. Continued deployments on humanitarian or peacekeeping missions to Third World countries expose our troops to environments where sometimes only rudimentary health care is available.

In the past, these service members could have been sent to one of our overseas medical facilities, but the reduction in forces now means we must be able to move patients quickly back to medical treatments facilities (MTF) in the United States. As a key player in the AEF, aeromedical evacuation (AE) has a vital role in transporting the sick and wounded. This mission is evolving to meet the changing requirements and provide an increased capability for “*care in the air*”. Our troops and their family members need the assurance that comes from knowing that they will be brought home quickly and safely from anywhere in the world. Through the implementation of the AEF packages, the aeromedical services have been able to re-engineer the goal of the AE system to meet the ever-changing needs of the Air Forces missions.

Aeromedical evacuation System

The definition of AE is the movement of “stabilized” patients from forward medical locations to another prearranged destination. AE significantly improves casualty survival rates by quickly moving the sick and injured to medical facilities where they can be adequately treated. This improves morale because our injured fighting forces know they will be transported rapidly to receive life-saving medical care. Additionally it reduces the MTF footprint by keeping beds empty. The purpose of AE is to provide the required airlift and AE resources needed to manage and operate intra-theater, inter-theater, and the continental US (CONUS) AE systems. The goals of AE are to keep the MTF beds empty, the MTFs open for business, and to evacuate those requiring further care to long-term facilities. The AE system is the essential piece that allows the medical support mission of the AEF to become complete. Without AE and the AEF, expeditionary medical support (EMEDS) capacity would never work.

Air and space expeditionary force

The mission of the AE system has expanded greatly since 2000. The Air Force realized the need to reorganize to become a light, lean, fighting-forward support division. This was made possible through the design of the EMEDS. EMEDS, the medical support function of the AEF for the Air Force, has provided the solution to use only 1.7 C-17 Globemaster III aircraft versus three C-17s (1.7/3 ratio) that were previously needed to airlift a 25-bed air transportable hospital (ATH).

EMEDS also brought forward deployed trauma resuscitation/surgical capability including critical care, along with the multifunctional team composition to decrease the number of medics required to deploy.

The EMEDS components are broken down into three EMEDS increments for readiness deployments: EMEDS Basic, EMEDS + 10, and the EMEDS + 25. Each functional unit has a specific scope of care and capabilities assigned for continuity. Each increment is manned and supplied with specific unit type code (UTC) billets. You will be exposed with a small portion of the UTCs available to the AEF, which consist of over 2,000 UTCs, starting with the EMEDS Basic increment.

EMEDS Basic

This increment is deployed when the biological warfare (BW) and chemical warfare (CW) threat is low. Populations-at-risk (PAR) listed represent military forces only. Since the BW/CW threat is low, members deploy with or have pre-positioned, adequate chemical warfare defense equipment (CWDE)

(i.e., mission-oriented protective posture [MOPP] gear), personal supply of BW/CW antidotes in accordance with theater guidelines and personal decontamination kits. When required, additional CWDE and decon kits are positioned at the deployed location but are not part of the EMEDS supplies. BW/CW supplies are limited to individual issue antidotes, and the necessary supplies to provide initial therapy to 10 patients exposed to nerve and BW agents.

The *scope of care* for the EMEDS Basic increment provides prevention, acute intervention, and primary care to support 500–2,000 deployed personnel. The 25-person EMEDS Basic force package is capable of providing medical and dental care for these personnel for 7 days in an uncomplicated environment without re-supply. The holding capacity of less than 24 hours with no dedicated inpatient beds, unless operational issues drive short-term deviations is expected. Patients treated by the EMEDS Basic increment are either returned to duty or aeromedically evacuated in accordance with (IAW) theater evacuation policy. Because airlift is available, AE capabilities support rapid evacuation of patients. Preparation for evacuation within 12 hours of notification for *urgent* patients and 24 hours for *routine* patients are critical to mission success. Configuration of the EMEDS Basic is dependent upon how many tents will be used. Figure 1–1 shows a two-tent configuration, and figure 1–2 shows a three-tent configuration.

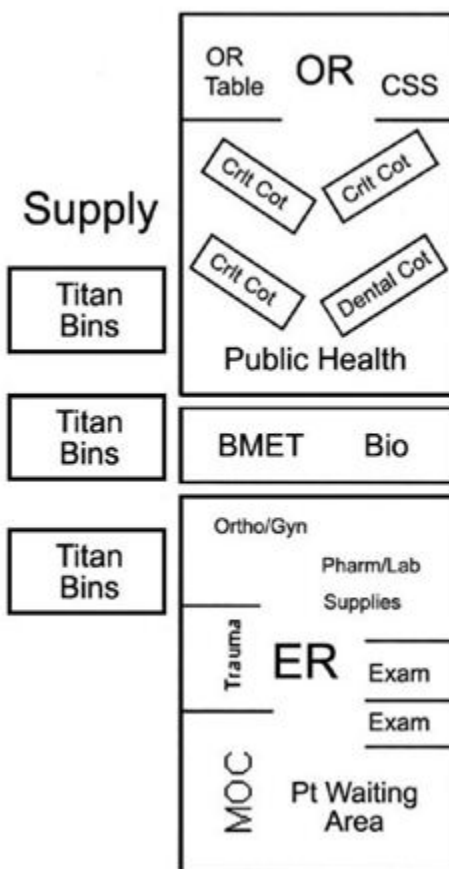


Figure 1–1. Two-tent EMEDS Basic configuration.

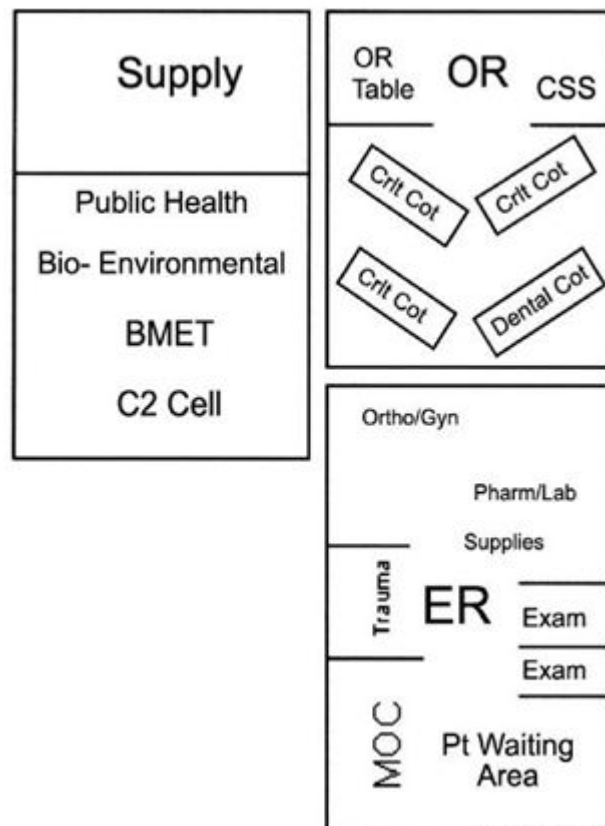


Figure 1-2. Three-tent EMEDS Basic configuration.

EMEDS Basic increment clinical capabilities cover numerous different areas, but there are very limited capabilities. These capabilities begin with preventive medicine such as medical surveillance, sanitation, epidemiology, public health, vector risk assessment, post-deployment (in theater) screening, immunization, early detection of biological and chemical agents limited to detection of environmental chemical hazards utilizing existing detection kits and tape, disease surveillance, infection control, food and water inspection/surveillance, communicable disease control, environmental surveillance, medical intelligence, health promotion, occupational health (e.g., field industrial hygiene), radiation safety, health hazard risk assessment, health hazard control, and education and training.

Trauma surgical resuscitation and stabilization is a significant capability found in the EMEDS, along with specific elements to accommodate this capability. With the trauma surgical resuscitation and stabilization element, the EMEDS Basic increment is capable of performing 10 major surgeries or 20 nonoperative trauma resuscitations in 24 hours. This team provides disaster response surgical capabilities with one operating table and supplies and equipment to provide this capability once during a 7-day period. Along with the trauma surgical resuscitation, an initial nonoperative evaluation and treatment capability is available. This will include limited advanced trauma life support.

The secondary (operative) damage control procedures include major thoracic, abdominal, orthopedic, maxillo-facial procedures, and anesthesia. For this trauma team, the limited management of thermal injury element provides support for pain control, fluid warming, and mechanical ventilator support; post-operative resuscitation for fluid replacement and capability for emergency blood transfusion; stabilization element for airway/hemorrhage control and fracture stabilization; patient holding/inpatient ward care, which can hold patients with conditions of minimal to intermediate acuity for up to 24 hours; and a post-operative and nonsurgical critical care element that can hold only three critical care patients for up to 12 hours prior to AE.

The EMEDS Basic increment allows for some primary care elements; again these elements have limited capabilities. The primary care element is capable of treating adult ambulatory care for non-battle injuries. Basic evaluation and treatment for specialized services as internal medicine, orthopedics, and other surgery specialties are available. The dental services are for acute dental complaints and stabilization of urgent dental injuries. Mental health provides basic assessment of acute intervention to include critical incident stress debriefing (CISD).

If a mental health specialist technician is not available, an aerospace medical service craftsman (AMSC) may obtain special training to fulfill this responsibility for the EMEDS Basic package. Disaster response is the final capability of the EMEDS Basic increment. This capability includes the disaster response team, who will provide triage, treatment/stabilization, and preparation for AE. Within the urgent care element, you will provide 24-hour operations for acute care for non-life threatening situations to include threats to life, limb, and eye. The patient evacuation element will prepare for evacuation within 12 hours of notification for urgent patients.

Support services for the EMEDS Basic increment include ancillary services as radiology, portable ultrasound, limited laboratory, and pharmacy. Clinical support will include both telemedicine and telemaintenance. Aerospace medicine is the final element to this portion of the disaster response capability. Aerospace medicine will include primary care aviation medicine and AE issues and coordination.

The EMEDS Basic UTCs and their description are shown in the following table.

UTC Code	Team Name	Brief Description
FFDAB	FLIGHT MEDICINE TEAM	Care for up to 2000 personnel with EMEDS. Stand-alone team provides clinical service for 300–500 personnel.
FFEP1	EMEDS/AFTH-EXPEDED CRITICAL CARE	Provides personnel and equipment for forward stabilization and preparation for active duty. Deploys within 24 hrs of FFMFS and is operational in 12 hrs of arrival.
FFEP2	EMEDS/AFTH COMMAND and CONTROL (C2) MEDICAL	Provides the personnel for emergency medical care and 24-hr sick call.
FFEP6	EMEDS/AFTH-NURSING AUGMENTATION	Provides the nursing personnel for forward stabilization and holding for AEF.
FFGL2	MEDICAL PREVENTATIVE & AEROMEDICAL TEAM	Provides initial public, occupational and environmental health surveillance and intervention. The team also provides vital input for sanitation layout and food and water safety. Deploys with lead wing to help established base infrastructure.
FFGL3	MEDICAL PREVENTATIVE & AEROMEDICAL TEAM 2	May deploy with follow-on UTCs to provide EMEDS basic capability, enhancing FFGL2.
FFMFS	MEDICAL MOBILE FIELD SURGICAL TEAM	Provides primary disaster medical capability for forward locations.

EMEDS + 10

With all EMEDS increments that are deployed, the EMEDS Basic is the starting point in which additional increments are added. The first additional increment that is attached to the EMEDS Basic is the 10-bed Air Force theater hospital (AFTH), called EMEDS +10. The EMEDS + 10 is composed of 31 additional personnel making a total of 56 personnel when added to the basic increment. There are six tents, which include an emergency room, surgical suite, and a 10-bed inpatient ward. Figure 1–3 illustrates the six-tent configuration.

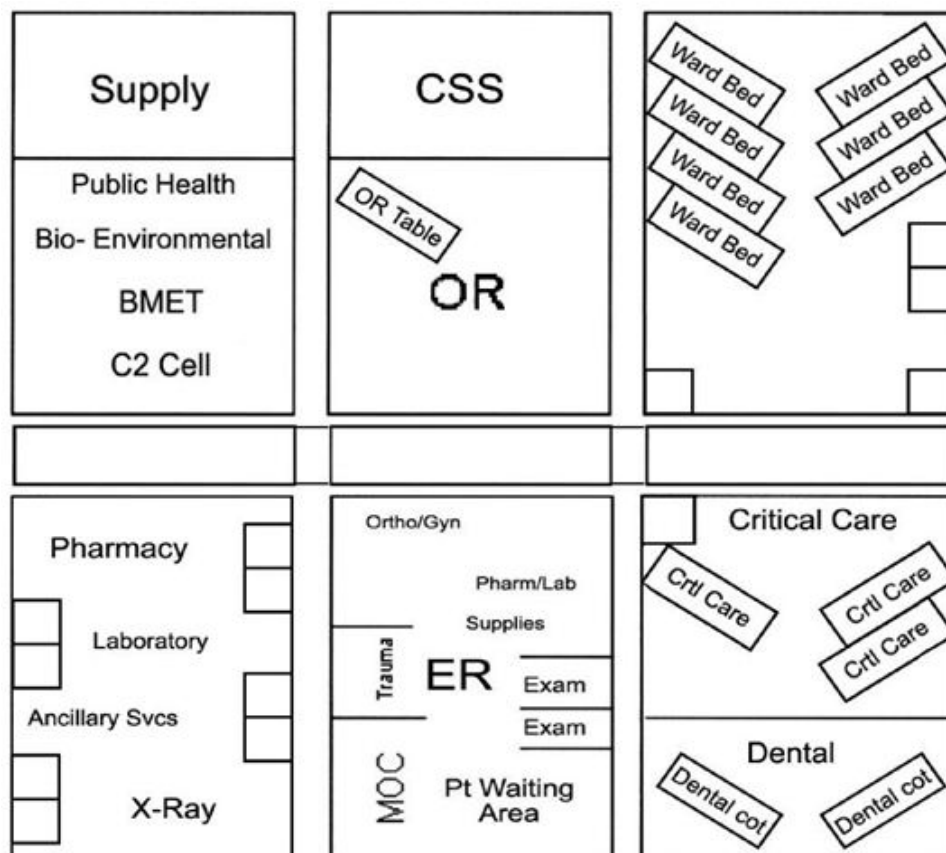


Figure 1-3. EMEDS + 10 configuration.

The EMEDS +10 UTCs and their description are shown in following table.

UTC Code	Team Name	Brief Description
FFEP3	EMEDS/AFTH 10 BED PERSONNEL	26 additional team personnel provide advanced cardiac life support (ACLS)/advanced trauma life support (ATLS) emergency services, limited inpatient/outpatient capability.
FFGL4	MEDICAL PREVENTATIVE & AEROMEDICAL TEAM THREE SUSTAINMENT	3–5 additional team personnel provide long-term force sustainability and reduced disease and non-battle injury through public health and occupational environmental disease surveillance for deployed base personnel up to 5,000.

The scope of care for this increment provides prevention, acute intervention, and primary care to support deployment of 2,000–3,000 deployed personnel. This 56-person EMEDS +10 bed AFTH force package is also capable of providing medical/dental care for these personnel for 7 days in a simple environment without re-supply. The EMEDS +10 provides the AFTH with the 10 beds for inpatient capability, along with additional ancillary support, medical equipment maintenance, and facility management. There is extremely limited blood storage with a limited capability for emergency blood collection/transfusion.

The clinical capabilities include all that have been previously listed that accompany the EMEDS Basic increment, and also include the postoperative and nonsurgical portion of critical care operations. This includes the 10 inpatient-bed increment with one bed specifically for sustained critical care. Additional surge capability exists to provide critical care for a total of three patients up to 12 hours prior to AE. Critical care provided includes mechanical ventilator management;

oxygenation; hemodynamic monitoring; fluid, electrolyte, and medication management; blood transfusion; ACLS; and post-anesthesia care.

In order to support the inpatient/critical care capabilities, certain ancillary/support functions are increased. The first is blood bank. It is still extremely limited in blood storage, but with the EMEDS + 10 increments, physicians are capable of having blood that is type specific and packed red blood cells (PRBC). Emergency blood collection/transfusion capability is added in order to have the ability to have fresh frozen plasma storage and issue capabilities.

The remaining ancillary/support elements remain the same as the EMEDS Basic increment unless augmented by specific UTCs. Surgery capabilities can be augmented by subspecialty surgical UTCs. Patient transportation may be augmented by the UTC FFAMB (ambulance augmentation team) or by using contract support. The mental health element can be augmented by the UTC FFGKV (mental health rapid response team). Pharmacy services may also be augmented with UTC FFBAT (biological augmentation team). The rest of the support elements— patient evacuation, communication, and aerospace medicine—are complete with the EMEDS Basic increment.

EMEDS + 25

This increment includes EMEDS Basic and EMEDS +10 bed AFTH force packages and UTCs FFEP4 (25 personnel ward staff), FFEP5 (five personnel surgery augmentation team), with an additional UTC-FFEE3 (equipment). This medical system is composed of 86 personnel.

The following table shows EMEDS + 25 UTCs and their description.

UTC Code	Team Name	Brief Description
FFEP4	EMEDS+25 BED PERSONELL	Provides personnel for 24-hr sick call and emergency medical care for the AEF. Provides core infrastructure for later addition of specialty UTCs providing additional professional specialties, ancillary support, and medical logistics equipment maintenance.
FFEP5	EMEDS SURGICAL AUGMENTATION	Provides 24-hr surgical capability when combined with complete EMEDS +25 bed AFTH.
FFEE3	EMEDS+25 EQUIPMENT	Provides equipment to support 24-hr sick call and emergency medical care for deployed.

Scope of care for this increment provides prevention, acute intervention, and primary care to support deployment of 3,000–5,000 deployed personnel. The EMEDS +25 AFTH, 86-personnel increment provides the core infrastructure for specialty UTCs (i.e., critical care, gynecology, otolaryngology, neurosurgery, oral surgery, ophthalmology, thoracic/vascular surgery, urology, mental health triage, and combat stress management).

With an increase in the inpatient capability and critical care, the postoperative and nonsurgical capability increases significantly. Trauma surgical resuscitation and stabilization capability increases to perform 20 major surgeries or 20 nonoperative trauma resuscitations in 72 hours. The EMEDS +25 force package alone includes initial nonoperative evaluation and treatment for advanced trauma life support (ATLS), airway securing, hemorrhage control, shock treatment, and fracture stabilization. EMEDS +25 increment capabilities are complete when the full complement of the EMEDS Basic and EMEDS +10 support capabilities. The EMEDS +25 is the component that provides the advanced surgical and trauma support and 25 beds in accordance with theater evacuation policy.

Additional UTCs for complimenting EMEDs increments

When the EMEDS +25 is deployed with full support capabilities, it provides the core infrastructure for later addition of specialty UTCs in the AFTH. These UTCs provide both the personnel and

equipment needed for the additional professional specialties, ancillary support, and medical logistics equipment maintenance. The following table shows additional UTCs and a brief description.

UTC Code	Team Name	Brief Description
FFBAT	MEDICAL BIOLOGICAL AUGMENTATION	Provides advanced diagnostic identification capability for naturally occurring or induced biologic agents at employed location. UTC is equipped for 7 days without resupply.
FFCCT	MEDICAL CRITICAL CARE AIR TRANSPORTATION TEAM	This UTC provides critical care augmentation personnel for patients requiring advanced care during AE transport.
FFCCU	4-BED INTENSIVE CARE UNIT	Deployed in conjunction with EMEDS +25. Provides the manpower and equipment to establish a 4-bed critical care capability with enough supplies for 30 days. Operates 24 hours a day, seven days a week.
FFCCV	4 BED ICU EXPANSION TEAM	Provides manpower to augment an existing 4-bed intensive care unit (FFCCU) with four additional intensive care beds.
FFCCS	CRITICAL CARE AIR TRANSPORTATION TEAM SUPPORT PACKAGE	Provides basic shelter equipment to critical care air transport team members and aeromedical evacuation personnel positioned at far forward, secured airfields.
FFGKV	MEDICAL MENTAL HEALTH RAPID RESPONSE	Provides rapidly deployable, lightly equipped manpower team to provide mental health triage, short-term management of combat/traumatic stress patients, CISD, and command consultation including outreach services.
FFGKU	MEDICAL MENTAL HEALTH AUGMENTATION	Deploys only where the UTC FFGKV is also available. Provides manpower and equipment to provide 20 cots for psychiatric triage and stabilization. Must have access to ancillary support, basic laboratory, thyroid functions, blood alcohol test, toxic screens, and basic medical support.
FFAMB	MEDICAL THREE-AMBULANCE AUGMENT PACKAGE	Supports bed downs during contingencies where patient transportation demands require additional ambulance support. Provides single patient transportation vehicle for both field and fixed medical treatment facilities.
FFGYN	MEDICAL GYNECOLOGICAL TREATMENT	Provides gynecological personnel and equipment component to diagnose and treat acute and non-acute conditions to the deployed force. Must be attached to the FFGKC, 25-bed ATH as a minimum.
FFVNF	CONTINGENCY AEROMEDICAL STAGING FACILITY (CASF) NURSING FUNCTION	Provides basic nursing function for all sizes of CASF from basic to CASF+250. Can deploy alone as CASF-basic to augment existing MTF as ward holding or medical billeting with limited staging function. Added to other UTCs for larger CASF builds. Administratively prepares patients for flight, ensures patients are clinically supported while in the CASF waiting transportation. Assists with transporting CASF patients to and from airframe. Can be deployed to perform basic nursing services in other scenarios.

003. Medical scope of practice

As a medical technician, there are rules involving what we can or cannot do while treating patients during performance of duties. This rule is termed “*scope of practice*,” and the specific limits of your job are listed in your training records and in the Career Field Education and Training Plan (CFETP). Each skill level (4N031, 4N051, 4N071, 4N091, and 4N000) has a set scope of practice, and the CFETP provides guidance for all responsibilities as a medical technician. Each skill level contains a set amount of duties, and the higher skill levels involve increased medical responsibilities. A brief

description of each scope of practice is provided below by skill level. Everything you learn in technical training and in this CDC follows the guidance of the CFETP.

You must become familiar with this document and learn what is expected of you as a medical technician at each skill level. Before examining the scope of practice, let's look at the specialty codes of the 4N0X1.

4N031 (3-skill level) apprentice

The role you perform as a 4N031 in the first year of your career is largely spent training and perfecting skills learned in technical training and clinical phases. The 4N031 medics are frontline medics; you are usually the first person to take care of a patient either in a clinic or hospital or out in the field. For example, a typical day could include taking vital signs, assisting physician with a minor surgery, or responding to a 911 medical emergency on base. Achieving your 5-skill level is the ultimate goal in your first year after earning the 3-level badge. These responsibilities improve medical knowledge as you're trained to perform increased levels of patient care enabling patients to trust you with their care anywhere.

4N051 (5-skill level) journeyman

At this level, 4N051s have completed in-residence technical training and clinical rotation (Phase I and II), have completed upgrade training (UGT) requirements, and are technically ready to accomplish the mission. You perform functions, such as care and treatment of patients, operating and maintaining therapeutic equipment, and correctly administering vaccinations. The 4N051 is one of the first members of a unit to have contact with patients and perform a great deal of the care and treatment with guidance from the nurse or physician. It is extremely important to develop excellent customer service skills because a patient's visit to a medical facility is heavily influenced by the interaction between the medical technician and the patient. In essence, you can make or break the visit of a customer! Your primary concern at this level should be to solidify your patient care skills and continue learning all you can as a medic and as a valued member of the military. You will start practicing leadership and management skills and be given more scope and responsibility as you show progress in these areas. Remember that the 4N051 is heavily relied upon and essential to mission completion, customer service, and patient satisfaction.

4N071 (7-skill level) craftsman

You become eligible to attain 7-skill level (4N071) if you are promoted to staff sergeant (SSgt)/E-5. Your role now changes as you transition from a journeyman to a craftsman. You are expected to supervise personnel assigned and ensure everyone adheres to rules and policies. Some responsibilities include supervising E-1 through E-4 personnel, conducting training, and putting together duty schedules. A specific position one can hold is the noncommissioned officer in charge (NCOIC) of a section. As a first-line supervisor, there are other individuals relying on you for leadership and mentorship. Your actions and words will directly impact those under and around you. As a supervisor, it is your responsibility to let Airmen know what is expected of them during individual feedback sessions. This session allows the supervisor to give the Airmen the tools they need to be successful. Think about it this way—we are training our replacements. Not only have you become a supervisor, you are also continuing your technical growth to becoming an expert hands-on technician. As a noncommissioned officer (NCO) you are being prepared to become a future manager with increased responsibility as a leader. Training is a very important aspect of being a 4N071. There will be new team members, students, and reservists that will require your expertise to learn the job.

Some examples of training can include inservice training, on-the-job training (OJT), or classroom instruction. After training the team members, it is your responsibility to make sure they work together to accomplish the mission. Remember, even though you have added managerial and supervisory responsibilities as a craftsman, you must still be able to perform your craftsman duties and learn how to mentor subordinate personnel at the same time. This may sound like a big responsibility. It is! Through time, you will learn how to juggle your efforts and talents as a supervisor and worker

without dropping the ball. These experiences will help you grow as a 4N0X1 and ultimately help you attain the higher skill levels within our career field.

4N091 (9-skill level)

We have all heard the saying “rank has its privileges.” With these privileges comes increased responsibility to progress as an individual, but to also help the next generation of aerospace medical service leaders attain the goal of senior master sergeant (SMSgt)/E-8. Because of the time it takes to meet the requirements of a SMSgt, as a craftsman, you have the greatest opportunity to impact a subordinate’s potential to achieve these long-term goals.

For progression to SMSgt, we are expected to meet certain requirements. The SNCO selection board will review your enlisted progress reports (EPR). This is where you, as the craftsman, play a critical role as supervisor. In order to encourage the progression of others, you must be aware of the criteria used in scoring SNCO boards and what “blocks” to fill in order to open the doors of opportunity for the progression to the group superintendent or major command (MAJCOM) functional manager position for the career field.

The SNCO board scores are based on the same concept used to rate EPRs. The board scores on how well the individual meets the areas of performance, education, breadth of experience, job responsibility, professional competence, specific achievements, and leadership.

You should work toward and encourage others to meet some specific examples of criteria considered during SNCO boards. Here are some of the qualities the Air Force is looking for in the leaders of tomorrow. Remember, these are not all-inclusive and are *not the rules* of the Air Force or selection board secretariat.

- Do you have a breadth of experience to include changing jobs within the group, squadron, and wing as well as PCSing (permanent change of station) to various locations?
- Have you been out of your career field too long (i.e., special duty to special duty)? This can hinder your progression.
- You must be a continuous performer.
- You must meet all requirements (i.e., PME [professional military education], CCAF [Community College of the Air Force], a 5 rating on EPRs, senior rater endorsement, appropriate decorations for positions held, etc.).
- Are you involved with the base and community? Examples are holding a chair in the various associations on base as well as involvement with committees such as Dining In/Out, and leadership committees.
- AF, headquarters (HQ), wing, and group level awards are also important.

These are just a few examples of what have been experienced on past SNCO review boards. Being promoted to SMSgt is perhaps one of the hardest promotions to achieve in the United States Air Force. Remember, there are limited vacancies, and competition is keen for the top two percent. Of this two percent, there are a smaller number of positions to fill the group superintendent and MAJCOM functional manager positions within the career field. However, there are things you, as an individual and as a supervisor, can heed to make sure you and your subordinates are competitive and prepared for the career progression.

4N000 Air Force career field manager

With competition so stringent at the 4N091 level by having only a fraction of the two percent of SMSgts progressing to group superintendents and MAJCOM functional managers, the competition is even greater for special position as the Air Force career field manager (AFCFM). The AFCFM has a multitude of responsibilities, and he or she needs a significant breadth of experience throughout their career to provide the leadership required at such a level. The number one prerequisite for this position is to volunteer.

Being selected for positions in the *technical training* arena, such as an instructor, CDC writer, or being selected to rewrite the specialty knowledge test (SKT) for the career field are some areas of experience that help in the selection process. Seeking out the opportunity to attend a utilization and training workshop (U&TW) can open other opportunities of experience. Working through a U&TW, you will have input in the workings and changes to the CFETP and work directly with the current AFCFM and MAJCOM functional managers. Seeking the opportunity to be involved in manpower and readiness issues at the local level will offer you the experience you need in order to work with the AF Guard and Reserve personnel at the AFCFM level. These are just a few of the opportunities available to those who are motivated to gain the experience needed to fulfill the responsibilities of an AFCFM.

The AFCFM is the enlisted consultant to the surgeon general and Air Staff. You can find the specific responsibilities of the AFCFM in Air Force Instruction (AFI) 44-104, *Military and Civilian Consultant Program and Medical Enlisted Career Field Manager Program*. As the enlisted consultant, one of the top priorities for the AFCFM is to develop and maintain currency of the CFETP for the Air Force specialty (AFS). With this responsibility, the AFCFM assists technical training managers and course personnel with planning, developing, implementing, and maintaining all AF specialty code (AFSC)-specific training courses. The AFCFM assists the Air Force occupational measurement squadron (AFOMS) in developing and administering job inventories and interpreting occupational survey report (OSR) data. The survey collects AFS task information as listed in the CFETP, specifically the level and frequency of each task performed in the field. The AFCFM is responsible to analyze this information in order to pave the way for the future of the aerospace medical service career field. Through experience, occupational data, and input from the MAJCOM functional managers, the AFCFM develops, coordinates, and implements career field classification/structure changes as necessary.

Your path of career progression is one thing you can control. You may be thinking, “My supervisor writes my EPRs; I don’t have control over what is written.” You are partially correct; your supervisor writes the EPR, but you are the one who performs the work that is reflected in your EPR. In order to achieve the top level, you must be willing to seek out opportunities that are new and may be unfamiliar. By doing this, it allows you to “fill the squares” necessary for your progression path.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

001. Basics of Air Force Medical Service doctrine

1. What is meant by the statement “doctrine is authoritative, but not directive in nature?”
2. To whom does the AFMS doctrine apply?
3. How does Air Force doctrine aid AFMS commanders in accomplishing the mission?
4. What type of doctrine guides organization and employment of forces within distinct objectives but is broad in its functional areas and operational environments?

5. Using the automobile example, which doctrine is best describe and explained if you are a buyer seeking a very fast car with specific qualities such as a “Candy Apple Red” paint job, racing rims and an extended warranty?
6. What are the operational doctrine principles of the Air Force Medical Operations on maintaining health and fitness?

002. Medical role in air and space expeditionary force

1. What is the purpose of the AE system?
2. What are the three increments that make up the EMEDS packages and their specific scope of care?
3. Match the appropriate EMEDS for package in column B with the information about utilizing them in column A. Answers may be used more than once.

Column A	Column B
____ (1) Care for 500–2,000 personnel at deployed site.	a. EMEDS Basic.
____ (2) 86 personnel assigned to EMEDS package.	b. EMEDS +10.
____ (3) Provide care to 2,000–3,000 deployed personnel.	c. EMEDS +25.
____ (4) Has the UTC FFEP6 is assigned to this force package.	
____ (5) Extremely limited blood storage.	
____ (6) Core infrastructure for specialty UTCs.	

003. Medical scope of practice

1. What specific position can be held as a 4N071?
2. For progression to SMSgt, what document is reviewed by the Air Force selection board review?
3. The SNCO board evaluates what aspects of the individual being scored?
4. What special duty assignments or positions can you fill that will help with career progression?
5. In what document can you find the AFCFM responsibilities?

1-2. Enlisted Specialty Training

Preparation is the first step any enlisted member must take to go from being a trainee to a skilled worker. This section addresses job training, duties, and progression of the 4N0X1 as well as educational opportunities as listed in your CFETP. As you have already learned, training can take place just about any time or place. However, training by itself is not enough! Training must be documented. There is an old adage: *“If it wasn’t documented, then it wasn’t done.”* Imagine spending hours training on a particular task to become proficient only to be told you are not qualified because it is not documented in your training record. To make sure this does not happen to you, learn what and where training is documented within your training folder and communicate often with your supervisor and trainer. The written record is the only means of identifying what has been trained, when it was trained, and when (if applicable) the training is due to be conducted again.

Training documentation helps assess capability, individual strengths/weakness, and resources needed to support quality patient care. It is also a way to meet accrediting agency and regulatory requirements.

The AFTR is now the standard used by all enlisted medical specialties to document and track education and training.

The purpose of AFTR is to provide one single location for maintaining all training documentation pertaining to an individual. In the past, hardcopy folders were used to group various types of training documentation. AFTR permits a central location that is easily deployable. This means that wherever a person goes, the folder with his or her entire training history goes with him or her anywhere there is computer access. AFTR is an electronic version of the CFETP and has advantages that the hard copy does not, such as accessibility to your training record anywhere in the world at any time.

AFTR may also be referred to as the individual training record, OJT record, or the enlisted training and competency folder. The information in this section also gives an overview of what is kept in each section of your AFTR. Changes to this guidance are only permitted when directed by the CFETP. This is very important to remember, because the USAF/SG endorses the CFETP itself. Local facilities do not reserve the right to alter the AFTR on their own.

004. Functions of the Career Field Education and Training Plan

The Aerospace Medical Service CFETP (4N0XX/B/C/F) contains extensive information pertaining to general duties for each skill level. The AFCFM is the approval authority for the CFETP. However, this training plan that is developed specifically for your training as a 4N0XX is a coordinated effort between the AFCFM, all the MAJCOM functional managers, personnel from the Aerospace Medical Service Course development team, and many experienced personnel from different specialties around the Air Force and Department of Defense (DOD). It is highly advised that you become familiar with the entire CFETP as you will find the answers to many of your questions about training and career progression.

4N0X1 Air Force specialty code

Your AFSC, 4N0X1, distinguishes your job from a large list of other AFS. The specialty code you now hold is 4N031, which identifies you as an aerospace medical service apprentice or semiskilled level. This coding system identifies knowledge, skill, and grade level. There are many AFSCs used to identify AFS. The AFSC is a five-figure code used to identify both general and specific job characteristics. Personal records for each individual designate the member’s primary AFSC (PAFSC), duty AFSC (DAFSC), and control AFSC (CAFSC). The PAFSC denotes the awarded AFSC in which the individual is best qualified to perform duty. It will always be the AFSC with the highest skill level. The DAFSC is used to denote the specialty in which the individual is performing duty. This explains how an individual who is a 4N071 may have a DAFSC of 4N051 because that is the position the individual is assigned to on the unit manning document (UMD) and is filling within their current organization. These two designators are needed because a member is sometimes assigned to fill a

position that does not necessarily reflect his or her current skill level. The CAFSC is a management tool used to make enlisted Airman assignments, assist in determining training requirements, and to consider individuals for promotion. For further explanation on enlisted classifications, please refer to AFI 36-2101, *Classifying Military Personnel (Officer and Enlisted)*. The following table is an explanation of the elements making up the specialty code. Using the medical service specialty as an example, the chart illustrates what each figure in the code identifies:

AFSC 4N0XX	
Character	Explanation
4	The career grouping (all medical AFSCs are identified by the number 4).
N	The career field family within the career group.
0	The career field subdivision.
X	The individual's skill level (3, 5, 7, 9, 0).
X	The specialty within a career field.

The 4N0XX career field identifies individual skill levels as follows:

- 4N031 – Aerospace Medical Service Apprentice (3 level).
- 4N051 – Aerospace Medical Service Journeyman (5 level).
- 4N071 – Aerospace Medical Service Craftsman (7 level).
- 4N091 – Aerospace Medical Service Superintendent (9 level).
- 4N000 – Chief Enlisted Manager (CEM) (0 level).

Career Field Education and Training Plan

The CFETP contains the STS portion used to document training start and completion dates, as well as the initials of the trainee, trainer, and certifier. Training on all core tasks is required every time you upgrade from one skill level to another (3, 5, 7, 9), but it depends on what tasks you perform in the duty section. Core task training is not required if the training capability does not exist at the individual's assigned base or another base within the local area. Remember that this must be correctly documented in the individual's training record on the AF Form 623A, On-The-Job Training Record-Continuation Sheet, and the supervisor should ensure that the training deficit is upchanneled to the career field manager (CFM). Also, ensure that your training records match the line items circled in your master training plan (MTP). Performance-based tasks and subject knowledge line items are documented similarly. The supervisor is responsible for circling the line items at the lowest level deemed necessary for qualification in the current duty position and upgrade training.

Part I

Part I of your CFETP provides information necessary for overall management of the 4N0XX and specialties. You can find explanations for abbreviations and terms, information on specific career field progression, duties and responsibilities, training strategies, and career paths. A more in-depth explanation is given for requirements for specialty qualification knowledge, education, experience, training, and so forth. Training requirements for National Registry of Emergency Medical Technician-Basic (NREMT-B) and CCAF degree requirements are broken down. Several diagrams help put the entire upgrade training piece into an easily understood picture. Becoming familiar with this section will save you time and effort now and in the future. Take a few minutes and read the *entire* section!

Part II

Part II of the CFETP is the documentation that allows and enables you to do your job as a 4N0XX. It contains the STS, the course objective training list that outlines training requirements, available

support material such as qualification training programs (QTP), a listing of training resources, MAJCOM-unique training requirements, and direction on required documentation in your AFTR. Details on the training record will be covered a little later in this unit. The part you will be the most concerned with at this point is the STS.

STS

Your supervisor, during your OJT, uses the STS in part II of your CFETP. This standard is used to develop a trainee's job proficiency. It provides the trainee a specific reference to an authoritative publication for each task performed in the current duty assignment. It is your supervisor's responsibility to develop and ensure effective use of your STS; however, the trainee (you) must make every effort to become qualified to perform as a 4N0X1. The success and quality of trainee training greatly depends on the relationship between the supervisor, trainer, and trainee. Keep in mind, you are your biggest advocate and should be fully engaged in your own training plan. Since the STS may not contain each task you perform, your supervisor must supplement and certify it. This specific duty position training is annotated on the AF Form 797, Job Qualification Standard Continuation/Command JQS.

MTP

This is where the master copy of the CFETP is kept. Your supervisor or a designated representative is responsible to ensure your section, the area that you work in, such as flight medicine, family practice, or an inpatient unit, has an MTP. This plan is developed by your supervisor and specifically outlines training goals and milestones for enlisted within the assigned area.

Your supervisor will circle the core tasks, upgrade training tasks, and unit specific tasks so you will know which items in the STS you are required to be trained on in order to accurately do your job and to obtain the next skill level. The MTP should also contain a copy of your job description and an upgrade training (UGT) plan.

Proficiency code key

The proficiency code key (PCK), shown in figure 1-4, describes how in depth you are trained in phase I/II and CDCs according to each STS task. There is a code key for the 4N0X1 duties in your training record. Supervisors review the key to plan how much additional training is needed upon trainee arrival at the first duty station. The PCK also provides written guidance from the CFM on not only what task 4N0X1s must know, but also how much knowledge must be taught at each level of training. Additionally, it displays how much you can or cannot do (*scope of practice*) at each skill level 5, 7, and 9.

There are three areas in the PCK (task performance, task knowledge, and subject knowledge). Each has either a letter or number combination based each task. Keep in mind, your supervisor is required to train you to the "Go" level. The overall goal is for you to perform 4N0X1 duties unassisted. Additionally, trainers and supervisors will assess your skills to ensure you meet local requirements for accuracy, timeliness, and correct use of procedures.

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

Figure 1-4. Proficiency code key.

Most tasks you perform in the duty section relate to a PCK. There are some exceptions for unique tasks performed at certain duty locations. Your role as a trainee involves communicating with supervisors what you can or cannot do so they can provide additional training to improve your knowledge. Phase I, II, and CDC training are not designed to make you 100 percent competent in all areas. A solid training program in your duty section provides ample opportunity to improve your skills and build on training provided in phase I/II and the CDCs.

005. Purpose of the job inventory and Graduate Assessment Survey

As technology improves or the mission of the Air Force changes there might be a need to update the CFETP. The AFOMS conducts surveys of each AFSC by using a tool called the job inventory (JI) survey. A JI is distributed to a large number of personnel in an AFSC. Completed surveys are then translated by AFOMS into a report known as the occupational survey report (OSR). The OSR provides the CFM with extensive information regarding the duties and skills being performed in the career field in support of a new CFETP.

Job inventory survey

The information provided by the OSR serves as one of the primary data sources used when constructing or updating the CFETP. This information also plays a key role in the development of the SKT used for promotion testing. Because of these two important uses of the OSR, members who are asked to complete a JI survey should take the task seriously. Completing the JI survey should not be a “pencil-whipping” exercise, since the result is the development of the STS used by the entire career field.

At some point in your career, you will be asked to complete questionnaires about your job, how often you complete certain tasks and how important you feel these tasks are in relation to specific ranks. You may remember taking at least one survey when you completed Phase I in technical training; that is just the beginning of many surveys you will likely be asked to complete. One survey that will greatly impact you is the JI. There are many reasons a JI may be initiated, such as a significant change to the career field, an AFSC merger or restructure, by special request of the CFM, or every 3 years. Surveys are sent out to 100 percent of eligible members within the AFSC. There are measures in place to disregard surveys that are incomplete or have obviously been completed erroneously. While you remain anonymous in the survey, essential data on the type of locations, facilities, ranks, and level of responsibilities is gathered.

This information is then given to the CFM and is usually discussed at the U&TW, where senior enlisted personnel meet to decide the future of all phases of training including but not limited to:

1. Phase I (technical training).
2. Phase II (clinical training).
3. CDC (5 and 7 level).
4. QTPs.
5. RSVP.
6. WAPS (Weighted Airman Promotion System) promotion testing.

As you can see, the information you provide is critical to the success of the training provided to your career field at all levels to ensure you are trained for what you will be doing in your day to day duties. It is very important that you complete these surveys accurately and on time.

Graduate Assessment Survey

As the name implies, the Graduate Assessment Survey (GAS) is a survey that your supervisor completes about YOU. This survey is an external source of feedback to determine the graduate's ability to perform tasks in the career field. The information is relayed back to the schoolhouse to look for ways to improve training based on the field supervisor's feedback. The supervisor should receive an e-mailed survey 3 to 6 months after graduation. The GAS is also another way to gather data on career field training needs based on the adequacy and utilization of training. Items that fall below 50 percent utilization are reviewed for retention, deletion, or consideration of an alternate training means.

Training is considered adequate when 90 percent of those surveyed rate the graduate's training at or above the required proficiency level that is listed in the CFETP. Questions on the graduates are related to the following areas:

- Adherence to military standards.
- Graduate's ability to perform at the apprentice level using the CFETP/STS as a guideline.
- Assessment of whether the apprentice job requirements outlined in the CFETP/STS meet the 3-level job requirement in your workplace.
- Graduate's familiarity/awareness of the Air Force expeditionary mission.
- Confirmation that the supervisor received the graduate trainee report.

The GAS is another of many opportunities to effect positive change within the course. Please take the surveys seriously, and complete them in an honest and timely manner.

006. Maintaining sustainment training programs

Sustainment training is required to maintain skills of a qualified individual to perform the duties required by the 4N0X1 AFSC or specific skills required by your duty location. Sustainment training

is accomplished through qualification training, formal training courses, inservice training, and exercises. This type of training continues throughout your career as a 4N0X1.

Qualification

Qualification is simply an assessment of an individual's ability to perform a certain job. Most qualifications are ensured by following established training guidelines stipulated by the CFETP. There are specific requirements to become and maintain your 4N0X1 status and may expand based on your position and duty location. This training occurs both during and after upgrade training to maintain up-to-date qualifications and hands-on performance training that is designed to qualify personnel in a specific position.

Basic qualifications for the 4N0X1 include completion of the Aerospace Medical Service Apprentice course which includes achieving your NREMT certification and readiness training. You are also required to complete QTPs, RSVP, annual, ancillary, and locally developed training.

NOTE: Ancillary training is guidance or instruction that contributes to mission accomplishment, but is separate from an AFS or occupational series per AFI 36-2201, *Air Force Training Program*.

Qualification Training Program

QTPs are instructional packages designed for use at the unit to qualify, or aid qualification, in a duty position or program, or on a piece of equipment. QTPs may be printed, computer-based, or in other audiovisual media format.

Required Specialty Verification Program

RSVP is designed to sustain AFSC training to ensure all members with a fully qualified AFSC maintain the currency of skills they perform in their duties as a medic within a deployed setting.

007. How to develop and present inservice training

As you gain experience and knowledge as a 4N0X1, you may be asked to provide training on a task you are qualified to do. This is completed by doing inservice training that may be formal or informal training encounters. Formal inservice training is often scheduled in advance, conducted within your unit and presented on training days. Informal inservice training occurs unscheduled (i.e., showing a new 4N0X1 how to use a blood pressure machine). Inservice training is generally given on tasks that you use frequently or have a high probability of encountering in your work area. Inservice training is a good way to focus on an area that needs improvement. For instance, someone in your section may give training on the proper handling of dirty instruments.

Overall, inservice training is a great opportunity for you to refine your skills and even learn a little more about a subject that you are familiar with. It also allows you to keep up with your continuing education hours.

Presentation skills

The first step in preparing for inservice training is researching the topic and lesson objectives needed. Use the following information as a guide to develop content of training:

- Analyze purpose and audience.
- Conduct the research.
- Support your ideas.
- Get organized.
- Draft and edit presentation.
- Fight for feedback.

Inservice training development

There are various tools to create an inservice training session. The four common ways to deliver training is by PowerPoint, video, lecture, and hands-on demonstration. The method used should keep everyone involved by providing a mixture that stimulates visual, auditory, and hands-on techniques to meet everyone's learning style. Lastly, if it's not documented, it's not done; record training in the student's AFTR.

Need assessment

Your supervisor should determine who needs training; he or she also manages that time training is scheduled during duty hours. The inservice training should be a part of a monthly schedule of training accomplished on a routine basis. A needs assessment should be completed to determine the skill level of personnel compared to all tasks used in the duty section; this is usually accomplished by reviewing the AFTR, MTP, and examining past feedback from previous inservice training.

Resources

Electronic training resources are available at the Air Force Medical Service Virtual Library located at <https://kx2.afms.mil/kj/kx8/VirtualLibrary/Pages/home.aspx>. Examples of various topics include:

- Adult Acute and Critical Care Nursing.
- Advanced Practice Nursing.
- Ambulatory Care.
- Critical Care Nursing.
- Emergency Nursing.
- General Nursing.
- High-Risk Obstetric Nursing.
- Maternal-Newborn Nursing.
- Mental Health Nursing.
- Neonatal Intensive Care Nursing.
- Oncology Nursing.
- Pediatric Acute-Critical Care Nursing.

Additionally, discuss training resources with your supervisor as equipment may be available at the workcenter or clinic/hospital simulation labs and education and training department.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

004. Functions of the Career Field Education and Training Plan

1. Match the proper skill level code from column B with the duty identified in column A. Items in column B may be used more than once.

<i>Column A</i>	<i>Column B</i>
____ (1) The skill level of the AFS.	a. 4.
____ (2) The career field family.	b. 4N.
____ (3) The career field subdivision.	c. 4N0.
____ (4) Enlisted specialty and specific expertise.	d. 4N05.
____ (5) The career grouping.	e. 4N051.

2. What is the difference between the PAFSC and DAFSC?
3. The CFETP is divided into how many parts? What is contained in those parts?
4. In what part of the CFETP would you find CCAF degree requirements, upgrade training diagrams, and requirements for specialty qualification?
5. On what form would you document specific duty position training that is not listed in the STS?
6. What is the MTP designed to do; what is circled?

005. Purpose of the job inventory and Graduate Assessment Survey

1. Which organization is responsible for conducting AFSC JI surveys?
2. Who receives the completed JI and for what is the information used?
3. What is a GAS and who completes it?
4. What areas does the GAS assess?

006. Maintaining sustainment training programs

1. How is sustainment training accomplished?
2. List at least three of the basic qualifications to be or maintain your status as a 4N0X1?
3. What are QTPs, and how are they used?
4. What is RSVP designed to sustain?

007. How to develop and present inservice training

1. List two types of training encounters.
2. When is inservice training conducted?
3. What types of topics are used for inservice training?
4. What is the purpose of inservice training within your unit?

1-3. Develop the Unit Training Program

Now that you've started your career as a 4N0XX plans developed by the Air Force career field manager are implemented AF-wide to ensure training continues throughout your career. The plan guides the AFTR training process and this section provides a step-by-step guide of what to expect when you arrive at a new duty section. It details what methods are used to track training from beginning to end.

008. Creating a workcenter master training plan

The hardcopy MTP is where the paper copy of the CFETP is kept. Your supervisor or a designated representative is responsible to make sure your section (the area you work in) has an MTP. This plan is developed by your supervisor and specifically outlines training goals and milestones for enlisted personnel within the assigned area. Core tasks, upgrade training tasks, and unit specific tasks will be circled in the MTP by the workcenter supervisor so you will know which items in the STS are needed in order to accurately do your job. This also will help you obtain the next skill level. The MTP should also contain a copy of your job description and an UGT plan. Before reviewing the steps, here are some tips on your section's MTP, which is accessed from the AFTR Data tab dropdown menu (fig. 1-5).

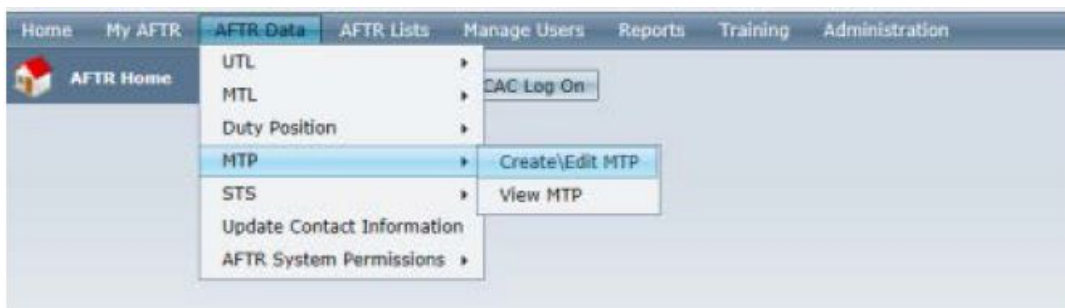


Figure 1-5. MTP.

User roles

The MTP menu option expands when the user hovers over the arrow for the MTP menu option under AFTR Data. This option allows the current user to either view a current MTP or create or edit an MTP. Each MTP is created for a particular workcenter and specialty and represents a “big picture

look” to ensure the required training is completed. The MTP is based off the master training list (MTL) training items; the ability to create or edit an MTP depends on the permission level of the user. Personnel assigned in six of the traditional roles outlined in AFI 36-2201 will actively utilize AFTR on a day-to-day basis. These include the unit training manager (UTM), workcenter supervisor, immediate supervisor, trainer, certifier, and trainee. The following table displays each person’s role in managing AFTR.

User Role	Responsibilities
Unit training manager (UTM)	Load one shop per AFSC. Manage unit records. Manage workcenter. Assign workcenter supervisor. Create unit task list (UTL). Manage training records of individuals.
Workcenter supervisor	Create MTP/MTL/duty positions. Assign immediate supervisors, trainers, and certifiers. Manage training records of individuals.
Immediate supervisor	Manage training records of individuals.
Trainers	Train trainees. Document JQS/1098/797.
Certifiers	Certify core tasks. Document AF QTP/JQS.
Trainees	Read CFETP. Train on task. Manage training record.

Create/Edit MTP

Here are the steps to change your MTP in AFTR (fig. 1-6):

1. Select the Create/Edit MTP option from the AFTR Data/MTP menu.
2. After selecting the Create/Edit MTP option from the menu, the page will open with a model dialog selection box with MAJCOM, base, unit, workcenter, specialty, and section as the field options.
3. The user must select options here in order to view the MTP. All fields in the model dialog search box are required fields.
4. The MAJCOM, Base, Unit, Workcenter, and Section will default to the user’s location.

Figure 1-6. Create/Edit MTP.

MTP STS

Here are the steps to change the MTP STS in AFTR (fig. 1-7):

1. The Create/Edit MTP STS page displays the STS MTL information for the selected MAJCOM, base, unit, workcenter, and specialty.
2. The specific tasks within a single Parent Task can be viewed by clicking the Parent Task number.
3. All Parent Task(s) can be *viewed* by clicking All.
4. All Parent Task(s) can be *hidden* by clicking Hide.
5. To search for a new item, click the SEARCH button on the top of the page and the Model Dialog Search Box will open.
6. The LEGEND button launches a new window that displays the codes used in AFTR in more detail.
7. To edit the tasks, click on the box to the left of the task(s) and click the EDIT button.
8. To clear the MTP information in the tasks, click on the box to the left of the task(s) and click the CLEAR TASKS button.

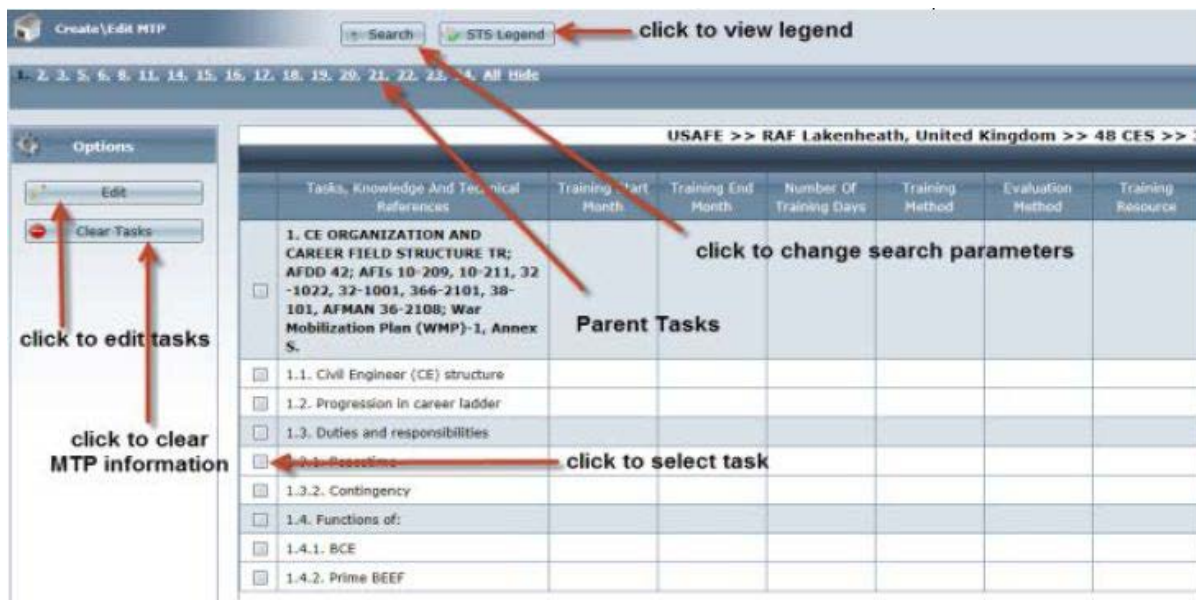


Figure 1-7. MTP STS page.

Edit MTP STS tasks

These are the steps to change a MTP STS task in AFTR (fig. 1-8):

1. After clicking the EDIT button, a prompt will be displayed to confirm the user wants to edit the tasks for the MTP. After confirmation, the user is redirected to the Edit MTP Tasks page.
2. The user must enter in all the fields to complete the MTP information.
3. The user must then enter in a Start Month, End Month, Training Days, Training Method, Evaluation Method, and Training Aid.
4. Click the update button to complete MTP edit.

When entering data, keep in mind the Start Month is the planned start month (0-48) for the task(s). The End Month is the planned ending month (0-48) for the task(s). The Training Days is an open text box that is the number of days needed to train on the task(s). The Training Method is a drop down box that allows the user to select what method will be used for the training on the task. The Training Method items are: Briefing, Computer Based Training, Demonstration Performance, Formal Training,

Guided Discussion, Lecture, and Reading. The Evaluation Method is a drop down box that allows the user to select what method will be used for the evaluation on the training on the task.

The Evaluation Method items are Computer Based Test, Performance Based, Verbal Questioning, Written Test, and Not Required. The Training Aid is a blank text field that allows the user to submit what type of aid will be used during the training on the task(s).

Figure 1-8. Edit MTP tasks.

Delete STS MTP Information

Here are the steps to delete the MTP STS information in AFTR (fig 1-9):

1. Select the task(s) by clicking the box next to the task information.
2. Then click the CLEAR TASKS button.
3. A prompt will be displayed to confirm the user wants to clear the task(s) information for the MTP.
4. After confirmation, all the MTP task information will be cleared.

	Tasks, Knowledge And Technical References	Training Start Month	Training End Month	Number Of Training Days	Training Method	Evaluation Method	Training Resource
<input checked="" type="checkbox"/>	1. CE ORGANIZATION AND CAREER FIELD STRUCTURE TR; AFDD 42; AFTs 10-209, 10-211, 32-1022, 32-1001, 366-2101, 38-101, AFMAN 36-2108; War Mobilization Plan (WMP)-1, Annex S.						
<input checked="" type="checkbox"/>	1.1. Civil Engineer (CE) structure	0	12	5	Computer Based Training	Computer Based Test	Test
<input checked="" type="checkbox"/>	1.2. Progression in career ladder	0	12	5	Computer Based Training	Computer Based Test	Test
<input checked="" type="checkbox"/>	1.3. Duties and responsibilities						
<input checked="" type="checkbox"/>	1.3.1. Peacetime	0	12	5	Computer Based Training	Computer Based Test	Test
<input checked="" type="checkbox"/>	1.3.2. Contingency	0	12	5	Computer Based Training	Computer Based Test	Test

Figure 1-9. Delete STS MTP information.

009. Creating a workcenter master task list

The MTL menu option allows the current user to either view a current MTL or create or edit an MTL (fig. 1-10). The MTL menu option allows for the control and review of training items at the workcenter level. The ability to create or edit a MTL depends on the permission level of the user. The MTL menu option also allows for the copy of an existing MTL into a new location. The menu option will expand out when the user hovers over the arrow for the MTL menu option under AFTR Data.

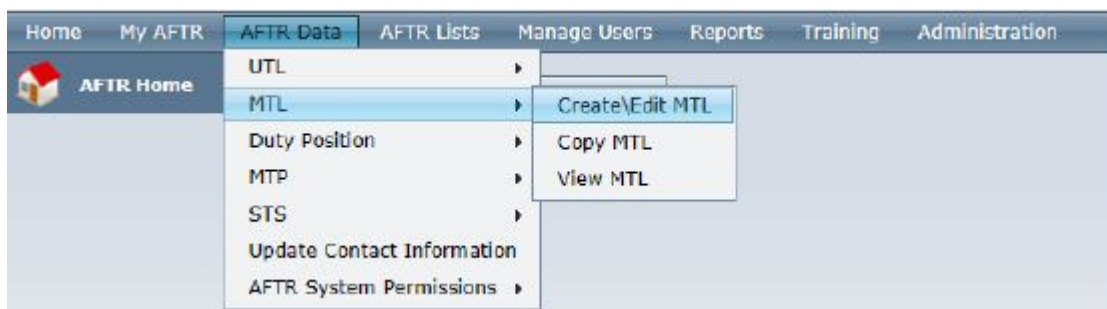


Figure 1-10. Create/Edit MTL.

Create/Edit MTL

The fields available under the AFTR Data/MTL (fig. 1-11) option include Create/Edit MTL, Copy MTL, and View MTL.

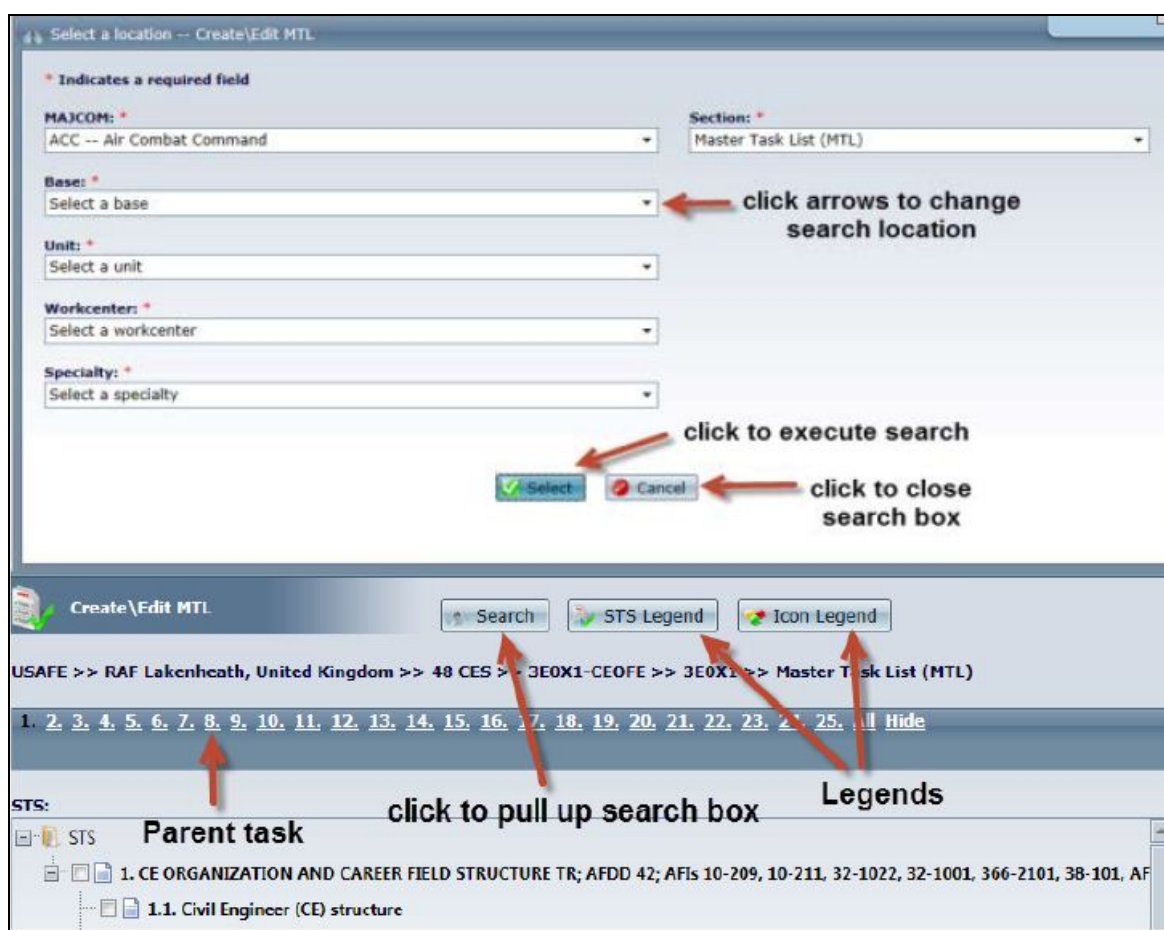


Figure 1-11. Create/Edit MTL.

Items available depend upon the permission level of the user. Only the personnel selected by the UTM have access to create/edit the MTL (e.g., the flight chief/NCOIC of a duty section). If you are not responsible for this function in the AFTR, you will only be able to Copy or View MTL.

1. After selecting an item, the user may switch pages by clicking on the SEARCH button located at the top of every page.
2. Select the Create/Edit MTL option from the AFTR Data/MTL menu.
3. After selecting the Create/Edit MTL option from the menu, the page will open with the options Model Dialog Selection Box with MAJCOM, base, unit, workcenter, specialty, and section.
4. The user must select options here in order to view their MTL item. All fields in the Model Dialog Search Box are required fields. The MAJCOM, Base, Unit, Workcenter, and Specialty will default to the user's location.
5. Users can then select/edit MTL Section items involving AF Form 797, Job Qualification Standard Continuation (used to document task completion); AF Form 1098, Special Task Certification and Recurring Training (used to document reoccurring task after certification); AF Form 623, Part II, CDC participation information (used to document CDC progress); and AF Form 623, Part III, Formal Training (used to document non-medical military training). Each form provides a different area to document various types of training that fall under the 4N0XX career field or military environment.
6. To change search criteria, the user will click the drop down in the field and change the search criteria.
7. To execute the search, click the SELECT button.
8. To change to a different Section other than the MTL, click the SEARCH button on the top left portion of the screen. This will bring up the Model Dialog Search. The LEGEND button launches a new window describing icons and/or references used. Legend content within the MTL menu changes depending on the Section the user is in.

The MTL Section is divided into two parts (fig. 1-12).

- STS on the left.
- MTL on the right.

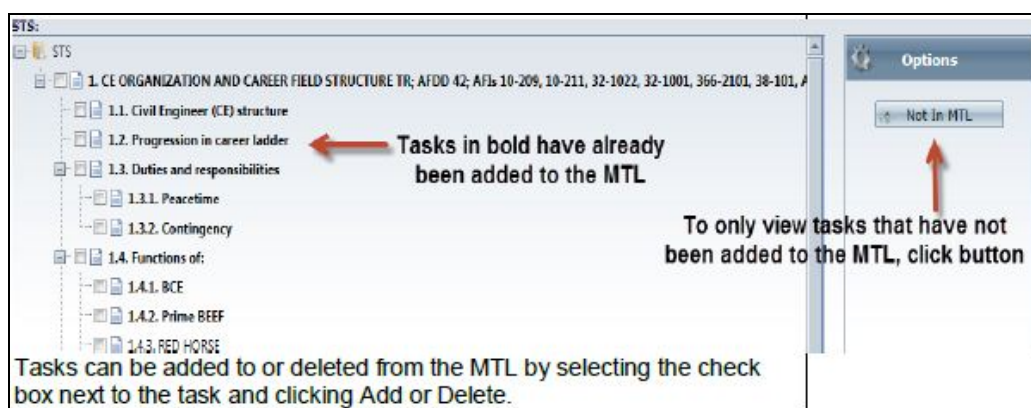


Figure 1-12. STS-MTL parts.

Tasks on the STS are listed by the Parent Task and specific tasks required of the specialty. By default, all tasks in the STS for the specialty are listed in the STS section. Tasks listed on the STS in bold have already been added to the MTL (fig. 1-13). To only view tasks that have NOT already been added to the MTL, click the Not MTL button (fig. 1-14).

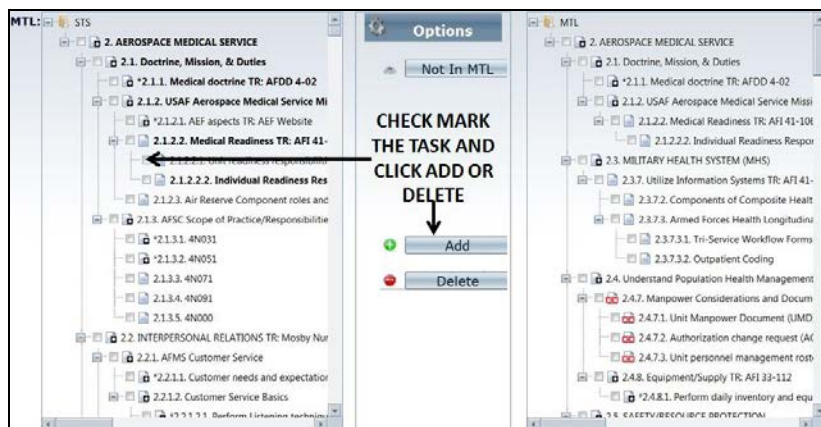


Figure 1-13. STS-MTL editing.

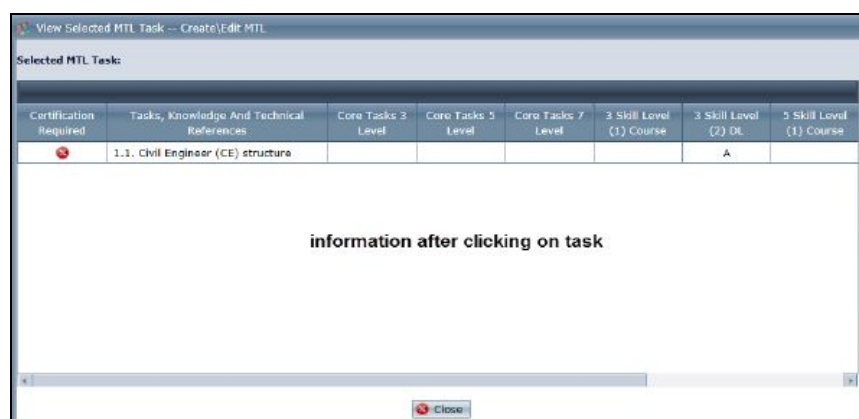


Figure 1-14. STS-MTL editing.

MTL—797, 1098, 623 II, and 623 III

The 797, 1098, 623 II, and 623 III sections are divided into two parts (fig. 1-15):

- UTL (unit task list) on the left.
- MTL on the right.

Tasks in the UTL are listed in alphabetical order. Tasks listed on the UTL in bold have already been added to the MTL. To only view tasks that have NOT already been added to the MTL, click the Not MTL button. Tasks can be added to or deleted from the MTL by selecting the check box next to the task and clicking Add or Delete.

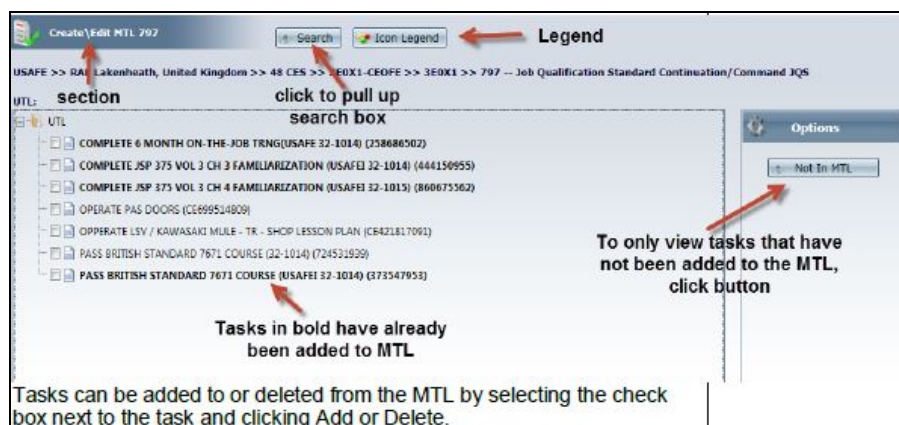
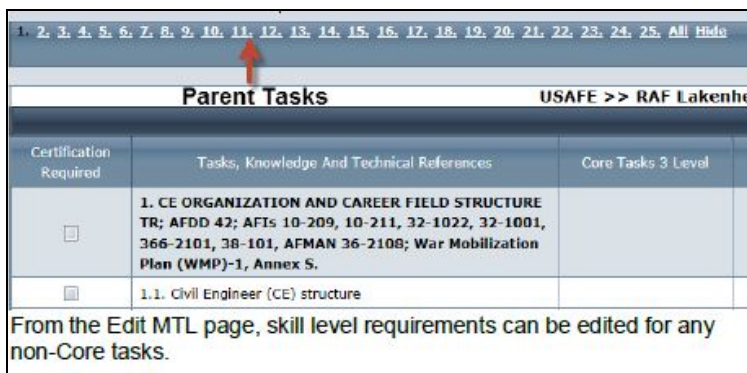


Figure 1-15. Edit MTL 797.

Edit MTL

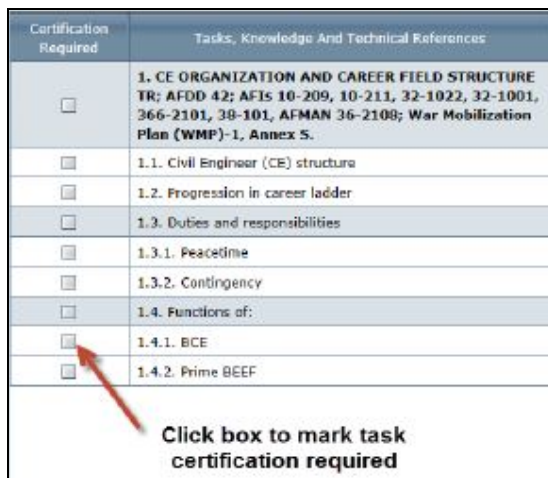
The Edit MTL menu option (fig. 1-16) allows users' MTL tasks 5 and 7 certification level requirements to be edited. Trainees cannot edit their own 5- and 7-level requirements. This option is for workcenter supervisors, but you are able to view the list. This function may be needed when 4N0XX personnel are moving from one duty section to another that has different patient care responsibilities. Tasks are listed by Parent Task(s). The specific tasks within a single Parent Task can be viewed by clicking the Parent Task number. All Parent Task(s) can be viewed by clicking All. All Parent Task(s) can be hidden by clicking Hide. If the certification box is checked (fig. 1-16), the task will require a certifier to sign off on it (fig. 1-17).



1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. All Hide		
Parent Tasks USAFE >> RAF Lakenhe		
Certification Required	Tasks, Knowledge And Technical References	Core Tasks 3 Level
<input type="checkbox"/>	1. CE ORGANIZATION AND CAREER FIELD STRUCTURE TR; AFDD 42; AFIs 10-209, 10-211, 32-1022, 32-1001, 366-2101, 38-101, AFMAN 36-2108; War Mobilization Plan (WMP)-1, Annex S.	
<input type="checkbox"/>	1.1. Civil Engineer (CE) structure	

From the Edit MTL page, skill level requirements can be edited for any non-Core tasks.

Figure 1-16. Edit MTL page.



Certification Required	Tasks, Knowledge And Technical References
<input type="checkbox"/>	1. CE ORGANIZATION AND CAREER FIELD STRUCTURE TR; AFDD 42; AFIs 10-209, 10-211, 32-1022, 32-1001, 366-2101, 38-101, AFMAN 36-2108; War Mobilization Plan (WMP)-1, Annex S.
<input type="checkbox"/>	1.1. Civil Engineer (CE) structure
<input type="checkbox"/>	1.2. Progression in career ladder
<input type="checkbox"/>	1.3. Duties and responsibilities
<input type="checkbox"/>	1.3.1. Peacetime
<input type="checkbox"/>	1.3.2. Contingency
<input type="checkbox"/>	1.4. Functions of:
<input type="checkbox"/>	1.4.1. BCE
<input type="checkbox"/>	1.4.2. Prime BEEF

Click box to mark task certification required

Figure 1-17. Edit MTL skill level requirements.

010. Creating a workcenter duty task list

Each workcenter can utilize a duty task list (DTL) to identify unique tasks done only in that duty section. For example, 4N0X1s that work in the emergency room should have DTLs covering suturing or putting on a cast while other medical technicians that work in family practice could have a DTL for reviewing medical records for individual medical requirements. The DTL supports the MTP and MTL by further narrowing tasks needed to support the patient care mission of the duty section.

Create/Edit DTL

The following instructions explain AFTR steps to create/edit/copy and view DTLs:

1. Select the Create/Edit DTL option (fig. 1-18) from the AFTR Data/Duty Position menu.
2. After selecting the Create/Edit DTL option from the menu, the page will open with a model dialog selection box with options: MAJCOM, Base, Unit, Workcenter, Duty Position, Specialty, and Section.

3. The user must select options here in order to view their DTL item.
4. All fields in the model dialog search box are required fields. The MAJCOM, Base, Unit, Workcenter, Duty Position, and Specialty will default to the user's location. The DTL Section contains 797, 1098, and 623 Part III. Specific workcenter training is documented here at the duty level and not at a higher level; for example, MTL (797, 1098, 623 Part III) is not specific to duty section and might involve several different workcenters.
5. To change search criteria, the user will click the drop down in the field and change the search criteria.
6. To execute the search, click the SELECT button.
7. To change the Section, click the SEARCH button on the top left portion of the screen. This will bring up the model dialog search.
8. The LEGEND button(s) launches a new window describing icons and/or references used. Legend content within the DTL menu changes depending on the section the user is in.

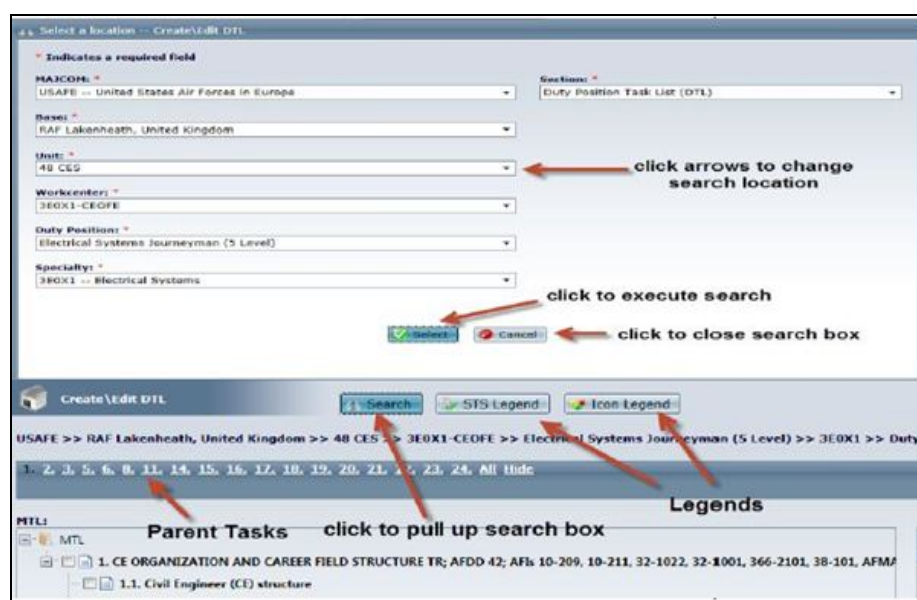


Figure 1-18. Create/Edit DTL.

The DTL section is divided into two parts:

1. MTL on the left.
2. DTL on the right.

Tasks on the STS are listed by the Parent Task and specific tasks required of the specialty. By default, all tasks from the STS tasks that were added to the MTL are listed in the MTL section. Tasks listed on the MTL in bold have already been added to the DTL. To only view tasks that have NOT already been added to the DTL, click the Not DTL button.

The 797, 1098, and 623 III sections are divided into two parts (fig. 1-19).

1. MTL on the left.
2. DTL on the right.

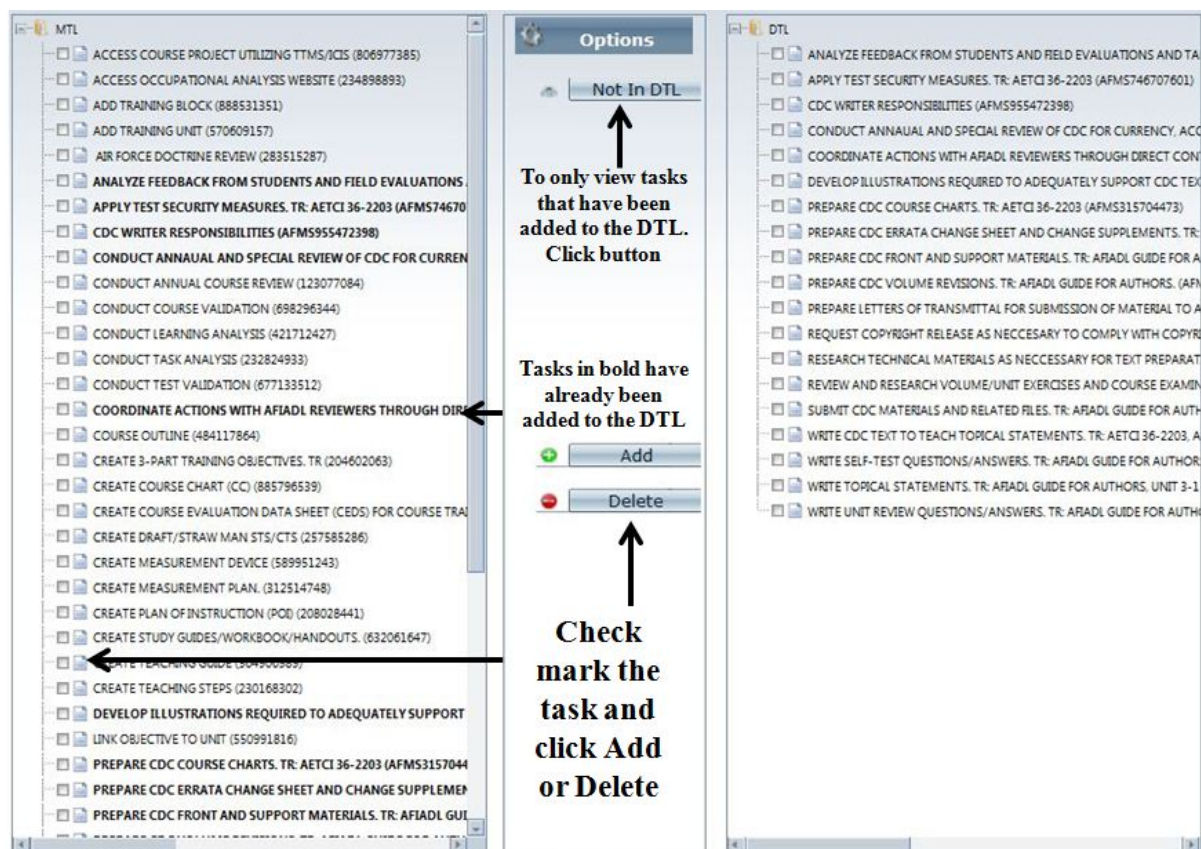


Figure 1-19. Add/Delete from MTL.

Tasks in the DTL are listed in alphabetical order. Tasks listed on the MTL in bold have already been added to the DTL. To only view tasks that have NOT already been added to the DTL, click the Not DTL button (fig. 1-20).



Figure 1-20. DTL Catalog.

Copy DTL

The Copy DTL function (fig. 1-21 and 1-22) allows a user with the trainees, trainers, immediate/workcenter supervisors, and certifiers to select an existing DTL and Duty Position from a MAJCOM, Base, Unit, Workcenter, and Duty Position and copy the DTL to a new location.

1. Select the Copy DTL option from the AFTR Data/Duty Position menu.
2. After selecting the Copy DTL option from the menu, the page will open with a model dialog selection box with MAJCOM, Base, Unit, Workcenter, and Duty Position as the search options. All the search items are required in order to proceed with the copy DTL.

Figure 1-21. Copy Duty Position (part 1).

3. After selecting the MAJCOM, Base, Unit, Workcenter, and Duty Position, the user will be redirected to the main Copy DTL page.
4. The copy source will be listed on the top of the page. If the user wants to change the copy source, click on the UPDATE SOURCE button and the model dialog search box will open up.
5. The user will need to select if they want to copy the 797, 1098, and 623 Part III. All catalog types can be selected or just one. At least one catalog item needs to be selected to copy.
6. The user will select the copy destination Workcenter. The user will need to have access to the Workcenter in order to select it to copy the DTL and Duty Positions to that location.
7. The user will click the COPY TO DESTINATION button to complete the DTL copy. Once the DTL is copied successfully, a success message will be displayed and the DTL and Duty Position will be copied to the destination location. All STS/Catalog items in the duty position you are copying MUST be present in the destination MTL. If there are STS/Catalog items in the source duty position that are not in the destination MTL, they will NOT BE COPIED.

Copy Duty Position

Copy Source

Source MAJCOM:
USAFE -- United States Air Forces in Europe

Source Base:
RAF Lakenheath, United Kingdom

Source Unit:
48 CES

Source Workcenter:
3E0X1-CE0FE

Source Duty Position:
Electrical Systems Journeyman (5 Level)

Select Items to Copy

Items to copy: *

	Catalog \ Duty Position
<input type="checkbox"/>	623
<input type="checkbox"/>	1098
<input type="checkbox"/>	623 Part III
<input type="checkbox"/>	STS

Copy Destination

MAJCOM: *
USAFE -- United States Air Forces in Europe

Base: *
RAF Lakenheath, United Kingdom

Unit: *
48 CES

Workcenter: *
3E0X1-CE0FE

Figure 1-22. Copy Duty Position (part 2).

View Duty Position

Use the following steps to view the Duty Position:

1. Select the View Duty Position option (figs. 1-23 and 1-24) from the AFTR Data/Duty Position menu.
2. After selecting the View Duty Position option from the menu, the page will open with a model dialog selection box with MAJCOM, Base, Unit, and Workcenter as the field options to choose from. The user must select options here in order to view the Duty Positions. All fields in the model dialog search box are required fields. The MAJCOM, Base, Unit, and Workcenter will default to the user's location. The View Duty Position page contains the Duty Position(s) in the MAJCOM, Base, Unit, and Workcenter selected.
3. The Duty Position information can be displayed if the user clicks on the drop down arrow next to the Duty Position. The Specialty Code(s), Specialty Title(s), Can Remove Core Tasks from MTL, and Trainer Can Be a Certifier fields will be the Duty Position information displayed.
4. To change search criteria, the user will click the drop down in the field and change the search criteria.
5. To execute the search, click the SELECT button.
6. To change the Section, click the SEARCH button on the top left portion of the screen. This will bring up the Model Dialog Search.

Search For Duty Positions -- View Duty Positions

* Indicates a required field

MAJCOM: *
USAFE -- United States Air Forces in Europe

Base: *
RAF Lakenheath, United Kingdom

Unit: *
48 CES

Workcenter: *
3E0X1-CE0FE

click to change

click to close

click to execute search

Figure 1-23. View Duty Position.

View Duty Positions

Search

click to open search box

AETC >> Fort Sam Houston, TX >> 383 TRS >> TRR-Training Resources Element >> Duty Positions

Title	Specialty Code	Specialty Title	Can Remove Core Tasks From MTL	Trainer Can Be Certifier
4C0 CDC Writer				
4N0 - CDC Writer				
	4N0X1	Aerospace Medical Service		
	4N0X1B	Neurodiagnostic		
	4N0X1C	Independent Duty Medical Technician		
	4N0X1F	Flight and Operational Medical Technician		
	X4N0X1	Aeromedical Evacuation		

click to open Duty Position info

Figure 1-24. View DTL.

View DTL from position menu

Use the following steps to view the DTL from the position menu:

1. Select the View DTL option from the AFTR Data/Duty Position menu. After selecting the View DTL option from the menu, the page will open with a model dialog selection box with MAJCOM, Base, Unit, Workcenter, Duty Position, Specialty, and Section as the field options to choose from. The user must select options here in order to view their DTL item. All fields in the model dialog search box are required fields. The MAJCOM, Base, Unit, Workcenter, Duty Position, and Specialty will default to the user's location.
2. The section contains DTL items, 797, 1098, and 623 Part III.
3. To change search criteria, the user will click the drop down in the field and change the search criteria. To execute the search, click the SELECT button.
4. To change the Section, click the SEARCH button on the top left portion of the screen. This will bring up the model dialog search.
 - The LEGEND button(s) launches a new window describing icons and/or references used. Legend content within the DTL menu changes depending on the section the user is in.
 - The view DTL page displays the DTL information for the selected MAJCOM, Base, Unit, Workcenter, Duty Position, and Specialty.
 - The specific tasks within a single Parent Task can be viewed by clicking the Parent Task number. All Parent Task(s) can be viewed by clicking All. All Parent Task(s) can be

hidden by clicking Hide. To search for a new item, click the search button on the top of the page and the model dialog search box will open.

- The LEGEND button launches a new window that displays the codes used in AFTR in better detail.
- The EXPORT button launches a new window that allows DTL search results to be exported as a portable document (.pdf), word document (.doc), excel document (.xls), or a rich text document (.rtf).

View DTL 797 page

The view DTL 797 page displays the Is Certifier Required, Catalog Event, Web Link, and 797 Details. If a certifier is required, a green check mark for yes will be next to the task. If certification is not required, there will be a red X next to the task. The Catalog Event is the name of the 797 item. The Web link will be a uniform resource locator (URL) of the course that users will need to access (i.e., <http://www.google.com>). The Details is a folder that opens up a model dialog pop up window that lists the course details.

View DTL 1098 page

The view DTL 1098 page displays the Catalog Event, Training Type, Due Period, Web Link, and 1098 Details. The Catalog Event is the name of the 1098 item. The Training Type is the type of training assigned to the 1098 item. The Frequency describes how often the training must take place. The Due Period is the time the training item is due to be completed by the trainee. The Web link will be a URL of the course that users will need to access (i.e., <http://www.google.com>). The Details is a folder that opens up a model dialog pop up window that lists the course details.

View DTL 623 Part III page

The view DTL 623 Part III page displays the Catalog Event, Web Link, and 623 Part III Details. The Catalog Event is the name of the 623 Part III item. The Web link will be a URL of the course that users will need to access (i.e., <http://www.google.com>). The Details is a folder that opens up a model dialog pop up window that lists the course details.

011. Identify personnel training needs

Once the MTP and MTL have been developed, you must determine the training needs within your workcenter. A 4N0XX can work in various types of workcenters (e.g., emergency room, acute care, urgent care, family practice, pediatric clinic, intensive care unit); all handle different types of patients that vary in age and medical condition. Due to this, you can certainly expect that your role in these sections might entail doing different tasks to help a physician or nurse treat injuries and illnesses. This is where the identification of training needs is formed, as the needs of the section is reviewed and needs are extracted to fill the gaps of what a 4N0XX does not know before they start working alone. To determine your training needs, you should identify your requirements, conduct initial evaluations, review previous training, and set training priorities.

Review what the trainee knows or can perform against the tasks in the MTL. The difference between what the trainee can perform and the work center requirements is the individual's training requirements. Determine individual requirements in one of the following methods.

Conduct initial evaluations

Using the MTL, identify what the trainee knows or can perform. If the trainee is a recent graduate from technical school, compare the tasks in 3-level course column to his or her level of expertise. Match the qualification of the trainee to the requirements of the duty position. This will help identify what training is needed and how long it will take to upgrade the trainee. If the trainee can perform the task without assistance to 100 percent accuracy, nothing more needs to be done. If the trainee cannot perform the task to the current standards, circle the task as a training requirement and open training when training begins.

Review training previously received

If the Airman is assigned from another base or work center, you will need to review the CFETP and verify the trainee's ability to perform the tasks (if required in the new workcenter). Match the qualifications of the trainee against the predetermined standard in your MTP. If the trainee can perform the task, no further action is required. If the trainee cannot perform the task (or the standard/method of performance changed) and the task is required in the new work center, decertify the tasks and look to evaluate trainee's future training progress. If the trainee can perform the task, but the task is no longer required in the new duty position, erase the corresponding circles (but not the previous certification dates or initials).

Set training priorities

When setting training priorities, keep in mind some tasks require training before others. Other tasks may have a prerequisite task or knowledge requirements. For example, if the task is to measure electrical output of a socket, the trainer might need to teach use of the multimeter first. Deployment requirements, AEF tasks, and other factors driving the training needed must also be considered when determining training requirements.

012. 4N0XX training plan

You will be required to pass all requirements listed in the duty section's training plan. An assigned trainer will evaluate you when you inprocess to the unit to determine what training is needed. Your supervisors will schedule training and try to avoid scheduling conflicts. They will request your feedback on tasks you are comfortable with and then properly set up the right training to build upon tasks learned in phase I/II.

To balance mission requirements, the supervisor schedules training far enough in advance to allow trainers enough time to schedule everyone who needs training. To the greatest extent possible, training should be scheduled in writing, and you must play an important part in communicating your needs throughout the process. The following paragraphs detail the prerequisites for setting up individual training plans so that you can follow along with your supervisor when it is developed and implemented in your duty section.

Plan for concurrent knowledge training

Most tasks require some type of background knowledge or skill. CDCs, AFIs, manufacturer's manuals, training references (TR), or other materials may be used to ensure you have the knowledge base to perform the task. Trainees cannot rely solely on memory for completing a task; they must incorporate a reference that pertains to each skill. These references can be relied on when practicing tasks so that you learn the correct way to perform medical care as a 4N0XX. Your role is to keep a list of these references nearby in the duty section and utilize it when needed as you go through 5-level upgrade training. If questions arise about the correct way of doing a task, you will have the proper resources available to answer any issues that arise.

Determine training capabilities and resources

Training capability is defined as the ability of a unit or base to provide training while considering resources, qualified trainers, and reference materials. Training capability is met when these elements exist in your workcenter. If your supervisor feels these elements are not met, he or she will contact your UTM for assistance. The UTM will contact base training to determine if the training can be provided within the base. For locations without base training, the UTM goes directly to MAJCOM for assistance. If this is not possible, base training will contact the MAJCOM for assistance. Generally, communicate any problems that occur with your supervisor when training assets are not available. The CFETP must be followed as these requirements set you up to succeed in any environment while performing your job as a 4N0XX.

Identify the most qualified trainers

In most cases, the trainer and supervisor are the same person. If this is not possible, trainers may be appointed. Trainers may provide training to one trainee or a small group of trainees, depending on the task. The trainer must work the same shift as the trainee, must be given time to train, and must meet the CFETP and MTP requirements.

If there is a training requirement for which there is no trainer or certifier, your supervisor contacts the base training office. If the base training office cannot find a trainer/certifier locally, the base training office contacts the MAJCOM training manager for assistance.

Training strategy

Next, decide how and where to provide the training. What is the training objective? What is the best method for conducting training? Is there a distance learning tool that can be utilized to assist in the training process? The following questions (fig. 1-25) may be used to assist in determining the best training strategy.

Step	Yes	No	N/A
(1) Do you need classroom time?			
(2) Does the knowledge in the CDC meet some of your training requirements?			
(3) Can the trainer train more than one trainee at a time?			
(4) Can training be conducted without equipment downtime?			
(5) Is related background training available from another source?			
(6) Can regularly scheduled work be conducted at the same time as the training?			
(7) Can the training be conducted in one session?			
(8) Are special training aids required?			
(9) Will special training sessions be required?			
(10) Do all trainees need to be trained on the same task?			
(11) When must training be completed to assure work center continuity and mission effectiveness?			
(12) Can the training be accomplished through distance learning or web-based training?			

Figure 1-25. Determining training strategy.

013. Evaluate personnel in upgrade training

Upgrade training (UGT) is the key to the total training program. It leads to award of the higher skill level and is designed to increase skills and abilities.

Before reading about how OJT applies to UGT, you need to be introduced to four people who are very important to your future—your UTM, trainer, task certifier, and supervisor.

Important People in your Upgrade Training	
Person	Responsibilities
UTM	Orders and tracks your progress in the CDCs. Contacts the base testing office to schedule you for your course exam when you have completed your CDC.
Trainer	Must be trained and qualified in the task to be taught. Recommended by supervisor. Has completed the Air Force Training Course (AFTC).
Certifier	At least SSgt/E-5 with a 5-skill level or civilian equivalent. Certified in the task being evaluated.

Important People in your Upgrade Training	
Person	Responsibilities
	Has completed the AFTC. Documents AF Form 797 as determined.
Supervisor	May be your trainer or certifier BUT NOT BOTH (e.g., supervisors cannot certify training they provided; however, they can certify tasks trained by someone else). Responsible for issuing your CDCs in the order they determine most beneficial to you and your duty section.

Training program

Throughout the training program, you're placed in an operational or clinical setting and asked to perform specific tasks. The training tasks follow a systematic schedule and each task must be trained on and completed within a certain number of days, weeks, or months. Hands-on training tasks *must not be simulated*. Remember, you are the key ingredient in participating in and following the plan. Usually, your trainer or supervisor starts you with these two types of task as you gain confidence.

1. Simpler tasks:
 - Processing administrative forms.
 - Taking a blood pressure, pulse, and respiration.
2. Harder tasks:
 - Applying a splint or cast.
 - Starting and maintaining intravenous therapy.

You need to be attentive to training opportunities, show enthusiasm and initiative, and don't be afraid to step up and ask if you can assist or have someone show you what they are doing. As you broaden your career knowledge and increase your job proficiency, your supervisor should assign other tasks that are more difficult until you master all the elements of your job. In the meantime, you are becoming an integral piece of the AFMS picture.

OJT

Learning in an OJT setting occurs because of the close association between the trainee and skilled journeyman or craftsman serving as the trainer. Group or one-on-one discussion is sometimes the most practical way of teaching information all trainees must know. This format often provides further explanation of such things as theory, background material, and safety precautions presented in the CDC.

Your CDC may not include the more recent changes in Air Force publications affecting your duties. This means your CDC cannot be used as a last authority in doing your daily job. Additionally, local procedures, standard operating procedures, or operating instructions may differ slightly from the CDC. Although 4N0 personnel constantly monitor and revise CDC material, it may take several months or more to get a change included in your CDC. Also, it may take several months or longer to get changes included in the SKT, one of the tests you will take for promotion consideration from staff sergeant/E-5 through master sergeant/E-7. However, your knowledge of various old procedures will help you understand new procedures. Use the most current Air Force publication as the last authority in doing your daily tasks, but study your CDC for OJT.

OJT offers you an opportunity to learn and grow in a more experience-controlled environment. Once you have mastered your tasks and completed your CDCs, you are on your way!

Evaluation

Now that you have graduated phase I/II, your supervisor continues to train you to the “Go” level for the next 12 months. Upon learning all tasks required for your 5-skill level, supervisors will test your ability to perform each task without assistance. A good way to know what is required is by asking:

1. What must I do or know in order to be considered qualified?
2. What reference was used to show how the task is accomplished if I have questions?
3. What equipment is needed to perform the task?

Trainers, certifiers, or supervisors assess your skills using a standardized approach. During training, these steps explain how you will be tested to confirm you are competent in each STS task.

1. The *behavior* you exhibit while completing the task.
2. The *conditions* where the task was performed.
3. The *standards* that fall under each task.

Not only do these steps tell if you are ready to become qualified on a task, but the steps can also be used to evaluate others in upgrade training when you attain the trainer/certifier role. Based on the CFETP, your role as a trainer/certifier could occur on average at the 3-year timeframe in your career.

Qualification training packages

Additionally, you can use the QTPs and the Instructional System Design checklist to train on proper techniques and standards used in the career field. The QTPs can be found on <http://www.e-publishing.af.mil/> or should be located within the workcenter MTP. The 4N0XX QTPs have been developed for the following specialties: Aerospace Medical Service Specialty (AMSS), Independent Duty Medical Technician (IDMT), Neurodiagnostic Technologist, and the Allergy/Immunization, Critical Care, Gastroenterology technicians.

The primary QTP that pertains to you at this point in your career falls under the AMSS. It contains a specialized list of tasks a basic 4N0XX must be able to perform. But more importantly, the QTP assists in standardization of training and to eliminate duplications based on duty position. All 4N0XXs are evaluated on each duty position QTP regardless of rank utilizing the following information:

Trainer's role

Trainers review each volume and identify which modules of QTPs are needed for the trainee's job position. Core task items are identified with the number “5” on the STS Column 2; these items are the minimum mandatory skills which are required for all 4N0X1 personnel to become proficient. You have the flexibility to arrange training for each module in the order you decide. Review the subject-area tasks in each module with the trainee. Direct the trainee to review the training references to gain a better understanding of the objective for each module. If the trainee has any questions about the objective, clarify the behavior that is expected in the objective. Review the performance checklist with the trainee, and allow him or her sufficient time to learn each step (some objectives may take longer to teach). Remember, the objective of each QTP is to standardize training and allow sufficient time for the trainee to learn each task thoroughly in order to perform the task without assistance.

When the trainee receives sufficient training and is ready to be evaluated on an objective, follow the evaluation instructions. The performance checklist must be used as you evaluate each task objective. When the trainee successfully accomplishes the objective, then make the appropriate documentation of the task completion in the AFTR.

Objectives

The 4N0XX personnel, given proper training resources and trainer demonstration, prepare the equipment required in accordance with the specific QTP module checklist. The training references will be available either in hardcopy or electronically. The QTPs were developed to enhance OJT for

AMSS personnel. As a trainee or trainer, the QTPs provide you with the breakdown of tasks into *teachable elements*. The teachable elements will help you guide everyone toward sufficient proficiency for task performance without assistance. QTPs are also used by the task certifiers/certification official to evaluate trainees concerning tasks which need third-party certification.

Evaluation instructions

These are the *evaluation instructions*:

1. After the trainee has received the applicable instructions and has observed the task demonstration, allow sufficient practice time for each task element. The trainee must satisfactorily perform all parts of the task without assistance.
2. Use the AMSS Performance Checklist, Volume X, Module X, when evaluating the task to ensure all steps of the task are completed correctly.
3. Upon satisfactory completion of the evaluation, document trainee competency. Initial evaluation is documented in the STS of the trainee's CFETP. All recurring evaluation is documented by using AF Form 1098, Special Task Certification and Recurring Training.
4. Using the QTP module as a source of information, discuss the trainee's performance; indicate strengths, weaknesses, suggested improvements, and so forth. If the trainee performed all steps of the task satisfactorily, document the results in the trainee's OJT record.

Evaluation results

Annotate QTP task completion on AF Form 1098. Do not file the individual checklists in each member's AFTR. File a master checklist in the hardcopy MTP folder. Additional training protocols are located on the Knowledge Exchange at <https://kx.afms.mil/Pages/default.aspx> and AFMS Virtual Library at <https://kx.afms.mil/kj/kx8/VirtualLibrary/Pages/home.aspx>.

Remember, the QTPs are a necessary tool for standardizing refresher/sustainment training. Such standardization benefits the CFETP training concept throughout each member's career. These documents also will be utilized for assessing/certifying the AMSS each time that he or she is assigned to a new duty position.

014. Career knowledge upgrade

Career knowledge upgrade includes task knowledge and subject knowledge. *Task knowledge* is the knowledge needed to perform a particular task safely, accurately, and effectively. It includes theories or principles common to a particular task and often the detailed step-by-step parts of a task. *Subject knowledge* is just as important as task knowledge. It includes identifying basic facts and terms, identifying relationships of basic facts, and enables the individual to analyze facts and principles and draw accurate conclusions about a subject. The combination of these two types of knowledge will give you the foundation for making decisions regarding patient or customer care.

In short, the first step you take to qualify for a higher skill level and higher rank in the Air Force is to study the applicable CDCs. Successful completion of your CDCs will satisfy most upgrade training requirements for the career knowledge part of OJT. Your OJT trainer or supervisor will provide specific training and information for particular tasks or knowledge you need to have for a specific job or duty location. Your specific responsibilities as a trainee are found below and also in AFI 36-2201.

Trainee responsibilities

The UTM will conduct a comprehensive orientation for covering the concept, scope, and objectives of the AF Training Program. Your supervisor must understand *your training plan*, how the plan affects you, and what his or her individual responsibility is towards training. Training not only affects the unit mission but also impacts promotion, assignment selection, and re-enlistment.

Your duties as a trainee include:

- Actively participate in the training process and understand the applicable CFETP and career path.
- Maintain knowledge, qualifications, and the appropriate skill level.
- Become a productive member of the unit and work center through task certification.
- Budget on- and off-duty time to complete training tasks, particularly for CDC and other self-study requirements.
- Request help from your supervisor, trainer, or UTM when having training difficulties.
- Gain task knowledge to perform specific tasks by studying TRs.
- Gain career knowledge through a planned program of self-study involving CDCs or TRs listed in the CFETP.

Trainer responsibilities

The trainer and supervisor may be the same individual. If necessary, the supervisor may assign someone else to provide the training. Trainers are selected based on their experience and ability to provide instruction to trainees. Trainers must do the following:

- Attend the AFTC.
- Maintain required task qualifications.
- Record task qualification according to prescribed instructions when a trainee performs a task to required standards.
- Plan, conduct, and document training.
- Develop evaluation tools. Evaluation responsibilities may be assigned to an equally qualified third party.
- Prepare and use teaching outlines or task breakdowns, as necessary.
- Brief the trainee and supervisor on the training evaluation results.

NOTE: To ensure effective and efficient execution of training programs, the trainer and trainee should be placed on the same work crew or shift unless the mission dictates otherwise.

Task certifier qualifications and responsibilities

Certifiers will provide third-party certification and evaluation on tasks identified by the AFCFM (if applicable). The responsibility of the certifier is to conduct additional evaluations and certify qualification on those designated tasks. Certifiers must:

- Be at least SSgt/E-5 with a 5-skill level or civilian equivalent.
- Attend the AFTC.
- Be capable of evaluating the task being certified.
- Evaluate training and certify qualifications.
- Use established training evaluation tools and methods to determine the trainee's ability and training program effectiveness.
- Develop evaluation tools.
- Brief the trainee, supervisor, and trainer on the training evaluation results. Identify the trainee's strengths and areas needing improvement.
- Request assistance from the supervisor and UTM, when necessary.

Understanding task and subject knowledge

Understanding task and subject knowledge identifies your ability to identify facts, state principles, analyze, or evaluate the subject. Some tasks are complicated, extremely large, or confusing. Some tasks are so simple that no further training need be conducted. When learning a large task, you need to break the task down into smaller, teachable units that will provide for a number of successes for you and is short enough to complete in one session. Some tasks take several days or weeks to complete; therefore, you will need to be able to teach it in several sessions. Not all tasks require a breakdown.

If there is a regulation or manual that provides step-by-step procedures, evaluation steps, checklists, and so forth, no task breakdown is required. However, reference your training source in the MTL.

If the task is covered under several regulations or manuals, is not covered under any regulations or manuals, is lengthy or complicated, a task breakdown or lesson guide is advisable. A well-designed task breakdown that's already established by the workcenter supervisor can also serve as an evaluation tool during the evaluation phase.

In order to understand a task fully you should be able to:	
Task Knowledge	Subject Knowledge
Name parts, tools, and simple facts about the task	Identify basic facts and terms about the subject
Determine step-by-step procedures for doing the task	Identify relationship of basic facts and state general principles about the subject
Identify why and when the task must be done	Analyze facts and principles and draw conclusions about the subject
Identify why each step is needed	Evaluate conditions and make proper decisions about the subject

015. Requirements of job proficiency upgrade

Job proficiency upgrade requires trainee, trainer, and supervisor involvement in order to complete all requirements in the CFETP and MTP. You must be proactive in ensuring your training is planned at the right time and documented in the right place. The following discussion shows a sequence of reviews your supervisor will perform to get you properly oriented to the workcenter.

Supervisor initial evaluation

In your first face-to-face meeting with your supervisor, he or she will evaluate your AFSC, duty position (including core and home station training tasks), deployment/UTC, requirements and current qualifications. This process includes validation of your previously certified task to ensure qualification. Additionally, your supervisor reviews the MTP for trainee's duty position and revalidates qualification(s) and timelines (milestones) for items that require further training. The supervisor will also review Part I of the CFETP, Work Center Master Training Plan, and Wartime and Contingency training. He or she then matches the duty position requirements to the qualification of the individual, if applicable.

Based on past training, the supervisor also conducts a review of other local or unique training requirements. He or she will determine exactly how much and what training the individual will need. He or she also ensures the trainee obtains 100 percent mission qualification. Trainees will also be enrolled in the CDCs and oriented to local and unique policies (professional relationships, ethics, joint community, and tech training squadron assignment).

Work center orientation

Job proficiency upgrade cannot be complete without a proper orientation to the work center. The following shows *minimum areas to cover*:

- Work center mission and duties.

- Duty hours and work areas.
- Safety and training requirements.
- Chain of command.

Job proficiency training increases “hands-on” skills while performing the duties and tasks of an AFSC. It’s the application of the knowledge you learned from studying your CDC. Your supervisor and the UTM must certify that you possess the needed job proficiency before you can upgrade to the next skill level. Hands-on training provides job proficiency while experience increases skills and builds confidence in the trainees. Successful upgrade requires the following documentation in AFTR:

1. Training start date (day, month, year).
2. Training complete date (day, month, year).
3. Trainee initials (upon completion of training).
4. Trainer initials (upon completion of training).
5. Certifier initials when required by AFCFM (for tasks requiring third- party certification).

Periodic updates must be accomplished in the training records to document upgrade progression. The following are examples IAW AFI 36–2201.

Upgrade training monthly supervisor documentation

According to AFI 36–2201, training progress entries should include the following checklist, as a minimum:

- ☐ CDC Progression (if applicable):
- ☐ Task Progression:
- ☐ Task Certification:
- ☐ Task Decertification (if applicable):
- ☐ Task Recertification (if applicable):
- ☐ Trainee Strengths:
- ☐ Trainee Weaknesses (if any):
- ☐ Trainee Attitude:
- ☐ Corrective Actions (if required):
- ☐ Other Supervisor Comments/Recommendations:

Supervisor review for upgrade

Once the supervisor feels an individual has completed all the prerequisites for a skill level, the supervisor annotates the records as follows:

Trainee has completed XXX set of CDCs and has completed all core task training. All Form 34s, Form 9 cards, and/or CDC EOC (end of course) score sheets have been signed by supervisor and trainee. Trainee has met minimum time in training requirements IAW AFI 36–xxxx. I have reviewed the Enlisted Classification Directory for AFSC XXXXX and trainee meets all requirements for XX skill level. List any courses that were required in the Air Force Enlisted Classification Directory, such as 7-level school or mandatory advanced training schools. As the supervisor for the member, I recommend xxxxx be upgraded to xxx skill level, effective dd mmm yyyy. I am processing AF IMT 2096 through our chain of command and to the UTM.

Duty position

Each time an Airman changes duty positions (transfers from another base or work center), the supervisor must perform an initial evaluation that includes a review of all previously certified tasks.

These tasks are compared against the MTL and will determine the extent of training required for the new duty position.

The supervisor will identify all new tasks applicable to the new duty position and erase all circles that do not apply to the current duty position. Do not erase the initials and certification dates of previously certified tasks. If the Airman was previously qualified on the task, the supervisor determines if he or she is still qualified. If the Airman is found to be qualified, no further action is required. If the Airman is found to be unqualified on a previously certified task, the supervisor must make sure the task is trained on and recertified. Record the initial evaluation on AF Form 623a or AFTR and retain it in the training record until PCS/permanent change of assignment (PCA).

016. Maintaining on-the-job training tasks

Proficiency training is additional training, conducted either in-residence, via advanced training courses (distance learning), or OJT provided to personnel to increase their skills and knowledge beyond the minimum required for upgrade. After achieving training and knowledge in a task, proficiency level is indicated by asking these questions:

- Can I do simple parts of the task? Do I need to be told or shown how to do most of the task (extremely limited)?
- Can I do most parts of the task? Do I need only help on hardest parts (partially proficient)?
- Can I do all parts of the task? Do I need only a spot check of completed work (competent)?
- Can I do the complete task quickly and accurately?
- Can I tell or show others how to do the task (highly proficient)?

Becoming confident in your skills does not occur overnight; supervisors will consider the following:

- Allowing you time to practice what has been learned.
- Determining when you are ready to be certified on the task.
- Requesting third party certification, if required. If the task requires third party certification, the training is certified complete after the task certifier conducts the task evaluation.

Transcribing

Task proficiency documentation in AFTR must be redone if a new CFETP is released AF-wide. Documentation to a new CFETP is an administrative function, not a re-evaluation of training. Therefore, supervisor and trainer are considered synonymous for the purpose of documentation. If a CFETP revision occurs, transcribe tasks within 120 days (240 days for Air Reserve Component [ARC]) of CFETP revision date or from the date the revision is posted to automated training records system.

Upon publication of a new CFETP, use the following procedures to transcribe:

1. Use the new CFETP to identify past and current training requirements and to transcribe qualifications from the previous CFETP.
2. For tasks previously qualified/certified and required in the current duty position, circle the subparagraph number next to the task statement and enter the current date in the completion column. The trainee initials in the trainee column and the current task certifier or supervisor/trainer initials in the trainer column.
3. For tasks previously certified, but not required in the current duty position (do not circle), transcribe only the previous certification date (no initials). If the task later becomes required in the duty position, recertify using current dates and initials.
4. Annotate the AF Form 623a or automated version, (for example, "I certify the information contained in the CFETP dated XX was transcribed to the CFETP dated XX, and the trainee

was given the superseded CFETP.” The entry is signed and dated by the supervisor and trainee).

5. Maintenance of CFETPs for personnel in retraining status. Maintain CFETP from previous AFSC until commensurate skill level is achieved, then give the obsolete field CFETP to the individual.

Decertification and recertification

If a supervisor determines an Airman is unqualified on a task previously certified for his/her duty position, the supervisor erases the previous certification or deletes certification when using an automated system.

Appropriate remarks pertaining to the reason for decertification are entered on the AF Form 623a or automated version. Begin recertification (if required) following these procedures:

1. The AF Form 623a or automated version will be used to document an individual’s training progression. This form will be used to reflect training status, counseling, and breaks in training. The supervisor and/or trainer and the trainee must sign and date all entries. All entries include the date the counseling/entry is made, the statement or entry, and the trainee and supervisor signature. These requirements apply to all AFCFM approved training forms, regardless of format.
2. Examples of AF Form 623a or automated version entries include initial CDC issue, CDC completion schedule, explanation of delays in CDC completion and/or training requirements, problems encountered with task certification (if any), and any training-related counseling statements.
3. When used for training-related counseling, include strengths, weaknesses, areas to improve, and means to improve.
4. Maintain the AF Form 623a or automated version as long as it pertains to the current training objective (i.e., award of the skill level or completion of qualification training). The supervisor will determine if any additional AF Forms 623a or automated version will remain in the training record.

017. Evaluate training effectiveness

Do you recall the hundreds of hours spent training during your phase I/II training? How effective were the topics instructed? If you are taking this course, it must have been effective as you successfully passed both phases. But as training continues throughout your career, you become an essential part to ensure it is effective for other 4N0X1s. In this lesson, training effectiveness starts with making sure you have key personnel who ensure training is effective, and puts training together along with how to evaluate its success in teaching personnel the duties of our career field.

Key personnel

The following is a list of requirements key personnel (trainers and certifiers) must meet:

- *Trainers* must be recommended by their supervisor, qualified to perform the task being trained, and have completed the AFTC. (**NOTE:** Members of sister services that are trainers of AF personnel are not required to complete the AFTC.)
- *Certifiers* must be at least SSgt/E-5 with a 5-skill level or civilian equivalent, capable of evaluating the task being certified, and have completed the AFTC.
- *Supervisors*, assisted by the UTM, develop a MTP for each work center to ensure 100 percent task coverage. Additionally, identify duty position, home-station training tasks (HST), deployment/UTC, and skill-level upgrade requirements for the work center.

EXCEPTION: Work centers with only one person assigned, or with only fully qualified SNCOs (skill level commensurate with grade) require only a MTL, unless otherwise directed by the

AFCFM. Ensure the CDC program is administered according to Air Force Career Development Academy (AFCDA) policies, and establish local policies to maximize effectiveness.

Standards and objectives

Supervisors, trainers, and certifiers ensure all trainees are receiving proper and adequate training and are evaluated against a predetermined standard. They also incorporate training objectives and inform trainees what they need to do or know in order to be considered “qualified.” A training objective defines the resultant behavior (what the trainee must do or know), the standard (how well the task must be performed), and the condition (what will be given or denied during the final evaluation).

Effectiveness

If training is effective, trainees should remember what was required to successfully complete the job. The following questions indicate things to consider when evaluating training effectiveness in your workcenter.

- Did everyone actively participate in the training process?
- Did training incorporate actual equipment or training aids?
- Did everyone practice hands-on, if applicable?
- Did everyone have the opportunity to provide feedback?
- Did the training instructor use established evaluation tools and methods?
- Did you increase knowledge of applicable duties?

Documentation

Documenting training effectiveness can be done in various ways based on the type of training performed. These are some examples:

- AFTR, AF Form 623a (record strengths and weaknesses).
 - AFTR, AF Form 803 (check trainee’s competency on completing a task).
 - Training critiques or surveys (review feedback from staff).
-

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

008. Creating a workcenter master training plan

1. Where is the paper copy of the CFETP located?
2. Who is responsible to ensure your work section has a MTP?
3. What does the MTP outline?
4. What items are circled so you will know which items in the STS are needed in order to accurately do your job and obtain the next skill level?

5. The MTP is a “big picture look” to ensure what?
6. The ability to create or edit an MTP depends on what?
7. List the steps to Create/Edit MTP in AFTR.
8. List the steps to Create/Edit MTP STS page.
9. What is the first step to edit STS MTP?
10. What steps delete STS MTP information?

009. Creating a workcenter master training list

1. What does the MTL menu option allow the current user to view?
2. What does the MTL menu option allow the user to do?
3. What are the available fields under the AFTR Data/MTL option?
4. The items available in a users’ AFTR depend upon what?
5. List the steps to Create/Edit MTL.
6. The MTL section is divided into what two parts?
7. The 797, 1098, 623 II, and 623 III sections are divided into what two parts?
8. What is the purpose of the Edit MTL menu option?

9. How are tasks listed in the UTL?
10. How can tasks can be added to or deleted from the MTL?

010. Creating a workcenter duty task list

1. What is the first step when creating/editing DTL in AFTR?
2. How do you change the DTL search criteria?
3. The DTL is divided into what two parts?
4. What is the purpose of the Copy DTL function in AFTR?
5. What is the first step in copying a DTL from one location to a new location?
6. What is the first step to View Duty Positions in AFTR?

011. Identify personnel training needs

1. How do you determine the training needs within your workcenter?
2. Why do you identify requirements?
3. How do you conduct an initial evaluation?
4. What do you verify when reviewing training previously received?
5. What other factors must be considered when determining training requirements?

012. 4N0XX training plan

1. What must supervisors try to avoid when scheduling training?
2. What material can the trainee use to make sure he or she has the knowledge base to perform the task?
3. Who does your supervisor contact if you there is not a trainer or certifier available for a training requirement?
4. To determine a training strategy (how and where to provide the training), what questions should you consider?

013. Evaluate personnel in upgrade training

1. What is the key to the total training program?
2. What does the total training program lead to?
3. Total training program is designed to increase what two areas?
4. The steps to evaluate a 4N0X1's competency on a task involve reviewing what three things?
5. What are the three evaluation requirements that aid you in knowing what's required when you are evaluated?

014. Career knowledge upgrade

1. What two areas are included in career knowledge upgrade?
2. Define task and subject knowledge.
3. What is the first step you take to qualify for a higher skill level and higher rank in the Air Force?

4. Who provides specific training information for particular tasks or knowledge?
5. Which AFI lists specific trainee responsibilities?
6. What is advisable when a task is not covered under any regulations or manuals or is lengthy and complicated?
7. What can serve as a tool during the evaluation phase?
8. What should you be able to do to show that you fully understand task knowledge?
9. What should you be able to do to show that you fully understand subject knowledge?

015. Requirements of job proficiency upgrade

1. What is the purpose of job proficiency training?
2. Who certifies that you possess the needed job proficiency before you can upgrade to the next skill level?
3. Hands-on training provides job proficiency. What does experience provide?
4. What areas in AFTR do you update successful upgrade training?
5. When does a supervisor conduct an initial evaluation?

016. Maintaining on-the-job training tasks

1. What is the purpose of proficiency training?

2. After achieving training and knowledge in a task, what questions do you ask to indicate proficiency level?
3. Being confident in your skills does not occur overnight; what do supervisors consider?
4. If a CFETP revision occurs, within how many days should you transcribe the tasks?
5. What is the first step to transcribe tasks due to a CFETP revision?
6. What form is used to document an individual's training progression?
7. What must be annotated on AF623a during a training-related counseling?

017. Evaluate training effectiveness

1. What key personnel ensure training is effective in the workcenter?
2. Define three things that training objectives provide.
3. What questions should you consider when developing and evaluating training effectiveness?
4. What are some ways you document training effectiveness?

1-4. Progression in the 4N0X1 Career Paths

You must progress in skill level to progress in rank. Each new rank obtained carries with it more opportunities to expand your career knowledge, abilities, and experiences. "Growing up" in the Air Force presents you with a number of special duty opportunities and career paths.

018. Progression in 4N0X1 career path

Various opportunities are available for medical service specialists. Some of them are normal progression opportunities that are possible with further training and time in the specialty. Other opportunities involve gaining new skills in addition to the basic AFSC requirements. Special experience identifiers (SEI) and shredouts are established when identifying experience or training is

critical to the job and person assignment match, and no other identification is appropriate or available. Both permit rapid identification of a resource already experienced to meet unique circumstances, contingency requirements, or management needs. They provide a means to track individuals and identify positions requiring or providing unique experience or training that otherwise would be lost. They may also be used to better distribute personnel and optimize the job and person match.

Career path titles

The 4N0XX career field offers many opportunities to excel and personnel are able to be trained in a wide variety of inpatient and outpatient duty positions AF-wide. This is done by applying through your chain of command 4N0XX functional manager at your duty location. The following table includes brief explanations of each specialty, shredout, and SEI.

Specialty Identifiers	
Identification	Explanation
4N0X1	Aerospace medical technician
4N0X1	Squadron medical element (SME) technician No SEI or shred is awarded, but individual maintains specialized training for specific skills required for duty position.
4N0X1	Gastroenterology technician
Shredout	
4N0X1B	Neurology technician (NT)
4N0X1C	Independent duty medical technician (IDMT)
4N0X1F	Flight and Operational medicine technician (FOMT)
SEI	
SEI 453	Allergy/Immunization technician (AIT)
SEI 455	Special Operations Command (SOC) medics
SEI 456	National registry paramedic
SEI 470	Flight and Operational Medicine technician (FOMT)
SEI 486	Hemodialysis medical technician (HDMT)
SEI 487	Critical care technician (CCT)
SEI 490	Hyperbaric medical technician (HBMT)
SEI 494	Aeromedical evacuation technician (AET)

Career path descriptions

The following table explains duty descriptions for each specialty, shredout, and SEI:

Duty Description	
Identification	Explanation
4N0X1 Squadron Medical Element Technician	Deploys as SME member with operational squadrons.
4N0X1B Neurology Technician	Prepares patients for examination, treatment, and diagnostic procedures. Assists in performing special electroencephalographic and electromyographic procedures.
4N0X1C Independent Duty Medical Technician	Renders medical and dental treatment at deployed operating locations and fixed sites. Gathers, interprets, and disseminates medical intelligence/threat data. Performs medical site surveys and performs bioenvironmental, public health, medical logistics, and medical administration duties.
Allergy/Immunization Technician (SEI 453)	Manages immunotherapy care and performs diagnostic tests as ordered by physician. Prepares allergenic extracts and specific allergy treatment extracts. Administers vaccinations IAW current guidelines. Manages patient's vaccination history in date system and oversight of immunization processes and programs. Manages the immunization back-up technician (IBT) program.

Duty Description	
Identification	Explanation
Special Operations Command Medics (SEI 455)	Performs special operations medical support providing combat trauma stabilization, on-going field trauma care and evacuation to definitive care.
National Registry Paramedic (SEI 456)	<p>The paramedic is an allied health professional whose primary focus is to provide advanced emergency medical care for critical and emergent patients who access the emergency medical system. This individual possesses the complex knowledge and skills necessary to provide patient care and transportation. Paramedics function as part of a comprehensive EMS response, under medical oversight.</p> <p>Paramedics perform interventions with the basic and advanced equipment typically found on an ambulance. The paramedic is a link from the scene into the health care system. The paramedic's scope of practice includes basic and advanced skills, to include invasive and pharmacological interventions, focused on the acute management and transportation of the broad range of patients who access the emergency medical system. This may occur at an emergency scene until transportation resources arrive, from an emergency scene to a health care facility, between health care facilities, or in other health care settings.</p>
4N0X1F Flight and Operational Medicine Technician (SEI 470)	<ul style="list-style-type: none"> Assists flight surgeon with aircraft mishap and physiological incident response, investigation, and reporting. Supports flight surgeon to develop flying safety and deployment briefings. Assists healthcare provider teams with interpretation and application of medical standards to determine medical qualifications for occupational duty, worldwide duty, mobility status, flying status, special duty, security clearance, PME, retraining, commissioning, and transition to Air Force Reserves or Air National Guard. Provides administrative management of duty limiting conditions reports. Assists with oversight of waiver management utilizing the Aircrew Information Management Waiver Tracking System (AIMWTS). Maintains grounding management on all aircrew assigned utilizing the Aeromedical Services Information Management Systems (ASIMS). Performs the paraprofessional portion of initial flying class/special operational duty (SOD) physicals. Conducts clinical entries for data into the Physical Examination Processing Program (PEPP) and manages physical until completion. Provides first point of contact for non-empanelled patients requiring physical examinations (i.e., Department of Defense Medical Examination Review Board [DODMERB], Reserve Officer Training Corps [ROTC], and others that are an extension of the occupational exam). Performs preventive health assessment (PHA) physicals for flying status and non-flying status personnel and updates results of required tests and examinations into ASIMS.
Hemodialysis Medical Technician (SEI 486)	Prepares patient and performs procedures using specialized renal dialysis equipment.
Critical Care Technician (SEI 487)	Provides nursing care for patients in various intensive care units and assists with patient examinations and special procedures including: mechanical ventilation, cardiovascular and neurovascular procedures and dialysis. Prepares patient with special equipment for transfers.
Hyperbaric Medical Technician (SEI 490)	Prepares patient and equipment for hyperbaric dive and functions as a hyperbaric crew member. Assists the provider or nurse with patient care. Including wound care, debridement and emergency care for patients in the event of medical or hyperbaric chamber emergencies.
Aeromedical Evacuation Technician (SEI 494)	Prepares patients and equipment for flight. Performs pre-flight/in-flight patient care and documentation. Operates specialized aircraft life support equipment, medical devices and aircraft systems related to patient care. Provides emergency care for patients in event of medical and/or aircraft emergencies.

NOTE: It is also possible for aerospace medical service specialists to apply for other special duties at various points during their careers. Some of these positions include technical school instructor duty, CDC writer, PME instructor duty, first sergeant duty, and recruiter duty.

019. Career path broadening

Career broadening opportunities exist that require supervisor recommendations for each specific special duty assignment. You must strive to become the best 4N0X1 in order to have the experience and knowledge required to succeed in another SEI, shredout, or special duty assignment. The following paragraphs describe your duties at each skill level and include the prerequisites for gaining a recommendation for training into another SEI or shredout.

Journeyman (4N051)

At this level, a 4N031 has completed in-residence technical training and clinical rotation (Phase I and II), all 4N051 upgrade training requirements, and is technically ready to accomplish the mission as a 4N051.

Craftsman (4N071)

The individual has completed all qualifications for the 4N051, all 4N071 UGT requirements in his or her primary duty, any required PME, and obtained the rank of staff sergeant.

A 4N071 is experienced in performing and supervising functions such as nursing activities, care and treatment of patients, operating and maintaining therapeutic equipment, conducting paraprofessional portions of physical examinations, and assisting with the medical treatment of patients.

Additionally, a 4N071 is in training to become a manager or is a mid-level manager responsible for supervising personnel, clinics, and the training of personnel within his or her area of responsibility.

Applying for formal training

Recommendation for training begins with meeting the requirements in the Air Force Enlisted Classification Directory (AFECD), Education and Training Course Announcements (ETCA) found at <https://etca.randolph.af.mil>, and in AFI 36-2626, *Airman Retraining Program*. As shown in figure 1-26, special duties require minimum education, training, and rank levels according to the CFETP. For example, those that apply for the 4N0XX technical training instructor duty are required to have NREMT certification, all qualification training package (QTP), and duty position training requirements for the assigned position.

Application process

Once minimum requirements are met, the following steps explain how to apply. If you decide to retrain and you meet the eligibility requirements, initiate a retraining request using the following procedures:

1. Step 1—Review the retraining advisory to identify AFSCs you may be interested in retraining into.
2. Step 2—Review Air Force Enlisted Classification Directory, for the AFSC description.

NOTE: Review Aptitude Qualification Examination (AQE) requirements for the AFSC you desire to retrain into. You are not currently qualified for that AFSC if your current AQE scores do not meet or exceed the required AQE. You may schedule a retest to try to improve your scores.

3. Step 3—Review retainability requirements for retraining in AFI 36-2626.
4. Step 4—Complete the retraining application by clicking the link.
5. Step 5—Submit your retraining application to the Total Force Service Center. The system will notify your commander that you have submitted an application and give your commander instructions on how to report any changes that might render you ineligible to

retrain. The Total Force Service Center will submit your completed application to the AFPC Retraining Office for final decision. You will be notified on the results of your application.

Education and Training Requirements	Grade Requirements	
	Rank	Special Duty
Upgrade to Journeyman (5-Skill Level) • Certified in all STS Core Tasks • Minimum NREMT certification • QTPs for assigned position • Complete all duty position training requirements	A1C/SrA	• Hyperbaric Technician • Allergy/ Immunization Technician • Aeromedical Evacuation Technician (AET) • Instructor Duty • Neurodiagnostic Technologist (NDT) • Military Entrance Processing Station (MEPS) • IDMT (SrA Only) • Squadron Medical Element (SME) (SrA Only)
Upgrade to Craftsman (7-Skill Level) • Minimum NREMT certification • QTPs for assigned position • Complete all duty position training requirements	SSgt	• IDMT • Flight and Operational Medic Technician • Squadron Medical Element (SME) • Medical Development NCO • Special Operations Command Medic • Hyperbaric • Neurodiagnostic • Aeromedical Consultation Service • Technical Training Instructor
Flight/Squadron/Division Superintendent Senior 4N0	MSgt	• International Health Specialist (IHS)
SNCOA	SMSgt	• Squadron Superintendent
Upgrade to Superintendent (9-Skill Level) • NREMT certification	CMSgt	• MAJCOM level assignments • MAJCOM Functional Manager
Chief Enlisted Manager (CEM) 4N000 • CLC	CMSgt	• Air Force Career Field Manager (AFCFM) • Medical Group Superintendent

Figure 1-26. Education and training requirements.

Additional retraining programs

Remember the core values (service before self)? You cannot leave your AFSC as a 4N0X1 unless there are adequate manning levels. The overall objective is to balance the career force of each AFSC as needed, and this occurs with two programs—the Career Airmen Reenlistment Reservation System (CAREERS) Retraining Program and the Noncommissioned Officer Retraining Program. If applying for an SEI, and special duty or shredout isn't your plan, retraining into another career field is also available. The following information explains the process based on what term of enlistment you fall under at the time of your application.

CAREERS Retraining Program

First Term Airmen (FTA) CAREERS early retraining is allowed at the half-way point (e.g., 4-year enlistee can apply upon completion of 24 months of service; 6-year enlistees can apply upon completion of 36 months of service). Retraining is restricted to 1C2X1 (Combat Control), 1T2X1 (Pararescue), 1T0X1 (Survive, Evasion, Resistance, and Escape [SERE]), 1AXXX (any aircrew AFSC), and 1N3XXX (any linguist skill). In addition, FTA in the following skills may apply for early CAREERS retraining into their lateral shreds: 3P0X1 (Security Forces), 4J0X2 (Physical Medicine), 4N0X1 (Aerospace Medical Service), 4N1X1 (Surgical Service), 4R0X1 (Diagnostic Imaging), and 4V0X1 (Optometry). FTA CAREERS retrainees applying under the early retraining program will be utilizing their one and only CAREERS option.

Airmen stationed overseas may apply for retraining 9 to 15 months prior to the date eligible for return from overseas (DEROS). However, if you are an FTA, eligibility is dependent on the amount of time you are serving (35th month for 4-year enlistees or 59th month for 6-year enlistees.)

The Quality Retraining Program (QRP) board for selection of retraining is conducted the third week of every month. After each QRP board, all applications that were not selected for that board will remain eligible until the next board. All applications meet three consecutive QRP boards and, if not selected, are disapproved. Approvals can take up to 3 to 4 weeks to update.

Because you will compete through the QRP board for the available retraining AFSCs with all other FTAs, Air Force-wide, you are highly encouraged to apply for the maximum number of AFSC choices available on the Request for Retraining.

The QRP board uses the following criteria to rank applications:

1. Most recent EPR.
2. Current grade.
3. Projected grade.
4. Next three EPRs.
5. Date of rank (DOR).
6. Total Active Federal Military Service Date (TAFMSD).
7. AQE score in the applicable area (electrical, mechanical, administrative, or general) requested AFSC preferences.

If you have already applied for retraining and your application was disapproved or cancelled, you may reapply only under the following conditions:

- You were removed from the Air Force career job reservation (CJR) waiting list and not within 120 days of date of separation (DOS). (Airmen in this category will meet one QRP board.)
- You were, through no fault of your own, unable to apply during the retraining window because of reenlistment ineligibility.

As an FTA, you must meet the following criteria to be eligible for *regular retraining* under this retraining program:

- Four-year enlistees must be within the 35th and 43rd month of their current enlistment to apply.
- Six-year enlistees must be within the 59th and 67th month of their current enlistment to apply.
- Must not be under investigation by the Office of Special Investigation (OSI) or law enforcement officials (excluding normal security clearance).
- Most recent EPR must be at least 3 or higher, not be a referral and not be a projected referral. (EPR rating 3 is average, 4 is above average, and 5 is truly among the best.)
- Must not be ineligible for promotion or reenlistment.
- Must not be in Training Status Code "0" (not recommended for entry into upgrade training).

Noncommissioned Officer Retraining Program

The Noncommissioned Officer Retraining Program (NCORP) is for second term Airmen or career Airmen only. As a second term Airman or career Airmen, you must meet the following criteria to be eligible for retraining under this retraining program:

- First, meet eligibility criteria of the Enlisted Retraining Management Section message announced at the start of each fiscal year program.

- NCOs must possess a 5-skill level or above in his or her CAFSC (3-skill level if no 5-skill level exists). Must not be under investigation by the OSI or Law Enforcement officials (excluding normal security clearance).
- Most recent EPR must be at least 3 or higher, not be a referral and not be a projected referral.
- Must not be ineligible for promotion or reenlistment.
- Must not be in Training Status Code “0” (not recommended for entry into upgrade training).

020. Components of your Air Force training record

The Air Force training record (AFTR) is the only means of identifying what has been trained, when it was trained, and when (if applicable) the training is due to be conducted again. Training documentation helps assess capability, individual strengths and weakness, resources needed to support quality patient care and determine scope of practice. It is also a way to meet accrediting agency and regulatory requirements.

The purpose of AFTR is to provide one single location for maintaining all training documentation pertaining to an individual. In the past, various folders were used to group various types of training documentation. The AFTR permits a central location that is easily deployable. This means that wherever a person goes, the folder with his or her entire training history goes with him or her.

The Individual Training Record may also be referred to as the OJT record or the Enlisted Training and Competency Folder.

The following information gives an overview of what is kept in each section of the AFTR. The first steps below indicate how to access AFTR components, followed by more detailed description of its contents and uses according to the CFETP.

To access electronic training record components, follow these steps:

1. Log into ADLS at <https://golearn.csd.disa.mil>.
2. Click on Training Records (fig. 1-27).
3. Click on AFTR logo.
4. If you don't have an AFTR account, click Register.
5. Fill out all information.

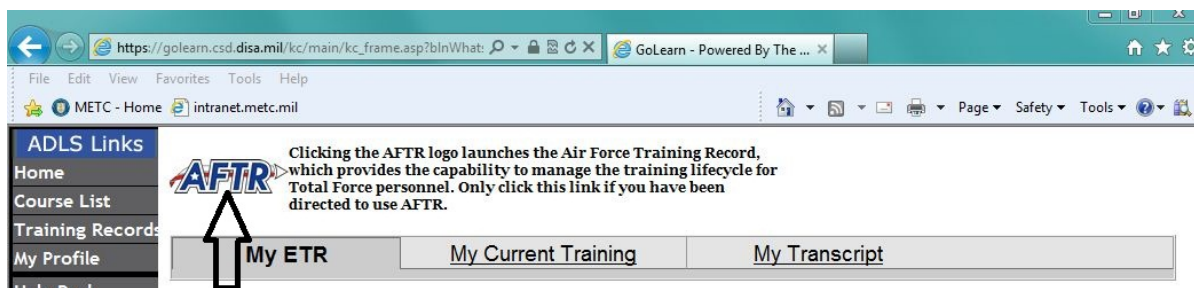


Figure 1-27. Training records.

Menu items

The menu items are located at the top of the AFTR page (fig. 1-28). The items available to the user will vary depending on the assigned role and permission levels associated with the user's role. The following is a complete list of items that may be available in the menu:

- Home: returns you to the welcome screen.
- My AFTR menu.
- My Record: Provides access to the Individual Training Record information for the current user.

- My AFTR Permissions: Shows the current user what permissions they have available to them within AFTR.
- CAC Log On: Allows the current user to associate their common access card (CAC) with the session of AFTR to allow for CAC sign offs.



Figure 1-28. Menu items.

Data menu

The following explains the purpose of each data menu (fig. 1-29):

AFTR Data Menu	
Data Menu	Description
UTL	Allows the UTL to be created, edited, modified, viewed, and copied.
MTL	Allows the MTL (master task list) to be created, edited, modified, viewed, and copied.
DTL	Allows the duty position DTL (duty task list) to be created, edited, modified, viewed, and copied.
MTP	Allows the MTP to be created, edited, and viewed.
STS	Allows the user to view the STS within AFTR.
Update Contact Information	Allows those with the appropriate permission level to update the help desk contact information for each community.
AFTR System Permissions	Allows each permission level to be viewed and to show what each permission level can do within AFTR.



Figure 1-29. Data menu.

Lists menu

The following explains purpose of each lists menu (fig. 1-30):

AFTR Lists Menu	
Lists Menu	Description
Master Catalog	Allows the master catalog items (1098 and 623 III) to be created, edited, modified, and viewed.
Workcenters	Allows workcenters to be created, edited, and viewed.
Units	Allows units to be to be created, edited, and viewed.
Bases	Allows all bases within AFTR to be viewed.
MAJCOMs	Allows all MAJCOMs within AFTR to be viewed.
Functional Communities	Allows all functional communities within AFTR to be viewed.
Specialties	Allows all specialties within AFTR to be viewed.
View AFTR Organizational Structure	Allows views of the structure of AFTR based on MAJCOM, base, unit, and workcenter.



Figure 1-30. AFTR lists.

Manage Users menu

The following explains the purpose of the Manage Users menu (fig. 1-31):

AFTR manage users menu	
Manage Users Menu	Descriptions
Manage Records	Provides access to manage user's training records within AFTR.
Manage User Location	Allows users with the guest role to be set to their proper location within AFTR.
Mass Assign Administrators	Allows the assignment of UTM, workcenter supervisor, immediate supervisor, or temporary supervisor to multiple users.
Deploy Users	Allows for deployment or redeployment back to home location of multiple users.



Figure 1-31. Manage Users.

Reports menu

The menu to run reports (fig. 1-32) includes training status code, training status, task coverage, excessive training summary, excessive training user, CDC pass rate summary, CDC pass rate user, qualification summary, UGT summary, and generalized status.

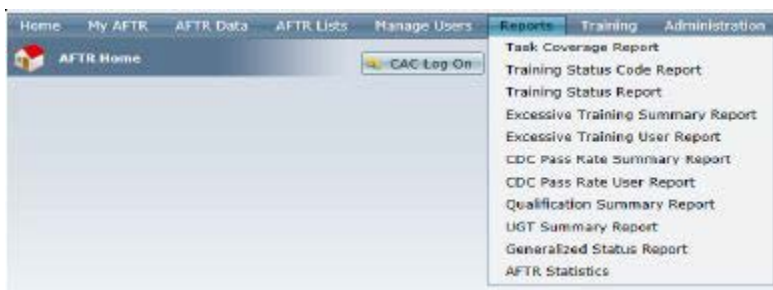


Figure 1-32. Reports.

Training menu

The following table explains purpose of the training menu (fig. 1-33):

AFTR Training Menu	
Training Menu	Description
CFETP	Provides links to the Career Field Education Training Program.
External Web Links	Provides links to external training information related to the Air Force.



Figure 1-33. Training.

Administration menu

This AFTR menu (fig. 1-34) provides maintenance help and the ability to update the server cache for administrators of AFTR.



Figure 1-34. Administration.

User login link

The user login link (fig. 1-35) is shown under the Navigation bar on the right hand side of the screen. This link opens a new window that displays the roles that have been assigned to the current user.

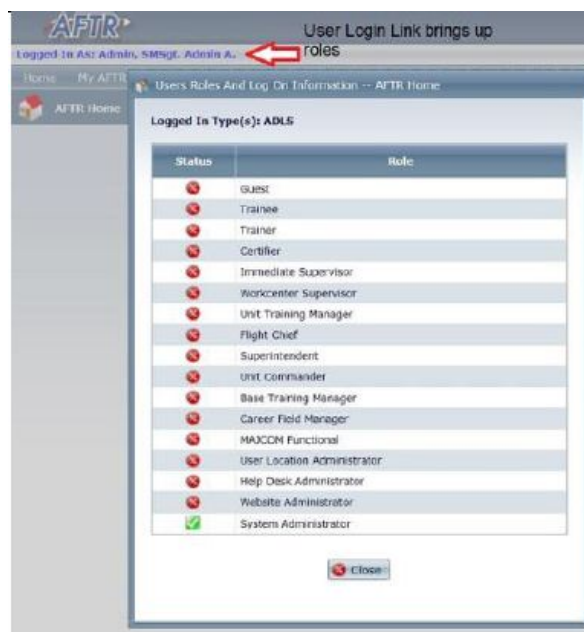


Figure 1-35. User login.

021. Updating Profile I

Profile I (fig. 1-36) in AFTR contains your training location information. The following information explains steps to keep information current. There are five sections in Profile I: (1) User Roles; (2) User Administrators; (3) User Status Information; (4) User Location; and (5) User Training Information.

Home My AFTR AFTR Data AFTR Lists Manage Users Reports Training

User Profile [Change Section](#) [Export](#)

Cole, E-B - (SMSgt) Christopher Dacosta (Active)

* Indicates a required field

User Roles

Roles *

☐ Guest

☒ Trainee

☒ Trainer

☒ Certifier

☒ Immediate Supervisor

☒ Workcenter Supervisor

☐ Unit Training Manager

☐ Flight Chief

☐ Superintendent

☐ Unit Commander

☐ Base Training Manager

☐ Career Field Manager

☐ MAJCOM Functional

☐ User Location Administrator

☐ Help Desk Administrator

☐ Website Administrator

☐ System Administrator

User Location

MAJCOM: *

AETC -- Air Education and Training Command

Base: *

Fort Sam Houston, TX

Unit: *

383 TRS

Workcenter: *

TRR-Training Resources Element

Functional Community: *

AFMS -- Air Force Medical Service

Specialty: *

4N0X1 -- Aerospace Medical Service

User Training Information

Duty Position: *

4N0 - CDC Writer

Date Entered Duty Position: *

September 21, 2011

Training Status Code: [Details](#)

R

Date Entered Upgrade Training (UGT):

Completed Air Force Training Course:

Yes

Special Experience Identifiers (SEI): [Details](#)

☐ 001 -- Arms Control

☐ 003 -- Victims Advocate

☐ 005 -- AFSC21 Level I Certification

☐ 006 -- AFSC21 Level II Certification

☐ 007 -- AFSC21 Level III Certification

☐ 012 -- Weapons of Mass Destruction Civil Support Team (WMD-CST) Member

☐ 020 -- Joint Special Operations Experience

☐ 021 -- Joint Special Operations Task Force Experience

☐ 031 -- Crime Prevention/ Resources Protection

☐ 032 -- Budget Experience

☐ 042 -- Special Planner

☐ 045 -- Tactical Air Control System Direct Air Support Center/Air Support Operations Center (TACS DASC/ASOC)

[Update](#)

Figure 1-36. Profile I.

User Roles

User Roles are updated by the UTM. User Administrators is updated by the UTM or the supervisor (if incorrect contact your UTM or supervisor). User Status Information is automatically updated by AFTR. User Location is updated by clicking My Profile, then entering a specific root and sub organization.

User Roles are assigned by the UTM upon your arrival to your first permanent duty section. It lists what roles you are granted in AFTR based on your training status. For example, graduates of 4N0X1 technical school are assigned the Trainee role upon arrival at their first duty station. Airmen in ranks of SrA-TSgt may hold the role of trainer as their experience is utilized to train younger Airmen AB-A1C. MSgt and higher usually hold the role of certifiers or other supervisory functions such as flight chief/NCOIC or superintendents. There are higher roles held at base/MAJCOM/AF levels; those are assigned to base training managers, MAJCOM functionals, and CFMs. The last roles are personnel that maintain the AFTR Web site; they involve help desk personnel and Web site and system administrators.

User Administrator

The User Administrator area in Profile I list names of assigned UTMs, workcenter, and immediate or temporary supervisors. These are personnel that manage people in the duty section, and they make sure everyone gets trained according to AFI 36-2201.

User Status

User Status Information displays if your access to AFTR is locked and also shows if user has an active AFTR account. Too many login attempts with incorrect username/password can lock your account. Upon separation/retirement, your user account is archived and will be no longer active.

User Location

The User Location section displays user assignment by MAJCOM, base, unit, workcenter, functional community, and specialty. Your responsibilities here involve ensuring the location is current; changes can be made by clicking My Profile and editing root and suborganizations using the Expand/Select links as shown in figures 1-37 and 1-38.

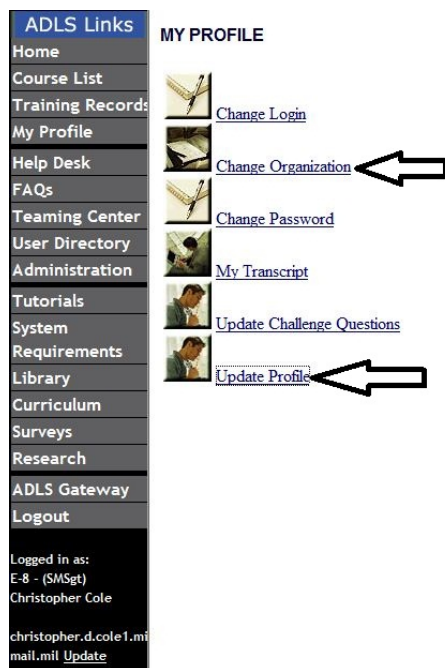


Figure 1-37. User location.

Figure 1-38. Organization change form.

User Training

User Training information displays duty position and date assigned to current duty section. Also listed is training status code A through Y; each letter displays your training level (i.e., a 4N031 in upgrade training to 4N051 is assigned code B [see AFI 36-2201 for full listing]). It's very important to make sure all areas in Profile I are current at all times; incorrect information negatively affects training progression and progress in your career field. If the information is incorrect contact your UTM.

Change Organization function

Change Organization allows you to change your organization affiliation in user location section. Your current organization is shown. To identify a new organization, select an organization from the menu below. To find divisions within that organization, click Expand. To choose the highlighted organization, click Select. Please make sure to expand down to the deepest level possible. Once the Expand button no longer shows a new sub organization, you have reached the deepest level available. To exit without changing your organization, click Cancel.

Update Profile

To update your profile, click Update Profile (fig. 1-39) then edit the field(s) and click Submit. To restore the original information in all fields, click Reset. To exit without changing any information, click Cancel. All required fields are marked with an asterisk (*).

To modify existing information, edit the field(s), then click **Submit**. To restore the original information in all fields, click **Reset**. To exit without changing any information, click **Cancel**. All required fields are marked with an asterisk (*).

ADLS Links

- Home
- Course List
- Training Records
- My Profile
- Help Desk
- FAQs
- Teaming Center
- User Directory
- Administration
- Tutorials
- System
- Requirements
- Library
- Curriculum
- Surveys
- Research
- ADLS Gateway
- Logout

Logged in as:
E-8 - (SMSgt)
Christopher Cole
christopher.d.cole1.mil@mail.mil Update

* **First Name:** Christopher

* **Middle Name:** Dacosta

* **Last Name:** Cole

* **Email:** christopher.d.cole1.mil@mail.mil

* **Re-Enter Email:** christopher.d.cole1.mil@mail.mil

Secondary Email:

* **Functional Communities:** AFMS -- Air Force Medical Service

* **Rank:** E-8 - (SMSgt)

Address 1:

Address 2:

* **Base:** Ft Sam Houston -OR- **City:**

* **State:** Texas

Province/Other:

Zip:

Country: United States

* **Primary Phone:** 2108085126 **Commercial** **DSN**

Secondary Phone: **Commercial** **DSN**

Fax: **Commercial** **DSN**

Mobile Phone: @ Provider

* **UTM/UDM's Email:**

Submit **Reset** **Cancel**

Figure 1-39. Update profile information.

022. Enrolling in AF Form 623 Part I/II/III

The content of your AFTR is protected under the Privacy Act of 1974; any AFTR user with an established training record signs this. Your signature provides acknowledgement that training records are handled in accordance within Privacy Act laws, and the use of the folders is to solely document, monitor, and maintain a comprehensive record of an individual's training.

AF 623 Part I

Before signing your AFTR records, follow these steps to update identification blocks (fig. 1-40):

1. Click Training Menu bar.
2. Click and enter current DAFSC.
3. Click Trainee.
4. Enter username and password to sign or utilize your CAC.

Figure 1-40. AF 623 Part I.

AF 623 Part II

AF 623 Part II contains documentation when trainees are enrolled in 4N051A/4N051B/4N071 CDC courses. It also lists the title of all enrolled CDCs to include volume title and set information. The UTM enrolls each user in CDCs once the trainee arrives at a permanent base after graduation from technical training school and phase II or III (if applicable) training. CDC progress is updated by following these steps:

1. Select My User Record.
2. Select AF 623 Part II.
3. Select UTILIZE FUNCTION buttons (left of screen) to enter CDC set information.
4. Supervisors UTILIZE FUNCTION buttons (left of screen) to enter start and complete dates for CDC volumes.
5. Supervisor also enters unit review exercise date/score throughout the completion of each CDC set by selecting Click to Select, and then the appropriate FUNCTION buttons (left of screen).

If training dates change (upon approval from chain of command and UTM), supervisors edit and adjust the timeframe as required. The items in this section are the driving factor that makes AFTR an actual OJT record. Ensure documentation is completed accurately. AF Form 623 Part II is recognized by the personnel system in contingencies and deployments as the official formal training record.

CDC pre-final exam

Upon completion of each CDC set (figs. 1-41 and 1-42), supervisors should give trainee a pre-exam to measure if Airmen are ready for the end-of-course exam. As shown in figure 1-42, documentation is accomplished by doing the following:

1. Clicking (Pre-Exam 1 Date) link to enter date, score, and pass/fail results.
2. If the trainee is successful and also passes the end-of-course exam, click Final Exam 1 Date to input test results in the proper pre or final exam score box.
3. Click the Update link to save information.

Home My AFTR AFTR Data AFTR Lists Manage Users Reports Training

AF Form 623 Part II [Change Section](#) [Legend](#) [Export](#)

Click to change section on user's record

Options

[Search Record](#)

[View Record](#)

[View Record](#)

[View Record](#)

[View Record](#)

[View Record](#)

[View Record](#)

Function Buttons

AEROSPACE MEDICAL SERVICE JOURNEYMAN(4N051A) (Deactivated) >> ECI/CDC Participation, etc.

	Volume Title	Start Date	Complete Date	Due Date	URE Score
<input type="checkbox"/>	AEROSPACE MEDICAL SERVICE JOURNEYMAN - VOLUME 1	February 02, 2004	March 03, 2004	March 03, 2004	
<input type="checkbox"/>	AEROSPACE MEDICAL SERVICE JOURNEYMAN - VOLUME 2	March 03, 2004	April 02, 2004	April 02, 2004	
<input type="checkbox"/>	AEROSPACE MEDICAL SERVICE JOURNEYMAN - VOLUME 3	April 02, 2004	May 03, 2004	May 03, 2004	
<input type="checkbox"/>	AEROSPACE MEDICAL SERVICE JOURNEYMAN - VOLUME 4	May 03, 2004	June 02, 2004	June 02, 2004	

Click to select

Set Information

Date Issued: Enrolled Date: Estimated Completion Date: Course Completion Date:

Set Exam Information

Pre-Exam 1 Date: Pre-Exam 1 Score: Pre-Exam 1 Pass/Fail:

Pre-Exam 2 Date: Pre-Exam 2 Score: Pre-Exam 2 Pass/Fail:

Pre-Exam 3 Date: Pre-Exam 3 Score: Pre-Exam 3 Pass/Fail:

Final Exam 1 Date: Final Exam 1 Score: Final Exam 1 Pass/Fail:

Final Exam 2 Date: Final Exam 2 Score: Final Exam 2 Pass/Fail:

Figure 1-41. CDC Enrollment.

Selected Set:
SERVICES JOURNEYMAN (SERVICES GENERAL AND FOOD)(3M051A) (Archived)

* Indicates a required field

enter in test score

click to change Pass\Fail Info

Pre-Exam 1 Information

Pre-Exam 1 Date: Pre-Exam 1 Score: Pre-Exam 1 Pass\Fail:

enter date manually or click calendar to select date

Pre-Exam 2 Information

Pre-Exam 2 Date: Pre-Exam 2 Score: Pre-Exam 2 Pass\Fail:

Pre-Exam 3 Information

Pre-Exam 3 Date: Pre-Exam 3 Score: Pre-Exam 3 Pass\Fail:

Final Exam 1 Information

Final Exam 1 Date: Final Exam 1 Score: Final Exam 1 Pass\Fail:

Final Exam 2 Information

Final Exam 2 Date: Final Exam 2 Score: Final Exam 2 Pass\Fail:

click to close and return to main 623 II page

click to save information

Figure 1-42. CDC Set Information.

AF 623 Part III

The 623 III page contains the *formal training information*. Formal courses are designed to provide the skills, knowledge, or classroom instruction on all tasks taught in the initial skills courses identified in the STS.

1. After selecting the AF Form 623 Part III – Formal Training option from the model dialog selection, the 623 Part III page will open with a model dialog selection box with field options: Training Type and Specialty. The user must select options here in order to view their 623 Part III items.

The Training Type drop down menu will contain *either* Qualification Training **or** Entire Training Record. If Qualification Training is selected, only 623 III marked as qualification training will be displayed. If Entire Training Record is selected, the specialty will not be an option. After the search is performed, all 623 III items will be displayed.

2. The Specialty drop down will contain all the specialties the user has on their record.

The 623 III items will be listed with the Course Title, Start Date, Complete Date, and Due Date displayed. The items will be listed in alphabetical order based on the Course Title. To search for additional 623 Part III items, click the SEARCH RECORD button (figs. 1-43 and 1-44). A user will not be able to edit any 623 III items from their own record.



Figure 1-43. Search Menu 1.

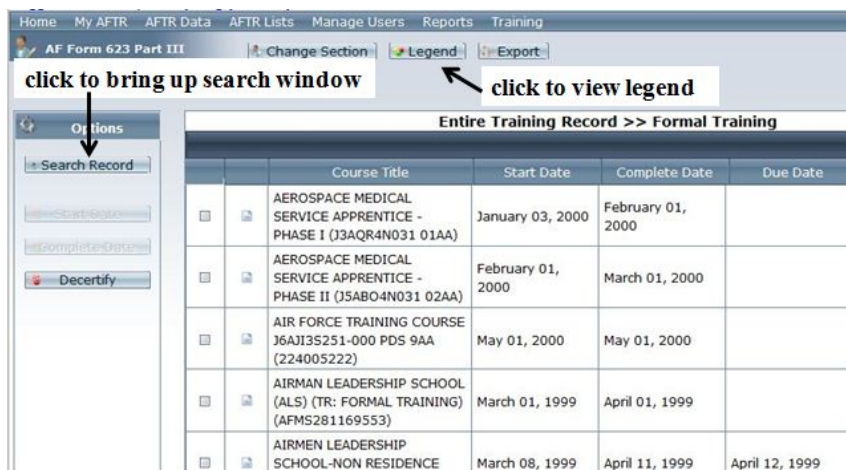


Figure 1-44. Search Menu 2.

023. How to document training progress on AF 623a

The AF 623a is used to chronologically document an individual's training progress as it occurs (figs.1-45 and 1-46). This includes facility orientation, unit orientation, upgrade training, CDC progress, failures, corrective actions, and any other pertinent information. In addition, decertification procedures and periodic reviews by the supervisor, trainer, and certifier are also documented here. Progress for individuals in upgrade training status must be documented at least monthly (per CFETP). The Job Description/Performance Standard/Initial Evaluation is typed and printed on a 623a by the supervisor, reviewed jointly by the supervisor and subordinate, and then acknowledged by signatures on this form. The supervisor and the trainee must sign all entries on this form.

Manage 623a Entries | [Change Section](#) | [Export](#) | **Click to export 623a items**

Click to change section on user's record

On-The-Job Training Record Continuation Sheet

Record Date	Record Type	User Signature	Administrator Signature	User Comments	Administrator Comments
July 03, 2013 02:17:43 PM	General Training Comment				
July 02, 2013 05:17:20 PM	General Training Comment				
June 28, 2013 03:32:52 PM	General Training Comment				

Function Buttons | **click to view user comments** | **click to view Admin comments**

Figure 1-45. AF 623a.

Add/Edit Form 623a Entry | [Users Search](#) | [Change Section](#)

(Active)

* Indicates a required field

Sign Off Information

Log On ID:

Password:

enter in Log On ID information for sign off

click to return to user search

click to change section on user's record

Record Type: **click to select**

Comments:

any comments made here will be added to the 623a Form

Words: 0 Characters: 0

click to add 623a | **click to cancel and return to main 623a page**

Figure 1-46. Edit AF 623a.

When a user is in their own 623a record, they will only be able to add a general comment 623a to their own record. They will also be able to sign off on a 623a item that was created by an administrator for their record.

Add a 623a entry item

To add an item, do the following:

1. Click My AFTR.
2. Click My Record.
3. Click 623a, On-The-Job Training Record Continuation Sheet.
4. Click the ADD button. The Add/Entry Form 623a entry page will be displayed. Only a general training comment can be added by a user to own record.
5. Enter in the Log On ID and password or user the CAC sign off.
6. Enter in the comment in the rich text field and click add and a new 623a entry will be added to the user's record. After a 623a entry is added successfully, a success message will be displayed and the main 623a page will be displayed.

Administrator sign off

If an administrator wants to sign off on a 623a entry:

1. Click the ADMINISTRATOR button and enter in the Log On ID and password or use the CAC sign off.
2. Enter in the comments in the rich text field and click the UPDATE button.

After a 623a entry is signed off by an administrator, a success message will be displayed and the main 623a page will be displayed.

User sign off

If the user wants to sign off on a 623a entry:

1. Click the USER button and enter in the Log On ID and password or use the CAC sign off.
2. Enter in the comments in the rich text field and click the UPDATE button.

After a 623a entry is signed off by the user, a success message will be displayed and the main 623a page will be displayed.

View comments

To view user comments (fig. 1-47), click on the folder next to the 623a entry and a new window will display with the user comments for that particular entry.

To view the administrator comments, click on the folder next to the 623a entry and a new window will display with the Administrator comments for that particular entry.



Figure 1-47. Comments.

024. Enroll users into AF Form 1098, Special Task Certification and Recurring Training

The 1098 tab contains the AF Form 1098. This form is used by supervisors to document selected tasks requiring recurring training or evaluation. The following describes the step-by-step approach in using the AF Form 1098 to document training in a workcenter.

Selecting AF Form 1098

After selecting the AF Form 1098 option from the model dialog selection, the 1098 page will open with a model dialog selection box with Training Type and Specialty as the field options. The user must select options here in order to view their 1098 items.

The Training Type drop down contains either Qualification Training or Entire Training Record. If Qualification Training is selected, then AF Form 1098 items marked as required for qualification training are displayed. Likewise, if Entire Training Record is selected, the specialty is not an option. After the search is performed, all AF Form 1098 items are displayed. The Specialty drop down contains all the specialties the user has on his or her record.

Updating AF Form 1098

A user is not able to assign a start date or edit a task that is on his or her personal record (fig. 1-48). If a user wants to search for a different set of 1098 items then he or she does the following:

1. Click the SEARCH RECORD button. Only items already assigned a start date will be able to be signed off on the user's record. For a user to sign a 1098 item:
 - a) Click the check box next to the task(s) and then press the TRAINEE button. A prompt will open to confirm the task sign off.
 - b) Click the TASKS SELECTED button to verify which task(s) have been selected.
 - c) Enter the Trainee Log On ID and Password or use the CAC sign off. Click the UPDATE button to submit the sign off. A prompt will open to confirm the sign off on the selected task(s).

- d) Click the check box next to the task(s) (fig. 1-49) and then press the CERT. OFFICIAL button. A prompt will open to confirm the task sign off.
2. Click the TASKS SELECTED button to verify which task(s) have been selected.
3. Enter the Certifying Official Log On ID and Password or use the CAC sign off. Click the UPDATE button to submit the sign off. A prompt will open to confirm the sign off on the selected task(s).

Function Buttons											
Entire Training Record >> Special Task Certification and Recurring Training											
	Task Title	Start Date	Complete Date	Trainee	Certifying Official	Due Date	Training Type	Frequency	Due Period	Score or Hours	
<input type="checkbox"/>	(EQUIP) BEAR HUGGER (AFMS131400600)							12 mo	14		
<input type="checkbox"/>	(EQUIP) BELMOUNT/LEVEL 1 RAPID INFUSER (AFMS463279331)							12 mo	14		
<input type="checkbox"/>	(EQUIP) CODMAN INTERFACE UNIT (AFMS909741186)							12 mo	14		
<input type="checkbox"/>	(EQUIP) CODMAN MONITOR (AFMS457874120)							12 mo	14		

Figure 1-48. 1098 information.

1 (Active)

Tasks Selected

* Indicates a required field

Sign Off Information

Trainee Log On Id: *

Password: *

Trainee Sign Off

Update Cancel

Figure 1-49. 1098 update.

Decertify 1098 item

A user cannot decertify their own 1098 item (figs. 1-50 and 1-51). To decertify a task, the certifying official follows these steps:

1. Select the task(s) and click the DECERTIFY button to decertify a trainee on previously completed 1098 task(s).
2. A prompt will open to confirm decertifying the task. Click the TASKS SELECTED button to verify which task(s) have been selected.
3. Enter the Login ID and Password of the Administrator. Enter additional text to the Additional 623a comments box.
4. Click the UPDATE button to submit the task decertification. A prompt will open to confirm the decertification of the task.

(Active)

Tasks Selected ← tasks being modified

* Indicates a required field

Sign Off Information

Certifier Log On Id: *

Password: *

← Certifying Official Sign Off

Update Cancel ← click to cancel and return to 1098 page

← click to submit signature

Figure 1-50. Decertify 1098.

(Active)

Tasks Selected ← selected tasks

* Indicates a required field

Sign Off Information

Administrator Log On Id: *

Password: *

← Administrator Sign Off

Update Cancel ← click to cancel and return to 1098 page

← click to decertify

Additional 623a Comments

Figure 1-51. Decertify 1098 Item.

Recertification of a 1098 item

It is possible to recertify a 1098 item. To do so, follow these procedures:

1. Select the task(s) and click the RECERTIFY button to recertify the current user on a 1098 task(s) (fig. 1-52). A prompt will open to confirm the recertification of the task. A user will not be able to sign off on the Administrator portion of the recertification on his or her own 1098 task.
2. Click the TASKS SELECTED button to verify which task(s) are selected. Enter the Trainee Login ID and Password.
3. Enter the Login ID and Password of the Administrator. An additional comment will be added to the 623a entry by adding text to the Additional 623a comments box.
4. Click the UPDATE button to submit the task recertification. A prompt will open to confirm the recertification of the task.

The screenshot shows the AFTR 1098 Recertification form. At the top, there is a navigation bar with links like 'My AFTR', 'AFTR Data', 'AFTR Info', 'Manage Users', 'Reports', 'Training', and 'Administration'. Below this, the form is titled 'AFTR 1098 Recertification' and includes buttons for 'Users Search' and 'Change Section'. A status indicator '(Active)' is shown. A red arrow points to the 'Tasks Selected' button with the text 'Tasks being modified'. Below this, a section for 'Start Date Information' contains 'Start Date' and 'Due Date' fields, with a red arrow pointing to the 'Start Date' field labeled 'Recertification Date'. A section for 'Complete Date Information' contains a 'Complete Date' field. Below this is the 'Trainee Sign Off Information' section, which includes a text area for 'Trainee Log On ID' and a 'Password' field, with a red arrow pointing to the 'Trainee Log On ID' field labeled 'Trainee Sign Off'. The 'Administrator Sign Off Information' section follows, with a text area for 'Administrator Log On ID' and a 'Password' field, with a red arrow pointing to the 'Administrator Log On ID' field labeled 'Admin Sign Off'. A note states: 'NOTE: An automatic entry indicating the task recertification will be placed in the user's AF form 623a. The box below is to add any additional comments to the automatic AF form 623a entry.' Below the note is the 'Additional Form 623a Comments' section, which is a large text area. At the bottom, there are 'Update' and 'Cancel' buttons. A red arrow points to the 'Update' button labeled 'click to recertify', and another red arrow points to the 'Cancel' button labeled 'click to cancel and return to 1098 page'.

Figure 1-52. Recertify 1098 Item.

Transcribe a 1098 item

Select the task(s) and click the TRANSCRIBE button to transcribe 1098 task(s). A user will not be able to transcribe his or her own 1098 item. A prompt will open to confirm the transcription of the task.

1. Click the TASKS SELECTED button to verify which task(s) have been selected. The user and the administrator have the ability to sign off on the task transcription at a later date, or they can immediately certify that the 1098 tasks listed were transcribed for the specified specialty and location.
2. The user must enter their Login ID and Password or use the CAC sign off.
3. The administrator must enter the Administrator Login ID and Password.
4. The administrator must select a completion date from the Select a Date drop-down menu.
5. The user should enter comments in the Additional 623a Comments block if additional comments are needed.
6. Click the UPDATE button to transcribe the task (fig. 1-53). A prompt will open to confirm the transcription of the task.

7. Select the task(s) and click the EXPORT button on the right-hand side of the screen to export a 1098 task(s). Answer the prompt to confirm the export and select the export format type of .pdf, .doc, .xls, or .rtf. The 1098 document can be saved or printed.

The screenshot shows the 'AF Form 1098 Transcription' web interface. At the top, there is a 'Change Section' link. Below it, a 'Tasks Selected' dropdown menu is annotated with 'Task being modified'. A red asterisk indicates a required field. The 'Complete Date Information' section has a 'Complete Date' field annotated with 'Completion Date'. The 'Trainee Sign Off Information' section has a dropdown menu for 'Do you want to sign the trainee portion at a later date?' annotated with 'Trainee Sign Off'. The 'Administrator Sign Off Information' section has a dropdown menu for 'Do you want to sign the administrator portion at a later date?' and a text area for 'Administrator Log On Id' annotated with 'Administrator Sign Off'. Below this is a 'Password' field and a checkbox for 'Use The Current CAC Account'. A note states: 'NOTE: An automatic entry indicating the task transcription will be placed in the user's AF Form 623a. The box below is to add any additional comments to the automatic AF form 623a entry.' Below the note is a text area for 'Additional Form 623a Comments' with a 'Click to transcribe' button. At the bottom, there is a 'Words: Characters: 0' counter and a 'Click to cancel and return to 1098 page' button. The 'Update' and 'Cancel' buttons are at the very bottom.

Figure 1-53. Transcribe 1098 Item.

Qualification training packages

Use this section to document ongoing completion of QTP. Supervisors develop AF Form 1098 overprints that group specific QTPs required within the duty section. The initial completion of a QTP is documented in the individual's STS. All recurring QTP training is documented in this section. The actual QTP is not maintained in AFTR, but rather in the duty section's MTP.

Readiness training

Readiness Skills Verification Program (RSV or RSVP) training is documented in the 1098 section. Members with a fully qualified AFSC must maintain the currency of skills to perform their duties in a deployed setting. RSV training is documented on the form available on the RSVP Web site. Other training documented in this section will be task qualification training such as self-aid and buddy care (SABC); Chemical, Biological, Radiological, Nuclear and High-Yield Explosive (CBRNE) and other readiness-required training. Required training will vary depending on team assignments and AEF requirements.

025. Enrolling users into the job qualification standard

The job qualification standard (JQS) contains all tasks in your AFSC according to your CFETP. It provides a listing of tasks identified by skill level 3, 5, 7, and 9. During the timeframe you are assigned a trainer, each task is trained and when you can perform the task successfully without assistance the task is signed off by both trainee and trainer. There are some tasks indicated by a > that require a certifier signature, and they are shown in the STS. The user will not be able to assign a start date on their JQS item; supervisors and trainers input start date and once trainee and trainer have signed the complete date is automatically updated. See the instructions below and figure 1-54 for assessing all STS tasks by each category.

Figure 1-54. JQS options.

JQS menu

Follow these steps to view workcenter JQS:

1. Select the JQS option from the model dialog selection.
2. The JQS page will open with a model dialog selection box with Training Type, Specialty, and STS Publication Date as the field options to choose from
3. The user must select options here in order to view their JQS items. There are three fields to choose from in the JQS search box. All three fields must have selections in them to perform the search.
 - a. The *Training Type Field* contains the options:
 - Qualification training.
 - Upgrade training.
 - All STS core tasks.
 - All STS UTC tasks.
 - Entire training record.
 - b. The *Specialty Field* contains all the specialties the user has on their profile.
 - c. The *STS Publication Date Field* contains all the STS publications related to the specialty selected.
4. After the user clicks SELECT to perform the search, the selected JQS information will be displayed showing the fields:
 - Task Title.
 - Start Date.

- Complete Date.
- Trainee.
- Trainer.
- Certifier.
- Due Date.

A user will not be able to assign a start date on their JQS item. An administrator will have to assign the start date from the Manage Records page.

Trainee responsibilities

If a task already has a start date (fig. 1-55), follow these steps:

1. Select a task and click the TRAINEE button to sign off as a Trainee on the JQS form. A prompt will open to confirm signing off the Trainee for the selected task.
2. Click the TASKS SELECTED button to view information in the View JQS Tasks Selected pop-up to verify which task(s) have been selected.
3. Enter the Trainee Login ID and Password or use the CAC sign off.
4. Click the UPDATE button to submit the sign off. A prompt will open to confirm signing off on the selected tasks.

(Active)

Tasks Selected Tasks being modified

* Indicates a required field

Sign Off Information

Trainee Log On Id: *

Password: *

Use The Current CAC Account

Update Cancel

click to cancel and return to JQS page

click to submit signature

Figure 1-55. JQS items trainee.

Trainer responsibilities

If a task already has a start date (fig. 1-56), follow these steps:

1. Select a task and click the TRAINER button to sign off as a Trainer on the JQS form. A prompt will open to confirm signing off the Trainer for the selected task.
2. Click the TASKS SELECTED button to view information in the View JQS Tasks Selected pop-up to verify which tasks(s) have been selected.
3. Enter the Trainer Login ID and Password. Click the UPDATE button to submit the sign off. A prompt will open to confirm signing off on the selected tasks.

Figure 1-56. JQS items trainer.

Certifier responsibilities

If a task already has a start date (fig. 1-57), follow these steps:

1. Select a task and click the CERTIFIER button to sign off as a Certifier on the JQS form. A prompt will open to confirm signing off the Certifier for the selected task.
2. Click the TASKS SELECTED button to view information in the View JQS Tasks Selected pop-up to verify which task(s) have been selected.
3. Enter the Certifier Login ID and Password. Click the UPDATE button to submit the sign off. A prompt will open to confirm signing off on the selected tasks.

Figure 1-57. JQS items certifier.

Decertification

To decertify a trainee on a previously completed JQS task as a certifier or administrator (fig. 1-58) follow these steps:

1. Select the task(s) and click the DECERTIFY button to decertify a Trainee on previously completed JQS task(s). A prompt will open to confirm decertifying the task.
2. Click the TASKS SELECTED button to verify which task(s) have been selected.
3. Enter the Administrator Log On ID and Password. Additional text will be added to the 623a when text is in the Additional 623a comments box.
4. Click the UPDATE button to submit the task decertification. A prompt will open to confirm the decertification of the task.

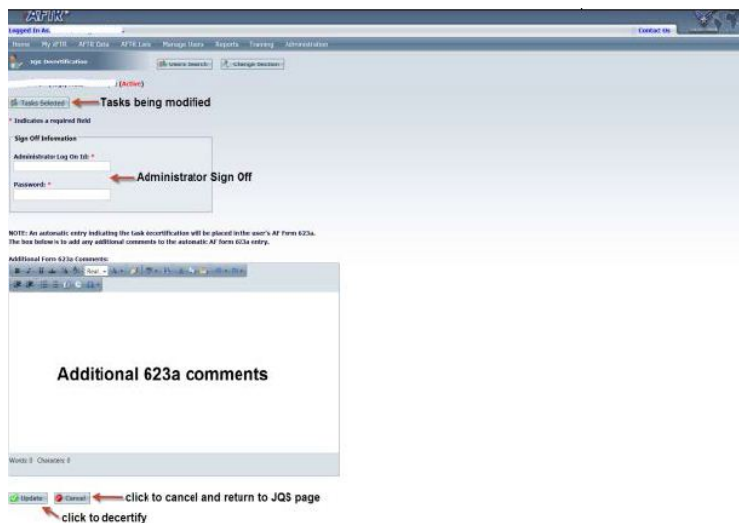


Figure 1-58. Decertify items certifier.

Exporting JQS items

To export JQS items, select the task(s) and click the EXPORT button on the right-hand side of the screen. Answer the prompt to confirm the export and select the export format type of .pdf, .doc, .xls, or .rtf. The JQS document can be saved or printed.

026. Completing AF Form 797 and AF Form 803

AF Form 797 list tasks requiring training and certification for a particular job type or duty position not otherwise included in the STS. One example is the CDC writer job. Task proficiency is documented on an AF Form 797 because it is unique to the position and not included in the CFETP. Additionally, tasks waived by the MAJCOM are also included on AF Form 797 (fig. 1-59).



Figure 1-59. AF Form 797 menu.

AF 797 menu items

The steps to view the AF 797 items are the same as the steps for other forms. After selecting the AF Form 797, Job Qualification Standard Continuation/Command JQS, option from the model dialog selection, the 797 page will open with a model dialog selection box with Training Type and Specialty as the field options. The user selects options here in order to view their 797 items. The Training Type drop down will contain either Qualification Training or Entire Training Record. If Qualification Training is selected, 797 items marked as qualification training will be displayed. If Entire Training

Record is selected, the specialty will not be an option. After the search is performed, all 797 items will be displayed. The Specialty drop down will contain all the specialties the user has on their record.

Trainee

A user will not be able to assign a start date on his or her individual record. If a user wants to search for a different set of 797 items, click the SEARCH RECORD button. Only items already assigned a start date will be able to be signed on the user's record. For a user to sign a 797 item, click the check box next to the task(s) and then press the TRAINEE button (fig. 1-60). A prompt will open to confirm the task sign off. Click the TASKS SELECTED button to verify which task(s) have been selected. Enter the Trainee Log On ID and Password or use the CAC sign off. Click the UPDATE button to submit the sign off (fig. 1-61). A prompt will open to confirm the sign off on the selected task(s). Click the check box next to the task(s) and then press the TRAINER button. A prompt will open to confirm the task sign off. Click the TASKS SELECTED button to verify which task(s) have been selected. Enter the Trainer Log On ID and Password or use the CAC sign off. Click the UPDATE button to submit the sign off. A prompt will open to confirm the sign off on the selected task(s).

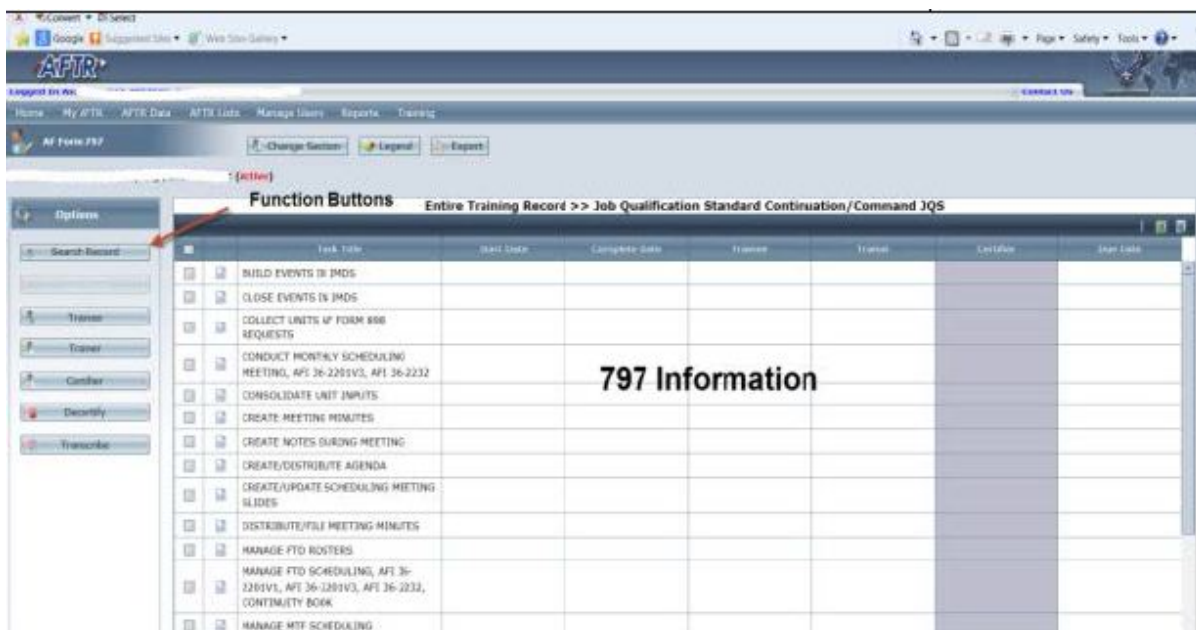


Figure 1-60. 797 information.

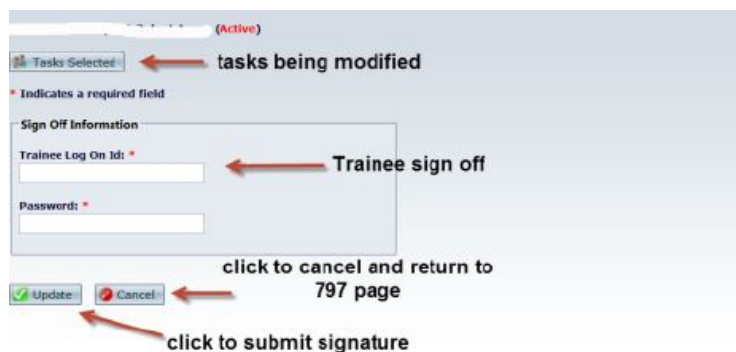


Figure 1-61. 797 trainee signature.

Trainer

Once you have evaluated a trainee on a training task, document that completion in the AFTR. Follow the following steps to sign off on a task specified in the MTP as it pertains to your duty section. The trainee must successfully perform all the steps needed to complete the task without assistance.

1. Click the check box next to the task(s) and then press the CERTIFIER button. A prompt will open to confirm the task sign off.
2. Click the TASKS SELECTED button to verify which task(s) have been selected.
3. Enter the Certifier Log On ID and Password or use the CAC sign off.
4. Click the UPDATE button to submit the sign off (fig. 1-62). A prompt will open to confirm the sign off on the selected task(s).

Figure 1-62. 797 trainer signature.

Certifier

If personnel fail to perform a task that was previously certified, then follow these steps to decertify the task.

1. Select the task(s) and click the DECERTIFY button to decertify a Trainee on previously completed 797 task(s). A prompt will open to confirm the decertification of the task.
2. Click the TASKS SELECTED button to verify which task(s) have been selected.
3. Enter the Administrator Login ID and Password or the CAC sign off. An additional comment will be added to the 623a entry by adding text to the Additional Form 623a comments box.
4. Click the UPDATE button to submit the task decertification (fig. 1-63). A prompt will open to confirm the decertification of the task.

Figure 1-63. 797 certifier signature.

AF Form 797 Task Transcribe

Task transcription might be required when a new CFETP is published and a new training record is needed to display new changes. You will not start a new training record that is empty when this occurs without first documenting tasks previously signed off in a past training record. To accomplish this function, follow the steps below to ensure your personnel don't lose any task that were previously completed.

1. Select the task(s) and click the TRANSCRIBE button to transcribe 797 Task(s). A prompt will open to confirm the transcription of the task.
2. Click the TASKS SELECTED button to verify which task(s) have been selected. The Trainee and the Administrator have the ability to sign off on the transcription at a later date. The Trainee and Administrator can immediately certify that the 797 tasks were transcribed.
3. Enter the Administrator Login ID and Password. An additional comment will be added to the 623a entry by adding text to the Additional 623a comments box.
4. Click the UPDATE button to submit the task transcription (fig. 1-64). A prompt will open to confirm the transcription of the task.

AF Form 797 Transcription

Andersson, E-4 (50K) Robert Aaron (Active)

courses being modified

* Indicates a required field

Complete Date Information

Complete Date: *

complete date

Trainee Sign-Off Information

Do you want to sign the trainee portion at a later date? *

Trainee: I certify that the 797 tasks listed were transcribed correctly.

Trainee Log On Id: *

Trainee Sign Off

Password: *

Administrator Sign-Off Information

Do you want to sign the administrator portion at a later date? *

Administrator: I certify that the 797 tasks listed were transcribed correctly.

Administrator Log On Id: *

Administrator Sign Off

Password: *

NOTE: An automatic entry indicating the task transcription will be placed in the user's AF Form 623a. The box below is to add any additional comments to the automatic AF form 623a entry.

Additional Form 623a Comments:

Additional Administrator 623a Comments

Words 0 Characters 0

Update Cancel

click to submit

click to cancel transcription

Figure 1-64. 797 transcribe.

Exporting AF Form 797

When users retire or separate from the military, a copy of AF Form 797 is attained before the training record is archived. It is important to provide personnel a record of what they can do as a medical technician because they might pursue a job as a medical technician after leaving the military.

In order to provide personnel a copy of their AF Form 797, select the EXPORT button (fig. 1-65) to export the user's 797. This will prompt the user to confirm the export and then select the export format type of .pdf.

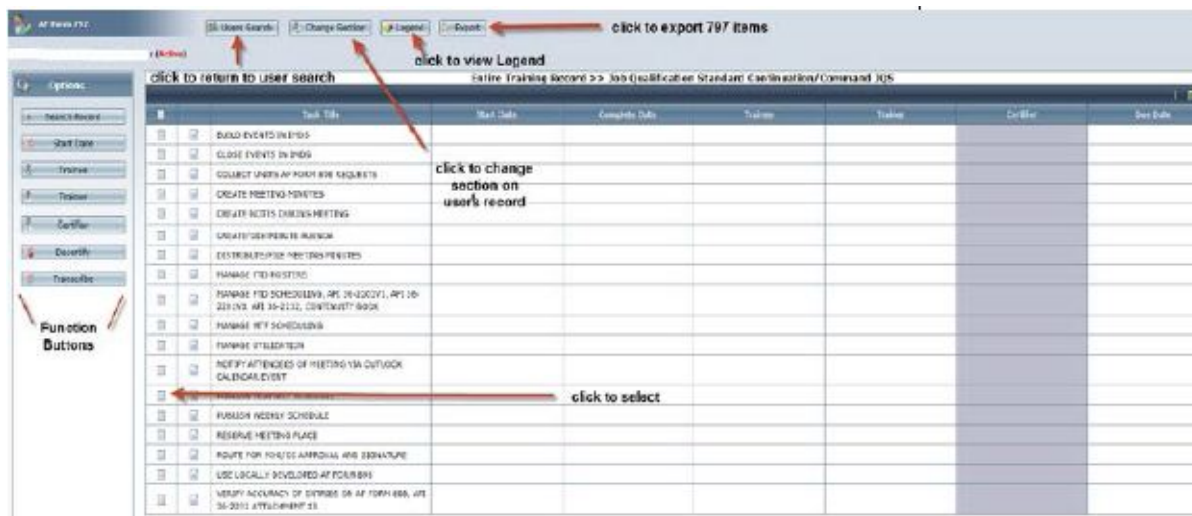


Figure 1-65. Export AF Form 797.

AF Form 803, Report of Task Evaluations

Evaluators use the AF Form 803 (fig. 1-66) to conduct and document completion of task evaluations during training, when directed by the commander, or when a task certification requires validation. The AF Form 803 contains the report of JQS Task Evaluations. These evaluations are used by supervisors, trainers, task certifiers, and UTM's to conduct and document completion of task evaluations during training. The report form includes these fields—Date, Evaluation, In UGT, JQS Task Items Evaluated, and Remarks.



Figure 1-66. AF Form 803.

These are the steps to edit AF Form 803:

1. Click the ADD button to add task evaluation information into the user's 803. A user can't add an 803 to their own record. An administrator will have to sign off on the 803 to add the user's record. Now, the user will be on the Add/Edit Form 803 Entry page.
2. Select the type of task being evaluated from the Task Type drop-down, which will be JQS Tasks, Form 797 Tasks, or Form 1098 Tasks. Then select a specialty, which comes from the user's specialties on the user's record. Select a task from the Task List drop down menu. A parent task cannot be selected in this list.

3. Select Satisfactory or Unsatisfactory from the drop down menu in the Evaluation Field.
4. Click the ADD TASK button to place the task in the JQS Task Items Evaluated box. The task must be declared if it's in Upgrade Training or not by selecting Yes or No in the In Upgrade Training field.
5. If additional comments need to be put in the 803, the Administrator will enter in the comments in the rich text box. The administrator will supply their Log On ID and Password and click Add to submit new 803 items. Only three tasks can be evaluated in the 803 section.
6. Click the DELETE button to remove the task from the JQS Task Items Evaluated box. To submit an 803, click the ADD button.

027. Uploading documents into the training record user file

Supervisors should monitor to ensure training is being accomplished and to prevent lapses in certifications. Place continuing education unit (CEU) documentation pertaining to certifications required by the career field in the AFTR. These documents include:

1. AF Form 2096, Classification/On-the-Job Training Action.
2. NREMT, cardiopulmonary resuscitation (CPR) and other specific certifications pertaining to the career field.
3. AETC Form 156, Student Training Report.
4. CDC enrollment cards and scorecards.
5. CEU tracking for NREMT.
6. Inservices.

Uploading User File

Ensure uploaded documents are 200 kilobytes or less and are in the proper format (.pdf, .doc, .xlsx, or .xfl). If they meet the requirements, follow these steps to make sure it's placed in the right area in user's training record.

1. After selecting the Upload User Files option from the model dialog selection, the Manage User Files page will open with all the documents the user has uploaded to their record.
2. The Title, File Name, and Download link will be displayed for every user file.
3. To add a new file, click on the ADD FILE button. AFTR will switch to the Upload User File page and the user will be required to add a file name and select a file to upload (fig. 1-67).
4. Enter in a file name that does not have any special characters. After clicking the SELECT button, the user will find the file they wish to upload and then press Upload to complete the upload (fig. 1-68).
5. After a successful upload, a success message will be displayed and the page will reflect the new file in the list of User Files.
6. To edit a file from the list of user files, the user will click on the file they wish to edit and press the EDIT FILE button.
7. A prompt will open to confirm the editing of the file. The user will be redirected to the Upload User Files page and the user will then edit the file as needed.
8. After either the Title is changed or a different file is selected, click the UPLOAD button to finish editing the user file. After a successful edit, a success message will be displayed and the page will reflect the new file in the list of User Files.
9. To delete a file from the list of user files, the user will click on the file they wish to delete and press the DELETE FILE button. A prompt will open to confirm the deleting of the file.
10. After a successful deletion, a success message will be displayed and the page will not have the user file in the list of user files.

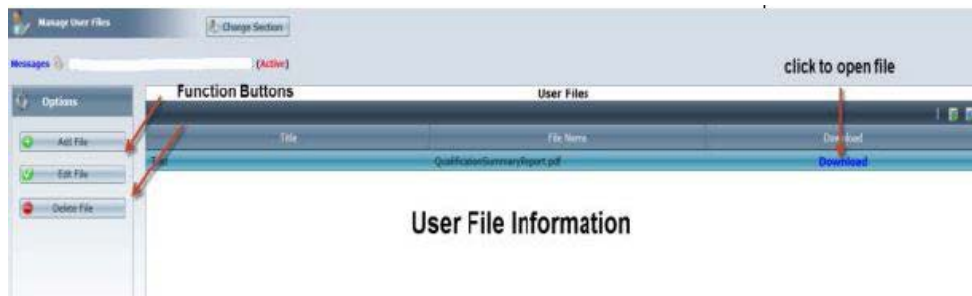


Figure 1-67. User file.

Figure 1-68. Upload user file.

Export User Record

The Export User Record page is used to select all training forms from the user's record and export those items into a .pdf document to be saved or printed. After selecting the Export User Record option from the model dialog selection, the Export User Record page will open with a list of all items available to export from the user record. The items available will include the User Profile menu.

- AF Form 623 Part I – Identification Data.
- AF Form 623 Part II – CDC Participation, etc.
- AF Form 623 Part III – Formal Training.
- AF Form 623a – On-The-Job Training Record Continuation Sheet.
- AF Form 797 – Job Qualification Standard Continuation\Command JQS.
- AF Form 803 – Report of Task Evaluations.
- AF Form 1098 – Special Task Certification and Recurring Training, Qualification Training Packages (QTP).
- Job Qualification Standard (JQS).

In the list of items (fig. 1-69) to select, the user can select all of the items using the SELECT ALL button or select any items individually. Once the item(s) are selected, the user will click the EXPORT button. A new page will open and a prompt to either open or save the document will be displayed to the user.

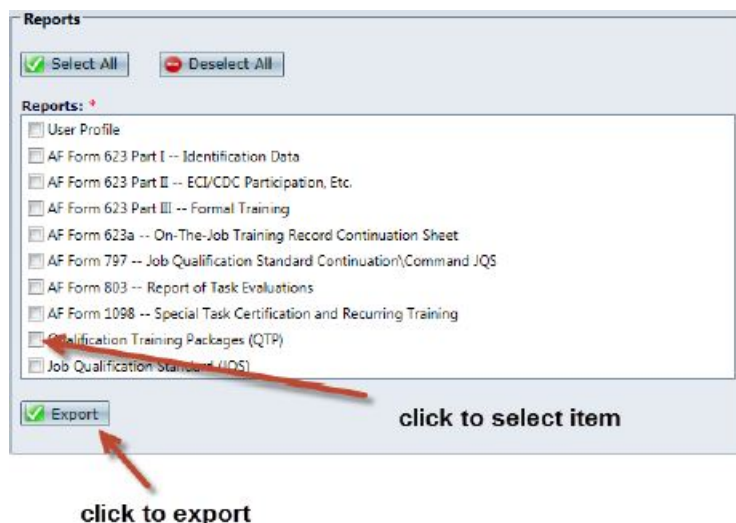


Figure 1-69. Export user file.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

018. Progression in 4N0X1 career path

1. Why are SEIs and shredouts important in the 4N0X1 career field?
2. What are the three shredouts for the 4N0X1 career field?
3. What are the eight SEIs listed under the 4N0X1 career field?
4. Besides SEIs and shredouts, what are some other special duties aerospace medical service specialists can apply for?

019. Career path broadening

1. What is your first step in successful recommendation for formal training?
2. What is the minimum rank for the Allergy/Immunization technician special duty?

3. What educational and training items must you complete before you apply for technical training instructor special duty?
4. What educational and training steps must you complete before you apply for International Health Specialist special duty?
5. What is the minimum rank requirement for the hyperbaric special duty?
6. What must you do prior to applying for retraining?
7. If you decide to retrain, what is the first step if you meet the minimum requirements?
8. If you decide to retrain, what is the second step if you meet the minimum requirements?
9. If you decide to retrain, what is the third step if you meet the minimum requirements?
10. If you meet the minimum requirements and decide to retrain, what are the last two steps you take?
11. When is FTA CAREERS *early* retraining allowed?
12. What criterion does the quality review board use to rank Airmen applying for retraining?
13. When is FTA CAREERS *regular* retraining allowed?

020. Components of your Air Force training record

1. How do you access the electronic record components in AFTR?
2. What menu items are located at the top of the AFTR page?

3. What is the purpose of each Data menu item?
4. What type of information is displayed in the AFTR Reports menu?
5. What procedure is used to access the CFETP in AFTR?

021. Updating Profile I

1. Who assigns a User Role and how is it updated?
2. If the User Administrator section is incorrect, what steps involve updating content?
3. How do you update the User Location in AFTR?
4. If your training status code changes from B, what steps are taken to update training information?
5. What steps do you take to Update Profile information, such as email address, rank, and phone number?

022. Enrolling in AF Form 623 I/II/III

1. Once logged into AFTR, how do you update current DAFSC?
2. Who enrolls personnel in a CDC?
3. Once enrolled in a CDC, how do you enter start and complete dates in AFTR?
4. How do you document CDC pre-exam test information in AFTR?
5. How do you update formal training courses in AFTR?

6. The AF Form 623 Part III Training Type drop down menu displays what information?

023. How to document training progress on AF 623a

1. What steps allow supervisors to add a 623a entry item to document training progression in AFTR?
2. How do trainees sign off on a 623a entry in AFTR?
3. How can trainee users review 623a administrator comments before signing entries?

024. Enroll users into AF Form 1098, Special Task Certification and Recurring Training

1. Special Task certification or recurring training is selected by clicking what button on the 1098 page?
2. What is the first step trainees make in searching for 1098 items to update the form?
3. In AFTR, what do you click on to verify which task(s) have been selected?
4. In what step can a certifying official decertify the task?
5. How are previous tasks recertified on the 1098?
6. What selection button do you click on to transcribe a 1098 item?

025. Enrolling users into the Job Qualification Standard

1. Describe the first step to view a workcenter JQS; what areas are available in the selection box?
2. Upon performing a search for a JQS item, what fields are displayed in step 4?

3. How must trainees sign off task if a task already has a start date?
4. How must trainer sign off task if a task already has a start date?

026. Completing AF Form 797 and AF Form 803

1. What procedures are involved in the first step to view a 797 menu item?
2. What two options are available when you open the 797 model dialog selection box?
3. According to trainee 797 update procedures, what must be selected to verify which task(s) have been selected?
4. What button must be clicked to sign off selected 797 items in AFTR?
5. What steps are required to transcribe a 797 task?
6. What do evaluators document on the AF Form 803?
7. What five fields are used on the AF Form 803 to document completion of task evaluations?
8. How do you add task evaluation information to a user's 803?
9. The purpose of AF Form 803 involves what two evaluation steps?
10. What step in editing an 803 allows users to select satisfactory results?

027. Uploading documents into the training record user file

1. What first step is used to access user file within your AFTR?

2. How do you add new file information to the AFTR user file?
3. How do you export user records in AFTR?

Answers to Self-Test Questions

001

1. While doctrine has an enormous amount of guidance and experience, it does not state what you must do or how you must complete a task or mission.
2. Air Force Medical Service doctrine applies to all active duty, Air Force Reserve, Air National Guard and civilian Air Force personnel.
3. Air Force doctrine provides commanders guidance to determine how to appropriately use its assets based on people, information, and support systems assigned to the mission.
4. Operational.
5. Tactical doctrine.
6. Integrating prevention-orientated health, fitness, and medical intervention.

002

1. The movement of “stabilized” patients from forward medical locations to another prearranged destination.
2. EMEDS Basic provides prevention, acute intervention, and primary care to support deployment of 500–2000 deployed personnel. The 25-person EMEDS Basic force package is capable of providing medical/dental care for these personnel for 7 days in an uncomplicated environment without re-supply. EMEDS + 10 provides prevention, acute intervention and primary care to support deployment of 2,000 deployed personnel. This 56-person EMEDS+10 bed AFTH force package is also capable of providing medical /dental care for these personnel for seven days in a simple environment without re-supply. EMEDS + 25 increment provides prevention, acute intervention and primary care to support deployment of 3,000–5,000 deployed personnel. The EMEDS +25 AFTH, 86-personnel increment provides the core infrastructure for specialty UTCs.
3. (1) a.
(2) c.
(3). b.
(4) a.
(5) b.
(6) c.

003

1. NCOIC.
2. EPRs.
3. How well does the individual meet the whole person concept to include performance, education, breadth of experience, job responsibility, professional competence, specific achievements, and leadership.
4. Working as an instructor or a CDC writer, volunteering to rewrite the SKT for the career field, seeking out the opportunity to attend a U&TW, working in areas of medical readiness and manpower.
5. AFI 44–104.

004

1. (1) d.
(2) b.

- (3) c.
- (4) e.
- (5) a.
- 2. The PAFSC denotes the member's highest skill level attained. The DAFSC is used to show the actual position the individual is filling within their current organization.
- 3. The CFETP is divided into two parts. Part I: Contains information necessary for the overall management of the 4N0XX and specialties. Part II: Contains the STS that outlines training requirements and enables you to do your job.
- 4. Part I.
- 5. AF Form 797, Job Qualification Standard Continuation/Command JQS.
- 6. The MTP is developed by the supervisor to outline training goals and milestones for all enlisted personnel within the specific area that you are assigned to. All core tasks and upgrade training tasks that you are required to be trained on will be circled.

005

- 1. AFOMS.
- 2. The CFM receives the completed JI. The JI is normally used at UT&Ws where senior enlisted leaders decide the future of all phases of training such as Phase I & II, CDC development, QTPs, RSVP and WAPS.
- 3. GAS is the Graduate Assessment Survey. It is a survey the supervisor completes about the new graduate's ability to perform tasks in the career field.
- 4. Military standards, ability to perform at the apprentice level outlined in the CFETP, assessment if apprentice skills meet the 3-level job required in your workplace, graduate's familiarity/awareness of the AEF, confirmation that the trainee arrived at designated duty station.

006

- 1. Through qualification training, formal training courses, inservice training, and exercises.
- 2. Completion of the Aerospace Medical Service Apprentice course, achieving your NREMT certification and readiness training, QTPs, RSVP, annual, ancillary and locally developed training.
- 3. Instructional packages designed for use at the unit to qualify, or aid qualification, in a duty position or program, or on a piece of equipment.
- 4. AFSC training.

007

- 1. Formal or informal.
- 2. They are often conducted within your unit or presented on training days.
- 3. They are generally given on topics that you use frequently or have a high probability of encountering in your work area.
- 4. They are a good way to focus on an area that needs improvement.

008

- 1. Hardcopy MTP.
- 2. Your supervisor or a designated representative.
- 3. Training goals and milestones for enlisted within the assigned area.
- 4. Core tasks, upgrade training tasks, and unit specific tasks.
- 5. Required training is completed.
- 6. Permission level of the user.
- 7. (1) Select the Create/Edit MTP option from the AFTR Data/MTP menu. (2) After selecting the Create/Edit MTP option from the menu, the page will open with a model dialog selection box with MAJCOM, Base, Unit, Workcenter, Specialty, and Section as the field options to choose from. (3) The user must select options here in order to view the MTP. All fields in the model dialog search box are required fields. (4) The MAJCOM, Base, Unit, Workcenter, and Section will default to the user's location.

8. (1) The Create/Edit MTP STS page displays the STS MTL information for the selected MAJCOM, Base, Unit, Workcenter, and Specialty. (2) The specific tasks within a single Parent Task can be viewed by clicking the Parent Task number. (3) All Parent Task(s) can be viewed by clicking All. (4) All Parent Task(s) can be hidden by clicking Hide. (5) To search for a new item, click the SEARCH button on the top of the page and the model dialog search box will open. (6) The LEGEND button launches a new window that displays the codes used in AFTR in better detail. (7) To edit the tasks, click on the box to the left of the task(s) and click the EDIT button. (8) To clear the MTP information in the tasks, click on the box to the left of the task(s) and click the CLEAR TASKS button.
9. After clicking the EDIT button, a prompt will be displayed to confirm the user wants to edit the tasks for the MTP.
10. (1) Select the task(s) by clicking the box next to the task information. (2) Then click the CLEAR TASKS button. (3) A prompt will be displayed to confirm the user wants to clear the task(s) information for the MTP. (4) After confirmation, all the MTP task information will be cleared.

009

1. Current MTL or create or edit a MTL.
2. Control and review of training items at the Workcenter level.
3. Create/Edit MTL, Copy MTL, and View MTL.
4. Permission level.
5. (1) After selecting an item, the user may switch pages by clicking on the Search button located at the top of every page. (2) Select the Create/Edit MTL option from the AFTR Data/MTL menu. (3) After selecting the Create/Edit MTL option from the menu, the page will open with a model dialog selection box with MAJCOM, Base, Unit, Workcenter, Specialty, and Section as the field options to choose from. (4) The user must select options here in order to view their MTL item. All fields in the model dialog search box are required fields. The MAJCOM, Base, Unit, Workcenter, and Specialty will default to the user's location. (5) The section contains MTL items, 797, 1098, 623 Part II, 623 Part III, and Edit MTL, Edit 797, and Edit 1098. (6) To change search criteria, the user will Click the drop down in the field and change the search criteria. (7) To execute the search, click the SELECT button. (8) To change the Section, click the SEARCH button on the top left portion of the screen. This will bring up the model dialog search. The LEGEND button launches a new window describing icons and/or references used. Legend content within the MTL menu changes depending on the section the user is in.
6. STS on the left and MTL on the right.
7. UTL on the left and MTL on the right.
8. It allows MTL tasks 5 and 7 certification level requirements to be edited.
9. Alphabetical order.
10. Selecting the check box next to the task and clicking Add or Delete.

010

1. Select the Create/Edit DTL option from the AFTR Data\Duty Position menu.
2. To change search criteria, the user will click the drop down in the field and change the search criteria.
3. MTL on the left and the DTL on the right.
4. Allows a user with the proper permission level to select an existing DTL and Duty Position from a MAJCOM, Base, Unit, Workcenter, and Duty Position and copy the DTL to a new location.
5. Select the Copy DTL option from the AFTR Data/Duty Position menu
6. Select the View Duty Position option from the AFTR Data/Duty Position menu.

011

1. Identify requirements, conduct initial evaluations, review training previously received, and set training priorities.
2. To review what the trainee knows or can perform against the tasks in the MTL.
3. Using the MTL, identify what the trainee knows or can perform. If the trainee is a recent graduate from technical school compare the tasks in 3-level course column to his/ her level of expertise. Match the qualification of the trainee to the requirements of the duty position. This will help identify what training is

needed and how long it will take to upgrade the trainee. If the trainee can perform the task, without assistance, to 100 percent accuracy, nothing more needs to be done. If the trainee cannot perform the task to the current standards, circle the task as a training requirement and open training when training begins.

4. The trainee's ability to perform the tasks (if required in the new work center).
5. Deployment requirements, AEF tasks, and other factors driving the training.

012

1. Supervisors try to avoid scheduling conflicts.
2. CDCs, AFIs, manufacturer's manuals, TRs, or other materials.
3. Base Training Office.
4. What is the training objective? What is the best method for conducting training? Is there a distance learning tool that can be utilized to assist in the training process?

013

1. UGT.
2. Higher skill level.
3. Skills and abilities.
4. (1) The behavior you exhibit while completing the task.
(2) The conditions where the task was performed.
(3) The standards that fall under each task.
5. (1) What must I do or know in order to be considered qualified?
(2) What reference was used to show how the task is accomplished if I have questions?
(3) What equipment is needed to perform the task?

014

1. Task and subject knowledge.
2. Task knowledge is the knowledge needed to perform a particular task safely, accurately, and effectively. It includes theories or principles common to a particular task and often the detailed step-by-step parts of a task.

Subject knowledge is just as important as task knowledge. It includes identifying basic facts and terms, identifying relationships of basic facts and enables the individual to analyze facts and principles and draw accurate conclusions about a subject.

3. Study the applicable CDC.
4. Your OJT trainer or supervisor.
5. AFI 36-2201.
6. A task breakdown or lesson guide is advisable.
7. Task breakdown.
8. (1) Name parts, tools, and simple facts about the task; (2) Determine step-by-step procedures for doing the task; (3) Identifying why and when the task must be done; (4) Identify why each step is needed.
9. (1) Identify basic facts and terms about the subject; (2) Identify relationship of basic facts and state general principles about the subject; (3) Analyze facts and principles and draw conclusions about the subject; (4) Evaluate conditions and make proper decisions about the subject.

015

1. To increase "hands-on" skills while you're performing the duties and tasks of an AFSC.
2. Supervisor and the UTM.
3. Increases skills and builds confidence in the trainees.
4. Training start date (day, month, year). Training complete date (day, month, year). Trainee Initials (upon completion of training). Trainer Initials (upon completion of training). Certifier initials when required by AFCFM (for tasks requiring third-party certification).

5. Each time an Airman changes duty positions (transfers from another base or work center), the supervisor must perform an initial evaluation that includes a review of all previously certified tasks.

016

1. It is additional training, either in-residence, advanced training courses (distance learning), or on-the-job training provided to personnel to increase their skills and knowledge beyond the minimum required for upgrade.
2. By asking yourself these questions, "Can I do simple parts of the task. I need to be told or shown how to do most of the task (extremely limited) Can I do most parts of the task. I need only help on hardest parts. (partially proficient) Can I do all parts of the task? I need only a spot check of completed work (competent). Can I do the complete task quickly and accurately? Can I tell or show others how to do the task (highly proficient).
3. Allowing you time to practice what has been learned; determine when you are ready to be certified on the task; request third party certification if required; if the task requires third party certification, the training is certified complete after the task certifier conducts the task evaluation.
4. 120 days (240 days for ARC).
5. Use the new CFETP to identify past and current training requirements and to transcribe qualifications from the previous CFETP.
6. AF Form 623a.
7. Include strengths, weaknesses, areas to improve, and means to improve.

017

1. Supervisors, trainers, and certifiers.
2. A training objective defines the resultant behavior (what the trainee must do or know), the standard (how well the task must be performed), and the condition (what will be given or denied during the final evaluation).
3. (1) Did everyone actively participate in training process; (2) Did training incorporate actual equipment or training aids; (3) Did everyone practice hands-on if applicable; (4) Did everyone have the opportunity to provide feedback; (5) Did the training instructor use established evaluation tools and methods; (6) Did you increase knowledge of applicable duties?
4. AFTR, AF Form 623a; AFTR, AF Form 803; and training critiques or surveys.

018

1. They are established when identifying experience or training is critical to the job and person assignment match, and no other identification is appropriate or available. Both permit rapid identification of a resource already experienced to meet unique circumstances, contingency requirements, or management needs. They provide a means to track individuals and identify positions requiring or providing unique experience or training that otherwise would be lost. They may also be used to better distribute personnel and optimize the job and person match.
2. 4N0X1B NT; 4N0X1C IDMT; 4N0X1F FOMT.
3. SEI 453 AIT; SEI 455 SOC medics; SEI 456 National Registry Paramedic; SEI 470 FOMT; SEI 486 HDMT; SEI 487 CCT; SEI 490 HBMT; SEI 494 AET.
4. Technical school instructor duty, career development course writer, PME instructor duty, first sergeant duty, and recruiter duty.

019

1. Meeting the requirements in the Air Force Enlisted Classification Directory, ETCA (<https://etca.randolph.af.mil>), and AFI 36-2626.
2. A1C/SrA.
3. NREMT certification; QTPs for assigned position; Complete all duty position training requirements.
4. Flight/Squadron/Division Superintendent/Senior 4N0.
5. SSgt.
6. Meet the eligibility requirements.

7. Step 1: Review the retraining advisory to identify AFSCs you may be interested in retraining into.
8. Step 2: Review Air Force Enlisted Classification Directory, for the AFSC description. NOTE: Review AQE requirements for the AFSC you desire to retrain into. You are not currently qualified for that AFSC if your current AQE scores do not meet or exceed the required AQE. You may schedule a retest to try to improve your scores.
9. Step 3: Review retainability requirements for retraining in AFI 36-2626, Airman Retraining Program.
10. Step 4: Complete the Retraining Application. Step 5: Submit your Retraining Application to the Total Force Service Center. The system will notify your commander that you have submitted an application and give your commander instructions on how to report any changes that might render you ineligible to retrain. The Total Force Service Center will submit your completed application to the AFPC Retraining Office for final decision. You will be notified on the results of your application. If you have reviewed and understand the eligibility requirements for your retraining program, select the "Retraining Application" link to initiate your retraining request.
11. 4-year enlistee can apply upon completion of 24 months of service; 6-year enlistees can apply upon completion of 36 months of service; retraining-in is restricted to 1C2X1 (Combat Control), 1T2X1 (Pararescue), 1T0X1 (SERE), 1AXXX (Any aircrew AFSC), 1N3XXX (Any linguist skill), in addition, FTA in the following skills may apply for early CAREERS retraining into their lateral shreds: 3P0X1 (Security Forces), 4J0X2 (Physical Medicine), 4N0X1 (Aerospace Medical Service), 4N1X1 (Surgical Service), 4R0X1 (Diagnostic Imaging), and 4V0X1 (Optometry).
12. Most recent EPR, current grade, projected grade, next three EPRs, DOR, TAFMSD and AQE score in the applicable area (electrical, mechanical, administrative, or general) requested AFSC preferences.
13. 4-year enlistees must be within the 35th and 43rd month of their current enlistment to apply. 6-year enlistees must be within the 59th and 67th month of their current enlistment to apply.

020

1. Log into ADLS at <https://golearn.csd.disa.mil/kc/login/login.asp> ; click on Training Records; then click on AFTR.
2. Home; My AFTR; My Record; My AFTR Permission; CAC Log on
3. Allows information to be created, edited, modified, viewed, and copied. The MTP allows its menu to be created, edited and viewed but not copied. The STS allows the user to view the STS within AFTR. The Update Contact Information allows those with the appropriate permission level to update the help desk contact information for each community. The AFTR System Permissions allows each permission level to be viewed and to show what each permission level can do within AFTR.
4. Training status code, training status, task coverage, excessive training summary, excessive training user, CDC pass rate summary, CDC pass rate user, qualification summary, UGT summary, and generalized status.
5. Click on the Training menu.

021

1. A User Role is assigned and updated by your UTM upon arrival to your first permanent duty section.
2. Contact UTM or supervisor.
3. Clicking My Profile and editing the root and suborganizations.
4. Contact UTM.
5. Click Update Profile then edit the field(s) and click Submit.

022

1. Click on the Training Menu bar, then click and enter the current DAFSC.
2. The UTM.
3. Select My User Record, then select AF 623 Part II.
4. Click (Pre-Exam 1 Date) link to enter date, score and pass/fail results. If trainee is successful and also passes the end of course exam, click Final Exam 1 Date to input test results in the proper pre or final exam score box. Click the Update link to save the information.

5. After selecting the AF Form 623 Part III – Formal Training option from the model dialog selection, the 623 Part III page will open with a model dialog selection box with Training Type and Specialty as the field options to choose from. The user must select options here in order to view their 623 Part III items.
6. Qualification Training or Entire Training Record.

023

1. (1) Click My AFTR. (2) Click My Record. (3) Click 623a On-The-Job Training Record Continuation Sheet. (4) Click the Add button. The Add/Entry Form 623a Entry page will be displayed. Only a General Training Comment can be added by a user to own record. (5) Enter in the Log On Id and password or user the CAC sign off. (6) Enter in the comment in the rich text field and click add and a new 623a entry will be added to the user's record. After a 623a entry is added successfully, a success message will be displayed and the main 623a page will be displayed.
2. (1) Click the User button and enter in the Log On ID and password or use the CAC sign off. (2) Then, enter in the comments in the rich text field and click the Update button. (3) After a 623a entry is signed off by the user, a success message will be displayed and the main 623a page will be displayed.
3. (1) Click on the folder next to the 623a entry and a new window will display with the Administrator comments for that particular entry.

024

1. (1) After selecting the AF Form 1098—Special Task Certification and Recurring Training option from the model dialog selection, the 1098 page will open with a model dialog selection box with Training Type and Specialty as the field options to choose from. The user must select options here in order to view their 1098 items.
(2) The Training Type drop down will contain either: Qualification Training or Entire Training Record If Qualification Training is selected, 1098 items marked as qualification training will be displayed. If Entire Training Record is selected, the specialty will not be an option. After the search is performed, all 1098 items will be displayed.
(3) The Specialty drop down will contain all the specialties the user has on their record.
2. Click the SEARCH RECORD button. Only items already assigned a start date will be able to be signed on the user's record.
3. Click the TASKS SELECTED button to verify which task(s) have been selected.
4. Step 1.
5. (1) Select the task(s) and click the Recertify button to recertify the current user on a 1098 task(s). A prompt will open to confirm the recertification of the task. A user will not be able to sign off on the Administrator portion of the recertification on own 1098 task. (2) Click the Tasks Selected button to verify which task(s) are selected. Enter the Trainee Login ID and Password. (3) Enter the Login ID and Password of the Administrator. An additional comment will be added to the 623a entry by adding text to the Additional 623a comments box. (4) Click the UPDATE button to submit the task recertification. A prompt will open to confirm the recertification of the task.
6. Click the TASKS SELECTED button to verify which task(s) have been selected.

025

1. Select the JQS option from the model dialog selection; The JQS page will open with a model dialog selection box with Training Type, Specialty, and STS Publication Date.
2. Task Title; Start Date; Complete Date; Trainee; Trainer; Certifier; Due Date.
3. Select a task and click the TRAINEE button to sign off as a Trainee on the JQS form. A prompt will open to confirm signing off the Trainee for the selected task. 2. Click the TASKS SELECTED button to view information in the View JQS Tasks Selected pop-up to verify which task(s) have been selected. 3. Enter the Trainee Login ID and Password or use the CAC sign off. 4. Click the UPDATE button to submit the sign off. A prompt will open to confirm signing off on the selected tasks.
4. Select a task and click the TRAINER button to sign off as a Trainer on the JQS form. A prompt will open to confirm signing off the Trainer for the selected task. 2. Click the TASKS SELECTED button to view information in the View JQS Tasks Selected pop-up to verify which tasks(s) have been selected. 3. Enter

the Trainer Login ID and Password. Click the UPDATE button to submit the sign off. A prompt will open to confirm signing off on the selected tasks.

026

1. After selecting the AF Form 797 – Job Qualification Standard Continuation\Command JQS option from the model dialog selection, the 797 page will open with a model dialog selection box with Training Type and Specialty as the field options to choose from.
2. Qualification Training and Entire Training Record.
3. TASKS SELECTED button.
4. UPDATE button.
5. (1) Select the task(s) and click the TRANSCRIBE button to transcribe 797 Task(s). A prompt will open to confirm the transcription of the task. (2) Click the TASKS SELECTED button to verify which task(s) have been selected. The Trainee and the Administrator have the ability to sign off on the transcription at a later date. The Trainee and Administrator can immediately certify that the 797 tasks were transcribed. (3) Enter the Administrator Login ID and Password. An additional comment will be added to the 623a entry by adding text to the Additional 623a comments box. (4) Click the UPDATE button to submit the task transcription. A prompt will open to confirm the transcription of the task.
6. Completion of task evaluations during training, when directed by the commander, or when a task certification requires validation.
7. Date; Evaluation; In UGT; JQS Task Items Evaluated; Remarks.
8. Click the ADD button to add task evaluation information into the user's 803. A user can't add an 803 to their own record. An administrator will have to sign off on the 803 to add the user's record.
9. Conduct and document completion of task evaluations during training.
10. Step 3.

027

1. After selecting the Upload User Files option from the model dialog selection, the Manage User Files page will open with all the documents the user has uploaded to their record.
2. Click on the ADD FILE button. AFTR will switch to the Upload User File page and the user will be required to add a file name and select a file to upload.
3. After selecting the Export User Record option from the model dialog selection, the Export User Record page will open with a list of all items available to export from the user record. Once the item(s) are selected, the user will click the EXPORT button. A new page will open and a prompt to either open or save the document is displayed to the user.

AF Form 623 Part I – Identification Data; AF Form Part II – ECI/CDC Participation, Etc.; AF Form 623 Part III – Formal Training; AF Form 623a – On-The-Job Training Record Continuation Sheet; AF Form 797 – Job Qualification Standard Continuation/Command JQS; AF Form 803 – Report of Task Evaluations; AF Form 1098 – Special Task Certification and Recurring Training, Qualification Training Packages (QTP) Job Qualification Standard (JQS).

Do the unit review exercises before going to the next unit.

Unit Review Exercises

Note to Student: Consider all choices carefully, select the *best* answer to each question, and *circle* the corresponding letter. When you have completed all unit review exercises, transfer your answers to the Field-Scoring Answer Sheet.

Do not return your answer sheet to the Air Force Career Development Academy (AFCDA).

1. (001) Which Air Force Doctrine Document (AFDD) is the primary guide used by Air Force Medical Service commanders to accomplish their mission?
 - a. AFDD 1, *Basic Doctrine*.
 - b. AFDD 1-1, *Leadership and Force Development*.
 - c. AFDD 2-8, *Command and Control*.
 - d. AFDD 4-02, *Medical Operations*.
2. (001) Why is Medical Doctrine necessary?
 - a. Recommends step by step actions.
 - b. Directs the actions of commanders.
 - c. Guides commanders in using assets.
 - d. Changes faster than Air Force guidance.
3. (001) What type of doctrine guides organization and employment of forces within distinct objectives, but is broad in its functional areas and operational environment?
 - a. Basic.
 - b. Tactical.
 - c. Operational.
 - d. Foundational.
4. (001) Tactical doctrine can be explained best by which of the following examples?
 - a. The Environmental Protection Agency because they establish rules and regulation such as fuel economy.
 - b. An automobile manufacturer such as Ford or Dodge because they design vehicles with broad functions and capabilities in mind.
 - c. An automotive designer because they use historical data such as size and gas mileage to develop vehicle structure.
 - d. A car buyer because they can choose specific qualities to fit their individual needs such as speed or safety factors.
5. (002) What kind of change to casualty survival rates occurs when aeromedical evacuation (AE) is available?
 - a. Significantly increase.
 - b. Significantly decrease.
 - c. Increased by only 10 percent.
 - d. Decreased by only 10 percent.
6. (002) Which Expeditionary Medical Support (EMEDS) increment has no inpatient beds?
 - a. EMEDS Basic.
 - b. EMEDS +10.
 - c. EMEDS +25.
 - d. All EMEDS have inpatient beds.

7. (002) Who is qualified to perform a critical incident stress debriefing (CISD)?
 - a. Mental Health personnel and the air and space expeditionary force (AEF) or Expeditionary Medical Support (EMEDS) commander.
 - b. Aerospace Medical Specialist and the AEF or EMEDS commanders.
 - c. Mental Health personnel and Aerospace Med Specialist with additional training.
 - d. The AEF or EMEDS commanders and Aerospace Medical Specialist with additional training
8. (002) Expeditionary Medical Support (EMEDS) Basic requires both routine aeromedical evacuation (AE) support and urgent AE support within how many hours of notification?
 - a. 12 hours for routine AE support, and 2 hours for urgent AE support.
 - b. 12 hours for routine AE support, and 4 hours for urgent AE support.
 - c. 24 hours for routine AE support, and 12 hours for urgent AE support.
 - d. 36 hours for routine AE support, and 24 hours for urgent AE support.
9. (002) What is the total number of personnel assigned to the Expeditionary Medical Support (EMEDS) +25?
 - a. 32.
 - b. 51.
 - c. 86.
 - d. 94.
10. (003) The Air Force career field manager (AFCFM) has which skill level?
 - a. 4N000.
 - b. 4N031.
 - c. N051.
 - d. 4N071.
11. (003) Who develops and maintains currency of the career field education and training plan (CFETP)?
 - a. Group superintendent.
 - b. Surgeon general.
 - c. Air Force career field manager.
 - d. Career development course writer.
12. (004) What figure in an Air Force specialty code (AFSC) identifies career grouping?
 - a. First.
 - b. Second.
 - c. Third.
 - d. Fifth.
13. (005) Who may request a 4N0X1 Job Inventory?
 - a. Chief nurse.
 - b. Command chief.
 - c. Career field manager.
 - d. Medical Group commander.
14. (005) How often is the 4N0XX Job Inventory normally completed?
 - a. Every 6 months.
 - b. Annually.
 - c. Every 3 years.
 - d. Every 5 years.

15. (005) Who is responsible for completing the Graduate Assessment Survey (GAS)?
 - a. Commander.
 - b. Supervisor.
 - c. 3-level.
 - d. 5-level.
16. (006) Why is it required for 4N0X1 personnel to complete sustainment training?
 - a. Maintain skills.
 - b. Prevent lawsuits.
 - c. Ensure promotion.
 - d. To complete formal training course.
17. (006) Required Specialty Verification Program (RSVP) is designed to sustain Air Force specialty code (AFSC) training in what location?
 - a. Stateside base.
 - b. Deployed setting.
 - c. Reserve duty station.
 - d. Air National Guard base.
18. (007) What timeframe is best to conduct inservice training within your unit?
 - a. During shift change.
 - b. On training days.
 - c. In the afternoons.
 - d. In the morning.
19. (008) The Master Training Plan (MTP) is used to outline
 - a. patient treatment plans.
 - b. patient treatment milestones.
 - c. training milestones for enlisted within the assigned area.
 - d. training goals and milestones for enlisted within the assigned area.
20. (008) Duty section job description and the upgrade training plan is kept in the
 - a. Career Field Education and Training Plan (CFETP).
 - b. Air Force Training Record (AFTR).
 - c. Specialty Training Standard (STS).
 - d. Master Training Plan (MTP).
21. (008) Your first step for creating and editing an Master Training Plan (MTP) in your Air Force Training Record (AFTR) is to select withi option from the AFTR Data/MTP menu?
 - a. Edit MTP.
 - b. View MTP
 - c. Delete MTP.
 - d. Create/Edit MTP.
22. (008) What is the fourth step in Air Force Training Record (AFTR) for editing an specialty training standard (STS) Master Training Plan (MTP) tasks?
 - a. The user must enter in a Start Month, End Month, Training Days, Training Method, Evaluation Method, and Training Aid.
 - b. The user must enter in all the fields to complete the MTP information.
 - c. The user selects what method will be used for the training on the task.
 - d. After confirmation, the user is redirected to the Edit MTP Tasks page.

23. (009) What two parts divide the Master Training List (MTL) section?
- a. MTP on the left and STS on the right.
 - b. STS on the left and MTL on the right.
 - c. 797 on the right and 1098 on the left.
 - d. UTL on the right and MAJCOM on the left.
24. (009) The Edit Master Training List (MTL) menu option allows which certification level requirement to be edited?
- a. MTP tasks 5 and 7.
 - b. MTL tasks 5 and 7.
 - c. STS tasks 7 and 5.
 - d. UTL tasks 7 and 5.
25. (010) The first step when creating/editing the Duty Task List (DTL) in your Air Force Training Record (AFTR) is to select the
- a. Create/Edit DTL option from the AFTR Data/Duty Position menu.
 - b. Edit DTL option from the AFTR Data/Duty Position menu.
 - c. AFTR Data/Duty Position menu.
 - d. AFTR Duty Position menu.
26. (011) Some additional factors must be considered when determining training requirements. What are they?
- a. Air and space expeditionary force (AEF) tasks.
 - b. No other factors are considered.
 - c. AEF tasks and other factors driving the training need must also be considered when determining training requirements.
 - d. Deployment requirements, AEF tasks, and other factors driving the training need must also be considered when determining training requirements.
27. (012) Who or whom do you contact, if there is a training requirement for which you have no trainer or certifier?
- a. Commander.
 - b. First Sergeant.
 - c. Base Training Office.
 - d. Unit Training Office.
28. (013) The total training program leads to
- a. lower pay levels.
 - b. higher pay levels.
 - c. higher skill level.
 - d. promotion.
29. (013) The steps to evaluate a 4N0X1's competency on a task involve reviewing the
- a. behavior exhibited while completing the task; the conditions where the task was performed; and the standards that fall under each task.
 - b. behavior exhibited while completing the task; and the conditions where the task was performed.
 - c. Career Field Education and Training Plan (CFETP).
 - d. Master Task List (MTL).
30. (014) Which personnel provide specific training information for particular tasks or knowledge?
- a. Certifier.
 - b. Supervisor.
 - c. On-the-job training (OJT) trainer.
 - d. Your OJT trainer or supervisor.

31. (014) What does task knowledge identify?
 - a. RN orders.
 - b. Physician orders.
 - c. Your ability to identify facts, state principles, and analyze.
 - d. Your ability to identify facts, state principles, analyze or evaluate the subject.
32. (014) To fully understand task knowledge, what step is used to assess your ability?
 - a. Name parts, tools, and simple facts about the task.
 - b. Follow sequence in the proficiency task listing.
 - c. Determine the final step needed to complete the the task.
 - d. Review the CFETP and identify task in the Part I specialty training standard.
33. (014) To fully understand subject knowledge, the steps to assess your ability include
 - a. analyzing task knowledge with another Aimen in upgrade training.
 - b. analyzing facts and principles and draw conclusions about the subject.
 - c. reviewing manufacturer's material on subject knowledge.
 - d. identifying detailed facts and acronyms about the subject.
34. (015) What information is updated when each task is successfully learned and demonstrated by the trainee in Air Force training record (AFTR)?
 - a. Job qualification standard training start and complete date.
 - b. AF Form 623 II, On the Job Training Record Continuation Sheet.
 - c. Start and complete date with trainee, trainer, and certifier initials (if applicable).
 - d. AF Form 1098, Special Task Certification and Recurring Training Qualification Training Packages.
35. (015) Each time an Airman changes duty positions (transfers from another base or work center), the supervisor must perform
 - a. a re-evaluation.
 - b. an initial evaluation.
 - c. an Enlisted Progress Report (EPR).
 - d. an Annual Progress Report (APR).
36. (016) After achieving training and knowledge, what is the 1st question you should ask yourself to determine proficiency level?
 - a. Can I do simple parts of the task?
 - b. Can I do most parts of the task?
 - c. How many supplies are needed?
 - d. How much equipment is needed?
37. (016) After achieving training and knowledge, what is the last question you should ask yourself to determine your proficiency level?
 - a. How many people can I train?
 - b. How many continuing education hours did I achieve?
 - c. Can I do all parts of the task? I need only a spot check of completed work.
 - d. Can I do the complete task quickly and accurately? Can tell or show others how to do the task?
38. (017) The Air Force training record (AFTR), AF Form 623, AF Form 803, and training critiques or surveys are used to document
 - a. weekly training procedures.
 - b. objective effectiveness.
 - c. quarterly training steps.
 - d. training effectiveness.

39. (017) If training is effective, what should trainees remember?
- The requirements to successfully complete the job.
 - Advanced requirements to complete the job.
 - 50% of their training information.
 - 80% of their training information.
40. (017) What is one of the methods used to develop and evaluate training effectiveness?
- Review test questions.
 - Review class survey.
 - Analyze if 90 percent actively participated in training process.
 - Analyze if everyone actively participated in training process.
41. (018) Name one of the three shredouts of the 4N0X1 career field.
- Allergy/Immunization technician.
 - Emergency room technician.
 - Neurology technician.
 - Vascular technician.
42. (019) Your first step in successful recommendation for formal training begins
- with meeting the requirements in the Enlisted Classification Directory, Education and Training Course Announcements (ETCA), and AFI 36-2626.
 - with meeting the requirements in the Officer Classification Directory and ETCA.
 - by submitting your last Enlisted Progress Report (EPR) and fitness test score.
 - by submitting your last achievement medal and quarterly award.
43. (019) What educational and training steps must be completed to apply for technical training instructor?
- Complete all duty position training requirements.
 - Qualification training packages (QTP) for assigned position; complete all duty position training requirements.
 - Basic life support (BLS) certification; QTPs for assigned position; complete all duty position training requirements.
 - National Registry of Emergency Medical Technicians (NREMT) certification; QTPs for assigned position; complete all duty position training requirements
44. (019) What must you meet prior to applying for retraining?
- Retainability requirements.
 - Eligibility requirements.
 - PCS requirements.
 - PCA requirements.
45. (019) What is one criterion used by the Quality Retraining Program (QRP) board to rank Airmen applying for retraining?
- Technical training school grade point average.
 - Armed Services Vocational Aptitude Battery scores.
 - Number of achievement medals.
 - Last three EPRs.
46. (019) The overall objective of taking advantage of retraining opportunities is to balance the
- career force of each Air Force speciality code (AFSC) as needed.
 - base force of each AF special experience identifier (SEI) as needed.
 - unit force of each AF shredout as needed.
 - career force of the AF squadron.

47. (020) To access your electronic training record in the Air Force Training Record (AFTR), log into the Advanced Distributive Learning System (ADLS), then click on
 - a. Course List.
 - b. My Profile.
 - c. Administration.
 - d. Training Records.
48. (021) The procedures to update the User Location section for MAJCOM, Base, Unit, or Workcenter is performed by clicking
 - a. My Profile and editing Root and Sub Organizations.
 - b. Administration and editing Organizations.
 - c. Root and Sub Organizations.
 - d. Sub Organizations.
49. (021) If training status code changes, whom do you contact to update the code in the user training information?
 - a. Base training manager.
 - b. Unit training manager.
 - c. Unit deployment manager.
 - d. Curriculum development manager.
50. (022) What section is used in Air Force Training Record (AFTR) to update career development course (CDC) start and complete dates?
 - a. Master Training List (MTL).
 - b. Master Training Plan (MTP).
 - c. AF 623 Part I.
 - d. AF 623 Part II.
51. (022) The Training Type drop down menu is used to view the Entire Training Record and
 - a. Qualification Training.
 - b. Quarterly Training.
 - c. Annual Training.
 - d. Initial Training.
52. (023) What's the first button trainee's click to sign off 623a entries in the Air Force Training Record (AFTR)?
 - a. ADMINISTRATOR.
 - b. CAC Sign Off.
 - c. Log On ID.
 - d. USER.
53. (024) What is the first step trainees make in searching for 1098 items to update the Air Force Form 1098?
 - a. Click the SEARCH RECORD button.
 - b. Click the USER RECORD button.
 - c. Click the My AFTR button.
 - d. Click the ADLS.
54. (025) What is the first step trainees use to sign off a task as a trainee on the Job Qualification Standard (JQS) if a task already has a start date?
 - a. Select a task and click the CERTIFIER button.
 - b. Select a task and click the TRAINEE button.
 - c. Select a task and click the TRAINER button.
 - d. Click the UTM button.

55. (026) Which form is used to access Job Qualification Standard (JQS) continuation items?
- a. AF Form 794.
 - b. AF Form 795.
 - c. AF Form 796.
 - d. AF Form 797.
56. (026) The purpose of an AF Form 803 involves what two evaluation steps?
- a. Completion of job evaluations and training.
 - b. Completion of task evaluations and training.
 - c. Conduct and document completion of task evaluations during training.
 - d. Conduct and document completion of Master Training Plan evaluations during training.
57. (027) What button do you click to add new file information to the Air Force Training Record (AFTR) User File?
- a. UPLOAD USER FILE.
 - b. READ FILE.
 - c. ADD FILE.
 - d. MENU.

Please read the unit menu for unit 2 and continue ➔

Student Notes

Unit 2. Resource Management

2-1. Management of Personnel	2-1
028. Manpower resources management.....	2-1
029. Basics of personnel management documents	2-3
2-2. Supervision.....	2-5
030. Daily workcenter operations.....	2-5
031. The right priorities	2-6
032. Duty schedules development	2-7
033. Workcenter personnel orientation.....	2-12
034. Position description and performance standards.....	2-15
2-3. Management of Medical Logistics.....	2-23
035. Supplies and equipment management.....	2-23
036. Patient transport item management.....	2-26
037. Tag In Tag Out	2-29
038. Report of Survey.....	2-30

DURING CAREER PROGRESSION, AEROSPACE MEDICAL SERVICE TECHNICIANS will encounter new challenges, opportunities, duties and responsibilities. One of those opportunities will likely be the management of personnel and supplies and equipment. As you advance to the 5-skill level you will begin to take responsibility for such duties. This unit addresses various aspects of managing resources to include personnel, supplies and equipment and will begin preparing you for your role as a supervisor.

2-1. Management of Personnel

Managing in the USAF Medical Service (USAFMS) involves being aware of many areas that apply to the job of a technician. Though an enlisted manager is usually a senior noncommissioned officer (SNCO), some of the actual management duties may be delegated to subordinates depending on the situation. Both managers and subordinates must be aware of policies and programs designed to enhance management of the career field. This section contains lessons pertaining to the management of personnel and resources.

028. Manpower resources management

In this lesson, important resource management considerations are covered. These areas include the Defense Medical Human Resource System Internet (DMHRSi), Medical Expense and Performance Reporting System (MEPRS), and calculating workloads.

Medical Expense and Performance Reporting System

The MEPRS is the medical personnel, workload, and expense accounting system used by the USAFMS. It's the primary tool used to make manpower, budget, and other important resource allocation decisions. MEPRS was developed to establish a uniformed accounting method and to improve the overall effectiveness of each medical treatment facility (MTF). It's a fully automated system now used in all facilities. The MEPRS data feeds information to the DMHRSi allowing tri-service monitoring of resource and personnel.

Defense Medical Human Resource System Internet

The DMHRSi incorporates tracking of tri-service management of healthcare resources. DMHRSi enables joint capability of monitoring all uniformed services resources and is used to reduce inefficiencies and deficiencies in managing three different manpower and personnel systems. The

system enables the Department of Defense (DOD) to avoid duplication as each service use their own systems to manage resources. The following list describes some basic facts about DMHRSi benefits to the DOD:

- Identifies staff and where they work.
- Identifies filled and vacant positions, training records, and all hours charged to each work center.
- Identifies readiness information for medical asset visibility.
- Deploys to over 800 military medical sites and has 170,000 customers worldwide.

DMHRSi also benefits the Defense Health Agency. It provides a combined view of medical assets including civilian and military personnel, contractors, and volunteers.

Basic function

Every activity occurring in the MTF is assigned a MEPRS code or is in some manner assigned to the MEPRS. All hospital activities are grouped according to type and section involved. The MEPRS permits viewing the overall operation of the MTF in one database. For example, the number of patient visits in each clinic is information that MEPRS provides. Other examples of MEPRS data include the amount of time individuals spend performing various duties and the amount of resources used to perform patient care and other functions.

Technician responsibilities

To ensure accurate MEPRS data, technicians must do their part in providing accurate and timely information. It is especially important to accurately record whether a patient's appointment was kept or cancelled, or if the patient did not show in the Composite Health Care System (CHCS) or Armed Forces Health Longitudinal Technology Application (AHLTA). MEPRS will pull the workload information from CHCS or AHLTA and compile the visits and procedure codes. It is also important that you accurately document time spent performing patient care and other functions on the time sheet. Work hours (or "time sheet") documentation is accomplished by appropriately recording the time spent in various coded categories. These categories are not limited solely to the performance of an individual's primary job. Other codes are established to track hours spent on readiness training, mandatory physical fitness, all required military training or class attendance, and personal situations such as quarters or leave status. Ensuring accurate MEPRS data benefits the mission as a whole, since the system is also used to justify budget and manning allotments for the facility.

Workload calculating and reporting

As mentioned previously, reporting the workload for each section is important for MEPRS. The individual workload for each section applies to inpatient, outpatient, and ancillary (radiology, lab and pharmacy) areas. Outpatient workloads are mainly recorded by the number of visits, while inpatient workloads often reflect additional data. Some of the inpatient workload reports may include time and supplies used to accomplish various patient care procedures. Outpatient workloads also reflect such data, though most outpatients primarily are screened, seen by a provider, and released without extensive procedures being conducted. Ancillary workload is recorded by the number of service provided as well as a weighted value based on the amount of time it takes to complete the task. For example, a prescription of pills takes less time to fill than a liquid requiring measuring and mixing. Therefore, for ancillary services, you will have a raw count (number of services) and a weighted count (based on difficulty and time) reported for each task. The workload mentioned above is not all inclusive of what is tracked and reported through MEPRS. Many other areas are tracked and reported such as immunizations, hours spent on medical equipment repair, pounds of laundry cleaned, and vehicle mileage, just to name a few. If there is a cost to the facility, it is reported through MEPRS in order to obtain a total cost for running the facility.

029. Basics of personnel management documents

Now that you understand how manpower resources are tracked through MEPRS and DMHRSi, it is time to introduce you to some of the programs and documents that are used to manage personnel resources. Included in this lesson are some explanations of common terms used when referring to manpower resources. You will also begin building the foundation to understand how manning resources work and what documents you need to be familiar with.

Manpower considerations and documents

Manpower management involves the authorizations for assigned personnel the MTF commander identifies as necessary to accomplish the mission. Determining the right amount of people needed is critical. The Air Force uses specific tools and techniques to determine and validate manpower requests and authorizations. The information is then used to request manpower authorizations from the DOD and Congress.

After the DOD establishes a limit on manpower authorizations, it allocates them to each branch of service. The Air Force, in turn, allocates its share to each major command (MAJCOM). Priorities are established since the authorizations usually are not enough to meet the total number of requirements.

The process of allocating manpower authorizations is extensive. Because of this, each wing has a manpower office that assists resource managers for the various groups and squadrons with the process. Various methods are used to determine manpower requirements and authorizations. These methods are collectively known as *manpower resourcing tools*. Being familiar with some of the terms and tools used in manpower management is extremely helpful to everyone involved in the process. These key terms discussed in this lesson include manpower requirements, manpower authorization, manpower standard, end strength, unit manning document, unit personnel management roster (UPMR), and authorization change request (ACR)/authorization change notice (ACN). Last is an introduction to manning assistance. AFPAM 36-2241, *Professional Development Guide*, is another source that you can refer to for basic understanding.

Manpower requirements

Manpower requirements is the manpower needed to accomplish a specified job, workload, mission, or program. There are two types of manpower requirements—funded and unfunded. Funded requirements are those that have been validated and allocated. Unfunded requirements are validated, but have been deferred (at least temporarily) because of budget constraints. In addition to the type of mission, the right mix of personnel such as military, civilian, and contract services is considered when determining manpower requirements.

Manpower authorization

A manpower authorization is a funded manpower requirement that defines the position in terms of function, organization, location, skill, grade, and any other characteristic needed to clearly define the position.

Manpower standard

A manpower standard is a description of a work center's man-hour requirements needed to respond to varying levels of workload. The standard includes a description of tasks and associated conditions used to build the manpower requirement. The manpower standard also defines the skill and grade requirements for each position.

End strength

The end strength is the total number of military and civilian positions the Air Force needs funded in order to accomplish the mission.

Unit manning document

The unit manning document (UMD) is used to help manage manpower resources. This primary document reflects all positions authorized to accomplish the mission. Names are not associated with this document. Supervisors periodically check the UMD for accuracy and to track authorized manpower for the work center. The UMD lists authorized positions by AFSC and duty title.

Unit personnel management roster

The UPMR is also a means to manage manpower by using a list of the actual people assigned to the work center. This tool matches the names of personnel to the actual position he or she is assigned. The UPMR also lists projected personnel gains and losses. The information on the UPMR should match the authorizations on the UMD. The supervisor should also review the UPMR periodically and make corrections to any errors.

Authorization change request/authorization change notice

An authorization change request (ACR) is a request by an organization to change its manpower authorizations. It can involve a request to move one position to another duty section, or even involve a desire to convert a position from one rank or skill level to another. An authorization change notice (ACN) is a MAJCOM response to an ACR. The MAJCOM either approves or disapproves the request.

Manning assistance

Manpower requirements are not changed to accommodate temporary changes. You can imagine how difficult and expensive it would be for the Air Force Personnel Center (AFPC) to generate orders every time a unit was going to be short of personnel due to deployments, personnel issues, formal schools, and so forth. However, there is an avenue to request temporary assistance when manning levels affect mission completion. That avenue is temporary assistance from another unit or base called *manning assistance*. The Air Force can authorize civilian employees to work overtime or perhaps hire a civilian employee to fill in for another civilian or military person on a temporary basis. The commander may also request a qualified military member from another unit or base to be put on temporary duty orders to fill critical manning shortage. While this is an excellent tool for the commander, requests for manning assistance must be carefully thought out and justified.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

028. Manpower resources management

1. What does MEPRS stand for?
2. What is the MEPRS and what is its primary use?
3. What is the purpose of DMHRSi and what are some of its features and benefits to the DOD and Defense Health Agency?
4. How are all hospital activities grouped in MEPRS?

5. What is the technician's responsibility in completing the MEPRS information?

029. Basics of personnel management documents

1. What is a manpower authorization?
2. What is the purpose of the UMD?
3. What tool is used to list the actual people assigned to a work center?
4. What is the purpose of the UMPR?
5. What is the difference between an ACR and an ACN?

2-2. Supervision

As a noncommissioned officer in charge (NCOIC), you manage resources—budget, unit equipment/supplies, staff, and time. There are many long-term objectives that managers must achieve, particularly with regard to the development, support, and motivation of his or her work-team. The ability to be an effective and efficient manager is not something we are born to do, but it is something we are able to develop. The benefits we gain by taking the time to develop our skills will far outweigh the time and energy we may spend having to put out fires we could have prevented. Being able to focus on your tasks at hand can be difficult when you are unable to manage your time. This one precious resource cannot be replaced, but there are tools to help us build a more efficient use of this resource.

030. Daily workcenter operations

Daily operations incorporate not only completing your responsibilities but also achieving the teams' mission. Planning is an integral part of the each medical technician's daily schedule, and altogether is the primary mechanism for guiding the efforts of your unit. The real test of your planning ability is your daily efforts to direct, plan, and prioritize assignments, which results in an efficient and well-run unit.

Direct personnel

Supervisors must lead their teams by setting the example, communicating often with team members, and establishing a clear set of standards in the workcenter. Direction of personnel depends on the skill level; for example, those technicians in upgrade training (UGT) will probably need more direct supervision versus a technician that is already qualified on a task. Supervisors must gauge this process and build each team member up while meeting or exceeding mission requirements.

Planning

Planning is not limited to top management; it is implemented throughout the organization and your work area. Planning is a *continual process* that moves from setting the unit's mission to setting the organization's benefits. A written plan is a useful and productive tool. When you plan ahead, you bridge the time span between where your unit is today and where it will be tomorrow. You will need to tailor your plan to your individual style and needs.

031. The right priorities

It is not sufficient to simply create a plan; you must also be able to set priorities and articulate and implement whatever you plan. For a plan to work, each step must receive equal attention and a specific completion time. This lesson describes how to forecast future decisions and how to manage your time.

Forecasting

In planning, you forecast the future and make decisions. When you combine your forecast with historical unit data you are able to determine the most appropriate course of action for your unit. With a clearly defined written plan, you are able to visualize between “the actual state of your unit” to “the desired state in the future.” This plan must then be prioritized. Each task needs to be placed into a category based on the timeliness of the completion expected. This provides you clear direction to accomplish all necessary tasks in order of importance.

As an NCOIC, you manage by increasing and decreasing resources such as budget, unit equipment, supplies, and staff. You even have the ability to control the information you seek or receive. But, *time is the one resource you cannot increase or decrease*; no matter what you do, you cannot get more time.

You may not have the choice of whether or not to spend time, but you do get to choose how you spend your allotted time. Prioritizing your plan of action enables you to make the best use of this precious resource.

Categorizing priorities are the most efficient time management tool utilized. The following categories are examples of this basic tool:

Categorizing Priorities	
Categories	Description
A	Urgent priority—hot items that must be completed by the end of the duty day.
B	Immediate priority—items that need to be addressed within the next two days.
C	Lowest priority—items that may be delegated out to other persons within the unit; the completion time for these projects may not be for a week or more.

Upon the completion of the category C tasks, you may need to oversee the final product. Remember to keep in mind that all tasks have a specific place; a plan full of all A-priorities will become overwhelming and unmanageable. Budget each of these priority levels in your plan, having no more than 10 percent of A-priorities daily, then evenly split your remaining time between B- and C-priorities. With proper planning and prioritizing as the key to unlock your plan, you will be able to bridge the time span between where your unit is and moving your unit forward to the next level.

Ongoing time management

There are many long-term objectives that you must complete. These tasks do not have specific deadlines because they are continual. Some of these particular tasks include, but are not limited to, the development, training, support, and motivation of your work-team. These long-term objectives have the potential to become problems because they are important but not urgent. They do not have concrete deadlines; therefore, they seem to be distant and remote. Without a plan to accomplish these

recurrent tasks, you can see that it is all too easy to ignore these tasks in order to accomplish the urgent A and immediate B priorities.

The advantage of time management is that through your planning and prioritizing, you control what you accomplish, and when it is completed. Simply put, you might decide that one hour a week should be devoted to personnel issues. You would then allocate a regular block of time to that activity. Of course, if the hospital is on fire, you may have to re-allocate this time in a particular week. Barring such crises, this time should become sacred and always applied to the same designated purpose. Similarly, time should be allocated to staff development and training. The actual time spent in managing this sort of long-term objective is small, but without that deliberate planning it will not be achieved.

032. Duty schedules development

Planning and prioritizing are primary mechanisms for guiding the efforts of your unit or clinic. The real test is your ability to direct efforts on a daily basis. Scheduling can be one of the biggest nightmares you will encounter as an NCOIC. You may think this is a difficult, frustrating, and unrewarding task. However, if done correctly, and with the right objective in mind, making a duty schedule can be the foundation of a well-managed unit. This information can help you eliminate many problems you might encounter when making a duty schedule. Planning for staffing is one of the most pressing issues in your day. There are four objectives you must meet when you develop a duty schedule:

1. Adequate patient care coverage while simultaneously avoiding overstaffing.
2. Desirable distribution of days off for each staff member.
3. All individuals are treated fairly.
4. Individuals know in advance when they are scheduled for duty.

Nurse manager and NCOIC responsibilities

Nurse managers and NCOICs are responsible for the final approval of the enlisted duty schedules within a unit or clinic. Their responsibilities are described in Air Force and group guidelines. The nurse manager and NCOIC are responsible for the review and approval of staff schedules on the unit, but they do not necessarily have to prepare the schedule. With training, most members of a unit can prepare schedules. The NCOIC can give these technicians the opportunity and teach others how to work out satisfactory schedules. It is imperative to provide an experienced instructor for novice schedulers; a 2- to 3-day schedule overlap is ideal for these two schedulers to work together.

The NCOIC is responsible for scheduling the enlisted personnel. The completed schedule is then reviewed and approved by the nurse manager/element chief. Both officer and enlisted personnel need experience in preparing these schedules. It is excellent preparation for the next managerial step. Preparing schedules is a groundbreaking activity to enter into supervision and management. A competent scheduler has to quickly adopt a managerial viewpoint. For others who continually complain, the responsibility of creating a schedule may give them the opportunity they need to gain new perspective. Complaints tend to slack off when the task of producing a schedule is delegated to the person complaining.

Scheduler responsibilities

The scheduler must use all AFIs, operating instructions (OI), and local guidance to prepare a duty schedule. The responsibility of the scheduler is to make sure all shifts are adequately covered. The scheduler develops the schedule and then totals the number of staff per shift.

The scheduler completes the schedule and gives it to the NCOIC. If necessary, the NCOIC will return the schedule to the scheduler, requesting any necessary corrections. By delegating the duty schedule, the nurse manager and NCOIC will help the staff grow and develop management skills. By correcting his or her own mistakes, the scheduler learns from the experience.

Official instructions

AFI 36-3003, *Military Leave Programs*, contains information pertaining to leave and administrative absence policy. This reference will help guide you in following policy. The MTF may have an OI on scheduling. If it does not provide enough guidance, the nurse manager and NCOIC may have to develop a unit OI on scheduling. Here are examples of what local nursing service policies might contain:

- Annual leave time may not be granted in conjunction with other long extended absences, such as a TDY, unless unusual circumstances prevail. What constitutes an unusual circumstance is a managerial decision.
- Technicians exchanging hours with other technicians must have supervisory approval beforehand. Supervisors must know who is and who is not on duty in the MTF. Technicians wishing to exchange shifts with others do not always know the needs of the MTF nor do they know the experience levels of the entire staff. The type of management and staffing centralized or decentralized, also has a bearing on this aspect.
- Personnel may not leave the duty section regardless of whether a unit is “slow or quiet,” unless excused by a designated supervisor. Again, your staff does not always know the needs of the MTF.
- Policy guidelines and OIs prevent risk or hazard to the patients and to the staff. They vary with each MTF. As a minimum, you should establish a policy to cover these categories if these items are not otherwise covered in a leave policy above your own.

Factors affecting duty schedules

While the previous lesson covers the guidelines for a basic duty schedule, the world of Aerospace Medical Service technicians is not staffed for production of a product. We deal with patients and the unpredictability of illnesses and disease processes. No one plans exactly when patients will need medical attention. In some instances, you can look at data to determine a trend for the patient needs within the MTF. The patients’ needs drive our staffing needs, so you must consider the patient care factors, patient census, and the age and sex of the patients in order to staff appropriately in an MTF.

Patient care factors:

- Level, complexity, duration, and timing of care needed for patients.
- Review the type (intensive or minimal) and the amount of care your patients will need or the type of cases you will work with.
- Overlapping shifts during heavy workloads.
- Schedule more technical staff when the workload requires more technical skill.

Patient census:

- You may be able to predict times when your census will be high or low.
- Your census may be low during the Christmas season or when certain physicians are on leave or TDY.
- You might have a high census during the flu season or during other epidemic times.
- If you have an adjunct work area, communicating and coordinating with that area(s) will help you estimate and plan for your heavy workloads.

A good example of this is the surgical inpatient unit where 90 percent of the patient load generates from the surgery clinic visits. Normally surgery clinic patients consult with their surgeons in the clinic and schedule their surgery during their clinic visit. The time of their surgery is recorded on a surgery log for the surgical suites to plan for the future surgery. The inpatient surgery unit needs to have an open communication line with the surgery clinic and the surgery suite so the patient care workload can be planned.

Age and sex of patients:

- Pediatric orthopedic or geriatric units may require heavier staffing than other types of units.
- Minimal care units function well with limited staff; however, the staff may need to be experienced.
- Consider the amount of patient teaching required.

The duty schedule must be developed so that adequate, qualified personnel are available to meet the patient care requirements. Knowing something about the workload of your unit makes scheduling easier. Develop your schedule to allow for planned classes, meetings, duties, TDYs, leaves, and emergencies.

If you schedule an inservice or staff meeting, make sure you have adequate staffing to cover the unit during those times. Whenever possible, schedule staff meetings at a time that permits staff members to attend during their duty time, not on their off time.

Balance of personnel

Remember to provide for effective utilization of nursing personnel and their nursing skills. Consider providing staff members a chance to use a variety of skills, while ensuring patient needs are being met. Also, consider staff needs for supervision as well as job and career growth.

Consistent patterns

Staff members will normally be happy with a schedule showing consistency and predictability.

Equal distribution

Inequities in duty schedules, such as “undesirable shifts or stretches,” can seriously affect the work area’s morale and staff productivity. Try to be as fair as possible when developing the duty schedule.

Maximum hours off between shifts

Arrange the schedule to allow for at least 12 hours off between shifts, making exceptions for emergencies. Twelve hours allows the staff member to rest between shifts. Compliance with all pertinent policies and procedures is necessary to ensure adequate coverage. This includes hospital policies, procedures, and local civilian labor contracts. You may find that these factors have a tremendous effect on how you develop your time schedule.

Schedule dos and don’ts

Providing high-quality patient care is your primary duty-scheduling objective. A secondary objective is developing a schedule that combines good personnel practices and staff satisfaction. Because the policies and procedures we follow when developing duty schedules affect both the quality and quantity of the nursing care we provide, you must always consider the dos and don’ts of scheduling:

DOs:

- Arrange duty hours and days off to allow for consecutive days off.
- Try to allow 12 hours off between shifts.
- Determine maximum length of work stretches with efficiency and satisfaction in mind.
- Grant compensation time to personnel when possible. Check your unit policies on granting compensation time to civilian personnel.
- Develop a system or plan to cover emergency situations.
- Once the duty schedule is published it should only be changed by the supervisor for emergency purposes.
- Schedule additional time for supervisory and administrative duties of all personnel.

DON'Ts:

- Do not double back.
- Do not allow staff members to make (annotate) changes on the duty schedule without approval of the supervisor or officer in charge (OIC). Allowing this to happen could create serious personnel conflicts.

Scheduling options

You can draw up your schedule in several different ways. You can schedule a conventional Monday–Friday, 0700–1600 schedule; a cyclical 12-hour schedule, or you can explore the possibilities of a flextime schedule. Depending on the number of personnel you have to schedule and their desires, you may be able to increase your workers' quality of life and your unit's capability.

Conventional schedules

Obviously, conventional schedules are the easiest way to develop your schedule. You simply require everyone to show up every morning and work for eight hours until the end of the duty day. They go home and return the next morning. This is repeated week after week with no changes.

A minor modification of the conventional schedule is having an “early tech” and a “late tech.” For example:

1. Early technician duties — Arrive at work at 0600. Prepare the clinic for receiving patients. Obtain records if needed. Other administrative duties as needed. Lunch at 1030 or 1100. Released for the day at 1500.
2. Late technician duties — Arrive at work at 0730. Immediately begin patient care. Lunch at 1130 or 1200. After clinic closes for the day, prepare record requests, straighten work areas, and replenish supplies. Released for the day at 1630.

This is an oversimplification of a schedule, but you can see the idea. This can help prevent that “we’re behind” feeling early in the morning. It also provides for late afternoon clean up following clinic closure.

The advantages of conventional scheduling are continuity, 100 percent daily coverage, and standardization with other clinics. The disadvantages consist of very little flexibility and less time off for recreation.

Cyclical/12-hour scheduling

Cyclical scheduling is a 4, 6, or 8-week schedule that provides even coverage and high stability. The cyclic schedule is typically seen with 12-hour shifts. The cost to maintain this type of schedule is low because it is easily accomplished through a *continuing cycle*. The decreased man-hours to produce a schedule are where the cost savings is seen. Some of the advantages of this system are as follows:

- Once the cycle is developed, it is relatively permanent and requires only temporary adjustments.
- Time off may be scheduled as far out as 6 months making personal planning easier.
- Requests are decreased because of the personal planning advantages.
- Can be used for permanent, rotating, or mixed shifts.
- Easy to modify known or anticipated periods of heavy workload and emergencies and/or unexpected shortages.

Once the master schedule has been developed, the cycle is a continual rotation. One disadvantage of using this method is that it is somewhat *inflexible*. Special requests for time off throw the cycle out of sync for a particular team or block of personnel. With any type of schedule, a constant, sufficient number and mix of personnel are required to make it work. A 2-week cyclic schedule has a repeated pattern of each staff member receiving every other weekend off (usually a 3-day weekend). Having

the ability to plan a schedule 4, 6, or even 8-weeks in advance contributes to staff satisfaction. As a result, continuity of care is enhanced and teamwork develops. This pattern also provides for float personnel to fortify the staff when the need arises. Review the pattern of your cyclic schedule periodically to ensure it still meets the purpose, philosophy, and objectives of your MTF and its mission. Make sure the schedule is practical in regard to the mix of your staff; that it continues to meet your patient care requirements. This will ensure you continue to utilize personnel effectively.

Flextime scheduling

The flextime scheduling concept is beginning to catch on throughout the federal work force. You may even have some civilian employees in your medical facility that utilize a variation of flextime. The two most common types of flex scheduling are five/four day biweekly schedule and the four-day week.

1. Five/four day biweekly schedule—This schedule involves working five 9-hour days one week and four 9-hour days the next week with the 10th day off. This keeps the length of the work day close to an 8-hour schedule while providing a 3-day weekend every 2 weeks. If all your personnel want this schedule, you could put half of your people on four/five schedule and the other half on five/four schedule. This way your people who are off on Friday cover the Monday that the other personnel are off. You could then flip-flop the schedule as needed.
2. Four-day week schedule—This schedule uses four 10-hour days. Every fifth workday your people are off. If you have enough personnel, this can be very effective for quality of life enhancement and increased clinic coverage. Again, you can stagger this schedule to provide coverage through the entire week.

Flextime scheduling comes with advantages and disadvantages just like conventional scheduling. Advantages include great flexibility for college classes, more time off, less travel time to and from work (avoiding rush hour), and greater coverage on any particular day. The disadvantages are greater potential for fatigue and possibly being shorthanded occasionally.

As with any type of management, many of these concepts are dependent on your personnel's acceptance of them. If the technicians that work for you don't want flextime, no amount of coercion is going to make them happy with the notion. If only a few of your technicians are interested, going to flextime may not be possible either.

The important thing is to be open minded. Realize that in today's Air Force many things are possible. As long as you are accomplishing the mission effectively and efficiently, you can try almost anything.

Compressed work schedule

A newer concept is the compressed or 4-day week schedule. This concept is usually utilized with clinic personnel working four 10-hour days per week, then having every fifth workday off. Some advantages can be that you are able to overlap time between shifts allowing for improved interpersonal relationships, increased staffing at busy times, and meal break coverage. The extended hours may also allow staff to attend inservices and classes and other training activities. The disadvantages included a greater potential for fatigue and it requires more staff than 8- or 12-hour shifts.

Self-scheduling

Self-scheduling is a new process by which the staff collectively decides and implements the monthly work schedule. Your staff is given the criteria for adequate staffing of the work area and then each member chooses which days of shifts he or she will work. Implementation of self-scheduling does require planning. In order to implement self-scheduling on your unit/clinic you need to set up a series of meetings designed to identify problems with your existing scheduling system, to present the concept of self-scheduling as an alternative system, and to establish a few practice sessions with the system. Specific criteria for the implementation must be set up indicating the number and mix of personnel needed to ensure the provision of quality patient care for each shift, every day of the week.

The staff must also be willing to negotiate with one another when scheduling conflicts occur to ensure the needs of the unit/clinic are met. Self-scheduling works more effectively if, as in the traditional method, your nights and evenings shifts are filled first. This allows your day shift to determine when they must rotate to fill in on another shift.

General guidelines

As supervisor, you will be responsible for reviewing and approving the duty schedule. Some general requirements you may need to consider when reviewing and approving your schedule are as follows:

1. Develop a system to cover emergency situations or unexpected changes to accommodate both employee and employer. Your entire staff should understand this system. If you are selecting a 12-hour schedule, check with civilian personnel policies and contracts.
2. Refer to specification contracts for civilian minimum/maximum works hours. For military, try not to exceed 44–48 hour week except in emergency situations. As the supervisor, you must place yourself on duty as much as possible during the normal duty week for coordination and supervision efforts.

When planning a duty schedule, you must keep in mind that people have emergencies and special circumstances that may need to be dealt with at the last minute. With teamwork and proper planning, you will be able to make the right decisions to be able to accomplish the unit mission.

033. Workcenter personnel orientation

Supervisors must be certain staff knows of specific rules as they apply to your unit. These are common items you may brief personnel when accomplishing a work center orientation.

Preparation of schedules

Personnel need to understand their chain of command and who to report at each shift. This also includes the type of duty shift and procedures to communicate issues that arise. The following is a list of the type of information you can provide all new personnel on the preparation of duty schedules:

- Authority, responsibility, and delegation.
- Length of cycle rotation and direction (forward, backward).
- Deadlines for posting.
- Guidelines for changes and/or exchanging hours.
- Reporting schedule changes.

Civilian employees

Civilian staff falls under certain requirements based on their contract. This contract establishes guidelines to assist in determining duty requirements:

- Review the union contract if applicable.
- Full time.
- Hours of work per week.
- Weekends and holidays per schedule.
- Permanent shifts.
- Lines of authority in absence of the nurse manager and NCOIC.

Orientation plans

Each staff member is evaluated based on their skill level and duty within the unit.

- 3-level personnel directly from tech school.
- 5-level personnel with no unit experience or personnel with 5 years' experience.

- SSGts or TSgts who have just cross-trained, but have management experience.

Specific requirements are listed in AFI 36-2201, *Air Force Training Program*. Additional orientation includes completing the following information in personnel AFTR.

Example of an Orientation Plan

On (date) I conducted an initial orientation with SSgt Snuffy and covered the following information in depth:

1. What the trainee will be doing and what the work center mission is. Reviewed work center description in section SharePoint training binder. We discussed the mission of the Air Education and Training Command (AETC), xxx Training Group (TRG), the XXX Training Squadron (TRS), XXXXX Flight and Section.

Work area: Bldg XXXX

- a) Describe and show around work center facilities.
- b) Show designated parking areas. Caution not to park in reserved areas.
- c) Duty address: XXXXXXXXXX.

2. Duty hours and shifts, including periods of rest (non-duty time). Duty hours are: _____

Work Habits:

- a) Utilization of duty time.
- b) Leave/Pass Policy.
- c) Military courtesy, bearing, and appearance.
- d) Other:

3. Safety requirements found on the AF IMT 55, Employee Safety and Health Record. My AF IMT 55 is located _____

- a) Applicable safety directive.
- b) Specific safety clothing/equipment required: IAW AFI 36-2903, *Dress and Personal Appearance of Air Force Personnel*.
- c) Other:

4. All time and training requirements for upgrade and/or qualification (AFI 36-2201, CFETP) and faculty development training (AETCI 36-2203).

- a) Upgrade training will be complete NLT: _____ (N/A if not in upgrade training).
- b) All duty position/qualification training will be complete NLT: _____ (look at MTP).
- c) All faculty development training will be complete NLT: _____ (reference position requirements in Air Education and Training Command Instruction (AETCI) 36-2202, *Faculty Development and Master Instructor Programs*, Att 3, Required and Recommended Training; feel free to list scheduled dates here also).

5. What is expected of the trainee? Trainee's responsibility to the supervisor, trainer, and training program.

6. Security:

- a) Applicable security directives: AFI 31-401, *Information Security Program Management*, AETC Sup 1, *Information Management Security Program* and AFI 31-501, AETC Sup 1, *Personnel Security Program Management*.
- b) Specific work center security areas, precautions, and instructions. See unit security manager for more detailed information.

7. Supervisor responsibility to the trainee. The most recent recall roster along with policies/procedures was given to the member. Member was informed that the chain of command is as follows:

- (1) Reporting Official: SSgt First Last.
- (2) Flight NCOIC: MSgt First Last.
- (3) Flight Superintendent: MSgt First Last.
- (4) Squadron Superintendent: MSgt First Last.
- (5) Unit Commander: Lt Col First Last.
- (6) Group Commander: Col First Last.

8. Trainer/Task certifier responsibility to trainee.

Special requests

Preparation of schedules should also incorporate consideration of personnel on leave, holidays, weekends, and military planned days off. This will assist in answering any request for personnel requesting unplanned funerals, weddings, graduations, and so forth.

Mandatory formations

In a military environment, personnel are required to also plan for training at either the squadron or base levels. Training educates your staff on mission requirements and strengthens each person's contribution to the mission. It also helps personnel understand their role in a workcenter and how they fit into the organizational plan. The list below provides other mandatory formations to keep in mind when making a schedule:

- Mobility exercises.
- Required training.
- Details.
- Inservice, teaching.
- Special projects.
- Additional duties such as committee membership.
- Classes, emergency medical technician (EMT), cardiopulmonary resuscitation (CPR), advanced life support, and so forth.

On call procedures

You must also consider personnel on-call during non-duty hours. They might be called in to duty and spend more hours on the job that may not be listed on the schedule. The duty schedule may have to be adjusted if the hours they work conflict with a regular schedule.

- Is a beeper required for being on-call?
- Must individuals check in every four hours?

Tardiness

There are situations that occur unexpectedly where personnel on the schedule are not present for duty. A plan must be in place to handle this occurrence; for example, personnel late due to traffic or medical illnesses and injury.

- If an individual calls 15 minutes prior to shift, they are not late.
- Individuals who are tardy more than three times per schedule will be counseled.

Compensatory time

You must also keep track of those personnel who stay late after duty hours. If approved by the chain of command, compensation of duty hours can occur at a later timeframe where adjustment of schedule is necessary such as:

- When individuals are called in for more than 4 hours during on-call time.
- Compensation will be given for mandatory formations during off-duty time.

Split shifts or other irregular schedules

Due to the size and differences in staff family circumstances, you must plan shifts for personnel who are approved by chain-of-command for an altered duty schedule. You should be aware of these circumstances so everyone involved is aware of those irregular shifts.

- Individuals with approved family/deployment circumstances are required to accrue adequate work time.
- Individuals approved to further their education may work only day or night shift (depending on their class schedule).

034. Position description and performance standards

You have been working hard on the ward all day. Now you are told to review and update all the position descriptions in your work area. As an NCOIC, you are responsible for preparing, reviewing, and editing the position descriptions and performance standards. These define the roles and responsibilities and describe the minimum standard of performance expected of each position in your work area. A position description is a written statement of key duties and responsibilities, required qualifications, and the conditions for the particular position identified. Combined with performance standards, which describe minimum standards of acceptable performance of position responsibilities, these descriptions become an important management tool used by the NCOIC to make certain responsibilities are delegated wisely, work is efficiently distributed, staff talents are fully used, and morale is maintained. Position descriptions and performance standards protect your staff from being asked to do things they are not qualified to do. These tools also set clear expectations of what you expect from those who work for you.

Supervisor responsibilities

The responsibilities of a supervisor are broad. You must ensure that all positions in your work area have position descriptions. If not, you must develop descriptions for these positions and any new positions. Remember, these need to be updated at least annually or more frequently if any changes to the positions occur. You can delegate the task of revision and updating to your staff when it is appropriate.

You must provide a copy of the position description to every staff member during orientation and feedback sessions. Discuss the position descriptions with each staff member, noting how their job contributes to the delivery of patient care; how much other staff members depend on them; and how they can meet the unit, clinic, department, or facility objectives. Make sure each staff member understands all aspects of their position description and has a current copy for future reference.

Position description

The position description is a comprehensive document that includes the specific position requirements such as supervision, promotion expectations, a job summary, and duties to be performed while on the job. A *job description* is a brief summary of jobs or tasks performed by the position.

Purpose of position descriptions

Position descriptions are used to establish staff member's role boundaries by providing an evaluation tool derived from job specifications. They provide outlines of the functions and activities (work) required to achieve the organization's objectives and aid in selecting the right person for a particular

job. They are used to orient new staff members, and they help staff members analyze their duties for a better understanding of their jobs. Position descriptions also identify potential training needs while maintaining continuity in constantly changing work environments by serving as a basis for planning staffing needs.

There are many *external factors that affect how and why we develop position descriptions* within our organization; first, is the Joint Commission (JC) accreditations. While it does not directly state a description is required for each position, it does require orientations to include, at a minimum, information about the individual's position description. Each staff member is assigned clinical and/or managerial responsibilities based upon their educational preparation, applicable licensing laws and regulations, and an assessment of their current competence. This requires the supervisor to look at what knowledge, skills, education, and experience are necessary to perform in a specific position, and to determine how much supervision is needed for that position.

The National League of Nurses also requires a written description for all nursing positions. This must define the role and responsibilities of each position. They must be written in terms of objectives, should form the basis for an individual's evaluation, must be reviewed and dated annually, must be discussed with each new staff member. We also have external factors based upon our professional organizations, such as NREMT and Association of Surgical Technologists. A new requirement specific to our career field requires the use of position descriptions and performance standards as orientation and feedback tools for all assigned medical service technicians.

The job analysis

A job analysis determines the *minimum* requirements (type and level of knowledge, skill, aptitude, and personal characteristics) for a position description. They set standards for factors such as education, experience, intelligence, personality, and physical strength. It does not have to be a formal project. This is the study of a position and helps to determine job characteristics, such as what knowledge, skills, aptitude, and personal characteristics are needed to perform the job successfully, but it does not include any attempt to change the tasks. You can accomplish this through the use of a job diary or log, interviews with your staff (talk to them and ask what they think the job should include), questionnaires, and observations of personnel in similar jobs.

How to define job duties

First, look closely at the standards of practice that will be used as a basis for the duties to be performed in a specific position. When formulating the duties of the position description, begin with the present tense using an active verb, (i.e., assesses, reviews, teaches, or plans ["I" or "you" is understood]). Next, indicate an object of the action to be performed (i.e., patient, records, families, or care). You can combine two related duties with one object, such as "develops and presents educational offerings." Don't state the quality or quantity of how a task is to be performed; this is done in the performance standard. The duties should be clear. Use words that are easily understood. Be precise so that it means the same thing to all personnel. Use abbreviations only after spelling them out once. Avoid technical jargon by using current terminology.

Where used

So, let's imagine that you have created the Pulitzer Prize of position descriptions. Where can you use it? The uses of a good position description are countless. First and foremost, it provides valuable guidance to the person doing the work. A good position description serves as the foundation for the development of performance standards. Position descriptions are normally used during the initial feedback session with the subordinate and as a refresher during other feedback sessions. Performance standard development is discussed later in this unit.

How used

Position descriptions also provide valuable information to outside agencies such as the Health Services Inspection (HSI) team. By reading the position description of personnel assigned to your

clinic, an inspection team gets a pretty complete idea of how well your clinic is performing. Weak position descriptions lead them to believe you may not have a clue as to what you are doing and who is responsible for doing it. Strong positions descriptions illustrate that all personnel assigned know what they should be doing.

Used as a tool

Another use of position descriptions is as a reference tool. All of us have struggled from time to time with various award packages. The first section on the AF Form 1206, Nomination for Award, is Leadership in Primary Duties. What better way to identify those characteristics in your personnel than by examining their position descriptions in the light of the specific award package and start from there? As you can see, solid, tight, and concise position descriptions can go a long way toward helping you run a more productive clinic.

SAMPLE POSITION DESCRIPTION

DEPARTMENT OF THE AIR FORCE

xxx TRAINING SQUADRON (AETC)

Sheppard Air Force Base, Texas xxxxx

POSITION DESCRIPTION

I. JOB TITLE: CCAF Instructor, Medical Service Craftsman Course-Resident

References: AFMAN 36-2108, 4N0XX Career Field Education and Training Plan, April 2007

a. Knowledge: Possesses in-depth knowledge in nursing theory and techniques, patient needs, nursing approaches, and team nursing. Also, possesses knowledge in medical terminology, anatomy and physiology, emergency care, drugs and their administration. The following knowledge is included as a requirement: medical and legal ethics, aseptic techniques, universal precautions, and infection control concepts. Supervisory knowledge is to include operating and maintaining therapeutic equipment, personnel and unit management, disaster preparedness and chemical warfare, risk management. This position also requires additional knowledge of preparation and presentation of technical training programs; classroom and laboratory instruction, student evaluation techniques, effective writing and speaking; interviewing and counseling. Possesses a working knowledge and general understanding of the Instructional System Design (ISD) process, research and development of curriculum materials. Has a comprehensive knowledge of personnel management, resource management, administration requirements and local policies pertaining to this course. Possesses an advanced knowledge of the enlisted specialty training programs to include maintenance of faculty folders, 6-part Education and Training folders, and continuing education requirements for instructors. Possesses a working knowledge of the use of computer skills for course development and the use and routine maintenance of audio-visual equipment used in training.

b. Education: Associate degree in Health Care Science or equivalent degree is the mandatory minimum level of education.

c. Training: Completion of basic Emergency Medical Technician (EMT) Training and current National Registry of Emergency Technicians certification is mandatory. Completion of American Heart Association and Cardiopulmonary Resuscitation Instructor Courses are highly desirable. Completion of Basic Instructor Course, Airman Leadership School (ALS), Basic Counseling Course and Instructional Systems Development is required. Completion of computer training courses is desirable.

d. Experience: Journeyman skill level/Assistant NCOIC required.

e. Grade Spread: SSgt through TSgt.

II. SUPERVISION: Supervision received:

a. Direct: Assigned Instructor Supervisor

b. Indirect: Course Supervisor, Medical Service Manager

Supervision exercised:

a. Direct: Assigned personnel, Assigned Classroom Students.

b. Indirect: Non-assigned Students.

III. PROMOTION TO: Assistant Instructor Supervisor**IV. JOB SUMMARY:**

- a. Conducts classroom, laboratory and computer based instruction.
- b. Trains_____ students yearly; maintains student records and forms for classes of up to 24 students.
- c. Subject-matter qualified in all objectives of classroom and laboratory instruction for 80-hour course.
- d. Evaluates students' learning and recommends action using performance and written examinations.
- e. Provides special individual assistance and counsel's students with academic and non-academic problems.
- f. Assists Instructor Supervisor with the development of instructional materials and curriculum improvements.
- g. Develops curriculum, computer based training materials and computer based instructional training aids.
- h. Nationally certified Emergency Medical Technician and Basic Cardiac Life Support Provider Instructor.
- i. Additional Duties:

V. DUTY PERFORMANCE:

- a. Conducts classroom and laboratory technical instruction IAW plans of instruction (POI) and course policies.
- b. Administers student performance and written evaluations.
- c. Documents student's progress.
- d. Interviews, counsels, refer and follow up on students in regard to academic performance.
- e. An interview, counsels, refers and follows up on students in regard to personal and behavior problems.
- f. Coordinates with Career Field Manager, Command Functional Manager's, Air Force Reserve and Air National Guard manager's, and Air Force Medical Treatment Facilities/Unit Training Managers as needed pertaining to training and student issues.
- g. Attends inservices and training sessions.
- h. Provides assistance to the Instructor Supervisor.
- i. Develops curriculum, computer based training materials and computer based instructional training aids Have the supervisor use the following task breakdown worksheet to train the 7-level upgrade trainee.

Using good position descriptions

While this may be a little out of proportion for a surgery clinic performing 50 biopsies a month, a large clinic or surgical suite with four doctors and six technicians ordering 100 biopsies a month will benefit from this level of management. The development and use of good position descriptions are something you can incorporate into your leadership and management style as you advance in the Air Force. Now that you understand something about position descriptions, let's look at the next level of personnel management.

Performance standards

All of us at one time or another have had an employee that we felt did not "make the grade" or "failed to meet standards." How exactly do you know that they do not meet standards? You cannot depend on some "gut feeling" that this employee won't make it. You must be able to demonstrate not only to the employee, but also to your supervisor, where exactly they are not meeting the standards.

What is a performance standard?

A performance standard is no different than any other military standard; it is the minimum acceptable performance you are expected to meet. It allows you to see how someone's performance "measures" up to the standard. Imagine having a measuring stick that you could hold up against your worker's ability to check-in patients or perform strength testing.

Standards should be directive, measurable, and conditional. When a standard is directive in nature, there is no question whether it is to be followed or not. To be measurable, a performance standard must be tangible, based on the reality of what is possible and attainable. The conditions placed on a standard are simply the setting of a minimum limit to the standard.

Good performance standards make your daily job of supervising equitable and easier to manage by making it easier to gauge the quality of patient care that is provided. While some differences are unavoidable, your goal should be that all patients receive high-quality care from everyone in the clinic. A patient should not receive good care one day from one technician and poor care from a different technician on the following day. Lastly, when you have good performance standards, it takes the guesswork out of writing evaluations; the performance standards are your expectations to the tasks performed by all unit/clinic personnel.

Development of performance standards

Performance standards are really just the end result of a multistep process. Prior to developing performance standards, you must ensure that the job duties are clearly stated. This is done during the development of the position description and job description. Once you outline the actual duties, you can begin to develop the standard criteria that allow you to accurately measure whether or not the work is being done to the required standard. The following table is an example of a portion of a performance standard.

Performance Factors	Duties Performed	Performance Standard/Condition	Does Not Meet Standard	Meets Standard	Exceeds Standard
9. Completes with recurring training requirements					
	9.1 Maintains BLS/EMT certification	No lapse in certification			
	9.2 Attends required annual training as scheduled	Absences approved by supervisor, make up completed within 30 days			
	9.3.1 Identifies disaster team assignment and where to report if activated	Reports IAW Med Grp recall guidelines			
	9.3.2 Attends monthly disaster team training	Absences approved by team chief, make up training completed within 10 duty days			

Performance criteria can generally be broken down into distinct types. These are qualitative, quantitative, or a combination of the two.

Qualitative

A qualitative criterion is exactly that—a criteria that defines the quality of an item.

Quantitative

A quantitative criterion defines itself. It is a criterion that measures the quantity of something done. It measures how much, how fast, or how often something is done.

Combined

A combined task is one where you are concerned not only about the accuracy of a task but also how quickly that task can be done. For example, students at the Aerospace Medical Service Apprentice Course can accurately perform and record blood pressure measurements when they graduate.

However, the time it takes for them to achieve that accuracy would not be tolerable in a busy clinic. The speed and accuracy needed comes from practice.

When performance criteria are set using these guidelines you can be assured that the standards should be measurable and attainable for all personnel. For example, let's look at the process of ordering and delivery of military spectacles in two days. This performance standard meets the criteria guidelines of being qualitative and quantitative, but when you evaluate the entire process, is it attainable? The ordering must be done accurately to meet the qualitative criteria. This is realistic and attainable. The problem occurs in the delivery of the spectacles in 2 days. Through tracking this standard you could see that this aspect of the performance standard would be unrealistic to meet. This is then a poor standard and needs revision.

Using performance standards during evaluation

Following development of the position description and performance standards, you can then develop actual statements that reflect the individual's behavior in the work environment. Essentially you are stating whether or not the individual exceeded the standard, met the standard, or failed to meet the standard. These statements accurately reflect how your personnel did in meeting the standard described above.

A good evaluation statement is clear and concise without ambiguous references. A good statement also comments only on the observable factors. If it is not observable, don't guess. Avoid using absolutes such as: always, never, everyone, and all staff; rarely are they true and they can set you up for making untrue statements. State what the person did, how they did it, and last but certainly not least, the impact on the mission.

Performance standard should accurately reflect the minimum expectations. Performance standards are used during the initial performance feedback to establish the minimum level of expected performance and to show how performance is measured in relation to peer performance. During the midway feedback, review the established standards and inform the individual if they meet, do not meet, or exceed the minimum performance standards. Using this approach allows the individual to improve on performance before the next EPR is due. If an individual doesn't meet the standard, a follow up feedback prior to writing the EPR should be accomplished. You will have a true measurement of individual performance in relation to previous performance measured against the prescribed standard. This method negates any misunderstandings about performance and allows you to accurately reflect the performance with a true, uninflated rating.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

030. Daily workcenter operations

1. Along with completing your own daily operations responsibilities, what other factor is important?
2. Who is responsible to lead their teams and establish clear standards for the workcenter?

3. What is the emphasis of planning in daily operations?
4. What is a productive tool used in the planning phase?

031. The right priorities

1. What is one resource you cannot increase when accessing the course of action you control?
2. When setting priorities what basic information is used to categorize priorities?
3. What is the percent of A level priorities to budget to assist in bridging the time between each category?

032. Duty schedule development

1. Planning for staffing is one of the most pressing issues in any manager's day. What are the four objectives in developing a duty schedule?
2. Who is responsible for final approval of the enlisted duty schedule?
3. What are the responsibilities of the NCOIC and nurse manager within a unit or clinic?
4. What references and guidance does the scheduler use to prepare a duty schedule?
5. What are the responsibilities of the scheduler within a unit or clinic?
6. What schedule provides a continual rotation, but the least amount of flexibility?
7. What scheduling technique could you possibly use to incorporate overlap between shifts, increase staffing at the busiest times, and offer staff the opportunity to attend inservice training?

033. Workcenter personnel orientation

1. What type of information can you provide all new personnel on preparation of duty schedules?
2. What type of information can you provide civilian personnel on preparation of duty schedules?
3. What type of information can you provide all personnel on mandatory formations?

034. Position description and performance standards

1. Define job description.
2. During orientation, you review the position description with A1C Matthews. What purpose does it serve to review the position description?
3. What nonmilitary guidelines govern the position description for the Aerospace Medical Service technician?
4. What does a job analysis determine?
5. What is a performance standard?
6. In order for a performance standard to be measurable, what criterion must it meet?
7. Prior to establishing the performance standards, what must be accomplished?
8. AMN Alexander is completing the end-of-day records review for the patients seen by his clinic team. What performance criteria would you use to evaluate his performance?

2-3. Management of Medical Logistics

In the previous section, we discussed manpower resources but we obviously can't take care of our patients with people alone. In order to provide care and treatment to patients, we need to have the necessary supplies and equipment to do the job. This section discusses some important facts and principles of supply and equipment.

035. Supplies and equipment management

Each duty section has an expected normal usage of supplies. Additionally, duty sections also have certain assigned equipment that must be accounted for and maintained in order to accomplish the assigned mission properly.

Proper management of supplies and equipment involves two key factors. First, each duty section must designate someone to serve in the role of custodian for the supplies and equipment. This person is often the NCOIC of the section, though the responsibility is sometimes delegated to another member. Second, the custodian must maintain accurate and up-to-date records to ensure a true reflection of the section's inventory.

According to military guidance, management of public property includes the proper allocation, control, care, use, and safeguarding of public property under control of the Air Force. This applies to each individual, whether they signed for the property or not. If it is being used by you, or under your supervision at the moment, it's your responsibility. Such responsibility includes pecuniary (financial) liability. If you are found neglectful of supplies or equipment, you may find yourself footing the bill for broken or misused supplies or equipment.

Key terms

The following table includes some of the common terms and definitions associated with the medical logistics responsibilities common to medical technicians. The terms listed here are defined per AFI 41-209, *Medical Logistics Support*. AFI 41-209 and AFMAN 41-216, *Defense Medical Logistics Standard Support (DMLSS)*, are the primary reference sources for all medical personnel who have supply and equipment responsibilities.

Term	Definition
Accountability	The added degree of responsibility for property that exists when a designated individual must maintain property records subject to audit.
Allowance standard	An equipment allowance document that prescribes basic allowances of organizational equipment and provides the control to develop, revise or change Equipment Authorization Inventory Data (EAID).
Consumable supply item	An expendable item that loses its identity when used, cannot be reused for the same purpose, or is not durable enough to last one year. Drugs, X-ray film, and adhesive tape are examples.
Controlled medical item	An expendable item of medical material that, because of its susceptibility to misuse and theft, requires special accounting, storage, shipment, and issue precautions.
Defense medical logistics standard support (DMLSS)	The software system used by MTFs Logistics activities for the procurement and management of supplies and equipment.
Durable supply item	An expendable item that is not consumed in use and has a life expectancy in excess of one year but does not qualify as an equipment item.
Electronic catalog (ECAT)	A web-based ordering system which enables DOD and Federal agency customers access to multiple manufacturer and distributor commercial catalogs.
Equipment-medical	A medical equipment item that has a life expectancy of 5 years or more, maintains its identity when in use, is nonexpendable, and costs more than \$2,500.
Equipment authorization inventory data	A record of in-use equipment, mission category and allowance source information.
Equipment-nonmedical	A nonmedical equipment item normally used for janitorial and office functions such as typewriters, paper shredders, pencil sharpeners, etc.

Term	Definition
Expense medical equipment	Medical equipment that costs more than \$2,500 and less than \$250,000.
Expiration dated material	Items labeled with a specific date beyond which the product either cannot be expected to yield its specific results or retain its required potency.
Equipment review and authorization activity (ERAA)	A group or individual appointed to review equipment authorizations for the medical activity and make recommendations to the approving official
Forward logistics	A proactive logistics function that is responsive to customer needs. It provides a complete medical logistics function to MTF customers.
Government-wide purchase card (GPC)	A means of purchasing supplies and equipment.
Investment medical equipment	Also called capital equipment. Medical equipment costing \$250,000 or more.
Local purchase (LP)	An authorized purchase from sources outside the DOD of materiel and services by a base activity for its own use or the use of a logistically supported activity. Local purchase is not limited to the immediate geographical area in which the base is located.
Medical equipment management office (MEMO)	A functional element within each base medical logistics activity responsible for managing medical and nonmedical equipment at each MTF.
Medical Logistics	The functional area within a medical organization responsible for support of patient care in peacetime, wartime or contingency. Medical Logistics functions include responsibility for Material Management, Facility Management, Medical Equipment Management, Biomedical Equipment Maintenance, Contract Services and War Reserve Material management
Organizational equipment	All equipment items authorized for, or on hand in, an organization to support its mission. All organizational equipment pertaining to a medical activity is managed by the base or command MEMO.
Prime vendor (PV)	A DOD program that provides the MTF with a prime supplier for a distinct commodity line, such as medications. A PV is a mandatory source of supply for all MTF local purchase requirements with specific types of contracts.
Property custodian	An officer, enlisted member, or civilian designated by the chief of the service, commander of the unit having the property, MTF commander, or the MTF commander's designated representative to maintain custody, care and safekeeping of property used by activities in the organization. The property custodian prepares and forwards requests for supplies and equipment.
Using activity	An organization or element of an organization that requests supplies from the medical logistics activity and/or equipment from the MEMO.

Accountability and responsibility

When you buy something from a store, the moment the sales clerk completes the sale, the store drops accountability. The item becomes your property, and you're accountable and responsible for it. Similarly, if supply issues you an item, accountability is transferred to you along with the item. However, you don't become the owner of the item; instead, the Air Force retains ownership, and you assume responsibility for the care and protection of the item.

There are three basic categories of responsibility, or accountability, when talking about medical materiel:

1. Command responsibility.
2. Custodial responsibility.
3. Supervisory responsibility.

Command responsibility

Commanders at all levels are charged with ensuring only qualified personnel are selected and assigned as accountable officers, which includes property custodians. In addition, commanders are responsible for ensuring the following regarding materiel accountability:

- Adequate space is provided for proper storage of medical supplies and equipment.
- Prescribed records are maintained.
- Supply discipline is understood and followed.

Obviously, with all the other responsibilities commanders have, they aren't going to be able to meet all these responsibilities alone, so they'll delegate the responsibility to someone else, making this person a property custodian. This someone else may be you. If you're entrusted with the care of government property, don't take the responsibility lightly. You're accounting for the materiel in your section as your commander's representative. Remember, commanders are still ultimately responsible for the materiel under their command. You're helping them out by serving as property custodian.

Custodial responsibility

The medical group commander or designated representative appoints a property custodian based on the recommendation of the clinic/unit leadership. The property custodian may be an officer, enlisted, or civilian member and is officially appointed in writing on a delegation of authority letter. Two copies are made containing sample signatures of the authorized representative (appointed property custodian). One copy is forwarded to the MEMO and the original is kept in the new property custodian's folder.

Once appointed by the commander, property custodians are authorized to request and receive medical materiel for their particular account (clinic/unit). The new appointee has assumed the commander's responsibilities for managing materiel for the clinic's account. The property custodian maintains the care, custody, and safekeeping of property under his or her supervision. If there are any questions, refer to AFMAN 23-110, *USAF Supply Manual*, Volume 2.

Usually, a property custodian has another person in the clinic acting as his or her alternate. This person receives the same training and is appointed as a property custodian by the commander. This way, if the primary is on leave, goes TDY, or is sick or injured, the alternate can take responsibility for managing the equipment and supplies in his or her absence.

The property custodian must promptly report any losses, or other irregularities relating to materiel, to his or her supervisor. Then, the property custodian should notify MEMO personnel, who will help establish what needs to be done to solve the discrepancy.

There will be times when a property custodian must turn his or her account over to someone else. For example, when the property custodian is being relieved from duty, transferred, separated from service, or will be absent from the account in excess of 45 days, MEMO personnel need to be notified so they can take action to have the property transferred to an authorized successor.

Supervisory responsibility

When it comes to medical materiel, supervisors have a two-fold responsibility:

1. Training their personnel on the proper use of equipment.
2. Ensuring supply discipline is exercised by those under their supervision.

When a new person arrives, he or she may encounter new equipment. The supervisor is responsible for training the new person on the proper operation of the equipment and identifying the safety features and any hazards related to the equipment. It may seem silly at the time, but the supervisory responsibility is to make sure people are trained on the equipment. The training may save someone from embarrassment, or it may actually save the equipment from damage or a patient from harm. Statistics show over 70 percent of medical equipment malfunctions can be attributed to operator error.

Proper training and orientation can usually prevent this. Medical equipment is extremely expensive and funds are limited. You must strive to get the maximum use out of all equipment.

If supervisors take their responsibilities seriously by training their people on the proper use of equipment and stressing the importance of knowing the equipment's capabilities, your equipment will last longer.

Supervisors are also responsible for teaching personnel the principles of supply discipline and ensuring they follow those principles. Since everyone in the section uses the supplies, it's important to have a basic understanding of the maintenance of supplies and equipment. Listed are some of the tenets of supply discipline:

1. Safeguard and preserve public property.
2. Use equipment and supplies only for their intended purpose.
3. Avoid ordering excess materiel. If excess is discovered, turn it in.
4. Adhere to the procedures contained in established directives governing requisition, storage, issue, and turn in of property.
5. Ensure requests for supplies and equipment are valid and in minimum quantities necessary to perform the assigned mission, and these assets are protected, conserved, and maintained in the best possible condition to meet Air Force commitments.
6. If safety hazards, broken or lost equipment, or low stock levels are found, report the information to your supervisor immediately. Remove any broken equipment or supplies or equipment that could cause harm to patients or staff immediately.

These tenets apply even if you aren't the property custodian. For example, you shouldn't tell the property custodian to order 24 pens when the section only needs six. Additionally, if you open a drawer and find 100 pens, get with the supply custodian to have him or her turn in what's not needed.

036. Patient transport item management

Medical Logistics uses the DMLSS system to procure and manage supplies and equipment. If you are selected as the property custodian or an alternate, you will receive specific training in the proper use of this system. However, you should have a basic understanding of how supplies and equipment are ordered and tracked whether you are the custodian or not. As you may already realize, there are supplies that you use on a daily basis, some that require special ordering, and some that you may need on an emergency basis. We discuss the most common ways you will deal with supplies and equipment. In addition to DMLSS, the GPC is also an avenue that logistics personnel may purchase authorized supply and equipment items. Another means of service is through a local purchase (LP) request. LP may be authorized for specific supplies, equipment or service but must be approved the proper authority.

NOTE: National stock numbers (NSN) are used to identify supplies and equipment. You will normally need an item's stock number, nomenclature (item description), unit of issue, and manufacturer when ordering it for the first time.

Supplies

The majority of Air Force medical supplies are procured and stocked by the PV and the GPC. Prime Vendor is a DOD program that provides the MTF with a prime supplier for a distinct commodity such as pharmaceuticals. PV is a mandatory source of supply for some requirements within your facility. Normally, routes for ordering supplies will be routine and can be completed through Forward Logistics, Manual Replenishment, and the MTF Catalog Search.

Forward Logistics

Forward Logistics is an automatic resupply system; that is, medical logistics personnel replenish supplies automatically, so the customer seldom has to inventory them. Under this system, the

property custodian will work with medical logistics to designate a primary supply storage area and establish reasonable levels on routine items for automatic resupply. Once the listing is established, Logistics personnel automatically inventory balances and deliver routine supply requirements to their customers via an established delivery schedule. Once the supplies are delivered to your supply point, it's your responsibility to ensure security and monitor consumption of the supplies.

In addition to this automatic resupply, logistics folks screen stock for quality control standards, such as destruction, suspension, and dated item control. You should review stock levels monthly and coordinate with your account rep or contact customer service with any required changes. In addition to being an automatic resupply system, the method also allows logistics to issue less than the standard unit of issue. For example, an item with a standard unit of issue of "box" containing 12 tubes, with a total cost of \$1.44, may now be issued as an individual tube costing 12 cents. This could drop operation costs significantly.

Manual Replenishment

The Manual Replenishment option is available in DMLSS. It is used to order items that you have ordered previously on your account. You should speak with your property custodian to order through this method. Only a trained custodian with access to DMLSS can order through this method.

MTF Catalog Search

The MTF Catalog Search option is used to order items that you believe may have been ordered somewhere else in the facility but is not in your list of items previously ordered. Again, access to this program requires a property custodian or designated DMLSS trained personnel.

Equipment

The office that manages equipment for a facility is the MEMO section of logistics. The property custodian will also use the DMLSS system to track equipment items.

The main form used for most equipment requests, transfers, and turn-ins is the AF Form 601, Equipment Action Request. The custodian should maintain a copy of each AF Form 601 until the action appears on the custodian action list and the actions are reflected on the Custodian Receipt /Locator List.

Ordering new equipment is a process that must be followed carefully to ensure the information is accurate and the equipment package request is complete. Generally speaking, incomplete packages will not be accepted by MEMO personnel. When ordering equipment you will likely need to complete the AF Form 601 and a 13-point justification. The 13-point justification is a detailed list of information that takes some time to complete. It is a good idea to speak with your MEMO personnel for assistance to complete a 13-point justification. Very detailed information is normally a benefit and will help ensure you get the product you are requesting. Though some equipment can be obtained fairly quickly, custodians should be aware that investment equipment might take several months to obtain. Preplanning is an important role of the custodian. Refer to AFI 41-209 for more information on equipment management.

There are five of the primary tools used in the normal supply and equipment record-keeping process: Activity Issue/Turn-in-Summary, Backorder Report, Custodial Actions/Custodial Report Listing, and AF Form 1297, Temporary Issue/Hand Receipt.

Activity Issue/Turn-in Summary

The Activity Issue/Turn-in Summary is updated each time a product is delivered to or turned in from your account. This listing contains information pertaining to all supply and equipment items issued to or turned in by the section. Custodians should monitor this report to ensure accuracy. Discrepancies must be promptly reported to Medical Logistics personnel. The DMLSS system allows the property custodian to access this information at any time.

Backorder Report

It's common for a section to order supplies or equipment items that are not immediately available. Such items are placed on backorder by the Medical Logistics office until actual delivery occurs. Like the Activity Issue/Turn-in Summary, this report is available to view and/or print in DMLSS. A due-in is established along with a due-out backorder and is written in the transaction history file. After the item is received and processed by MEMO personnel, your clinic receives it.

Custodians are responsible to validate that items on the list are still needed. If an item is no longer needed, Medical Logistics must be informed. An attempt to cancel the order with the supplier is initiated by Medical Logistics. Custodians should never assume that a backorder item would eventually arrive without some action on their part. If an item has been listed on backorder for more than 30 days, get in touch with MEMO personnel again to have them follow up on the order. This helps ensure it doesn't disappear as a requirement for your clinic. Don't let a needed item become an ignored request. The property custodian should follow-up on backorder item every 30 days.

Custodian receipt/locator list

A current copy of a signed Custodian Receipt/Locator List (CRL) is maintained in the equipment custodian folder. This is a list of all equipment within your custodian account. The property custodian receives this list upon assuming property custodian responsibilities. A new CRL can be provided by the MEMO office at any time. When an updated list is received and the property custodian has ensured all equipment and actions are accounted for, the old CRL may be destroyed. It is very important for you to realize that you take responsibility for the account and the materiel on it when you sign the CRL. Before signing the CRL, you and the current property custodian must perform a physical inventory. As custodian, the equipment becomes your administrative and financial responsibility. Both you and the previous custodian must check that every piece of equipment is present and accounted for before the account is transferred.

If an item has been loaned out or isn't present, there should be record of its location documented on an AF Form 1297, Temporary Issue Receipt. As the new custodian, review all AF Forms 1297 on file, then go to the people who signed out the equipment and verify they still have it. Again, the item should be physically seen. Don't accept verbal statements. Once an item has been located, annotate on the AF Form 1297 and on your CRL the date and name of the person contacted. This shows when it was last accounted for. If an item isn't found and it isn't signed out on an AF Form 1297, it's likely the item is missing and an investigation needs to be done to determine the responsible party.

Once your physical inventory is complete, the original signed CRL is returned to MEMO and you retain a signed copy as a record of what equipment was signed for and is your responsibility. As items are issued to or turned in from the account, a signed AF Form 601 or a Custodian Action List (CAL) is maintained showing the item's status until the item is correctly listed or removed from the CRL. Once the item shows up or is removed (as appropriate) from the CRL, the AF Form 601 or the CAL may be thrown away. After the initial inventory is completed, you must conduct an inventory at least annually. The recommendation is to complete inventories once a quarter or as mandated by the commander.

Custodian actions list/custodial report list

If there are any changes to your account, the property custodian will receive a CAL with the change. Changes can result from new equipment being received, turning in old equipment, or transferring equipment to another account. The CAL should be maintained with the CRL to show any changes since the last inventory.

The CAL can be destroyed once you receive and sign an updated CRL. Before you discard any of the CALs, be sure that the actions have been reflected on your current CRL.

AF Form 1297, Temporary Issue/Hand Receipt

This form is used when equipment items are temporarily loaned to anyone outside of the duty section. This includes other MTF personnel and patients. A copy of this form is maintained in the duty section until the item is returned. Ensure that you have good contact information for patients as well as staff that may be using your equipment in another part of the MTF. It is a good idea to check these items when you are completing quarterly inventories. Often you will find that the individual or section that borrowed the item no longer needs it. If that is the case, have the patient or section return the item to you as soon as possible.

Once the item arrives, inspect it for damage and normal wear and tear; also see if it needs to be calibrated. If you have a calibrated item on loan to a patient, make sure the patient knows how often to bring it back for maintenance to ensure they are using equipment that is functioning properly.

037. Tag In Tag Out

Everyone in a duty section plays a role in the normal maintenance of the equipment they use. Failing to conduct appropriate routine maintenance according to a manufacturer's instructions may result in damage to equipment or injury to a patient or staff member.

Operator maintenance of medical and nonmedical equipment

Regular inspections (usually on a daily basis) are conducted to ensure all equipment operates safely and properly. Inspecting for faulty electrical cords and inoperable parts or functions is everyone's job. Biomedical equipment repair technicians (BMET) conduct medical equipment repairs in the facility, but you cannot rely solely on them as they do not inspect equipment on a daily basis. If a discrepancy is detected, the problem is reported to the appropriate authority. Here is a tip to remember what to do:

- **Inspect:** Inspect all equipment before using on a patient.
- **Remove:** Immediately remove any broken or improperly working equipment. It is important that you remove the hazard when you first find it so you don't forget or so that someone else does not take the equipment and use it before you can remove it.
- **Report:** Report the broken equipment to your supervisor or proper authority so steps can be taken to replace or repair the equipment as soon as possible.

The importance of equipment safety absolutely cannot be stressed enough. Faulty equipment or misuse poses a great danger to the safety of our patients, staff, and facility. We can replace broken or hazardous equipment but we cannot replace the damage done to a staff member or patient that is injured or killed by faulty or misused equipment. Take the time to inspect, remove, and report unsafe equipment.

NOTE: Your on-the-job training (OJT) trainer or supervisor will provide specific information for a particular task.

Reports and requests for calibration or repair

As you have gathered from the information you have already read, there is a considerable amount of paperwork and reports you must maintain. You will also maintain reports on any maintenance that is required whether the maintenance is due to normal scheduling or due to a problem with the equipment. The primary sources of recording equipment repair are the AF Form 1297 and the CRL. These also are used to track the location of your equipment while they are away from your section for repairs or maintenance. In conjunction with good record keeping of equipment inventories, documentation of equipment maintenance will ensure you always know where your equipment is and that it is safe and accurate for use. Consult your local BMET to resolve any problems and to obtain the most current procedures as well as local policy.

038. Report of Survey

If the property is lost, destroyed, or damaged by means other than fair wear and tear, obtaining relief from property responsibility can be costly to the person charged with the custodial responsibility. This process usually begins with a Report of Survey (ROS), which is an in-depth investigation performed by a designated survey officer.

Report of Survey process

The ROS is documented on a DD Form 200, Financial Liability Investigation of Property Loss. There are four general purposes of a ROS:

1. Research and investigate the cause of loss, damage, or destruction of property and determine if it was attributable to an individual's negligence or abuse.
2. Assess monetary liability against individuals who have lost, damaged, or destroyed government property or relieve them from liability if there is no evidence of negligence, willful misconduct, or deliberate unauthorized use of the property.
3. Provide documentation that can be used to support the adjustment of accountable records.
4. Provide commanders with case histories that will enable them to take corrective action to prevent recurrence of the incident.

There are two primary categories of items that require ROS documentation—supply system stocks and property record items.

Supply system stocks

Supply system stocks are those inventories where a stock record account is required to be maintained showing by item, the receipt, issue, disposal, balances on hand, and other such identifying or stock control data as may be required. Within Medical Materiel, documentation is kept for each supply item that enters and exits your account, and you'll use the DMLSS computer to account for and manage your inventory of supplies.

Property record items

Property record items include all AF accountable property other than supply system stocks. This category is broad and includes several types of properties. The following categories list some examples:

- *Military real property* includes property such as land, buildings, structures, utility systems, and improvements. This includes equipment (such as heating systems) that are attached to and made part of buildings and structures, but are not movable. It also includes installed equipment, such as elevators, lavatories, plumbing, and electrical systems. Machine tools and production equipment are not included under this category.
- *Military personal property* includes property such as accountable property of any kind, except real property (as defined above), supply system stocks, and tools used or capable of use in the manufacture of supplies or in the performance of services for any administrative or general plant purposes. It also includes excess, surplus, and foreign excess personal property such as personal property on which disposal action has been initiated by the DOD component. It may have come from your supply system inventories or from equipment in use. In either case, accountability is dropped at the time of transfer from owning agency to the property disposal agency.

Mandatory ROS

AFI 41-209 lists the conditions for mandatory ROS, and investigation is required for all items meeting the following criteria:

- Over \$50,000 – All items.
- \$100 or more – Pilferable items.
- Any value – Sensitive items (includes notes code Q and R items).
- Classified items.
- Personal arms.
- Ammunition (only when personal liability or systematic pilferage over time is evident).
- Bulk petroleum (loss exceeding stated allowance).
- Repetitive losses if the dollar value of the adjustment equals or exceeds projected cost of report of investigation.
- Any discrepancy when there is an indication or suspicion of fraud, theft, or negligence.
- When requested by the medical logistics flight commander (MLFC).

When a loss or theft of controlled substances is determined, the MLFC will immediately prepare Drug Enforcement Administration (DEA) Form 106, Report of Theft or Loss of Controlled Substances, and submit it to the nearest DEA regional office. For further information, refer to AFI 41-209, Chapter 5.

ROS procedures

When property is lost, damaged, or destroyed by an individual or an organization, the organization that has possession of the property will initiate the ROS and that unit commander, or in some cases an appointing authority, will appoint an investigating officer who must determine the facts in the case. The investigating officer must be “disinterested” and have no interest in the custodianship, care, accountability, or safekeeping of the property. Further, when appointed as investigating officer, completing the investigation becomes a primary duty and the officer is relieved of other duties or assignments that would interfere with the investigation. The investigating officer (the term “officer” applies to anyone appointed to investigate the case), at a minimum, will answer what, how, where, when, and who was involved, and whether or not there is any evidence of negligence, misconduct, or deliberate unauthorized use or disposition of the property. The investigating officer, based on the facts, makes findings and recommendations on the issue of liability of the person(s) involved. The next step is to refer the ROS to the accountable officer so that the records can be adjusted. Note that this action is not affected by the action the approving or appellate authority takes; therefore, the accountable records are adjusted as soon as possible.

Next, the investigating officer allows the person(s) involved to review the case and provide verbal or written information to refute the findings and recommendations. The ROS is then processed to the appointing authority for assignment of financial responsibility against the individual(s) charged or relieves them from responsibility. If financial responsibility is to be assessed, the ROS is referred to the legal office for review. If the investigating officer did not perform a thorough job, the ROS is returned to have it reaccomplished.

In some cases, the appointing authority may assign a financial liability officer to re-investigate the case. This is a second investigation and is performed when it is necessary to re-evaluate the initial investigation or because of the complicated nature of the case. In most cases, a financial liability officer should not be required if the investigating officer accomplishes a proper investigation.

In unusual cases, the approving authority may appoint a financial liability board to evaluate the findings of the appointing authority and the financial liability officer. Upon conclusion of these actions, the approving authority reviews the ROS and assigns financial responsibility or relieves the

individual(s) of responsibility. At this time the ROS is submitted for acknowledgment by the individual(s) charged who are advised that the ROS action may be appealed to the next level in the chain of command above the person who assigned the financial liability assessment.

Basis for government compensation

Since the ROS is an official report of facts and circumstances supporting the assessment of financial liability for the loss, damage, or destruction of AF property, it serves as the basis for the government's claim for compensation. In the Air Force, the ROS system is the method used for declaring a claim against military and civilian personnel who have lost, damaged, or destroyed public property in their possession. Pecuniary liability is generally limited to a maximum of one month's base pay of the person who lost or damaged the property. There is, however, no limit on liability for accountable officers; individuals who damage equipment; or individuals who, through negligence or willful misconduct, damage their assigned living quarters.

The unit commander, or accountable officer responsible for the damaged property, initiates the ROS process. If two or more persons are responsible for the loss or destruction, each is held jointly liable. If collection cannot be made from one of the liable parties, the remaining parties are still liable. The Air Force cannot collect more than the total amount of the loss or damage. The approving authority allocates how much will be collected from each party. Detailed instructions for preparing DD Form 200 are in AFMAN 23-220, *Reports of Survey for Air Force Property*.

AFI 23-220 provides guidance for determining when a report is mandatory. If a ROS is not mandatory, and the item is valued at \$500 or less, and an individual wants to voluntarily pay for property he or she lost, damaged, or destroyed, a ROS is not required. In this situation, use DD Form 362, Statement of Charges/Cash Collection Voucher, or DD Form 1131, Cash Collection Voucher, instead of a ROS for property record items. Payment must be voluntary and not coerced or threatened. Use DD Form 362 when military personnel or civilian employees admit liability and wants to pay, but don't have enough money to pay cash for damaged or lost property. This document authorizes payroll deductions to pay for the property in question; it is processed through the Accounting and Finance office. If the individual wants to pay cash, use DD Form 1131.

Property not on property records

You should not record government property that is not carried on the property records simply to initiate a ROS. You can initiate a survey on property not recorded and take action to obtain reimbursement for any government property lost, damaged, or destroyed regardless of whether or not it is considered as "accountable" property. This is particularly relevant considering the large number of local purchase items that are deleted from accountable records. Many items used in the Air Force are no longer on accountable records. However, commanders are still responsible for assuring they are properly maintained; when they are no longer required or usable, they are turned in to the appropriate property disposal office.

Disciplinary actions

Commanders decide if a case warrants taking disciplinary action under the Uniform Code of Military Justice (UCMJ). This is a separate action and is not related to the assessment or non-assessment of financial liability. Assessment of financial liability cannot be used instead of, or as a form of disciplinary action. Commanders are encouraged to use administrative actions when assessment of financial liability by ROS is not practical or desirable.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

035. How to manage supplies and equipment

1. According to military guidance, who is responsible for management of public property and allocation, control, care, use, and safeguarding of public property under control of the Air Force?
2. What is the commander's responsibility regarding materiel accountability?
3. Who provides the recommendation to the hospital commander for appointing the clinic or unit property custodian?
4. How is the appointment of the property custodian made? Describe the process.
5. What actions are property custodians authorized to perform with the medical materiel in their particular account?
6. When the property custodian finds equipment or supplies missing, or damage to equipment, who should he or she notify?
7. What is MEMO?
8. What must occur if the property custodian will be absent from the account for 46 days or more?
9. What are the supervisory responsibilities regarding medical materiel?
10. What percentage of medical equipment malfunctions can be attributed to operator error?

036. Patient transport item management

1. What type of action is recorded on the Activity Issue/Turn-in Summary?

2. How is the Activity Issue/Turn-in Summary accessed?
3. If an item listed on the Backorder Report is no longer needed, what should the custodian do?
What does MEMO do?
4. How often should the property custodian follow-up on backorder items?

037. Tag In Tag Out

1. How often should inspections be conducted on medical and nonmedical equipment?
2. Whose responsibility is it to check for faulty electrical cords and inoperable parts or functions?
3. Who repairs medical equipment?
4. What are three simple tips to detect and correct equipment problems?
5. What are the primary sources to record equipment repair?
6. Who should you consult to resolve equipment maintenance problems or confirm current and local maintenance policy?

038. Report of Survey

1. List four general purposes of a ROS.
2. What are two primary categories of items that require ROS documentation?
3. What minimum dollar value must a pilferable item exceed before a ROS is mandatory?
4. What agency reviews the ROS if financial responsibility is assessed against an individual?

Answers to Self-Test Questions

028

1. Medical Expense and Performance Reporting System.
2. It is the medical personnel, workload, and expense accounting system used by the USAFMS. It is the primary tool used to make manpower, budget, and other resource allocation decisions.
3. It incorporates tracking of tri-service management of healthcare resources. It enables joint capability of monitoring all uniformed services resources and is used to reduce inefficiencies and deficiencies in managing three different manpower and personnel systems. Product features includes identifying staff and where they work; filled and vacant positions, training records and all hours charged to each workcenter; readiness information for medical asset visibility; deployed to over 800 military medical sites and has 170,000 customers worldwide. Benefits to the Defense Health Agency include providing a combined view of medical assets, including civilian and military personnel, contractors and volunteers.
4. According to type and section.
5. He or she must provide accurate and timely information.

029

1. A funded manpower requirement that defines the position in terms of function, organization, location, skill, grade and any other characteristic needed to clearly define the position.
2. It is used to help manage manpower resources. It is the primary document that reflects all positions authorized to accomplish the mission.
3. UPMR.
4. It is also a means to manage manpower by using a list of the actual people assigned to the work center. This tool matches the names of personnel to the actual position he or she is assigned.
5. The ACR is a request by an organization to change its manpower authorization. The ACN is the MAJCOM's response to approve or disapprove the ACR.

030

1. Team's mission.
2. Supervisors.
3. Planning is a continual process that moves from setting the unit's mission to setting the organization's benefits.
4. A written plan.

031

1. Time.
2. Priorities can be categorized by these categories: A—Urgent priority, hot items that must be completed by the end of the duty day. B—Immediate priority, items that need to be addressed within the next two days. C—Lowest priority, items that may be delegated out to other persons within the unit, the completion time for these projects may not be for a week or more.
3. 10 percent.

032

1. (1) Adequate patient care coverage while simultaneously avoiding overstaffing. (2) Desirable distribution of days off for each staff member. (3) All individuals are treated fairly. (4) Individuals know in advance when they are scheduled for duty.
2. Nurse managers and NCOICs.
3. They are responsible for the review and approval of staff schedules on the unit but do not necessarily have to prepare the schedule.
4. AFIs, OIs, and local guidance.
5. To make sure all shifts are adequately covered.
6. The cyclic schedule.

7. Compressed work schedule.

033

1. Authority, responsibility, and delegation; length of cycle rotation and direction-forward, backward; deadlines for posting; guidelines for changes and/or exchanging hours; reporting schedule changes.
2. Review the union contract if applicable; full time; hours of work per week; weekends and holidays per schedule; permanent shifts; lines of authority in absence of the nurse manager and NCOIC.
3. Mobility exercises; required training; details; inservice, teaching; special projects; additional duties such as committee membership; classes, EMT, CPR, advanced life support, and so forth.

034

1. A brief summary of jobs or tasks performed by the position.
2. Help staff members analyze their duties for a better understanding of their job as well as identify potential training needs.
3. JC guidelines, NREMT guidelines, the Association of Surgical Technologists, and the National League of Nurses govern position descriptions.
4. The minimum requirements for a position description and the type and level of knowledge, skill, aptitude, and personal characteristics needed to perform the job.
5. It is the minimum acceptable performance expected to be met.
6. It must be tangible and based on the reality of what is possible and attainable.
7. Job duties must be clearly stated through the development of the position and job description.
8. You need to use a qualitative approach to evaluate the quality through accuracy of the task performed.

035

1. Each individual.
2. Ensuring only qualified personnel are selected and assigned as property custodians; that adequate space is provided for proper storage of medical supplies and equipment; the prescribed records are maintained; and that supply discipline is understood and followed.
3. Based on the recommendation of the clinic/unit leadership.
4. By a written delegation-of-authority letter. Two copies will be made, containing sample signatures of the authorized representative (appointed property custodian). One copy will go to the MEMO and the other copy will be kept in the new property custodian's folder.
5. Request and receive.
6. Their supervisor, then the MEMO personnel.
7. The Medical Equipment Management Office.
8. The account must be transferred to someone else.
9. Training of personnel on proper use of equipment and ensuring supply discipline is exercised by those under their supervision.
10. Over 70 percent.

036

1. Information pertaining to supply and equipment items issued to or turned in by the section.
2. Through DMLSS.
3. Medical Logistics must be informed. MEMO will attempt to cancel the order with the supplier.
4. Every 30 days.

037

1. On a regular basis, usually daily.
2. Everyone.
3. BMETs.
4. Inspect, Remove, Report.

5. AF Form 1297 and the CRL.
6. Local BMET.

038

1. (1) Research and investigate the cause of loss, damage, or destruction of property and determine if it was attributable to an individual's negligence or abuse. (2) Assess monetary liability against individuals who have lost, damaged, or destroyed government property or relieve them from liability if there is no evidence of negligence, willful misconduct, or deliberate unauthorized use of the property. (3) Provide documentation that can be used to support the adjustment of accountable records. (4) Provide commanders with case histories that will enable them to take corrective action to prevent recurrence of the incident.
2. Supply system stocks and property record items.
3. \$100.
4. Appointing authority.

Do the unit review exercises before going to the next unit.

Unit Review Exercises

Note to Student: Consider all choices carefully, select the *best* answer to each question, and *circle* the corresponding letter.

58. (028) What system is the primary tool used to make manpower, budget, and other important resource allocation decisions for medical personnel?
- a. Unit Manpower Document.
 - b. Unit Manpower Personnel Record.
 - c. Career Field Education and Training Plan.
 - d. Medical Expense and Performance Reporting System.
59. (029) Who approves or disapproves an Authorization Change Request?
- a. United States Air Force Medical Service (USAFMS).
 - b. Major command (MAJCOM).
 - c. Squadron commander.
 - d. Medical group commander.
60. (030) Who is responsible to lead their teams and establish clear standards for the workcenter?
- a. Commander.
 - b. Supervisors.
 - c. First sergeant.
 - d. Superintendent.
61. (031) When setting priorities, what category is used to assign an urgent priority?
- a. Category A.
 - b. Category B.
 - c. Category C.
 - d. Category D.
62. (032) What are the responsibilities of the scheduler within a unit or clinic to make sure all shifts are adequately covered?
- a. Use local guidance only to prepare a duty schedule.
 - b. Use all group operating instructions (OI), and local guidance to prepare a duty schedule.
 - c. Use all squadron OIs, and local guidance to prepare a duty schedule.
 - d. Use all Air Force instructions, OIs, and local guidance to prepare a duty schedule.
63. (032) Who is responsible for final approval of the enlisted duty schedule within a unit or clinic?
- a. The noncommissioned officer in charge (NCOIC).
 - b. Nurse managers.
 - c. Nurse managers and NCOICs.
 - d. Commander, nurse managers, and NCOICs.
64. (032) What references and guidance does the scheduler use to prepare a duty schedule for the unit or clinic?
- a. Air Force instructions (AFI), operating instructions (OI), and local guidance.
 - b. OI's and local guidance.
 - c. Local guidance.
 - d. AFI 36-3003.
65. (032) What duty schedule provides a continual rotation, but the least amount of flexibility?
- a. Conventional.
 - b. Compressed.
 - c. Cyclical.
 - d. Flextime.

66. (033) What type of information can you provide all new personnel on preparation of duty schedules?
- a. Local policies; chain of command; unit manning document; unit personnel management roster.
 - b. Base policies; chain of command; unit manning document; unit personnel management and recall roster.
 - c. Authority, responsibility, and delegation; length of cycle rotation and direction-forward, backward; accountability; chain of command, unit manning document, unit personnel management and recall roster.
 - d. Authority, responsibility, and delegation; length of cycle rotation and direction-forward, backward; deadlines for posting; guidelines for changes and/or exchanging hours; reporting schedule changes.
67. (033) What mandatory formations do you keep in mind when making a schedule?
- a. Mobility exercises.
 - b. Off-duty employments.
 - c. Volunteer charity events.
 - d. Dependent spouse conferences.
68. (034) Performance can be broken down into what two types of criteria?
- a. Visible and qualitative.
 - b. Visible and quantitative.
 - c. Qualitative and understood.
 - d. Qualitative and quantitative.
69. (035) Who is responsible for the control, care, use, and safeguarding of public property under control of the Air Force?
- a. Each individual.
 - b. Unit supervisor.
 - c. Group commander.
 - d. Account custodian.
70. (035) By training new personnel on proper equipment, what is the supervisor likely to prevent?
- a. Equipment damage and injury to a patient.
 - b. Injury to a patient and buying new technology.
 - c. Reporting damage and buying new technology.
 - d. Reporting damage to the commander and logistics.
71. (036) What is the name of the product that is generated through the Defense Medical Logistics Support System (DMLSS) and lists information pertaining to all supply and equipment items that have been issued to or turned in from a section?
- a. Backorder report.
 - b. Activity issue/turn-in summary.
 - c. Custodial actions/custodian report listing.
 - d. Medical equipment review and authorization activity.
72. (036) What actions should the property custodian take if a backorder item is no longer needed?
- a. Accept the item; once an item is ordered you must receive it when it arrives.
 - b. Build extra supply inventory; it is always better to have extra supplies on hand.
 - c. Tell the Medical Equipment Management Office (MEMO) you did not order the item and that you will not pay for it.
 - d. Attempt to cancel the order through MEMO.

73. (036) What should you do if an item has been on backorder for more than 30 days?
- a. Cancel the order.
 - b. Complain to the commander.
 - c. Wait another 15 days and then follow up.
 - d. Ask Medical Equipment Management Office (MEMO) personnel to check on the order.
74. (037) How often are medical and nonmedical equipment inspections usually conducted?
- a. Daily.
 - b. Weekly.
 - c. Monthly.
 - d. Quarterly.
75. (037) What is the primary source for recording medical or nonmedical equipment repair?
- a. AF Form 1297, Temporary Issue Receipt only.
 - b. AF Form 1297, Temporary Issue Receipt or custodian actions/custodial report listing.
 - c. Activity issue/turn-in summary or backorder report.
 - d. Activity issue/turn-in summary only.
76. (037) Who should you contact to obtain the most current procedures and local policy for medical or nonmedical equipment problems or concerns?
- a. District sales and maintenance representative.
 - b. Base supply and equipment maintenance.
 - c. Biomedical equipment repair technician.
 - d. Original equipment manufacturer.
77. (038) Which are the two primary categories of items that require report of survey (ROS) documentation if lost, damaged, or destroyed?
- a. Supply system stocks and property record items.
 - b. Supply system stocks and military real property.
 - c. Military real property and property record items.
 - d. Military real property and military personal property.
78. (038) Pecuniary liability is generally limited to a maximum of one-month's base pay of
- a. a person who lost or damaged property.
 - b. an accountable officer who through negligence damaged assigned living quarters.
 - c. an accountable officer who through willful misconduct damaged assigned living quarters.
 - d. an individual who, through negligence or willful misconduct, damaged assigned living quarters.
79. (038) A report of survey (ROS) is referred to the legal office for review when
- a. the dollar value of the lost or damaged property is over \$500.
 - b. the investigating officer did not perform a thorough job.
 - c. the report of survey pertains to lost ammunition.
 - d. financial responsibility is assessed.
80. (038) What form is used when an individual admits pecuniary liability and wants to make a cash payment?
- a. AF Form 106.
 - b. AF Form 198.
 - c. DD Form 362.
 - d. DD Form 1131.

Unit 3. Interpersonal Relations and Population Health

3–1. Ethical and Legal Standards	3–1
039. Professional standards of ethics	3–1
040. Legal aspects of patient care	3–7
3–2. Professional Relationships	3–14
041. Positive professional relationships	3–14
042. Performing electronic communication	3–19
3–3. Patient Centered Medical Home	3–24
043. Purpose and core principles	3–24
044. Overview of information systems	3–30
045. Utilizing Tri-Service workflow forms	3–33
046. Outpatient coding	3–36
047. Using the Aeromedical Services Information Management System	3–39
048. Population health management principles	3–45

THIS UNIT COVERS IMPORTANT FACTORS relating to relationships that medics have with two key groups of people. These people include other health care personnel and the patients who are cared for in the health care facility. The sections addressed here pertain to ethical and legal standards, professional relationships, and the primary care management concept.

3–1. Ethical and Legal Standards

Adhering to ethical and legal standards is paramount to providing proper patient care. This section covers professional standards of ethics and the legal aspects pertaining to patient care.

039. Professional standards of ethics

Ethics pertain to choices you must make involving what is right versus what is wrong. Ethical judgment is making a moral decision on what should (or should not) be done in a given situation. Most professions have a code of ethics that relate to the job. This code includes both rules and a standard of conduct that members of the profession are expected to follow. Most ethical standards in the medical profession have an early root in the Hippocratic Oath that dates back to the fourth century BC. The medical community still uses this oath as a foundation for medical doctors today.

The American Nurses Association has a code of ethics that pertains to registered nurses (RN). The National Federation of Licensed Practical Nurses also has a code of ethics that licensed practical nurses (LPN) must adhere to. In the aerospace medical service specialty, the ethical standard followed includes portions of these previously described standards. All stipulate that health care providers must have certain character traits and perform their duties in a moral way. They include such traits as service above self, doing no harm, keeping patient confidences, and treating all patients with compassion. Think service before self.

Moral character

What is moral character? What attributes or virtues make up a moral health care provider? The ancient Grecian traits of temperance, wisdom, courage, and fortitude were all facets of moral character. These are still valid today. Christian attitudes of faith, hope, and charity are also still valid, as is the Puritan ethic of industriousness. Add to this list confidentiality, honesty, and compassion and you should have a good idea the conduct of a person in the medical profession is expected to be above reproach. Good moral character usually boils down to treating others as you'd like to be treated.

Moral obligations

What is an obligation? Many philosophers agree an obligation is more than just a feeling we have. It's more of a pull to do something based on certain character traits. If you feel compelled to act a certain way, it's because your moral character pulls or tells you to act that way. If the moral character is sound, then the moral obligations and resultant behavior will be sound; you'll perform your duties with a high standard of conduct. As we progress through life, we are continually changing our behavior based on new morals.

What was acceptable before we came in the Air Force may not be acceptable now. With that in mind, our morals are influenced thus changing our behaviors. This is a good thing as we become more professional in our daily lives. It doesn't make a difference what the duty is, as long as it's performed ethically. Though many professions have a formal written code of ethics, following the guidelines should be a matter of common sense. Ask yourself, "What is the right thing to do?" The answer becomes evident in most cases. It's all a matter of applying good moral judgment to all situations.

Terms related to nursing ethics

Various terminologies are used to define certain aspects of professional ethics. The following table gives a brief definition of each of these terms:

Term	Definition
Autonomy	Respect for others; recognize the right of individuals to make their own decisions.
Justice	Fairness.
Moral principles	General philosophical concepts pertaining to morals and ethics.
Moral rules	Specific guidelines applied in ethical discussions or decision-making.
Nonmaleficence	The duty or responsibility to do no harm. Nonmaleficence is a basic ingredient for a code of ethics.
Beneficence	Doing good.
Fidelity	Faithful to do good. Acting in a responsible manner.
Veracity	Truthful. Veracity breeds trust.

Standards of conduct for patient care

When sound moral and ethical work practices are defined, a standard of conduct for patient care becomes evident. The underlying foundation for conduct in the medical profession is a respect for all individuals as human beings. In addition to the personal side of these standards, a professional aspect must be considered. What does the term "professional" mean to you? As you progress in your military career, you'll hear the term often. But how does the term apply to you? We commonly think of a professional as a doctor, dentist, or lawyer. However, the term "professional" can be applied to you as well. Professionalism is the key to standards of conduct. Moral character, a sense of moral obligation and high professional standards make up a large portion of the standards of conduct. But, there is one more professional attribute that is a very important piece to put the whole puzzle together. This professional attribute is known as the *scope of practice*.

Scope of practice

Scope of practice is a defined area of responsibility that members of a specific specialty are trained and expected to perform. The scope of practice for AFSC 4N0X1 is clearly specified in the specialty training standard (STS) of the 4N0XX Career Field Education and Training Plan (CFETP). The items identified in the basic STS for the specialty are the items that medical technicians are authorized to perform after appropriate formal course training and/or on-the job training (OJT).

The scope of practice, as defined by the STS, permits two key things:

1. It identifies those skills that technicians are permitted to (and should) perform.
2. A skill *not* listed in the STS, or local document such as an AF Form 797, Job Qualification Standard Continuation, is something that a technician should *not* be performing on the job. This protects the technician, the patient, and the Air Force from potential legal problems.

When performing duties that are within the scope of practice, the following standards must always be evident in the actions of medics:

- Respect every patient as an individual.
- Do not perform tasks that are not within your scope of practice.
- Recognize the limitations of your own individual skills and knowledge; seek help when necessary.
- Do not perform tasks that you are not adequately trained or prepared to perform.
- Follow the instructions of your superiors.
- Be loyal to your profession and to your peers.
- Act with honesty and integrity.
- Maintain the patient's confidentiality.
- Strive to become more proficient in all aspects of your job.

Patient rights and responsibilities

The patient has both rights and responsibilities within the health care setting. Patient rights are designed to protect the patient, while responsibilities protect healthcare workers and other patients. All health care personnel are responsible to ensure that the rights of patients are upheld. By ensuring these rights, patients are relieved of unnecessary stress that could hinder the healing process. The following list provides *examples of these rights*:

- The right to receive quality medical and dental care consistent with available resources and accepted standards.
- The right to refuse treatment to the extent permitted by law and government regulations and to be informed of possible negative consequences associated with this decision.
- The right to receive considerate and respectful care with recognition of his or her personal dignity.
- The right to privacy and confidentiality concerning medical care to the extent permitted by law and military regulations.
- The right to know the professional status and credentials of health care personnel involved in the patient care process, including the right to know the name of the responsible primary health care provider.
- The right to receive an explanation concerning diagnosis, treatment, procedures, and prognosis pertaining to the patient in terms that the patient can understand.
- The right to be provided all information necessary to make a decision regarding consent for or refusal of treatments. Such information must include significant complications, risks, benefits, and available alternative treatments.
- The right to be advised if the health care facility intends to conduct research associated with his or her treatment, and the right to refuse participation in such projects.
- The right to receive care and treatment in a safe environment.
- The right to be informed of facility rules and policies that relate to patient and visitor conduct. The patient also has the right to expect compliance with these guidelines by other individuals.

- The right to be informed of procedures pertaining to the initiation, review, and resolution of patient complaints.

Patient responsibilities

Patients are responsible to follow certain measures that assist in an effective health care process. Close cooperation between health care personnel and the patient are a necessity at all times. The following list provides *examples of patient responsibilities*:

- To provide, to the best of his or her knowledge, accurate and complete information about complaints, medical history, and other matters relating to his or her health.
- To inform the primary health care provider whenever he or she does not understand explanations pertaining to treatment and other expectations.
- To be considerate of the rights of other patients and health care personnel, and to assist in the control of noise, smoking, and visitors in the health care facility.
- To comply with all rules and policies established by the health care facility.
- To respect the property of other individuals and the health care facility.
- To comply with medical and nursing treatment plans, including follow-up care as recommended by the provider. This responsibility includes keeping scheduled appointments and notifying the health care facility when appointments cannot be kept.
- To ensure that medical records are promptly returned to the facility when in the patient's possession for transportation to other appointments or consultations.
- To assist in the facility's quality improvement process by informing the patient advocate of all recommendations, questions, and complaints pertaining to the health care facility.

Chaperone responsibilities

AFI 44–102, *Medical Care Management*, provides guidance on the use of chaperones during medical procedures. A chaperone is simply a third party person who is present as a witness during a sensitive procedure. Each military treatment facility (MTF) must develop a local policy regarding the use of chaperones. At a minimum, the local policy must include the following:

- Assurance the patient has privacy during examination and treatment.
- Consideration of strict privacy for dressing and undressing.
- Circumstances requiring the presence of a third party during an examination or treatment at the request of the provider or the patient.
- Circumstances requiring the presence of a third party during the exposure, examination, or treatment of the genitals, rectum, or female breasts.
- Communication necessary to provide to the patient regarding the nature and purpose of examinations and treatments, to include the purpose of undressing.
- Education and training requirements for providers and staff personnel on the role of chaperones, procedures for identifying and reporting suspected misconduct, and procedures for resolving questions pertaining to the use of chaperones.

Whenever possible, a chaperone of the same sex as the patient should be used. Additionally, AFI 44–102 provides an exception to the use of chaperones during emergencies and life-threatening situations.

Death and dying

An important ethical responsibility of every member of the nursing team is to exhibit compassion and understanding for those patients who are dying. It's also very important to consider the tremendous impact the death of a patient has on his or her family and friends.

Patient attitudes toward death

For many patients who are in the process of dying, death can be viewed as a welcomed end to suffering. For others, it can be an extremely sad process if they refuse to accept. In either case, your role is to provide consistent, appropriate care as you would for any patient. Additionally, the emotional support you can offer is an invaluable factor.

Support can be provided in many forms. The most common, and probably the most helpful way to show support is to be available as a listener. You don't need to offer long speeches in order to help the patient emotionally. Your presence as an available listener (even if the patient isn't really saying much to you) is very important.

A patient's attitude toward death is closely related to his or her religious belief. For this reason, assisting in arranging visits from clergy can be very beneficial. Allow the patient the time he or she needs to be alone with clergy from his or her respective religious background.

Concepts of death by age group

There are varying concepts of death in general that are associated with different age groups. We address the general concepts that may be observed. Remember, the concept of death changes as a person grows older.

Infants and toddlers obviously have no concept of death. Curiosity about death is usually first evident for children between the ages of 3 and 5. This curiosity is usually first aroused because of the death of a family member that the child may have known, or possibly because of the death of a pet. In general, these toddlers usually view death as something temporary.

An important obstacle to avoid when discussing death with small children is the temptation to minimize the event. Honesty, as painful as it may be at the time, is always the best approach. Children have an amazing way of dealing with such events, though they may be catastrophic at the time.

Death is usually first viewed as "final" by children between the ages of 5 and 7. These children normally only view death as "something that happens to other people," as opposed to something that could ever happen to them. Children in this age group usually have strong feelings that death can always be avoided.

Young and middle-aged adults usually experience the most difficult reactions toward death. Since this is the age group where responsibilities to both younger and older family members are most likely, a great degree of anxiety concerning the well-being of surviving family members can be present. Adults will often, more than any of the other age groups, experience fear toward the possible pain and suffering that can be associated with the dying process. Things left undone, goals not yet achieved, and regrets for mistakes made in their life can become consuming thoughts.

Those who usually accept death better than any of the other age groups are the elderly. This is usually because of more experiences with death and dying throughout their lives. Some may welcome death as freedom from pain and suffering, or even as a long-awaited chance to reunite with those loved ones who preceded them in death.

Patient sensitivity and emotional support

By practicing the various guidelines discussed up to this point in this unit, many aspects of patient sensitivity are ensured.

A good rule to follow in all patient care situations is to ask, "*How would I want to be treated in this situation?*" or "*How would I want one of my family members to be treated in this situation?*" Practicing patient sensitivity includes being sensitive to their right to privacy and to their physical and emotional needs. In addition, understanding how people react emotionally in various situations is important. People respond to illness in different ways, however, certain emotional stages are often

common. These stages of emotional reaction associated with the grieving process include denial, anger, bargaining, depression, and acceptance.

Denial

The first response to a bad report is often denial. People initially tend to refuse to believe the worst in certain situations. As a health care person, avoid sharing in the denial and, instead, provide support and comfort.

Anger

Anger is frequently the next stage noticed. Often, a patient or family member's anger is directed toward those in closest proximity to the patient—the health care workers. An important reaction in these situations is to practice self-control in order to avoid directing the anger back toward the patient or family member. Additionally, it's important to help the individual understand their anger is a normal emotion in the situation. Health care personnel can also help during this stage by continuing to provide structured and professional care. Withdrawing from the situation in an attempt to avoid the patient only makes matters tenser.

Bargaining

The third stage of the grieving process involves bargaining. Bargaining is the act of thinking, "If I just do this, then everything will be okay again." Patients or family members may tend to blame themselves completely for the situation. Listening to the patient is very important during this stage. Arranging external support from clergy or other counselors is also helpful during the bargaining stage.

Depression

Depression occurs when the individual feels powerless to change the situation. However, this stage is indicative that the final stage of acceptance is near. Permit expressions of sadness at this time by being a good listener. Of all the stages, this is one time where allowing the patient to do most of the talking is very important.

Acceptance

The final stage of the grieving process is the acceptance stage. At this time, a person finally comes to terms with the situation. He or she may even begin making logical plans to adjust to the reality of the circumstance. Healthcare workers should permit the patient as much time alone as possible during this time. Getting the patient or family members involved in the health care process helps immensely during the acceptance stage.

Nursing considerations

As mentioned previously, the nursing role is to provide appropriate care for all patients, regardless of their prognosis. Be aware that members of the nursing team can be the targets of family member's frustrations during the process of losing a loved one. This can be one of the most trying times associated with your job. Keep in mind that you are not to blame for what is actually a normal fact of life. Your integrity must kick into high gear in these situations. A normal response might be to feel the need to "fight back" and defend yourself.

However, the greatest and (in the long run) most rewarding attitude you can exhibit is to remain professional and caring in spite of the circumstances. The image you present as a professional "sounding block" reflects greatly on the integrity of the medical profession as a whole.

This is not to say that you are in a position to be abused. If you feel circumstances have become overwhelming, talk to your supervisor. Above all, never try to bury your own sadness about a situation. Use the support of your peers when it comes to situations dealing with death.

Though you will undoubtedly see the effects death and dying have on patients and their family and friends many times during your career, it doesn't have to be a self-destructing part of your job. You

can learn from each experience you encounter, and soon you'll find that others look to you for support when they encounter the same situations.

040. Legal aspects of patient care

Consider the legal aspect of patient care in all situations. Laws are implemented by official governing bodies (such as the Congress of the United States) to protect both the patient and the health care worker. To ensure a patient's right to privacy is maintained, Congress passed two Acts—The Privacy Act of 1974 and the Health Insurance Portability and Accountability Act (HIPAA). Other terms associated with the legal aspect of patient care include unintentional torts, intentional torts, consent for treatment, standards of care, living wills, and durable powers of attorney. Let's begin with the Privacy Act of 1974.

Privacy Act of 1974

Information in the health record is personal to the individual and will be properly safeguarded. Medical records are maintained within a system of records protected by Public Law (PL) 93-579 and the Privacy Act of 1974. Electronic and hard copy records are covered by the "Medical Record System" which identifies the records, including secondary files, as inpatient and outpatient records of care received in Air Force medical facilities. The Automated Medical/Dental Record System covers automated records. Disclosure to third parties is prohibited, except pursuant to the written consent of the individual to whom the record pertains or in specified limited circumstances.

Regardless of position, all medical personnel must comply with the Privacy Act and associated laws and codes, such as 5 United States Code (USC) 552a, *Records Maintained on Individuals*, AFI 41-210, *Tricare Operations and Patient Administration Functions*, and any locally developed guidance. AFI 41-210 provides additional information for military facilities.

Informing the patient

Use a DD Form 2005, Privacy Act Statement – Health Care Records. This single form eliminates the need for a separate privacy act (PA) statement for each medical or dental document requiring an individual's identifying information. The form applies to medical and dental forms, as well as any related documents required in providing health care. Remember, most AF Form 2100A-series (Health Record – Outpatient) record jackets will have the Privacy Act Statement located on the outside cover or on the back of the folder. Patients utilizing these jackets do not require DD Form 2005, Privacy Act Statement—Health Records, is placed within the record.

The DD Form 2005 is not a consent form. It serves as evidence that, as prescribed by the Privacy Act, the individual was informed of the purpose and uses of the information collected and was advised of his or her rights and obligations with respect to supplying the data.

NOTE: The signature of the patient on the DD Form 2005 is not mandatory. The individual requesting the patient's signature should in no way coerce or even imply the signature is necessary before treatment is given. If a patient refuses to sign, the requesting individual should note such a refusal on the DD Form 2005 and sign it.

Privacy Act statement in outpatient records

The patient signs and dates the DD Form 2005 or AF Form 2100A only once for each outpatient health record, regardless of the time covered. The nonmilitary patient completes DD Form 2005 or AF Form 2100A at the time of his or her first clinic visit. Military members complete the form at the time of entry into service.

If the form is not in the military member's outpatient record or preprinted on the reverse of the patient's outpatient record jacket, it is prepared at the time of his or her first clinic visit. A completed DD Form 2005 is placed in records filed at other locations, such as mental health clinics.

Privacy Act statement in inpatient records

Place a signed copy of the DD Form 2005 in the inpatient record. For newborns, either parent can sign the Privacy Act statement.

Health Insurance Portability and Accountability Act

The purpose of the HIPAA is to improve the portability and continuity of health insurance coverage, improve access to long-term care services and coverage, and to simplify the administration of health care. Congress recognized the need for patients to maintain good health insurance and still maintain their privacy; therefore, Congress passed Public Law 104-191, *Health Insurance Portability and Accountability Act of 1996*.

The HIPAA touches all areas of our medical treatment facilities. HIPAA is not just a computer systems issue; it affects everyone who handles patient information. HIPAA is more of an information management issue than an information technology issue. The best and most expensive technology in the world will be of no use towards HIPAA compliance if the medical staff using the technology is not trained, educated, and focused on protecting patient privacy properly. Every medical facility is required to provide initial and refresher HIPAA training; however, the Privacy Officer located at your MTF should be able to answer any specific questions you have. The Privacy Officer will have a copy of any local operating instructions (OI) guiding release of protected health information and the process by which this can be accomplished. AFI 41-210 provides information on the Privacy Act and HIPAA and is a good reference; become familiar with it. For general HIPAA guidance, see DOD 6025.18-R, *DoD Health Information Privacy Regulation*.

Penalties for noncompliance

Each MTF will appoint a Privacy Officer to oversee ongoing activities related to the development, implementation, and maintenance of MTF policies and procedures covering access to and privacy of patient health information. Remember that HIPAA is a public law and this law requires you to ensure that reasonable safeguards are taken to protect patient information. Your role is to do the following:

- Protect health information.
- Review policies and procedures.
- Report suspected violations.
- Promote privacy awareness.

Failure to protect a patient or staff member's personal information may lead to military and civilian actions being taken against you. HIPAA is serious business!

Military actions

Imagine that you have just called a patient back to an exam room. While screening this patient you put down another patient's record on the table with a note for the doctor to please call her about pregnancy test results. Your actions have just violated HIPAA rules because patient information was inadvertently disclosed. If you notice this kind of violation, you should report it to your supervisor immediately and take actions to correct the violation.

Your supervisor will probably verbally counsel you. Depending on local policy and the infraction that incurred, you could face nonjudicial punishment or even a court-martial.

Civilian actions

Under HIPAA, Congress also established criminal penalties for knowingly violating patient privacy. Criminal penalties are a \$50,000 fine and one year in prison for knowingly violating patient privacy; a \$100,000 fine and five years in prison for obtaining protected health information under false pretenses; and a \$250,000 fine and 10 years in prison for obtaining or disclosing protected health information with the intent to sell, transfer, or use it for commercial advantage, personal gain, or malicious harm.

If civilian actions are taken against you, there will likely be military actions taken against you that could result in discharge from the military in a negative fashion.

There are some instances when patient information can be disclosed. Some examples would be release to appropriate command authorities to ensure a military member is mission ready or fit for duty. Pay close attention to the rules of your medical facility. When in doubt, ask your Privacy Officer for clarification.

Patients' rights

Under HIPAA, patients have significant rights to understand and control how their health information is used. Most of these rights are not new for our DOD patients, as we have had processes in place required by the Privacy Act, but we changed some of our business practices to comply with the new rules.

Patient education on privacy protections

Providers and health plans are required to give patients a clear written explanation of how the covered entity may use and disclose their health information.

Ensuring patient access to their medical records

Patients can see and get copies of their records, and request amendments. This is a new right for civilian patients. Our procedures for this are in AFI 41-210, and AFI 33-332, *Air Force Privacy and Civil Liberties Program*. In addition, a history of disclosures of a patient's information made to people outside of our system must be available upon request by the patient.

Receiving patient consent before information is released

Health care providers who see patients are required to obtain patient consent before sharing their information for treatment, payment, and health care operations. Patients have the right to request restrictions on the use and disclosure of their information.

Providing recourse if privacy protections are violated

People have the right to file a formal complaint with a covered provider, health plan, or the Department of Health and Human Services (HHS), about violations of the provisions of this rule or the policies and procedures of the covered entity.

Unintentional torts

Unintentional torts are acts in which the outcome was not intended. Two types of unintentional torts are applicable to the health care profession. These types include negligence and malpractice. In reality, these two torts are actually a breach of the standard of care.

Negligence

Negligence is an unintentional wrong where harm was not intended, though it did occur. Negligence results when an individual fails to act or not act in a reasonable manner. This applies to all personnel, even unlicensed caregivers. It can often be considered carelessness. An example would be not putting the bed rails up on a patient who had just returned from surgery.

Malpractice

Malpractice is negligence by a professional. Failing to be very careful (i.e., failing to report an adverse condition detected in a patient, leaving a hot compress on the patient too long, etc.) is malpractice. Technicians are legally responsible for their own actions. Medics must be careful in this area, especially if instructed to perform a task not within the scope of practice for technicians. For example, if a nurse or physician instructs a technician to perform a procedure outside his or her scope of practice, the proper response is to inform the nurse or physician immediately that the order is beyond his or her scope of practice. In many cases, the person who asks a technician to accomplish a

task that is beyond the scope of practice is simply unaware of the boundaries. This type of problem can be prevented by educating nurses and physicians on the purpose and content of the CFETP.

If you encounter a situation where you are asked to perform outside of your scope of practice, you should immediately decline professionally and inform your supervisor. If you perform an action that you later realize was out of your scope of practice, you should notify your supervisor and include your patient safety representative. You will likely need to document the incident so it can be investigated and ensure safeguards are put in place to keep the same or similar incident from occurring again to you or someone else.

Intentional torts

Torts considered to be intentional in nature include defamation, assault, battery, false imprisonment, invasion of privacy, and fraud.

Defamation

Making false statements about someone that results in injuring his or her name and reputation is called defamation. Defamation can occur in two ways—slander or libel.

Slander

Slander involves making an oral false statement about someone. It can be avoided by refraining from talking about others in an unprofessional manner.

Libel

Libel also results in harm to a person's name and reputation. In the case of libel, false statements are made in writing. This includes both written and printed words and pictures or drawings that depict a false impression.

Assault

Assault is the threat or attempt to touch another person without his or her consent. Actual assault results in a fear by the individual that bodily harm may occur. An example of assault in the health care setting would include threatening to take a rectal temperature on someone who refuses to permit an oral temperature measurement.

Battery

Battery is the actual touching of a person's body, regardless of how minor the procedure may be (i.e., starting an IV) without obtaining proper consent. Patients have the right to consent or refuse to consent to treatments. Various types of consent can be obtained and are described later in this lesson.

False imprisonment

Unlawfully restricting or restraining a person's freedom of movement is called false imprisonment. Even the threat of restriction/restraint can be considered false imprisonment. Examples of this tort include telling someone that he or she may not leave the facility or using restraints unnecessarily and without an order from a provider.

Invasion of privacy

Patients have the right not to have their name, photograph, or private affairs made public without proper consent. A violation of this right is considered an invasion of privacy. This problem is best avoided by ensuring patient information is only discussed or revealed to those health care workers with a need to know.

The privacy rights of patients must be guarded at all times. The following are examples of measures that should be taken to ensure that the patient's privacy is protected: using privacy curtains/screens, draping the patient to prevent unnecessary exposure, and ensuring that patient records are not left

carelessly where others without a need to know can see them. Be careful on the telephone when others are inquiring about a patient.

Fraud

Fraud is the act of deception. In the health care setting, a technician who leads a patient to believe that he or she is a doctor is an example of fraud. Lying to a supervisor about a job that was supposed to be performed is another example.

Consent for treatment

Two main types of consent for treatment are considered in health care—informed consent and implied consent.

Informed consent

In general, consent is “giving permission.” Patients have the right to decide whether they want an examination and treatment. Informed consent means the patient has given his or her consent only after the details of the procedure have been explained to them:

- The reason for the procedure.
- How the procedure will be performed.
- Who will perform the procedure.
- Any possible risks associated with the procedure.
- Other treatment options, if applicable.
- The expected outcomes of the procedure.
- Negative effects are possible if the procedure is not performed.

Authorization consenting to treatment should be obtained in writing for most procedures. Consent must be obtained directly from mentally competent adults. Parents or legal guardians must give consent for minors (usually those persons under 18 years old, depending on the state).

Legal guardians must also give consent for mentally incompetent patients who have been deemed incapable of giving consent for themselves.

Implied consent

In cases where a person is temporarily unable to consent to a lifesaving treatment because of illness or injury (i.e., unconscious or incapacitated), the law provides a form of consent known as implied consent. Implied consent legally assumes that if the person were able to consent to treatment, he or she would. This type of consent also applies to minors and mentally incompetent patients who are in need of lifesaving treatment when no parents or legal guardians are available to give consent for them.

Standards of care

Standards of care are defined as guidelines that specify the predicted care for specific situations. These guidelines provide a detailed list of actions to take in various medical circumstances. A standard of care is established for each group of disorders that can occur. Very often, a standard of care is reflected in a written plan known as a *protocol*.

Protocols permit action in a situation that is recognized as a standard operating procedure for the facility, the Air Force, and/or the medical profession in general. An example of a standard of care is the procedures health care professionals are trained to perform when CPR is necessary as established by the American Heart Association (AHA).

Living wills

A will defines how someone wants his or her property distributed in the event of death. A living will is designed for a different purpose.

Living wills state which medical treatment or treatments the patient does not want performed in the event he or she is in a terminally ill condition and unable to communicate his or her desires at the time. For example, a living will may specify that the patient does not want to be kept alive on a mechanical respirator should the situation ever occur. Another example is the institution of an order known as do not resuscitate (DNR). A DNR order prohibits the initiation of pulmonary or cardiopulmonary resuscitation in the event that respiratory or cardiorespiratory arrest occurs.

As with any will, living wills are no help in a critical situation if their existence is not known. Family members and the health care team must be aware of the document in order to honor it. The Air Force aerospace medical service allows patients who have a living will to maintain the document in the outpatient medical record. This permits visibility of the will in cases of sudden illness or injury. If a patient with a living will is admitted to the hospital, the document is placed in the inpatient record.

Durable powers of attorney

A power of attorney is a legal document designating someone other than the individual to make decisions pertaining to him or her. Parents often have a power of attorney constructed that designates an alternate caregiver (such as a babysitter) as legally permitted to make health care decisions for a minor. The durable power of attorney is unique in that it designates someone other than the individual as the primary decision maker on health care issues should the individual become incapable of making decisions for him or herself.

Hopefully you learned a few things in this unit that can help you become more professional and build the patient's confidence in you and other medical personnel who treat them. Next, you saw how important patient confidentiality and discretion can be. Also, you should be able to see how our core values influence every aspect of our daily lives. If you missed it, you might want to review this unit again before moving on to the questions.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

039. Professional standards of ethics

1. Describe the meaning of moral character.
2. Describe autonomy.
3. What two things does the scope of practice, as defined by the STS, permit?
4. How can patients assist in a facility's quality improvement process?
5. What must be developed by each MTF regarding the use of chaperones?

6. What important obstacle should be avoided when discussing death with small children?
7. What are the stages of the grieving process?

040. Legal aspects of patient care

1. Medical records are maintained within a system of records protected by what?
2. Medical personnel must comply with what guidelines?
3. What single form eliminates the need for a separate Privacy Act statement for each medical or dental document?
4. What are some military actions for noncompliance with HIPAA guidelines?
5. What are the civilian actions for noncompliance with HIPAA guidelines?
6. What legal term is used to describe negligence by a professional?
7. Making a photograph of a patient available to the public without the patient's consent is what type of violation?
8. Before obtaining informed consent, what details must be explained to the patient?
9. What does a DNR order prohibit?
10. What is the unique feature of a durable power of attorney?

3-2. Professional Relationships

One of the most important traits for health care workers to possess is the ability to work well with people. This section focuses on various aspects of professional relationships.

041. Positive professional relationships

Medics need to lead the way in the promotion of positive patient and professional relationships. This is most important because the medical technician is often the very first person whom a patient encounters in the health care facility. This lesson addresses key aspects associated with professional relationships.

Interpersonal relationships

An interpersonal relationship, as applied to the health care setting, is defined as the relationship established between the health care worker and the patient. Interpersonal relationships also extend to the working atmosphere present between health care workers.

Patient relationships

The basis for all relationships established between health care personnel and patients is as a helper. Medical workers are in the role of helper, while the patient is in the role of customer, or recipient of the services. During a typical health care process, a helping relationship goes through four key phases: preinteractive, introductory, working, and termination.

Preinteractive phase

In most cases, the preinteractive phase occurs before actually encountering the patient personally. Similar to a planning process, the preinteractive phase involves assembling information known about the patient's personal and medical status. Proper preinteractive planning helps ensure the actual patient care process gets off to a good start.

Introductory phase

The introductory phase begins when the patient and health care worker actually meet to begin the health care process. This phase is very important because the success of the first encounter establishes the general nature of the relationship that endures throughout the other phases. During the introductory phase, initial business is taken care of by establishing the identity and role of both the worker and patient. This is followed by time spent clarifying the exact reason for the hospitalization, appointment, or procedure. Finally, the introductory phase ends when both parties arrive at a general understanding of the processes to follow.

Working phase

During the working phase, the health care worker conveys care and understanding to the patient as situations unfold. The patient begins to feel understood and valued during this time. Most of the patient care processes occur during this phase of the relationship.

Termination phase

Finally, the termination phase occurs when the care process is completed. At this time, the health care worker and patient prepare to part ways, hopefully with memories on the part of both that the entire process has been successful and rewarding to each. A patient's general opinion of an entire facility may very well depend on a successful termination phase.

Relationships with medical personnel

Like any profession, the ability to get along with coworkers is important, but the marks of a proper interpersonal relationship go much further than that. Maintaining a positive interpersonal relationship with peers, supervisors, and subordinates is paramount to providing quality patient care. In addition, the importance of maintaining good relationships serves to enhance job satisfaction.

Key attributes of a professional relationship between members of the health care profession include, but are not limited to, the following:

1. Demonstrating respect for others.
2. Following orders promptly and without complaining.
3. Demonstrating fairness to subordinates.
4. Behaving in a manner that is not offensive to anyone.
5. Showing loyalty.
6. Helping when needed.
7. Avoiding participation in gossip.
8. Handling problems in private and never in the presence of patients.
9. Encouraging others, especially when they are in need of it.

Finally, by maintaining a positive, professional relationship with other health care professionals, medics can foster a spirit of teamwork that is unsurpassed and admired by everyone.

Effective communication

Communication is defined as exchanging information, and it can occur in various forms. With all communication, there is a sender (the one who is conveying the information) and a receiver (the one who must interpret the information). Effective communication requires that the message have the same meaning to both the sender and the receiver.

When discussing issues with a patient, the terminology used must often be different from discussing similar topics with another health care professional. For example, a patient understands the term “shot” very well, but when speaking with another health care worker, terms such as “intramuscular injection” or “subcutaneous injection” are used. A good rule to follow when communicating with all patients is to use *lay terminology*. Lay terminology is simply those words understood by persons who are not health care professionals.

The health care worker who tries to impress someone with his or her medical vocabulary actually finds the patient can’t (or won’t) relate to him or her at all. It’s also equally important not to talk down to the patient, as though he or she were in some sort of inferior position while receiving medical care. The bottom line is to communicate appropriately to everyone at all times.

Communicating with children presents a unique situation. Children need to be given information in a manner they can interpret on their own level. Remember, the hospital is a symbol of fear to most children simply because it is often associated with pain. Avoiding big business terminology and making an effort to be kind and understanding goes a long way in reducing fears. In turn, a child who is less fearful often is more cooperative; it’s a win-win situation for everybody.

All communication can be divided into two categories: verbal and nonverbal. Verbal communication includes both spoken and written words. Nonverbal communication involves body language. Examples of body language include gestures, posture, facial expressions, eye contact, appearance, and body movements. When communicating to a patient, learn to be observant of the nonverbal messages he or she sends in response. This can help interpret whether or not the patient understands what he or she is being told. When communicating with anyone, avoiding the barriers to effective communication is very important.

Some of the barriers to effective communication include:

- Language differences (when necessary, use an interpreter).
- Changing the subject.
- Giving opinions instead of facts.
- Talking too much.

- Not paying attention.
- Illness (certain health problems can inhibit the ability of a person to listen or respond).

Effective communication has one key element that good communicators use all the time—the art of listening. Listening is much more than hearing. Hearing does not involve thinking, while listening involves interpretation of both verbal and nonverbal feedback from the message receiver. Becoming a good communicator takes time and practice. Effective communications is a vitally important skill all health care professionals must develop.

Patient Advocate/Patient Advocacy Program

An advocate is someone who provides support for someone in a particular situation. Each facility is responsible for implementing and administering a patient advocacy program.

Patient advocate

In most cases, the patient advocacy program has a central office that serves as an overall point of contact for the entire facility. Many facilities also designate a patient advocate representative in each clinic and inpatient unit. This individual is often the officer in charge (OIC) or noncommissioned officer in charge (NCOIC) of the duty section. Having a patient advocate assigned to each section makes it possible to solve problems on the lowest level possible and in a timely manner.

While medical facilities generally have a designated patient advocate, every staff member is actually a patient advocate. This means staff members provide customer service, conflict resolution, prevention, and a host of other actions. Each staff member is a front line advocate and the unit supervisor or OIC is the next advocate in the chain of command. If a patient feels he or she cannot resolve an issue at the clinic or unit level, then he or she should elevate the problem to the designated facility patient advocate.

There are also times when a patient may have difficulty with an off-base referral service, need processes or policies explained, or just need assistance obtaining information or direction to the correct area or service. The patient advocate is an excellent resource to take care of these types of issues.

Patient Advocacy Program

Medical treatment facilities have a patient advocacy program. The patient advocacy program provides patients an avenue to address concerns and complaints pertaining to the health care facility, as well as acting as an information source for patient questions. The patient advocate is the main point of contact in the patient advocacy program. The program was developed to provide an unbiased third-party representative for the patient in order to investigate perceived unfair treatment, complaints, or concerns. Customer concerns can range from an informal question to inspector general or congressional inquiries.

As you can see, the care and customer service we provide to our patients is valuable and taken very seriously. As the front line advocate, you should be in tune with your patients and their concerns. Quite often, just taking a few minutes to ask if there is anything else we can assist our patients with or explain to them will make the difference between a pleasant experience or one that needs a patient advocate to intervene. Each clinic has an in-house patient advocate to assist customers and it is normally best to resolve patient issues before they get to the group level. However, the facility patient advocate and patient advocacy program are there to assist when needed.

Determine customer needs and expectations

Now that you understand a little about being an advocate for your patients, it is important to learn how to determine customer needs and expectation. One of the easiest ways is to practice good communication techniques, some of which have already been covered, however, these tips will help

you determine what your customer is really wanting and what you can do to meet those needs and expectations.

Guidelines for good communication are as follows:

- Concentrate on what's being said; listen as if you'll be tested on content.
- Occasionally repeat back a paraphrased version of what's being said.
- Ask questions if you don't understand the message.
- Don't interrupt people in the middle of a thought.
- Think of the feelings behind the words.
- Be conscious of nonverbal signs.
- Look people in the eye.

A high percentage of a patient's perception of quality health care comes from personal contact with the technicians of the health care team. Good communication is the key to improving this perception. Another tip is to practice *situational awareness* whether you are walking in from the parking lot or working within your unit. It sounds simple, but you would be amazed at the number of times medical personnel will walk past an elderly patient limping down the hall coughing and breathing hard. Here is an opportunity for you to determine a potential customer need. Perhaps this person could use some assistance? Ask if you can assist or if you can get a wheelchair for him or her. You may find the individual a great deal of physical stress and you will surely demonstrate a competent, caring, and professional attitude. The last tip may actually be the easiest. Ask, "How may I help you, Ma'am or Sir?" in a pleasant tone of voice; with good eye contact and a smile, the patient will generally tell you what his or her need and expectation is. That way, there is no guessing, misinterpreting, disappointment, or frustration on the part of the patient or you.

Customer service surveys

By now, you have probably completed several questionnaires or surveys on everything from in- and out-processing to the quality of food and service in the dining facility. What is the purpose for the surveys? It's pretty simple actually. The purpose of the survey is to collect feedback from the customers in order to serve them better. The exact same information is true about customer service tools in the medical field. Surveys can be computer generated for customers to complete at work or at home. Some units may choose to use a locally developed survey or the medical facility may provide one for all services.

The bottom line is to recognize the surveys intended use. Some benefits of the customer service survey are:

- Identifies areas or personnel providing outstanding service.
- Identifies opportunities for improvement.
- Suggests improvements in processes or services.

Surveys are a great way to evaluate whether you are meeting the needs and expectations of your customers.

Conflict resolution

Have you ever had a bad day? Most of us have had one or two in our lifetime, right? Have you ever noticed that on a bad day, things that you normally would not have given a second thought become a world-ending issue? Our patients experience the same problems, crises, and bad days that the rest of us do, but on top of the issues that might put them in a negative mood, they are also not feeling well or have a family member that is sick or injured and they are anxious or scared. If you try to remember there are probably many things going on in the life of a patient (or staff member) that is being difficult to get along with, it may help you deal with the issue more effectively. While patients should

not be rude or threatening to staff members, they sometimes are. We still should take great care to be polite and professional.

The following are some responses or actions you can take if you do encounter a patient that is difficult to deal with:

1. Never argue—this only adds fuel to their fire!
2. Be calm, keep your voice low and remain professional at all times! As long as you remain professional, your supervisor can stand up for you in the event the patient complains about you. However, the second you lose professionalism and yell, use inappropriate actions or language, or become threatening to a patient or staff member, you risk corrective action and will have made yourself appear unprofessional.
3. Ask the customer to step into an office or an area that is not surrounded by onlookers while you try to sort out an issue. Confrontations draw a great deal of attention, risk making you and your area look unprofessional, and often spur a disgruntled customer on even if they know they are in the wrong in order to save face in front of others.
4. Be aware of your body language. You may feel that you are being calm and professional but your hands balled up into fists may send the opposite message.
5. Realize when things are beginning to escalate or that you are in over your head. Get help! Politely let the individual know that you are going to seek assistance with someone else that may be able to assist them more than you can. Your supervisor, the NCOIC, or the unit's patient advocate can often help resolve the issue. Your supervisor will likely have knowledge of resources that you may not have learned about yet and can intercede before you and the patient get frustrated. Give the patient advocate a brief description of the patient's needs or concern so the patient doesn't have to repeat the information and re-ignite his or her frustration.
6. As difficult as it may be, don't take the patient's comments personally. You are likely the one who is feeling the effects of several other issues that have just come to a head.
7. If you are feeling really stressed over after the encounter, ask your supervisor if you can have a few moments to calm yourself down or to talk to him or her.

If no one in your section is able to resolve the issue, contact the facility patient advocate for assistance. There will be times that no matter how hard you try or how professional you are, you will encounter a patient that is not happy with your service and will feel that you are not meeting his or her expectations. This would be an excellent time to have someone outside your unit step in to assist.

Cultural diversity and characteristics

At any given time, the patients being cared for in a facility represent a wide range of cultural backgrounds. Culture is not a term that should be confused with race or ethnic origin. An individual's culture applies to his or her traditional background as handed down from generation to generation. It takes on several characteristics, some of which are listed below. Your supervisor will likely have knowledge of a resource that you have not learned and can intercede before you and the patient get frustrated.

- Parents teach culture to children through both verbal and nonverbal communication.
- Culture is learned through life experiences; it's not an inborn trait.
- Culture develops in an individual through social interaction.
- Cultural traits may change in order to adapt to an environment. In other words, social situations may cause a certain cultural trait to be abandoned. For example, a family may have a cultural history of living in close proximity to each other. A job change may affect this tradition if relocation to another area becomes necessary.
- Culture is satisfying. Individuals often experience a sense of pride and safety through the cultural connection they share with others, particularly in their own family.

Nursing considerations

Awareness of various cultures is an important health care aspect. Every attempt should be made to work within a patient's cultural needs when planning and conducting care. Much can be learned about a patient's culture during initial assessment procedures. Notes should be made in the patient record when applicable regarding diet, spiritual, or other ideals important to the patient. Documenting such facts helps ensure all members of the health care team are aware of any specific desires or needs that can and should be respected.

Always avoid creating a mental stereotype about an individual and his or her cultural background. This is best avoided by remembering that a person's culture is not dependent on race or ethnic origin. Observing, listening, and attending to patients' needs in a caring and professional manner ultimately results in cultural sensitivity.

042. Performing electronic communication

As an Airman and a medical professional, you are required to adhere to AFI 1-1, *Air Force Standards*, DOD 6025.18-R, *DOD Health Information Privacy Regulation*, AFI 41-210, and AFH 33-337, *The Tongue and Quill*. The nature of your profession provides increased access to patient information that must be safeguarded at all times. Additionally, electronic communication is commonly used to exchange information among various levels of personnel. Therefore, the following steps and guidelines list how to properly communicate in this environment while at the same time meet Air Force, DOD, and Public Law for online communication.

Patient communication

All communications of protected health information (PHI), which includes identifiable health information, must be properly safeguarded in accordance with HIPAA and Air Force Messaging guidelines. Use of e-mail to transmit PHI is only authorized For Official Use Only (FOUO) purposes and must comply with encryption and digital signature requirements of AFMAN 33-152, *User Responsibilities and Guidance for Information Systems*, and permissible uses/disclosures as described in AFI 33-332 and the HIPAA privacy rule.

The Corporate Dental Application (CDA), MiCare secure messaging, and other Air Force Medical Service (AFMS) approved secure messaging programs are authorized. The use of clinical e-mail between MTF personnel and a beneficiary is not authorized. Common examples of clinical e-mail include, but are not limited to, the following:

- Communications of health information.
- Discussion of services and treatment options.
- Providing healthcare consultation or advice.
- Coordinating prescription refills.
- Scheduling appointments and referrals.

Use of e-mail between MTF personnel for treatment, payment, and healthcare operations functions is permissible within the .mil domain.

Under no circumstances will e-mail containing PHI be transmitted to an address outside the .mil domain or to any address within the .mil domain that is unable to receive public key infrastructure encrypted messages. This includes e-mail messages transmitted via the Preventive Health Assessment and Individual Medical Readiness system to appropriate command authorities; all messages must be properly encrypted prior to transmission.

Safeguarding for transmitting FOUO email

You must make sure there is an official need to send the information before transmitting by doing the following:

- Confirming all recipients are authorized to receive the information under the Privacy Act and HIPAA.
- Protecting the message from unauthorized disclosure, loss, or alteration through use of DOD public key infrastructure-based encryption.
- Adding FOUO to the beginning of the subject line, followed by the subject. Do not annotate any PHI in the subject line.
- Inserting the following statement at the BEGINNING of the e-mail message: FOR OFFICIAL USE ONLY. This electronic transmission contains For Official Use Only (FOUO) information which must be protected by the Privacy Act and AFI 33-332 and the Health Insurance Portability and Accountability Act and DOD 6025.18-R. The information may be exempt from mandatory disclosure under the Freedom of Information Act, 5 U.S.C. § 552. If you have received this message in error, please notify the sender by reply e-mail and delete all copies of this message.
 1. Double-checking all recipients e-mail addresses before transmitting.
 2. Do not indiscriminately use FOUO disclaimers or encryption on messages not warranting it.

E-mail containing PHI may be sent to organization/office symbol e-mail addresses (e.g., AFMOA/SGAT, AFMSA/SG3SA) and must comply with encryption and digital signature requirements of AFMAN 33-152 and permissible uses/disclosures as described in AFI 33-332, *Air Force Privacy and Civil Liberties Program*, and HIPAA Privacy and Security Rules. Individuals with access to the organization/office symbol e-mail boxes must have a need for the information as the proper recipients of the PHI. As a general precaution, remove any personally identifiable information (e.g., Social Security numbers, names, addresses, dates of birth, etc.) whenever possible. The use of de-identified or purposeful unidentifiable information should always be used if the intent of the issue can be conveyed without including PHI in the e-mail message.

Social media for Airmen

In general, the Air Force views social media sites positively and respects your rights as Americans to use them to express yourself. However, by the nature of your profession, you are always on the record and must represent our core values. AFI 1-1 outlines how Airmen should conduct themselves on social networking Web sites. Here are a few things to remember when communicating online via social media as an Airman:

- You are personally responsible for what you say and post on social networking services and any other medium.
- Consider how a post can be interpreted by the public. Be cautious about crossing the line between funny and distasteful. If you have doubts about whether you should post something, err on the side of caution. If the post in question concerns the Air Force, discuss the proposed post with your supervisor or your local public affairs office.
- Maintain appropriate communication and conduct with officer and enlisted personnel, peers, superiors and subordinates (including civilian superiors and subordinates).

Social media for families

Your family members are integral to the success of the Air Force. Without their support, Airmen wouldn't be able to accomplish the great work they do every day. The Air Force stories they share on social media help maintain the morale of Airmen and educate the public about the Air Force. You're encouraged to use social media to talk about the Air Force and keep in contact with the Airmen in

your life. However, you should use it safely and effectively. It's important for Airmen and their families to identify and safeguard critical information about military operations. Be cautious about sharing personal information or communicating with people over social media. Posting too much information could jeopardize the security of Airmen and missions.

If you wouldn't want to see the information on the news, do not post it on the Web. Social content shared by Airmen and families is a major target for those looking to gain access to sensitive information in order to impersonate, blackmail, or intimidate. While there is a definite benefit to using social media, be wary of the details you provide. Don't post the exact whereabouts and activities of deployed Airmen:

- Be general about the dates and locations concerning an Airman's trip arrival and departure.
- Don't make your vacation dates public on social networks. Criminals may track your activities and know exactly when to break into your home while you're on vacation.
- Don't publicly post exactly how long your Airman will be gone on a trip or deployment.
- Be careful about publicly posting children's photos, names, schools, ages, and schedules.
- Consider the image you portray on social media. Think before you share information that could jeopardize you and your Airman's career or reputation.
- Let children know they should seek help for cyber-bullying.

According to the AF Social Media Guide, you're encouraged to use social media to engage in support networks, such as spouse's clubs, event committees, child care groups, or local civic activities. These groups are not considered official Air Force social media, and you don't need permission to form a group of your own. You may want to limit the membership and visibility of the group to help protect the information exchanged.

You may also want to follow the main Air Force social media accounts, your local base's accounts, or the accounts of your Airman's base for the latest information on the work your Airman does. You can help support their specific missions by sharing their social media content and experiences with your followers and friends.

Useful social media tips

Here are some social media tips that could be very useful to you and your family.

No classified information

Don't post classified, sensitive or FOUO information (e.g., troop movement, force size, weapons details, etc.). If in doubt, talk to your supervisor or security manager.

Stay in your lane

Discussing issues related to your career field or personal experiences are acceptable and encouraged. However, you shouldn't discuss areas of expertise where you have no firsthand, direct experience or knowledge.

Obey applicable laws

You must keep federal law, DOD directives and instructions, AFIs, and the Uniform Code of Military Justice (UCMJ) in mind when using social media in official and unofficial capacities. As an Airman, you are on duty 24 hours a day, 365 days a year.

Differentiate between opinion and official information

You can tell people what you think—just make sure you state this is your opinion and not that of the organization.

Use your best judgment

What you write may have serious consequences. Once you post something on social media, you can't "take it back." Even deleting the post doesn't mean it's truly gone. Ultimately, you bear sole responsibility for what you post.

Replace error with fact

When you see misrepresentations made about the Air Force in social media, you may certainly identify and correct the error. Always do so with respect and with the facts. When you speak to someone who has an adversarial position, make sure what you say is factual and respectful. Don't argue, just correct the record.

Be aware of the image you present

Any time you engage in social media, you're representing the Air Force. Don't do anything that discredits you or our service.

Be cautious with information sharing

Maintain privacy settings on your social media accounts, change your passwords regularly, and don't give out personally identifiable information. Be cautious about the personal details you share on the Internet.

Avoid the offensive

Don't post any defamatory, libelous, vulgar, obscene, abusive, profane, threatening, racially or ethnically hateful, or otherwise offensive or illegal information or material.

Don't violate privacy

Don't post any information that would infringe upon the proprietary, privacy, or personal rights of others.

Don't violate copyright

Don't post any information or other material protected by copyright without the permission of the copyright owner.

Don't misuse trademarks

Don't use any words, logos, or other marks that would infringe upon the trademark, service mark, certification mark, or other intellectual property rights of the owners of such marks without the owner's permission. The Air Force symbol visually represents our service's brand identity. To use the Air Force symbol on a social media platform, you must follow display guidelines found at <http://www.trademark.af.mil>.

No endorsements

Don't use the Air Force name to endorse or promote products, political positions, or religious ideologies.

No impersonations

Don't manipulate identifiers in your post in an attempt to disguise, impersonate, or otherwise misrepresent your identity or affiliation with any other person or entity.

Don't promote yourself for personal or financial gain

Don't use your Air Force affiliation, official title, or position to promote, endorse, or benefit yourself or any profit-making group or agency. For details, refer to the Code of Federal Regulations, Title 5, Volume 3, sec.2635.702, *Use of Public Office for Private Gain*, in the Joint Ethics Regulation, or Air Force Instruction 35-101, *Public Affairs Responsibilities and Management*.

Follow terms of service

Become familiar with each social media site's "terms of service" and follow them. For example, having two personal profiles on Facebook violates Facebook's terms of service.

Geotagging

Geotagging adds geographical identification data to photos, videos, Web sites, and text messages through location-based applications. This technology helps people find images and information based on a location from a mobile device or desktop computer.

How should Airmen use geotagging?

Airmen should be cautious when enabling the geotagging feature on mobile, location-based apps because geotags could potentially create personal and operational security risks. Disable geotagging at sensitive or deployed locations.

Penalties for noncompliance

Failure by military personnel to comply with electronic communication policies is a violation of the *Uniform Code of Military Justice*, Article 92, *Failure to Obey Order or Regulation*. Violations by civilian employees may result in administrative disciplinary action without regard to otherwise applicable criminal or civil sanctions for violations of related laws. Violations by contractor personnel will be handled according to local laws and the terms of the contract. Additionally violations of ANG military personnel may subject members to prosecution under their respective State Military Code or result in administrative disciplinary action without regard to otherwise applicable criminal or civil sanctions for violations of related laws.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

041. Positive professional relationships

1. What are the four phases of a helping relationship?
2. What are six barriers to effective communication?
3. What benefit does the patient advocate provide?
4. What are some ways to determine patient needs and expectations?
5. What actions constitute good communication?
6. List some benefits of the customer service survey.

7. What is the number one way of handling a customer that is dissatisfied and difficult?

042. Performing electronic communication

1. Name some measures MTF personnel can take to safeguard protected health information when transmitting FOUO emails?
2. How does the Air Force view social media sites used by Airmen and their families?
3. What is geotagging and how should Airmen utilize geotagging with mobile location based apps?
4. It's important for an Airman's family to identify and safeguard critical information about military operations. What steps can AF families take to communicate information safely online?
5. Remember that HIPPA is a public law and this law requires you to ensure that reasonable safeguards are taken to protect patient information. What is your role and how are violators held accountable?

3-3. Patient Centered Medical Home

Change continues to sweep across the healthcare industry, and the Military Health System (MHS) is not immune to the effects. We must maintain a fit and ready force, respond to world crises, and yet remain competitive with our civilian counterparts. To do this, we must deliver the promised benefits of managing health and maintaining customer satisfaction at a competitive cost. We do this by delivering primary care services through a concept referred to as patient centered medical home (PCMH).

043. Purpose and core principles

We can simplify PCMH in the phrase "Trusted Care Anywhere." This is the vision of the Air Force Medical Service (AFMS). The AFMS goals are to achieve its vision through optimization of readiness, better care, better health, and best value. Our priorities align with Air Force priorities to ensure mission success. We embrace our heritage of innovation and relentlessly pursue advances to enhance safety, effectiveness, and efficiency of care we deliver to beneficiaries and support we provide to combatant commanders. The PCMH is a team-based model, led by a physician; which provides continuous, accessible, family-centered, comprehensive, compassionate and culturally-sensitive health care in order to achieve the best outcomes. The model is based on the concept that the best healthcare has a strong primary care (PC) foundation with quality and resource efficiency incentives. The PCMH is a departure from previous, traditional healthcare models because it focuses on the "whole person" concept that includes preventive care, early intervention, and management of health problems rather than on high-volume, episodic, over-specialized, and inefficient care.

Core principles

A PCMH practice is responsible for all of a patient's healthcare needs and for coordinating and integrating specialty healthcare and other professional services. The following paragraphs describe seven core PCMH principles:

Personal physician

Each patient has an ongoing relationship with a personal physician trained to provide first contact and continuous and comprehensive care.

Physician-directed medical practice

The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole-person orientation

The personal physician is responsible for providing all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life—acute care, chronic care, preventive services, and end-of-life care.

Care is coordinated and/or integrated

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family and public and private community-based services). Care is facilitated by registries, information technology, health information exchange, and other means to ensure that patients get the indicated care in a culturally and linguistically appropriate manner when and where they need it.

Quality and safety

Quality and safety are hallmarks of the medical home. Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family. The care planning process utilizes these elements to achieve overall quality and safety:

- Evidence-based medicine and clinical decision-support tools guide decision making.
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision making, and feedback is sought to ensure patients' expectations are being met.
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.
- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient-centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level.

Enhanced access

Enhanced access to care is available through systems such as open scheduling; expanded hours; and new options for communication between patients, their personal physician, and practice staff.

Payment reform

Payment appropriately recognizes the added value provided to patients who have a PCMH. The payment structure should:

- Reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.

- Pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- Support adoption and use of health information technology for quality improvement.
- Support provision of enhanced communication access such as secure e-mail and telephone consultation.
- Recognize the value of physician work associated with remote monitoring of clinical data using technology.
- Allow for separate fee-for-service payments for face-to-face visits. Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits.
- Recognize case mix differences in the patient population being treated within the practice.
- Allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- Allow for additional payments for achieving measurable and continuous quality improvements.

Quadruple Aim

The MHS uses the Quadruple Aim model to illustrate the following four goals: readiness, experience of care, population health, and per capita cost. The PCMH model is consistent with and supports all four goals in the MHS Quadruple Aim.

Readiness

Readiness ensures military deployability and delivers health care anytime, anywhere to support a full range of military operations.

Experience of care

Experience of care provides a caring experience that is patient and family centered, compassionate, convenient, equitable, safe, and always of the highest quality.

Population health

The population health goal improves the beneficiary population's health by encouraging healthy behaviors and reducing the likelihood of illness through prevention.

Per capita cost

Per capita cost creates value by focusing on quality, eliminating waste, and reducing unwarranted variation.

Team member roles/responsibilities

For the PCMH concept to function fluidly, a team of health care experts must work in harmony to ensure the best care is given to our troops and beneficiaries. Although each team position has specific functions, every position is dependent on the other to ensure the maintenance of a fit and ready force. The PCMH team is made up of the provider, the nurse, the aerospace medical service technician (4N), and the health services management technician (4A). The roles and responsibilities of the PCM team are different from our traditional concepts of who performs what duties for, or provides what skills to, the patient. The goal of optimizing the team is to have all its members contributing at their highest level of scope of practice. There are eight habits of successful PCMH teams that lead to delivering effective health care:

1. Take personal responsibility and accountability for the ongoing care of patients.
2. Be accessible to their patients on short notice for expanded hours and open scheduling.
3. Be able to conduct consultations through email and telephone.

4. Utilize the latest health information technology and evidence-based medical approaches, as well as maintain updated electronic personal health records.
5. Conduct regular check-ups with patients to identify looming health crises, and initiate treatment/prevention measures before costly, last-minute emergency procedures are required.
6. Advise patients on preventive care based on environmental and genetic risk factors they face.
7. Help patients make healthy lifestyle decisions.
8. Coordinate care, when needed, making sure procedures are relevant, necessary, and performed efficiently.

The responsibilities of each team member are outlined below:

Health care provider

Each enrolled patient is assigned to a specific provider who is responsible for the patient's care, coordination, and oversight. The provider addresses medical issues in a compassionate, comprehensive, and integrative manner utilizing a team approach. The provider ensures wellness and medical reconciliation needs are addressed by the health care team. The provider monitors care coordination, as necessary. The provider uses evidence-based clinical practice guidelines (CPG) and engages patients actively in their health care, ensuring self-management instructions are given at all appropriate opportunities.

Team nurse

The RN is an instrumental resource in providing continuity of care within the PC clinic environment. The RN serves as the care manager for assigned patients to coordinate care and other necessary services to meet the needs of the patient, as determined by the patient's PC provider. The RN also provides necessary leadership and fulfills an educator role in the clinic. These leadership responsibilities include, but are not limited to, supervision of the ancillary nursing and support staff in their daily activities and professional development. The RN ensures team members maximize their training and competencies. The RN also collaborates with the case management (CM) and disease management (DM) staff on chronic health care services.

Medical technician

The ancillary nursing staff (LPNs, enlisted or equivalent personnel, certified nursing assistants, medical technicians, etc.) provides invaluable support to the PCMH team. They assist in provider support activities related to patient care, patient education, documentation of chronic medical conditions, documentation of preventive services, medication reconciliation, and coordination of patient check-out and follow-up. They receive direct guidance and supervision by both the nurse and provider.

Clerical staff

The clerical staff includes medical clerks and others who provide administrative support of clinic activities, front desk operations, telephone management, and records management. They are vital members of the team. They facilitate patient check-in, verification of Defense Enrollment Eligibility Reporting System (DEERS) eligibility and collection of other health insurance information. In addition, they assist patients in navigating the health care system including supporting clinic team management of population health, coordinating and/or scheduling acute and chronic care, arranging follow-up, coordinating specialty referrals, and telephone/asynchronous secure patient messaging.

Team huddles

Huddles are intended for problem solving and updating the daily work plan. Huddles should be used to establish the PCMH team's awareness of the day's clinical situation, such as identifying a plan for the day and assessing if there are any needed adjustments to the plan. A huddle checklist (fig. 3-1) should be used every morning to discuss the expected flow of the day, but also can be used at a

moment's notice when the situation changes (e.g., staff member's child is sick and that person needs to leave, very ill patient presenting to the clinic who needs treatment/coordination significantly more intense than what was originally anticipated).

Team meetings (daily huddles)/expectations

For daily team meetings ensure the following is documented and discussed:

- Attendees.
- Frequency.
- Review the huddle video.
- Situational awareness.
- Prioritize care.
- Develop plan for the day.
- Maximize communication between all members of team (appointments, unexpected absences, etc.).
- CPG usage within the team with each person's roles.

Daily Team Huddle Checklist																																													
<p>➤ Scan reasons for appointment</p> <p>➤ Check ASIMS for items overdue or coming due</p> <p>➤ Checked if preventative care due</p> <p>➤ Check for any team staffing issues or coverage required</p> <p>➤ Complete T-Cons/Message Slips within 72 hours</p> <p>➤ Pick up-return medical records as needed</p> <p>➤ Address any/all MiCare Messages</p> <p>➤ Ensure exam rooms are stocked</p>																																													
2014 Teams will indicate check list completion by checking off each date accordingly																																													
	Su	Mo	Tu	We	Th	Fr	Sa	Su	Mo	Tu	We	Th	Fr	Sa	Su	Mo	Tu	We	Th	Fr	Sa	Su	Mo	Tu	We	Th	Fr	Sa	Su	Mo	Tu	We	Th	Fr	Sa										
January								1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31							
February															1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28			
March															1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
April															1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
May															1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
June	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30															
July								1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31							
August															1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
September	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30															
October								1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31							
November															1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
December	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31														

Figure 3-1. Daily team huddle checklist.

Team meetings (weekly huddle)/expectations

Weekly huddles are not required, but if completed, follow figure 3-2 to determine expectations. The weekly huddle enables the PMCH team to evaluate the schedule for the following week. This is the optimal time to also discuss planned staff absences and coverage, review the appointment schedule to identify issues that could be handled in a different manner than a face-to-face appointment, and review lab/diagnostic results from the previous week that needs to be communicated to patients.

Additionally, medications should be reviewed for potential refills prior to the patient's visit. Finally, this is the perfect time to identify any patients who have preventive health needs and make a plan for how the team will notify the patient of these services. Here are some additional items to cover at weekly huddles:

- Attendees.
- Frequency.
- Strategic.
- Proactive Patient Management Review for following week.
- Results.
- Referrals.
- Medical Board/Review in lieu of lists for the following week.


<div>  HEALTHCARE TEAM WEEKLY HUDDLE CHECKLIST Items to be tailored to meet healthcare team needs </div>				
Category	Task	<input checked="" type="checkbox"/>	Notes	Primary POC
Administrative Management	Record staff in attendance for huddle	<input type="checkbox"/>		
	ID chronic patients to ensure labs are ordered and completed (communicate with patient 1 week prior to ensure completion)	<input type="checkbox"/>		
	See if there are any issues/questions on TeamSTEPPS that need to be addressed. Schedule follow-on meeting to discuss identified issues/questions	<input type="checkbox"/>		
	Debrief last week's tasks, lessons learned, changes or process improvements	<input type="checkbox"/>		
	Identify upcoming week's tasks; discuss any issues or concerns (use proactive approach)	<input type="checkbox"/>		
	Confirm the Healthcare Teams are conducting AM Brief and/or PM Debrief daily huddles	<input type="checkbox"/>		
	Discuss/review future access utilizing MTF specific Access to Care report	<input type="checkbox"/>		
	Review the following week's schedule and ensure providers are available	<input type="checkbox"/>		
	Discuss/review Open DHA List in ASIMS	<input type="checkbox"/>		
Ancillary Staff Coordination	Ensure that completed Paps have been sent to the Lab/Letters to Monitor	<input type="checkbox"/>		
	Communicate with Ancillary Services, so they are aware of outstanding labs to ensure close monitoring and quick results	<input type="checkbox"/>		
	Verify that all medical records have been returned to the Records Room and/or that EMR notes are closed out	<input type="checkbox"/>		
	Confirm that the next day's patient medical records are available and have been collected	<input type="checkbox"/>		
	Review patient schedule for any next day tasks that may require labs, etc.	<input type="checkbox"/>		
	As needed, communicate directly with Ancillary Services staff so they can be better prepared to support Healthcare Team	<input type="checkbox"/>		
MiCare	Verify POC for MiCare duties	<input type="checkbox"/>		
	Check if any absences in staffing for upcoming week will effect MiCare message monitoring and responding, and assign duties accordingly	<input type="checkbox"/>		
	Send out reminders or broadcast messages via MiCare corresponding with upcoming events or closures	<input type="checkbox"/>		
	Identify bottlenecks in responding to MiCare that team members can assist with during the week	<input type="checkbox"/>		
	Identify weekly push messages to send to patients highlighting monthly, weekly, daily health themes	<input type="checkbox"/>		
	Identify next week's patients that are enrolled in MiCare	<input type="checkbox"/>		
	Identify next week's appointments that can be handled via MiCare	<input type="checkbox"/>		
	Contact lab for next week's test results that will be sent to patients via MiCare	<input type="checkbox"/>		

Figure 3-2. Weekly huddle checklist.

CarePoint

The Military Health System Population Health Portal (MHSPHP)/CarePoint module transforms DOD and network health care administrative data into actionable information. The application utilizes health care action lists to identify MTF TRICARE Prime and Plus enrollees in need of potential clinical preventive services, DM, or CM. The Healthcare Effectiveness Data and Information Set methodologies or DOD/Veteran's Affairs (VA) Clinical Practice Guidelines outline the specific data sources and methodology used within MHSPHP. The data available through this application provides both patient level and general population statistics concentrating on demographics, DM, and preventive services information. This evolution of the MHSPHP provides an intuitive "front end" for the user that is tab based.

CarePoint offers users a single location, or portal, to the applications and information needed for daily work for AFMS personnel.

The CarePoint portal is the cornerstone of the AFMS healthcare application framework for business intelligence, healthcare content management, user collaboration, and personalization of healthcare applications with a consistent and familiar user experience.

The newest features of this CarePoint iteration include:

- Ability to enter lab results and screenings for patients with other health insurance and/or who are seen in purchased care.
- Nightly processes to capture lab and screening tests with updates to both action lists and patient counts.
- Option to exclude patients off patient lists (e.g., chronic refusers, patient deceased, miscoded diagnosis).

Account requests and service representative information can be found at <https://carepoint.afms.mil>. Select the Request Access link.

044. Overview of information systems

You can already see that your function as a 4N0 is critical in the care and well-being of a fit and ready force. It is also important for you to have a general understanding of the commonly used information systems within most medical treatment facilities. These information systems are important in compiling pertinent personal and medical information on our patients. These systems are essential in documenting and tracking patient care and information. Remember that all patient care and treatment must be documented. “If it wasn’t documented, it wasn’t done” still holds true in all we do. There is certainly no shortage of computer software tracking programs used in the MHS. This lesson will briefly discuss the Composite Health Care System (CHCS), Armed Forces Health Longitudinal Technology Application (AHLTA), and the Defense Enrollment Eligibility Reporting System (DEERS).

Defense Enrollment and Eligibility Reporting System

DEERS functions as both a repository and database of record. It captures, edits, and maintains sponsor/family member demographic data. From the MTF view, DEERS tracks those individuals who are enrolled to your MTF for primary care, regardless of duty status. By definition, those patients who receive their primary care at your MTF are enrolled in TRICARE Prime. DEERS is the “gold standard.” It “talks” to CHCS, but CHCS doesn’t talk to DEERS. If information is correct in CHCS but incorrect in DEERS, a DEERS check/update will wipe out the correct CHCS data. If data is correct in DEERS but incorrect in CHCS, a DEERS check/update will correct the information in CHCS. Incorrect DEERS data must be changed by the patient at their local DEERS office. This is critical, as incorrect DEERS information will adversely affect patients’ ability to make appointments, and will affect clinical ability to document care in AHLTA.

DEERS provides the most timely, accurate status of a customer’s enrollment location. You cannot be enrolled simultaneously at two or more MTFs in DEERS—only one. That is not the case with CHCS. An individual may be “present” at two or more MTFs within CHCS. Therefore, any decisions or metrics that use CHCS as the source of enrollment data will be flawed.

Consequently, the Office for Prevention and Health Services Assessment (OPHSA) and the Population Health Support Office (PHSO) will always use DEERS as the definitive source of enrollment data. This is consistent with MHS policy.

Enrollment information from DEERS is sent to MTFs from the PHSO, at least quarterly. If you need a special subset of enrollment data, request it from the PHSO through their Web page.

Composite Health Care System

CHCS is the system that was used before AHLTA but is still an integral piece in our medical facilities. It is primarily used for scheduling appointments and for some order entry procedures. In the future, AHLTA will take over all CHCS functions with the added ability to code each patient visit. AHLTA serves more than eight million beneficiaries of the DOD MHS worldwide. AHLTA is installed in more than 700 DOD hospitals and clinics providing health care to the men and women of the armed services and their families, as well as the retired military community.

Overall, AHLTA means shorter waits for patients, faster reporting of diagnostic test results, improved use of medical and professional resources, and significant improvement in the quality of patient care. While all patient care documentation is completed in AHLTA, to include coding, some specific functions are listed here:

1. Patient registration, admission, disposition, and transfer.
2. Inpatient activity documentation.
3. Outpatient administration data.
4. Laboratory.
5. Drug/laboratory test interaction.
6. Quality assurance.
7. Radiology.
8. Clinical dietetic administration.
9. Pharmacy.
10. Results reporting and order entry.
11. Ad Hoc reporting.
12. Managed care.
13. Interfaces to 40 other clinical and administrative systems.

AHLTA

AHLTA is the electronic medical record. A medical and dental clinical information system generates and maintains a comprehensive, life-long, computer-based patient record for each MHS beneficiary. Enterprise-wide implementation of this system supports the commitment of the DOD to conduct population health management throughout the MHS.

AHLTA is used for all aspects of patient care including order entry and coding. It supports Force Health Protection, Population Health, and MHS Optimization by enabling the MHS to determine the deployment status of units; demand management effectiveness; and disease prevalence, management, and outcomes.

Once a provider completes/signs an AHLTA encounter (the patients record), the data is stored in the Central Data Repository (CDR) located in Montgomery, Alabama. There are back-up CDRs in Oklahoma City and San Antonio. *CDR data is kept forever and is not deleted.* This is a critical point because information is extremely hard to change once it has been completed. If documentation is completed on the wrong patient encounter, it will be permanently locked in. The only way it can be deleted is if it is a critical error (sexually transmitted disease, human immunodeficiency virus, etc.) and it takes DOD approval to change.

Inpatient electronic health record

The military's inpatient electronic health record is used in acute hospital environments, providing point-of-care data capture at the patient's bedside for physiological devices, fetal/uterine devices, ventilators, and other patient care machines. Essentris (inpatient electronic health record) allows worldwide documentation of inpatient care for all service members and their beneficiaries. Essentris is also used to assist injured service members returning from the theater to Landstuhl Regional

Medical Center in Germany for acute care. Information captured in Essentris is accessible to other providers across the continuum of care, ensuring continuity of care for service members returning to the US for additional care in the DOD and VA facilities. Essentris helps reduce the majority of paper-based inpatient documentation at DOD military treatment facilities. The use of this solution allows for standardization of processes and sharing of documentation across DOD and VA treatment facilities.

Essentris key features

Here are the key features that enable worldwide documentation of DOD and VA health data:

- 24-hour monitoring of heart, fetal, and other critical data.
- Data sharing with AHLTA and VistA users.
- CHCS communication links.
- Includes inbound ADT (admission, discharge, and transfer), laboratory results, and radiology text interpretation from CHCS.
- Allows real-time data backup for every single transaction through the Essentris server.
- Provides enhanced order entry workflow as well as task lists, notifications, and user preferences.

Essentris key benefits

The key features provided results in these benefits to the DOD and VA inpatient health care facilities:

- Enhances the process of care to ill and injured service members.
- Enhances the delivery of patient care interoperability with the VA.
- Ensures continuity of care to ill and injured service members.
- Enhances medical readiness.
- Increases clinical and administrative efficiency.
- Provides enhanced order entry workflow as well as task lists, notifications, and user preferences.

Record contents

Although Essentris is the system used to document inpatient medical information, hardcopy inpatient records (fig. 3-3) still exist for occasions when the system is not available. Both methods, whether electronic or hardcopy, consist of the medical forms and other information used to document a patient's case. Although there are many forms that could be filed in an inpatient record, let's look at the most common.

ACTIVE DUTY	COAST GUARD
RETIRED	NATO
DEPENDENT	OTHER

1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000

DO NOT REMOVE FROM HOSPITAL - RETURN TO INPATIENT RECORDS DEPARTMENT

AF Form 7892, Sep 89

Figure 3-3. Inpatient Record.

Cover sheet

The record of inpatient treatment (automated AF Form 565, Record of Inpatient Treatment), produced by the CHCS, is filed as the top form for each inpatient episode in the inpatient record. It provides a quick summary of diagnoses, procedures, and other administrative data.

Narrative summary

A concise clinical summary is dictated by a physician, dentist, or certified nurse midwife (CNM) and must be typed (not handwritten) on Standard Form 502, Medical Record-Narrative Summary, for patients who:

1. Die after admission.
2. Are received by transfer for further treatment.
3. Remain in the hospital, as a bed occupant, for eight days or more.

045. Utilizing Tri-Service workflow forms

Medical appointments at hospitals or clinics require physician and technician documentation of patient evaluation and treatment. Each military facility (according to branch of service) uses different templates to document medical care. To simplify this function, the DOD has created Tri-Service workflow templates to standardize the process. This section will explain steps to access these templates along with discussing resources available for DOD and VA medical facilities.

Tri-Service workflow

Tri-Service Workflow (TSWF), formerly known as COMPASS, provides a simple infrastructure to provide a standard, repeatable, sustainable process. It stands on a three-pillar approach to provide frequent communication, training, and sustainment. Business processes were developed to increase coding accuracy and readability of AHLTA notes. The workflow has a direct impact upon the mission by allowing more efficient, effective healthcare and documentation by responding to a gap between the technology function and user needs. Furthermore, its features provide standardized documentation entry into AHLTA while seeing patients at the same time as appointment check in. This provides repeatable ways of documenting information resulting in improved readability. Clinic and hospital specialty templates exist and provide unique workflow forms to capture patient information in a standardized way. The AIM forms are available based on area of patient visit as displayed in figure 3-4, see paragraph below for an example of the template.

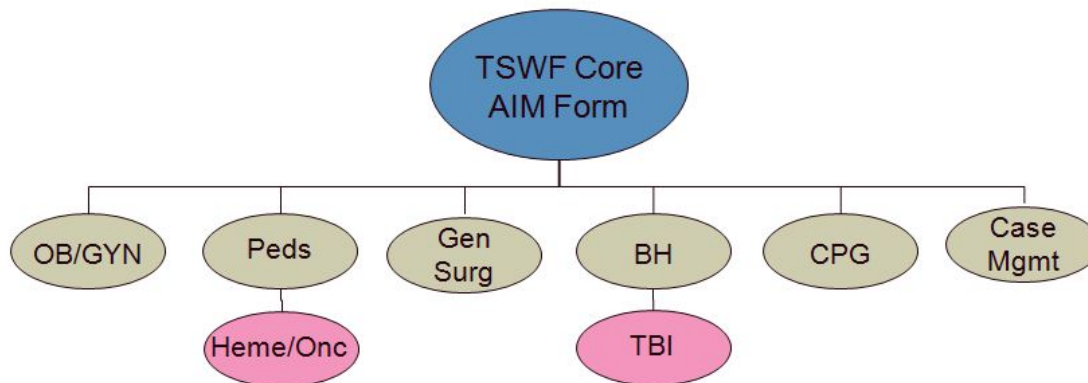


Figure 3-4. Areas using Alternative Input Method (AIM) form.

Features and benefits

The technician provides a standardized and consistently high-quality history to the provider. The standardized history is specifically designed to support inspection compliance and simplified coding. Providers take responsibility of the information on the AIM form, document their work and calculate appropriate coding. Below are common features and benefits of Tri-Service workflow forms:

Tri-Service workflow AIM Form	
Features	Benefits
<ul style="list-style-type: none"> • Uses one core AIM form across MHS-PCMH. • Works with the computer system (AHLTA) we have today. • Simplified standard coding guidance. 	<ul style="list-style-type: none"> • Point of care clinical decision support. • Evidence-based tools built into template to focus on root cause of medical illnesses and injuries. • Standardized practice among different DoD and VA medical facilities. • Simplified training embedded within AHLTA.

Tri-Service workflow template

Utilize the following steps, shown in figures 3–5 and 3–6, to access the library of templates. Study the steps (1 through 8) carefully.

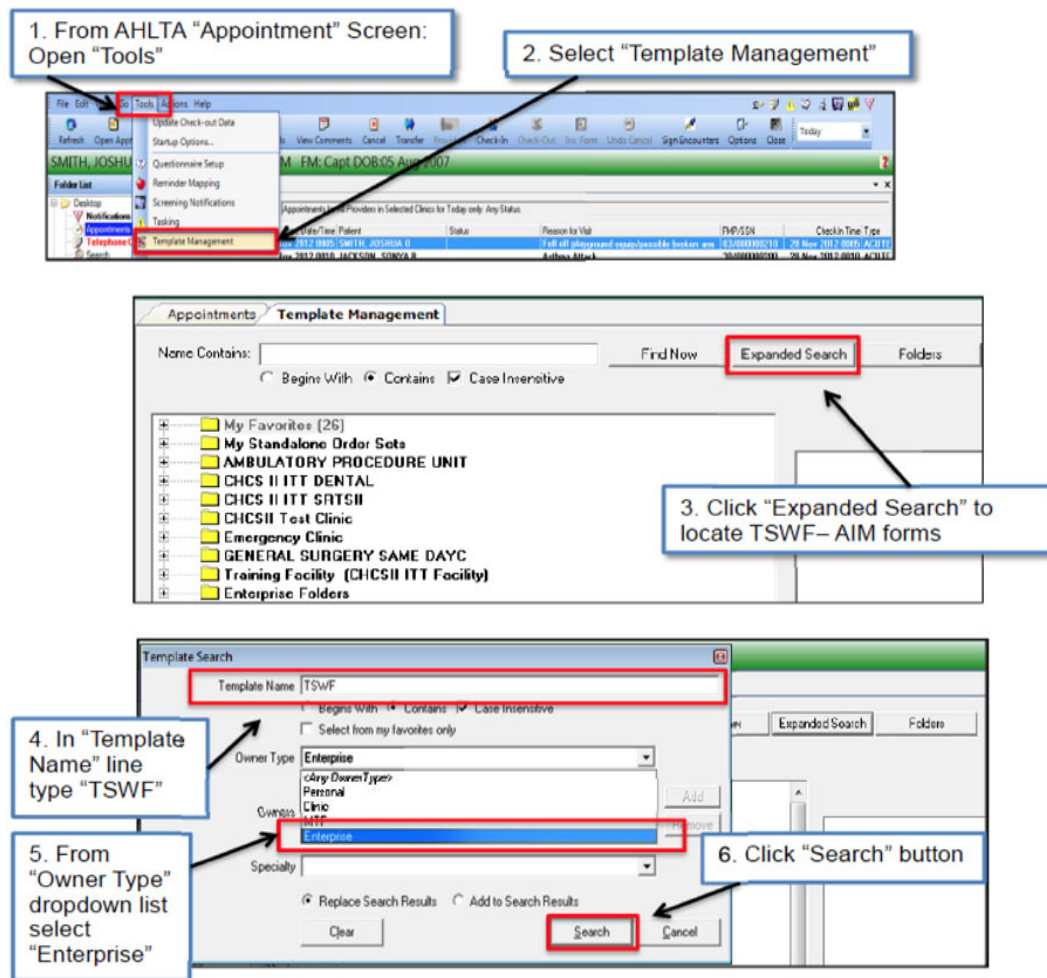


Figure 3–5. Tri-Service workflow template (steps 1–6).

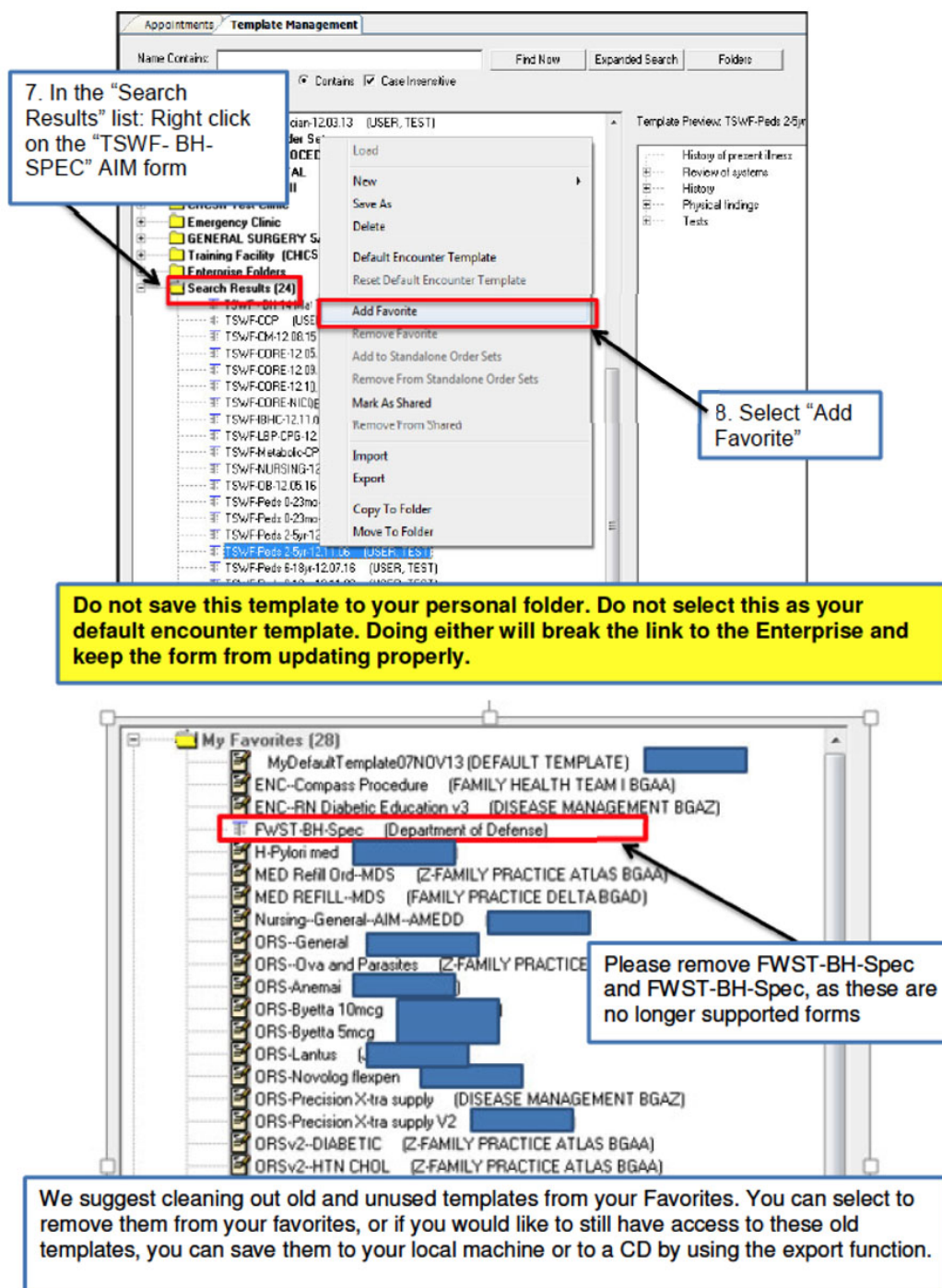


Figure 3-6. Tri-Service workflow template (steps 7-8).

Workflow process

Figure 3-7 displays the process after template is selected. At this time the patient signs in and data is entered in an encounter worksheet or SF 600, Chronological Record of Medical Care overprint. The medical technician and provider uses a common AIM form to enter data into AHLTA. Then, the provider takes over the AIM form document and reviews the technician's input. The provider inputs data into AIM form and then completes and signs the form.

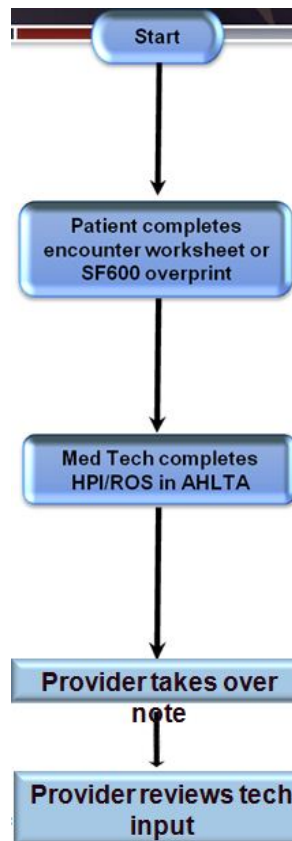


Figure 3-7. Workflow process.

046. Outpatient coding

Coding is another way we ensure accurate and complete information on the care of our patient is documented in the patient's record. Providers are solely responsible for coding their patient encounters. Providers cannot complete or sign their encounters until the encounter is properly coded. Because of the seriousness, certified coders audit the encounters to ensure applied codes are accurate and appropriate for the diagnosis.

It is rare that you will need to code an encounter, though there are infrequent "tech" specific clinics. In those cases, you will use the "99499" code. The 99499 code is a "non-count" code used by technicians, nurses, and other non-credentialed providers. "Non-count" means third party billing is not applicable. "Count" visits are performed by credentialed providers only. For example, if a nurse enters a telephone consult (T-Con) and talks directly to the patient, the nurse will have a "non-count" encounter. If the nurse transfers the T-Con to a provider, and the provider sends it back to the nurse with specific instructions, it's still a non-count visit in the nurse's name. However, if the nurse transfers the T-Con to the provider and the provider actually speaks directly to the patient, the T-Con becomes a "count" visit in the provider's name. Additionally, each specialty (techs, nurses, physicians, etc.) are assigned a "role" in AHLTA. The roles assigned to non-credentialed providers restrict the availability of certain aspects of AHLTA documentation, including coding. So, anytime non-credentialed providers document an encounter in their name (as the "provider"), the only code available to them is 99499. International Classification of Diseases, 9th Revision (ICD-9) coding and disease diagnosing codes are not used by technicians. Coded data must be accurate because it is used for patient record documentation, reimbursement, staffing considerations, program management, and utilization control.

Coded clinical encounters are used at various levels within the DOD to assist in decision-making processes. In today's health care environment, both civilian and military, an improper coding of the

visit or procedure performed can cost the clinic money and manpower and may cause an investigation on insurance fraud. Aside from potential monetary and legal concerns, care and treatment will not be correctly reflected in the patient's record. For the most part, we don't collect our money from insurance agencies but instead gain reimbursement in the form of our facility's annual budget and manpower authorizations. However, we do get some money returned to our facility through third-party collections.

Medical coding is completed for each encounter (visit, exam, procedure, etc.) and has a corresponding numeric code for the events of the visit. The following information gives an overview of how codes for patient visits, care and treatment are completed. You will receive additional training at your facility if you need more in-depth knowledge on the subject.

Diagnoses and procedures from each inpatient case are coded using diagnosis-related groupings (DRG) and an internationally recognized diagnosis and procedure classification system. The US Department of HHS and other health care organizations publish this classification system in a book entitled *International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)*.

There is no way we can cover all of the aspects of the sophisticated ICD-9-CM and coding in this single unit; therefore, our goal is twofold:

1. To familiarize you with the coding process.
2. To pique your interest so that you find other avenues to become an expert in this exciting and rewarding field.

The ICD-9-CM, better known as the ICD-9, is the most important reference in a coder's arsenal. It is what every records technician uses to code diagnoses. The statistical classification system in the ICD-9 codebook was specifically designed to code diseases. Try to borrow a copy of the ICD-9 so that you can actually see the various lists and indexes discussed in this lesson. The patient records section should be able to get you a copy of an older version that will work just fine.

A classification system is an arrangement of the elements of a subject into specific groups according to established criteria. Initially, using the ICD-9 can be compared to looking up a word in the dictionary or a subject in the index of a reference book. Looking up a particular word or subject may lead you to several other locations or subjects before you find exactly what you are looking for. After finding the disease, condition, or procedure listed in an alphabetical listing, you are guided through a series of checks and balances until you find the numerical code that best describes the diagnosis or procedure from the inpatient record.

The ICD-9 is divided into four sections:

1. Coding guidelines.
2. Disease Alphabetical Index.
3. Diseases Tabular List.
4. Appendixes.

Coding guidelines

Coding guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided with in the ICD-9-CM itself. Adherence to these guidelines when assigning ICD-9 diagnosis and procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The diagnosis codes (volumes 1 and 2) have been adopted under HIPAA for all healthcare settings.

Diseases Alphabetical Index

The Diseases Alphabetical Index lists diseases in alphabetical order using a series of main terms and sub-terms. To find a specific disease, you must be familiar with the different uses for punctuation, type, and specific terminology.

Diseases Tabular List

The Diseases Tabular List lists diagnoses in numeric sequence. Once the coder has located a particular disease or condition in the alphabetical listing, he or she will then locate the associated numeric code in section two of the ICD-9, Tabular List, to verify that the selected code is correct. You can think of this process as a “double-check.” The tabular list of diseases is broken down into 17 main classifications. Each classification contains a series of numbers (codes) that identify diagnoses related to the main classification.

Appendixes

The appendixes have information pertaining to Morphology of Neoplasms, Classification of Drug by AHFS List, 3-Digit Categories, and Tables relating to specific diagnosis codes.

Abbreviations and punctuation

There are two major abbreviations used in the ICD-9:

1. NEC means “not elsewhere classified (classifiable).” This abbreviation is used only when the coder lacks the information necessary to code to a more specific fourth-digit subcategory or when the ICD-9 code book does not provide a code specific for the patient’s condition.
2. NOS means “not otherwise specified” and is the equivalent of “unspecified.”

Several punctuation marks are used in the ICD-9. These are listed in the following table:

Name	Punctuation Mark	Explanation
Brackets	[]	Brackets enclose synonyms, alternative terminology, or explanatory
Parentheses	()	Parentheses enclose supplementary words called nonessential modifiers that may be present in the narrative of a disease or procedure without affecting the code to which it is assigned.
Colons	:	Colons are used in the tabular list after an incomplete term that needs one or more of the modifiers that follow in order to make it assignable to a given category.
Braces	{ }	Braces enclose a series of terms, each of which is modified by the statement appearing to the right of the brace.

Procedural coding

The Current Procedural Coding book, better known as the CPT, is what will be used to code procedures such as injections ordered by the provider, nebulizer treatments, IVs and any other procedures performed by you. The CPT is made up of three sections.

1. Index.
2. Tabular List.
3. Appendixes.

This book is used much the same way as the ICD-9. You search for key words and then continue with the leads until you reach the most specific procedure code.

Accurate and complete coding benefits the AFMS, the MHS, and our patients. Accurate coding is needed to reflect the scope, severity, and quantity of health care delivered within our system. Most important, it is needed to reflect the quality of health of our members, which is proven through accurate documentation and coding. Certainly, health outcomes must be balanced against cost but perhaps a healthcare system that focuses on and can prove it delivers superior health outcomes that are worth more.

047. Using the Aeromedical Services Information Management System

Health care providers, nurses, and medical technicians utilize the Aeromedical Services Information Management System (ASIMS) as a tracking tool documenting individual medical requirements (IMR). ASIMS also assists in reducing disease injury risks through optimum application of Aerospace Medicine capabilities and relays real-time readiness status of a unit, wing, or base.

ASIMS is comprised of a Web application called ASIMS Web and desktop (Preventive Health Assessment and Individual Medical Readiness (PIMR)/Air Force Complete Immunization Tracking Application (AFCITA); these two tools work jointly to provide complete point of service management of immunizations (active duty and dependents), PHAs, IMR, medical employee health tracking, occupational exam tracking, deployment and duty limiting profiles, pre and post deployment health assessments and resiliency assessments, grounding management (AF 1041, Medical Recommendation for Flying or Special Operational Duty Log/1042 Medical Recommendation for Flying or Special Operational Duty), and other tools.

ASIMS has separate access levels for three types of personnel:

1. Medical staff members who provide direct patient care or manage the programs listed above.
2. Designated unit points of contact (POC).
3. AF members to access their own IMR status.

The following information displays your responsibilities in ASIMS by covering how to update IMR step-by-step. Let's first review the different roles of each user then describe how updates are performed while using ASIMS in your duty section.

ASIMS access

The three different access levels for ASIMS include (1) medical level, (2) unit POC level, and (3) individual level for AF members. Each level has a separate URL that works for users who have been granted appropriate permissions by local software administrators.

Request for access to ASIMS is performed by following these steps:

1. The administrator requires the following information to establish an account <https://asims.afms.mil/webapp/NewAccount.aspx>.
2. Users will be asked to complete the following:
 - A. Certify status as a medical employee.
 - B. Complete demographic information (fig. 3-8).

Figure 3-8. General information.

C. Select MTF (fig. 3-9).

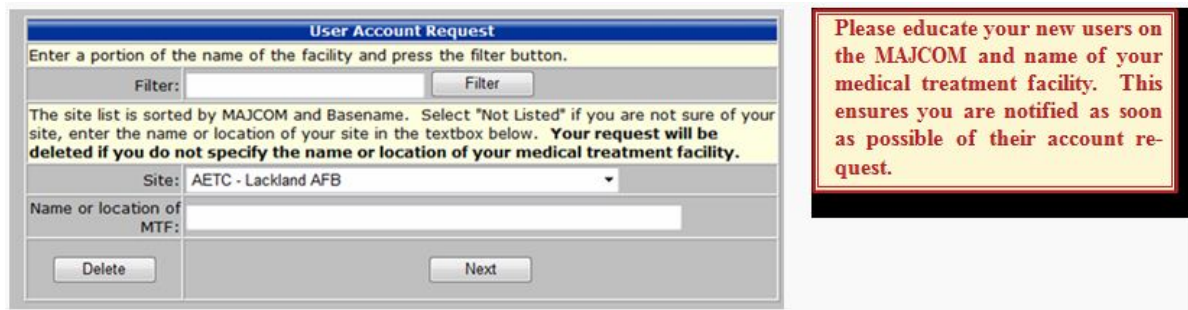


Figure 3-9. User account.

D. Input requested access levels (fig. 3-10).

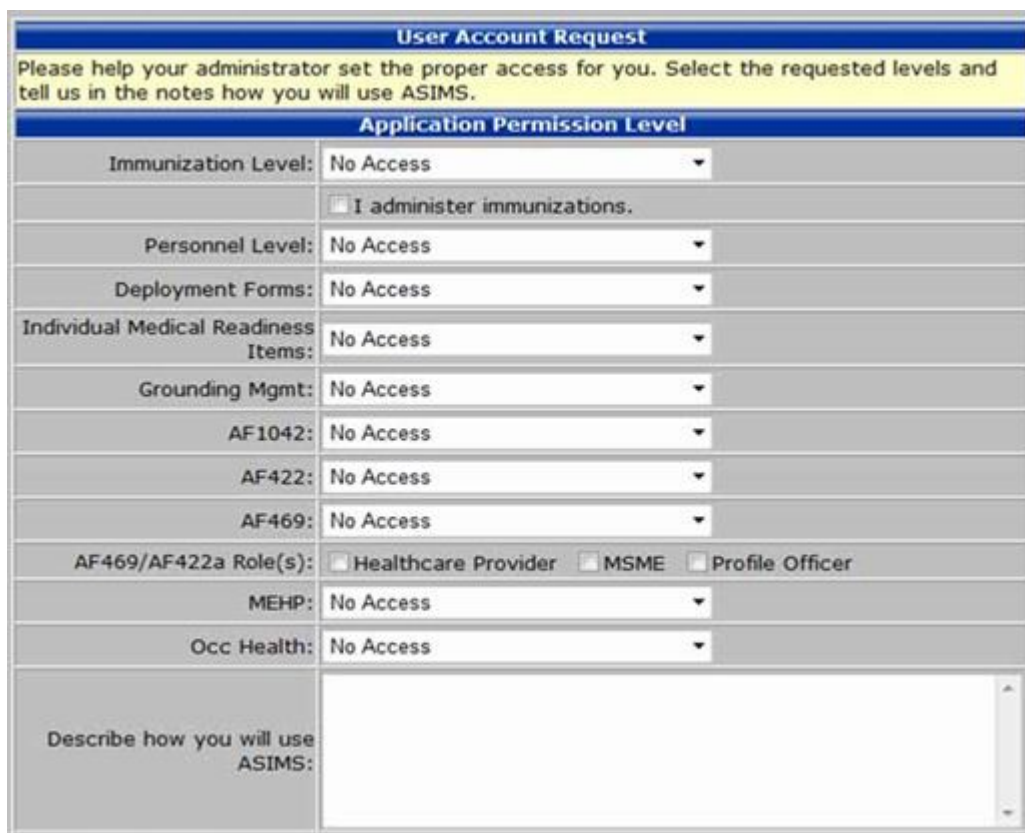


Figure 3-10. Access levels.

Medical

For medics, permission within ASIMS can be granted based on the member's user account in desktop PIMR/AFCITA or directly in the ASIMS Web application. Authorized medical personnel will access ASIMS via <https://asims.afms.mil/webapp/login.aspx>. Contact local clinic or hospital ASIMS administrator for access.

Unit POCs

Officially designated unit POCs must be listed in the PIMR Unit POC table and will access their level of ASIMS via <https://asims.afms.mil/imr/loginunit.aspx>.

Individual AF members

AF members can check their own IMR status at any time and get completed copies of the most recent AF Form 469, Duty Limitation Condition Report and AF Form 422, Notification of Air Force Member's Qualification Status, at this Web site: <https://asims.afms.mil/imr/MyIMR.aspx>.

If the requested immunization level is above Read Only, the AF member is prompted to select their Immunization Clinic (fig. 3-11) to ensure they have the most current immunization record.

Figure 3-11. User account request.

Finally, they can review their account request and confirm all information entered.

ASIMS roles and responsibilities

There are numerous roles for different users in ASIMS. Information on your specific responsibilities per AFI 44-170, *Preventive Health Assessment*, is outlined below.

Preventive Health Assessment Cell

As a 4N0X1 you may be assigned within a clinic to complete Preventive Health Assessment (PHA) on patients assigned to your medical facility. This includes scheduling appointments, reviewing questionnaires and coordinating assessment of IMR. Here are some other roles and responsibilities you might perform:

- Acts as the MTF POC for the administrative management of the PHA program.
- Manages the administrative tracking, scheduling through the unit health monitor (UHM), as locally applicable, processing, and quality control of PHAs through technician level reviews. The PHA cell team is not required to track or notify members of the Air Reserve Component (ARC) or sister service that PHAs are due unless specific local processes to conduct these functions are set up with the ARC or sister services.
- Generates a patient listing each duty day and addresses findings according to instructions in AFI 44-170, clinical circumstances, AFMOA and/or locally developed PHA business rules.
- Based on PHA business rules, schedules required appointments with patient care teams and directs patients to ancillary services (e.g., Health and Wellness Center, lab, immunizations).
EXCEPTION: The Flight and Operational Medicine Clinic (FOMC) schedules required appointments for its assigned population, health technician team for Air National Guard and Air Reserve technicians for Air Force Reserve members.
- Orders necessary PHA and IMR labs as directed by IMR guidance, PHA business rules, and Executive Committee of the Medical Staff (ECOMS)-approved business rule modifications. Patient care clinics are responsible for follow-up of lab results. Health Technician Teams/Air Reserve Technicians are responsible to ensure proper follow-up of ARC-ordered labs.
EXCEPTION: The FOMC will order all necessary labs for its assigned population.
- Clinical interventions within the PHA Cell are limited to directing follow-up care (to the provider, nurse, health and wellness center, etc.); brief counseling and education; distributing Air Force Medical Operations Agency (AFMOA)- or ECOMS-approved, PHA-related, patient education handouts; and weight, height, blood pressure, and other required

measurements as prescribed by the 4E CFETP and AFMOA- or ECOMS-approved protocols.

NOTE: For ARC, requirements are prescribed by 4N CFETP.

- Documents all patient interventions and brief counseling, including attempts to contact member, in the medical record (e.g., the DOD electronic medical record, AHLTA or hard copy, if AHLTA not available).
- At in-processing, conducts an initial medical records review (includes ASIMS, hard copy records and AHLTA) to ensure IMR requirements are up-to-date and to identify possible mobility or duty restricting limitations. The PHA Cell will forward records requiring further evaluation (e.g., possible AF Form 469, Duty Limiting Conditions Report, actions) to the Medical Standards Management Element (MSME).

ASIMS IMR updates

The primary purpose of IMR is to provide a real-time medical readiness assessment of IMR requirements to commanders, individuals, and primary care management (PCM) teams so they can manage and optimize the readiness status of their assigned or enrolled Air Force personnel. The assessment of an individual's medical readiness must be a continuous process. It is independent of the recurring PHA cycle or assessment. For example, if an individual completes their PHA in January and becomes due for a required immunization in March or becomes pregnant in June, their IMR status will be reflected in the PIMR program immediately. In order for IMR status to be kept current in PIMR, these items must be updated continuously throughout the year because, as you know, medical conditions do change. The vast majority of information for the IMR portion of PIMR will be imported into the software from other computer systems or a central server. The rest will be manually entered into the PIMR system as needed. IMR factors are explained in the following paragraphs.

Immunizations

Immunization requirements (including tuberculosis [TB] skin testing) are established and linked automatically to PIMR. When a required immunization or TB skin test becomes due, the IMR status changes to RED (individual is not cleared for deployment) until it is completed.

Dental classification

Dental classification is managed through the Dental Classification Management System (DCMS) and passed on to PIMR automatically. A dental classification of 1 or 2 is reflected as IMR GREEN (individual meets all readiness requirements for deployment); 3 or 4 is reflected as RED.

Physical profile

All profiles are managed within the PIMR software. Providers initiate the profile as indicated in AFI 48-123, *Medical Examinations and Standards*, Volume 2, *Accession, Retention, and Administration*, Chapter 4, and by using the guidance in AFPAM 48-133, *Physical Examination Techniques*, Chapter 10, para 10.3. Any profile that brings a member's deployment qualification into question is reflected as RED.

Medical readiness lab test

The following lab tests are required at the indicated frequency and must be recorded in PIMR as displayed in table below:

Lab Test	Frequency
G6PD	Once
DNA	Once
Blood Type	Once
Sickledex	Once
HIV	Within 5 years

If these lab tests have not been accomplished and are not in the PIMR software, this area shows as RED until the requirements are met. The data must be entered manually into the PIMR software in order to change the RED to GREEN.

PHA

Preventive health assessments become due (turn yellow) 12 months (366 days) from the last PHA completion date. Once the PHA becomes due, there is a 90-day “yellow” window to accomplish the PHA before the PHA “turns red” and the unit is penalized on their PHA IMR (i.e., the PHA is green for 365 days; turns yellow [due] on day 366, and turns red [overdue] 90 days later on day 456).

NOTE: It is not the intent of the 90-day yellow period to establish a firm 15-month PHA requirement. PHAs performed just prior to the 15-month cut-off should be the rare exception and not the rule. Due/Overdue gives a snapshot of the overall unit readiness level by showing what items are due/overdue through action items, such as profiles, labs, and so forth, according to Department of Defense Instruction (DODI) 6025.19, *Individual Medical Readiness*.

There are six requirements that must be met for members to be IMR ready (or IMR green)

1. Current health risk review (HRR)/PHA.
2. Deployment limiting conditions.
3. Dental readiness.
4. Immunization status.
5. Medical readiness laboratory test.
6. Individual medical equipment.

Green

The color green indicates the military member is current and no action is needed at this time. The goal of annual PHAs is to fulfill this requirement (IMR) so military members are medically fit for duty.

Yellow

A member’s overall PHA status will remain yellow for three months up to the due date until all items are completed. Individual requirement within a PHA will only remain yellow for one month. This color indicates no immediate concerns but provides an indicator of an IMR coming due within a three-month timeframe. It allows the military member the opportunity to schedule and complete those IMR items.

Red

Red indicates immediate action is needed and member needs to complete medical requirements as soon as possible (e.g., immunizations, PHAs, dental, and deployment health assessments). It turns red on day 456.

The PHA is complete when the AHLTA and/or paper medical record review have been completed. The Airman’s patient care team (or surrogate) must also address AF Web health assessment (HA) results including all critical and priority findings, and make definitive care plans and dispositions (referral, appointment, etc.) pertaining to these responses. The face-to-face provider visit must be accomplished along with recommended clinical preventive services, education and counseling, and referrals placed. ARC medical components will document when ARC Airmen are advised to see their non-military patient care team for clinical preventive services. Any required documentation must be accomplished by a technician and the patient care team. Additionally, the provider must review and signed the PHA, including the PHA AHLTA electronic signatures. For ANG, qualified health technicians can sign the Web HA with no critical/priority findings and the member has no other PHA requirements.

The PHA AHLTA note must be accurately coded. PHAs not requiring a face-to-face provider visit should normally be coded with evaluation and management code 99420. PHAs in conjunction with medical evaluation boards and review in lieu of medical evaluation board may require disability exam codes. ARC medical units are not required to code PHA visits. For personnel requiring AF Form 1042, complete and record the information in ASIMS at the same time as the PHA. The provider must also make a duty limiting condition determination or initiate a diagnostic work-up, if appropriate and/or review in lieu of medical board or fit for duty actions have been completed. The patient care team records PHA in ASIMS with a completion date. The clinical preventive service results, including laboratory and completed educational/counseling programs (e.g., tobacco cessation programs), are not required to complete a PHA for ASIMS and unit reporting purposes. Concerns regarding worldwide duty qualifications should be addressed with an AF Form 469 and not delay PHA completion. Lastly, reservists and Air Guard members assigned to units with sufficient medical assets will receive their PHAs within their own Reserve or Guard units.

Quarters program

Quarters is a full-duty excuse provided to active duty uniformed service members receiving medical or dental treatment for a disease or injury that, based on sound professional judgment, does not require inpatient care (fig. 3-12). A *quarters patient* is treated on an outpatient basis, and is to remain at home during the quarters period. Quarters periods generally last 24-72 hours depending on the providers prescribed rest/recovery period.

QUARTERS AUTHORIZATION/SICK SLIP		
SECTION I: DURATION OF QUARTERS		
DURATION: (circle one)		
24 Hrs or Less	48 Hrs	72 Hrs OB Patient
		DATE: _____
Date & Time Patient is Expected to Return to Work: _____		Return Appointment (if necessary): _____
SECTION II: GENERAL CHARACTERIZATION OF QUARTERS CONDITION		
(circle all that apply)		
ILLNESS	NON-BATTLE INJURY	BATTLE CASUALTY RELATED INJURY
AIRCRAFT RELATED	MOTOR VEHICLE RELATED	OTHER
SECTION III: PATIENT IDENTIFICATION		
LAST NAME: _____		FIRST NAME: _____
RANK: _____	Last 4 (SSN): _____	Service Branch: _____
Organization/Unit: _____		Station of Assignment: _____
SECTION IV: UNIT NOTIFICATION:		
DATE & TIME: _____		PERSON CONTACTED: _____
SECTION V: MEMBER ACKNOWLEDGEMENT		
<p>My provider has explained the "quarters" process to me and I understand that my excusal from duty is temporary and I am to return to work in accordance with the time indicated above. I further understand that my excusal from duty is to rest and recover from an injury or illness, in my own home. I have been instructed to contact my immediate supervisor and inform him/her of my status. I will take this form to my immediate commander or commander's support staff before proceeding home. I also understand that failure to follow the instructions listed in this agreement may result in negative administrative action.</p>		
Signature of Patient _____		
<p>Example AFB Form XX-XX</p> <p>This document may contain information covered under the Privacy Act, 5 USC 552, Health Insurance Portability and Accountability Act, Public Law 104-191, and DoD 6025.18-R. It must be protected in accordance with those provisions.</p>		

Figure 3-12. Quarters authorization form.

NOTE: Physician assistants/nurse practitioners may not place a patient on quarters for longer than 48 hours without approval by a physician.

Unit commanders and supervisors have the authority to grant up to 24-hours sick status at their discretion if a member's illness/injury does not require MTF intervention. If the illness/injury persists beyond 24 hours, then the commander or supervisor must refer the member to the MTF for treatment and subsequent clinical examination.

Obstetrical quarters

As a general rule, obstetrical (OB) quarters should be the primary method for managing OB patients with prenatal medical issues when continued duty must be temporarily limited or suspended. The use of OB quarters is designed for ongoing medical issues that may require medical re-evaluation (not convalescence), which implies a period of recovery. For ongoing medical problems during pregnancy, providers are encouraged to use quarters and the profile system rather than recommending convalescent leave.

Quarters notification procedures

The provider or support staff notifies the member's unit commander or designee regarding the patient's quarters status. Command authority notification is documented on a DD Form 689, Individual Sick Slip, or a locally created form. Disclose only the minimum information necessary and account for the disclosure in the protected health information management or MTF approved centralized disclosure accounting tool.

Notwithstanding any other installation document creation and approval mechanism, the Health Records Review Committee must approve locally created clinical forms. Forward a copy of the quarters notification or sick slip to the member's unit commander or authorized representative to receive quarters information. Provide a second copy of the quarters notification to the member so he or she may give it to his or her supervisor. Develop local procedures for program management, including, but not limited to the following:

- Notifying Public Health for communicable disease tracking.
- Extending quarters past the initial rest period.

Complete quarters notifications

After the healthcare provider completes the quarters notification form, the current manual notification process requires clinical or support personnel to call and/or fax a copy of the quarters notification form to the member's unit (usually the member's orderly room) to make the quarters notification.

Once received by the member's unit, the medical quarters data is manually entered into the Air Force Personnel Center (AFPC) Military Personnel Data System (MILPDS) to update the member's duty status. Another copy of the quarters notification form is provided to the member.

However, your facility may be using an automated process to make quarters notifications. As of this publication, this process is not mandatory; however, future policy decisions mandating its use are forthcoming. The automated quarters notification process improves timeliness, accuracy, and the reliability of the notification by providing near-real-time information to the commander's support staff and AFPC personnel. It also reduces man-hours spent on the manual notification process and makes it easier to track and analyze trends.

In the automated process, the medical staff inputs the quarters authorization into the automated system and the provider e-signs the form. Once the provider e-signs the form, the automated system automatically sends an e-mail notification to the commander/designated unit monitor. The member can obtain a copy of his/her signed quarters notification form from the MyIMR page (accessed through the Air Force Portal). Medical staff can also print a copy and give it to the member.

048. Population health management principles

The Military Health Service's mission is to support the DOD and our nation's security by providing health services for the full range of military deployments and by sustaining the health of members of

the armed forces, their families, and others. You can sum up the mission by saying that you will deliver the RIGHT CARE by the RIGHT PEOPLE at the RIGHT TIME. Changes continue to sweep across the healthcare industry, and the MHS is not immune to the effects. We must maintain a fit and ready force, respond to world crises, and yet remain in competition with our civilian competitors. In order to remain competitive and in our present form, we must give all eligible beneficiaries a reason to join our managed care organization, TRICARE Prime. To do this, we must deliver the promised benefits of managing health and maintaining customer satisfaction at a competitive cost. As the medical technician, you are often the individual who will be “selling” the TRICARE Prime product to your population, and in the process, teaching the other Airmen in the work center that you believe in the MHS. The MTF budget and manpower are both directly linked to the amount of patients enrolled into TRICARE Prime. So if TRICARE Prime enrollment is so vital, how do you maintain the necessary level of patients into the facility? It starts with patient care management.

The overall strategy of population health management is to focus on managing the health of a defined population; optimum health is the ultimate goal of medicine. This focus defines predecessor initiatives (e.g., managing utilization, managing costs, and managing disease) as supporting strategies for population health management. If every policy, program, tool, software system, and strategy is evaluated for its support of optimizing health, then everyone, from medics to MAJCOMs to policy makers, could see where their efforts fit into the overall strategy of population health management.

Continuum of care

Before managed care, “fee for service” health care was physician-centered and evolved around those who sought care for illness. Acute illness was treated, and any follow-up care depended on “patients” taking the initiative to return for that care. Early attempts to provide some continuity of care focused on maximizing function and involved disease-based programs such as cardiac rehabilitation and diabetes educational programs.

These disease-centered or disease-management programs centered on individual disease states; they rarely integrated with other programs or care. However, these programs gained momentum because they were believed to improve long-term function (tertiary prevention).

Some military health professionals soon learned that those who showed up in traditional disease management programs were too few and far along the health/disease continuum to improve the health of the population as a whole. Since these services were needed by the vast majority of our population, military health professionals realized the need to intervene earlier in the disease cycle (secondary prevention) with screening programs or even earlier before the disease had a chance to develop (primary prevention).

The vast majority of people are well, but at varying risk for disease. They make up the majority of the population. Since only a relative few have diseases, disease management programs affect only a small proportion of those in the population. However, many more people have risk factors for future disease. A program that attempts to decrease or eliminate health risk factors has the potential for moving much larger groups of people towards good health. A program’s impact on the population is multiplied by the percentage of the population having that risk factor.

This health-centered model logically leads one to intervene earlier in the health/disease continuum. This type of thinking led to the rise in clinical preventive service initiatives, such as improving the delivery of mammography, pap screening, or immunizations, which were organized in an implementation strategy called Put Prevention into Practice (PPIP).

Case management

Case management (CM) is a collaborative process under the population health continuum that assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual’s health needs through communication and available resources to promote quality, cost-

effective outcomes. The MHS incorporates CM as a component of a comprehensive medical management (MM). These strategies involve:

- Supporting patients through transitions of care.
- Decreasing fragmentation of healthcare services.
- Supporting patient safety, education, and self-determination by establishing an active partnership with patients, their families, and the entire healthcare team to achieve optimal healthcare outcomes.

Figure 3–13 highlights the role of CM over the various stages of health care. Specifically, as the focus of healthcare delivery moves along the population health continuum from secondary toward tertiary prevention, a more individualized approach is required to manage the unique circumstances of patients with a particular disease/illness/injury. The MHS has established wounded, ill, and injured (sometimes referred to as WII) Service member requirements, which provide a unique level of intensive CM services for active duty service members (ADSM) with complex medical needs serving in the Army, Navy, Air Force, Coast Guard, and Reserve components.

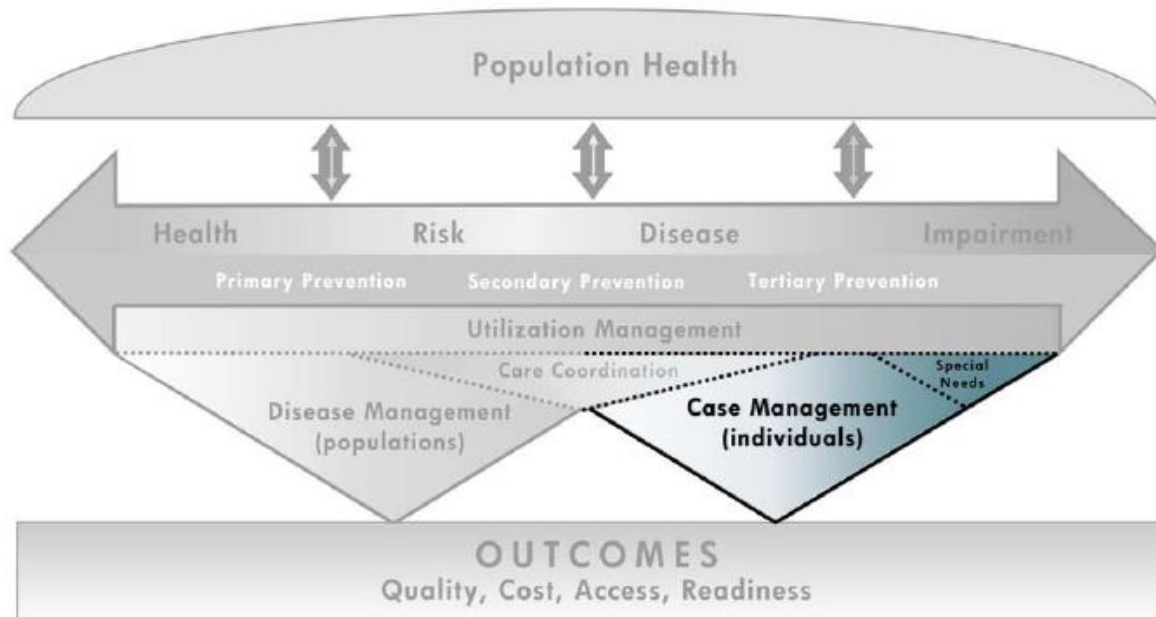


Figure 3–13. Case Management within the Integrated MM Model (IM3).

The MHS has three *primary goals* for CM:

1. Improve the care, management, and transition of recovering Service members.
2. Broaden the application of CM to include beneficiaries with complex needs and at-risk beneficiaries before they require complex care.
3. Evaluate the impact of CM on the quality and efficiency of military health care.

There are additional goals applicable to caring for wounded warriors:

- Assist the recovering service member in receiving quality medical and behavioral health (BH), which may include lengthy inpatient stays and transitions between facilities or between outpatient medical and BH services.
- Assist the recovering service member and his or her family in understanding the recommended treatment (including BH services) and in receiving timely access to that treatment.

The goal for patients coping with chronic disease is self-management and patient empowerment. While disease managers provide the medical care needed for the patient's specific disease, the hand-off to case managers supports much-needed, ongoing holistic coping and management strategies as patients strive to achieve optimal functioning and quality of life.

The purpose of CM is to:

- Promote quality and safe and cost-effective care.
- Promote utilization of available resources to achieve clinical and financial outcomes.
- Facilitate appropriate access to care.
- Collaborate with the patient/family, physician, healthcare providers, and others to develop and implement plan that meets the needs and goals of the patient.
- Develop individualized patient plans of care.
- Offer objectivity, healthcare choices, and self-management solutions.

Disease management

Disease management is focused on optimizing health in specific populations. It should be noted that all components of MM—utilization management (UM), CM, and DM—blend together when they are operationalized. The lines of distinction between UM, CM, and DM programs may become less defined as UM, CM, and DM personnel collaborate with MTF providers and UM referral management health care integrator (HCI) staff to achieve the best healthcare benefit possible for the patient and the organization. Specifically, as the focus of healthcare delivery moves along the population health continuum, when the focus of healthcare is primary prevention, interventions are most effective for groups of people with similar characteristics. The same is true when providing healthcare services at the level of secondary prevention for people who are at risk for exacerbating or complicating their disease.

In the DOD, MTFs have successfully implemented DM programs for a number of conditions and disease states. In accordance with the National Defense Authorization Act (NDAA) of 2007, the MHS was tasked with developing DM programs for a variety of diseases and chronic conditions including asthma, chronic obstructive pulmonary disease, diabetes, depression and anxiety disorders, cancer, and heart disease. Thus, MTFs and managed care support contractors (MCSC) have begun to systematically incorporate these disease states into their DM programs.

Definition, goals, and purpose

DM is an organized effort aimed at achieving desired health outcomes in populations with prevalent, often chronic, diseases for which healthcare delivery may be subject to considerable variation. In contrast to CMs focus on individual patients, DM is aimed at sub-populations of patients with a specific condition, disease, or two of more coexisting medical conditions (e.g., the metabolic syndrome associated with diabetes, hypertension, and hyperlipidemia). The principles of DM are applicable to all venues of healthcare delivery, including the inpatient and outpatient settings in both the primary and specialty care arenas. According to the Disease Management Association of America the Care Continuum Alliance (hereafter referred to as DMAA), DM is “*a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant.*”

The DMAA has broadened its focus from strictly DM to a population health model, of which DM is a component. This model promotes a proactive, accountable, patient-centric approach featuring a “physician-guided” healthcare delivery approach designed to “develop and engage informed and activated patients over time to address both illness and long term health.” The MHS population health model is based on a healthcare delivery approach that incorporates six key components illustrating this paradigm from a provider-guided approach.

DM program goals are to improve clinical outcomes, increase patient and provider satisfaction, and promote appropriate utilization of resources throughout the MHS. The purpose of DM is to improve the quality of life for individuals by preventing or minimizing the impact of a disease or chronic condition. This purpose is accomplished by activities such as implementing more standardized care and improving patients' ability to care for themselves.

Per the DMAA (2009), a DM program does the following:

- Emphasizes prevention of exacerbations and complications by using evidence-based practice guidelines and patient empowerment strategies.
- Supports the healthcare provider/patient relationship and plan of care.
- Evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

Utilization management

Effective UM (fig. 3-14) is a key process within MM for improving the quality of health care and ensuring the cost effectiveness of health care services. UM relates to all components of a health care delivery system, including care within the primary, specialty, and inpatient settings.

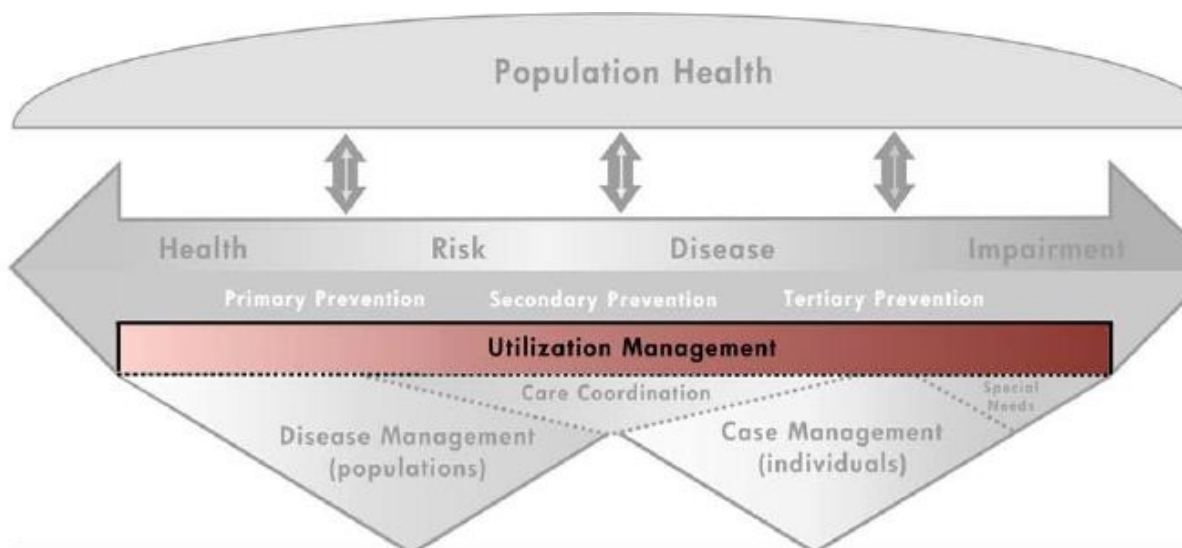


Figure 3-14. Utilization management.

Definition, goals, and purpose

UM is a methodology that addresses the issue of managing the use of resources in the delivery of health care, while also measuring the quality associated with the delivery of that care. UM is an organization-wide, interdisciplinary approach to balancing quality, risk, and cost concerns in the provision of patient care. It is the process of evaluating the medical necessity, appropriateness, and efficiency of healthcare services. Utilization review (UR) is the process of determining whether all aspects of a patient's care, at every level, are medically necessary and appropriately delivered. In addition, UR in the private sector includes pre-certification review, admission review, continued stay review, retrospective review, discharge planning, bill review, and individual medical CM. The difference between the two is that UR examines past history while UM concentrates on current and future processes.

The ultimate goal of UM is to maintain the quality and efficiency of healthcare delivery by:

- Providing patients with the appropriate level of care.
- Coordinating healthcare benefits.

- Promoting the least costly, most effective treatment benefit.
- Determining the presence of medical urgency.

The purpose of UM within the MTF is to identify, monitor, evaluate, and resolve issues that may result in inefficient healthcare delivery or that may have an impact on resources and services.

Referral management

Referral management (RM), considered a subcomponent of a UM program, is the process of managing and tracking internal/external patient referrals within the MTF, to another MTF (i.e., within the DCS), or to network specialists (i.e., to the permanent change of station). RM provides a mechanism for determining patient access to specialty clinics, durable medical equipment (DME), and network inpatient admissions that use evidence-based criteria and predetermined clinical/business outcomes. RM is an important business and clinical process within the MHS. It provides a clear capability to minimize costs for care referred to the network.

RM goals promote continuity of care, timely intervention, and access to care. The goals allow us to recapture care appropriately and make informed decisions about the most effective utilization of resources. MTFs hold primary responsibility for coordinating the tracking and closure of specialty referrals for their enrolled population. A referral is the process of directing an MHS patient from one healthcare provider to another within the DCS or to a network (preferably) or non-network (as necessary) civilian provider. A referral request is expected in most cases; in some circumstances, a preauthorization may be required. A consult report, known as a clearly legible report (CLR), is the primary method used to close out a referral.

The RM process involves two types of component—clinical and administrative. The clinical component includes performing UR for medical necessity of specialty referrals and determining appropriateness of care. RM staff should apply the use of approved clinical practice guidelines and proactively identify and refer patients for CM or DM.

The use of CPGs can facilitate the RM process, since recommended referrals for specialty care are included within the practice guidelines. The ability to verify the appropriateness of a referral for a particular disease or procedure is available as a function in Milliman Ambulatory Care Guidelines (<http://www.careguidelines.com/brochures/ac/ACebrochure.pdf>) and McKesson InterQual evidence-based decision support criteria. Clearly identifying recommended referral points can decrease inappropriate referrals and improve the timeliness of appropriate referrals.

The administrative component of RM relates primarily to managing the electronic transmission of specialty referral requests from the MTF to the MCSC, to include ensuring referrals meet access and continuity of care standards. The administrative staff needs to closely monitor and track the return of referral results. Tracking of referrals encompasses monitoring, timeliness of result return, and legibility. The utilization manager initiates services by sending a referral to the MCSC. Contact the MCSC in your region on how to appropriately send a referral. With contract modifications, the MCSC performs benefit and medical necessity reviews for all patients except ADSMs. RMC staff must perform benefit and medical necessity reviews for ADSMs since the MCSC will not deny their care. However, the MTF may establish its own internal review process to select referrals for appropriateness and medical necessity.

Additionally, red flag situations such as the following may require further review:

- Travel.
- Out-of-area care.
- Non-network provider requests.
- Continuity of care.
- Care following PCS enrollment.

The MTF should have established processes to appropriately respond and coordinate high-expense requests. However, these items are available to the beneficiary but should be closely reviewed for cost containment and appropriately addressed by MTF staff prior to “defer to network.”

The following are some tips for implementing a successful RM program:

- Perform retrospective reviews to validate referral patterns.
- Evaluate the appropriateness of referrals for ADSMs and the strategy for further review.
- Evaluate multiple referrals for quality and continuity of care (e.g., referrals for new versus established patients).
- Maintain current capabilities list to facilitate *right of first refusal* (ROFR) opportunities.
- Monitor access for specialty appointments within the MTFs through sound template management.
- Identify opportunities to refer patients for CM or DM.
- Collaborate and coordinate processes and problem resolution with the MCSC.
- Educate patients and staff about the referral process.
- Establish a tracking process to account for 100 percent referrals.

Health care integrator

The health care integrator leads assigned teams in population health initiatives that integrate all aspects of care along the health continuum. HCIs ensure acuity-based enrollment is completed with oversight provided by the senior medical physician, in coordination with the group practice manager (GPM) and flight leadership, as appropriate. The HCI provides training to the PCMH teams on how to obtain actionable lists of patients and populations of patients at risk for chronic, complex, and co-morbid conditions and mentor the teams on management of those patients. The HCI ensures proactive patient care meetings occur on a routine basis, care coordination meetings occur as needed, and the MM staff members interact on a routine basis with PCMH teams to provide for proactive patient care. The HCI will ensure all PCMH staff has access and training materials on and the Dashboard (as available) and are briefed on the concepts of population health according to the Population Health Guide, current edition.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

043. Purpose and core principles

1. According to the AFMS’s vision, how can we simplify PCMH with a phrase?
2. What type of model is PCMH and who leads its responsibilities to provide continuous, accessible, family-centered, comprehensive, compassionate and culturally-sensitive health care?
3. What is the difference between PCMH and the previous traditional health care models?
4. List all PCMH practice concepts that should lead to delivering effective health care.

5. What are the responsibilities of medical technicians when assigned in a PCMH team?
6. What is the purpose of CarePoint when utilized by AFMS personnel?
7. What program is the cornerstone of AFMS healthcare application framework?
8. List the features CarePoint provides for AFMS personnel on a daily basis.

044. Overview of information systems

1. What does DEERS function as?
2. List five functions of AHLTA.
3. What does AHLTA support?
4. What are the key features of an electronic inpatient health record?

045. Tri-Service workflow forms

1. What is the purpose of Tri-Service workflow forms in documenting patient care and what are its three pillar approaches?
2. How do Tri-Service workflow forms improve the process and what steps do technician and provider use to enter data into AHLTA?
3. The workflow uses a simple process to document patient care; what is the first step and who completes the documentation?
4. Once the patient fills out the paper worksheet, what is the next step in the process?

5. What are the last two steps after the medical technician completes his or her responsibilities in AHLTA?

046. Outpatient coding

1. For what purpose is coding used?
2. What are the four sections in the ICD-9?
3. What are the benefits to accurate and complete coding towards the AFMS?

047. Using the Aeromedical Services Information Management System

1. What two tools work jointly to provide complete point of service management of immunizations (active duty and dependents)?
2. The steps involved with gaining access to ASIMS require the medical technician to log on to what site and perform what two steps?
3. When do PHAs become due and what are the six requirements that must be met to maintain currency?
4. When do PHA statuses turn yellow in ASIMS and what does it indicate?
5. When do PHA statuses turns red and what items may be overdue?
6. What is the purpose of the quarters program and how long is rest/recovery time periods?

7. Who has the authority to grant additional rest/recovery time and how long?
8. How are units notified that a member has been placed on quarters and what form is used to document status?

048. Population health management principles

1. What are the principles of population health management?
2. The strategies of CM involve what three areas?
3. What is the purpose of CM?
4. What is DM's focus areas?
5. What are the goals of DM?
6. Define the process of UM.
7. The ultimate goals of UM involve what four processes?
8. What is the purpose of UM?
9. What are the processes involved with RM?
10. Who is the leader in population health-based initiatives and what do they ensure?

Answers to Self-Test Questions

039

1. It usually boils down to treating others as you'd like to be treated.
2. Respect for others; recognizing the right of individuals to make their own decisions.
3. Identifies those skills technicians are permitted to (and should) perform, and skills that should not be performed if the skill is not listed in the STS.
4. By informing the patient advocate of all recommendations, questions, and complaints pertaining to the health care facility.
5. A local policy.
6. The temptation to minimize the event.
7. Denial, anger, bargaining, depression, and acceptance.

040

1. Public law; Privacy Act of 1974.
2. Privacy Act of 1974, 5 USC 552a, AFI 41-210, and locally developed guidance.
3. DD Form 2005, Privacy Act Statement – Health Care Records or AF Form 2100A-series (Health Record – outpatient).
4. Military actions may include verbal counseling, nonjudicial punishment or even a court-martial.
5. Civilian actions include up to \$50,000 fine and one year in prison for obtaining or disclosing protected health information; up to \$100,000 fine and five years in prison for obtaining protected health information under “false pretenses”; and up to \$250,000 fine and 10 years in prison for obtaining or disclosing protected health information with the intent to sell, transfer, or use it for commercial advantage, personal gain, or malicious harm.
6. Malpractice.
7. Invasion of privacy.
8. The reason for the procedure, how the procedure will be performed, who will perform the procedure, any possible risks associated with the procedure, other treatment options if applicable, the expected outcomes of the procedure, and any negative effects that are possible if the procedure is not performed.
9. Initiation of pulmonary or cardiopulmonary resuscitation in the event of respiratory or cardiorespiratory arrest.
10. Designates another individual as the primary decision-maker.

041

1. Preinteractive, introductory, working, and termination.
2. (1) Language differences, (2) changing the subject, (3) giving opinions instead of facts, (4) talking too much, (5) not paying attention, and (6) illness.
3. Having a patient advocate assigned to each section makes it possible to solve problems on the lowest level possible and in a timely manner.
4. Execute good communication skills, practice situational awareness, and ask “How may I help you, Ma’am or Sir?”
5.
 - (a) Concentrate on what’s being said; listen as if you’ll be tested on content.
 - (b) Occasionally repeat back a paraphrased version of what’s being said.
 - (c) Ask questions if you don’t understand the message.
 - (d) Don’t interrupt people in the middle of a thought.
 - (e) Think of the feelings behind the words.
 - (f) Be conscious of nonverbal signs.
 - (g) Look people in the eye.
6. Identifies areas or personnel providing outstanding service, identifies opportunities for improvement, and suggests improvements in processes or services.

7. Never argue—this only adds fuel to their fire.
8. Because individuals often experience a sense of pride and safety through the cultural connection they share with others, particularly in their own family.

042

1. Confirm all recipients are authorized to receive the information under the Privacy Act and HIPAA. Protect the message from unauthorized disclosure, loss, or alteration through use of DOD PKI-based encryption. Add FOUO to the beginning of the subject line, followed by the subject. Do not annotate any PHI in the subject line. Insert the FOUO statement at the BEGINNING of the e-mail message.
2. The Air Force views social media sites positively and respects your rights as Americans to use them to express yourself.
3. Geotagging adds geographical identification data to photos, videos, Web sites and text messages through location based applications. This technology helps people find images and information based on a location from a mobile device or desktop computer. Airmen should be cautious when enabling the geotagging feature on mobile, location-based apps because they could potentially create personal and operational security risks. Disable geotagging at sensitive or deployed locations.
4. Don't post the exact whereabouts and activities of deployed Airmen; be general about the dates and locations concerning an Airman's trip arrival and departure; don't make your vacation dates public on social networks; criminals may track your activities and know exactly when to break into your home while you're on vacation; don't publicly post exactly how long your Airman will be gone on a trip or deployment; be careful about publicly posting children's photos, names, schools, ages and schedules; consider the image you portray on social media; think before you share information that could jeopardize you and your Airman's career or reputation; let children know they should seek help for cyber-bullying.
5. Failure to comply with electronic communication policies by military personnel is a violation of the *Uniform Code of Military Justice*, Article 92, Failure to Obey Order or Regulation. Violations by civilian employees may result in administrative disciplinary action without regard to otherwise applicable criminal or civil sanctions for violations of related laws. Violations by contractor personnel will be handled according to local laws and the terms of the contract. Additionally violations of ANG military personnel may subject members to prosecution under their respective State Military Code or result in administrative disciplinary action without regard to otherwise applicable criminal or civil sanctions for violations of related laws.

043

1. "Trusted Care Anywhere."
2. It is a team-based model led by a physician.
3. It focuses on the "whole person" concept, preventive care and early intervention and management of health problems rather than on high-volume, episodic, over-specialized and inefficient care.
4. (1) Take personal responsibility and accountability for the ongoing care of patients; (2) Be accessible to their patients on short notice for expanded hours and open scheduling; (3) Be able to conduct consultations through email and telephone; (4) Utilize the latest health information technology and evidence-based medical approaches, as well as maintain updated electronic personal health records; (5) Conduct regular check-ups with patients to identify looming health crises, and initiate treatment/prevention measures before costly, last-minute emergency procedures are required; (6) Advise patients on preventive care based on environmental and genetic risk factors they face; (7) Help patients make healthy lifestyle decisions; (8) Coordinate care, when needed, making sure procedures are relevant, necessary and performed efficiently.
5. They assist in provider support activities related to patient care, patient education, documentation of chronic medical conditions, documentation of preventive services, medication reconciliation, and coordination of patient check-out and follow-up.
6. It offers users a single location, or portal, to the applications and information needed for daily work for AFMS personnel.
7. CarePoint Portal.
8. Ability to enter lab results and screenings for patients with other health insurance and/or who are seen in purchased care; Nightly processes to capture lab and screening tests with updates to both action lists and

patient counts, and option to exclude patients off patient lists (e.g., chronic refusers, patient deceased, miscoded diagnosis, etc.)

044

1. It functions as both a repository and a database record.
2. Any five of the following: (1) Patient registration, admission, disposition, and transfer, (2) Inpatient activity documentation (3) Outpatient administration data, (4) Laboratory, (5) Drug/laboratory test interaction, (6) Quality assurance, (7) Radiology, (8) Clinical dietetic administration, (9) Pharmacy, (10) Results reporting and order entry, (11) Ad Hoc reporting, (12) Managed Care, (13) Interfaces to 40 other clinical and administrative system.
3. It supports Force Health Protection, Population Health, and MHS Optimization by enabling the MHS to determine the deployment status of units, demand management effectiveness, and disease prevalence, management and outcomes.
4. Allows 24-hour monitoring of heart, fetal and other critical data; data sharing with AHLTA and Vista users; CHCS communication links; Includes inbound ADT, laboratory results and radiology text interpretation from CHCS; Allows real-time data back-up for every single transaction through the Essentris server; Provides enhanced order entry workflow as well as task lists, notifications and user preferences.

045

1. It provides a simple infrastructure to provide a standard, repeatable, sustainable process and stands on a three -pillar approach to provide frequent communication, training, and sustainment.
2. It allows more efficient, effective healthcare and documentation by responding to a gap between technology function and user needs. Steps 2, 3, and 4.
3. The patient completes the encounter worksheet or SF600 overprint.
4. The Med Tech AIM form to enter data into AHLTA.
5. The provider takes over and reviews tech input.

046

1. Patient record documentation, reimbursement, staffing considerations, program management, and utilization control.
2. The coding guidelines, disease alphabetical index, diseases tabular list, appendixes.
3. Accurate coding is needed to reflect the scope, severity, and quantity of health care delivered within our system. Most important, it is needed to reflect the quality of health of our members, which is proven through accurate documentation and coding.

047

1. Preventive Health Assessment and Individual Medical Readiness (PIMR); Air Force Complete Immunization Tracking Application (AFCITA).
2. The administrator requires the following user to establish an account at <https://asims.afms.mil/webapp/login.aspx>. They will be asked to certify status as a medical employee and complete demographic information.
3. PHAs become due (turn “yellow”) 12 months (366 days) from the last PHA completion date. Members must be current in HRR/PHA; Deployment Limiting Conditions; Dental Readiness; Immunization Status; Medical Readiness Laboratory Test and Individual Medical Equipment.
4. PHA’s member will remain yellow for 3 months, for all other action items member will only remain yellow for 1 month.
5. Member needs to complete medical requirement(s) as soon as possible (immunizations, PHAs, dental, and DHAs). It turns red on day 456.
6. Quarters is a full duty excuse provided to active duty uniformed service members receiving medical or dental treatment for a disease or injury that, based on sound professional judgment, does not require inpatient care. Quarters periods generally last 24–72 hours depending on the providers prescribed rest/recovery period.
7. Unit commanders and supervisors have the authority to grant up to 24 hours sick status at their discretion if a member’s illness/injury does not require MTF intervention. If the illness/injury persists beyond 24 hours,

then the commander or supervisor must refer the member to the MTF for treatment and subsequent clinical examination.

8. The provider or support staff will notify the member's unit commander or commander's designee regarding the patient's quarters status. Command authority notification must be documented on a DD Form 689, Individual Sick Slip, or a locally created form.

048

1. Support the DOD and our nation's security by providing health services for the full range of military deployments and by sustaining the health of members of the armed forces, their families and others.
2. Support patients through transitions of care; Decrease fragmentation of healthcare services; Support patient safety, education, and self-determination by establishing an active partnership with patients, their families, and the entire healthcare team to achieve optimal healthcare outcomes.
3. Promote quality, safe, and cost-effective care; Promote utilization of available resources to achieve clinical and financial outcomes; Facilitate appropriate access to care; Collaborate with the patient/family, physician, healthcare providers, and others to develop and implement plan that meets the needs and goals of the patient; Develop individualized patient plans of care; Offer objectivity, healthcare choices, and self-management solutions.
4. It is focused on optimizing health in specific populations.
5. The program goals are to improve clinical outcomes, increase patient and provider satisfaction, and promote appropriate utilization of resources throughout the MHS.
6. It is the process of evaluating the medical necessity, appropriateness, and efficiency of healthcare services.
7. Providing patients with the appropriate level of care; Coordinating healthcare benefits; Promoting the least costly, most effective treatment benefit; Determining the presence of medical urgency.
8. To identify, monitor, evaluate, and resolve issues that may result in inefficient healthcare delivery or that may have an impact on resources and services.
9. Clinical and administrative.
10. The HCI leads assigned teams in population health initiatives that integrate all aspects of care along the health continuum. They ensure acuity-based enrollment is completed with oversight provided by the SGH, in coordination with the GPM and flight leadership as appropriate.

Unit Review Exercises

Note to Student: Consider all choices carefully, select the *best* answer to each question, and *circle* the corresponding letter. When you have completed all unit review exercises, transfer your answers to the Field-Scoring Answer Sheet.

Do not return your answer sheet to the Air Force Career Development Academy (AFCDA).

81. (039) Which of the following defines nonmaleficence?
 - a. Telling the truth.
 - b. Respect for others.
 - c. The duty to do no harm.
 - d. Being faithful to do good.
82. (039) Each medical treatment facility (MTF) must develop a local policy that includes circumstances requiring the presence of a third party during an examination or treatment at the request of the provider or patient for which of the following responsibilities?
 - a. Administrative.
 - b. Chaperone.
 - c. Supervisory.
 - d. Appointing.
83. (040) Which category of personnel does the Health Insurance Portability and Accountability Act (HIPAA) affect?
 - a. Patients handling their information.
 - b. Anyone handling patient information.
 - c. Medical staff handling patient information.
 - d. Administrative staff handling patient information.
84. (040) For general guidance regarding the Health Insurance Portability and Accountability Act (HIPAA) use
 - a. DOD Regulation 6025.18-R
 - b. AFJI 44-17.
 - c. AFI 41-210.
 - d. AFI 33-332.
85. (041) Which is an appropriate way to help relieve a patient's stress?
 - a. Ensure pictures of family are put away to decrease loneliness.
 - b. Remain honest and in control to decrease the patient's anxiety.
 - c. Take the patient to a room to wait 20-30 minutes before the provider.
 - d. Refrain from briefing policies on admission to decrease the patient's fear.
86. (042) Which procedure is not a useful social media tip when Airmen and their families are communicating online?
 - a. Differentiate between opinion and official information.
 - b. No precautions are taken while off-duty.
 - c. Obey applicable laws.
 - d. Stay in your lane.

87. (043) Which model is the correct type for Patient Centered Medical Home (PCMH)?
- Physician-led model.
 - Nurse-led model.
 - Air Force-led model.
 - Team-based model.
88. (043) What is the purpose of Team Huddles and how often do they occur within a Patient Centered Medical Home (PCMH)?
- Intended for problem solving and updating the team's work plan; daily.
 - Intended for updating the team's work plan; bi-weekly.
 - Intended for updating the team's work plan; monthly.
 - Provides a method to delegate responsibilities and maintain control over assets and resources.
89. (043) What updates are completed nightly by CarePoint?
- Lab, x-rays, medication inventory, urgent outpatient category.
 - Monthly processes to capture lipids and screening tests with updates to patient coding statistics.
 - Diabetes screening results to determine circulatory health within action lists and patient count.
 - Lab and screening tests with updates to both action lists and patient counts.
90. (044) Enrollment information from the Defense Enrollment and Eligibility Reporting System (DEERS) is sent to the medical treatment facility (MTF) at least
- weekly.
 - monthly.
 - quarterly.
 - annually.
91. (044) If you are trying to determine the deployment status of a unit, what system should you use that will support Force Health Protection, Population Health, and Military Health System (MHS) optimization?
- Composite Health Care System.
 - Armed Forces Health Longitudinal Technology Application.
 - Defense Enrollment Eligibility Reporting System.
 - Defense Medical Logistics Standard.
92. (044) When patient care is not documented what can be assumed about the patient's treatment?
- No care or treatment was accomplished.
 - There is no follow up care required.
 - There were no complications.
 - The outcome was positive.
93. (045) What step does a medical technician provide in the workflow process?
- Uses a common Alternative Input Method (AIM) form, and the provider enters data into AHLTA.
 - Uses a Tri-Service Input Method (TIM) form to enter data into AHLTA.
 - Uses a common AIM form to enter data into AHLTA.
 - Uses a common AIM form to enter data into CHCS.
94. (045) Who starts the Tri-Service workflow form documentation?
- The patient signs in and data is entered in an encounter worksheet or SF600 overprint.
 - The med technician completes the encounter worksheet or SF600 overprint.
 - The provider completes the encounter worksheet or SF660 overprint.
 - The patient completes the encounter worksheet or SF660 overprint.

-
-
95. (046) What does the abbreviation NEC stand for when used in International Classification of Diseases (ICD-9)?
- Not elsewhere classified.
 - Next event cancelled.
 - Not elsewhere coded.
 - New event code.
96. (047) When do Preventive Health Assessment (PHA) member's status turn yellow in Aeromedical Services Information Management System (ASIMS)?
- When PHA is due within 3 months.
 - When PHA is due within 6 months.
 - To indicate a medical board is in-processing.
 - If individual dental and immunization requirements are due within 60 days.
97. (047) When do Preventive Health Assessment (PHA) status turns red and what items may be overdue?
- When patient no-shows for a medical appointment and due for immunizations, PHAs and dental exam.
 - If scheduled PHA appointment is cancelled without 24 hour notice and due for immunizations and PHA.
 - Member needs to complete immunizations, PHAs, dental, and deployment health assessments (DHAs). It turns red on day 456.
 - Member needs to complete medical requirement(s) as soon as possible (immunizations). It turns red on day 455.
98. (048) What are the principles of population health management?
- Support the USAF and our nation's security interest.
 - Provides health services for the full range of military deployments.
 - Provides health services for the full range of peacetime deployments.
 - Support the DOD and our nation's security.
99. (048) What is the purpose of case management?
- Increase teamwork and cost-effective care.
 - Promote quality care.
 - Promote quality, safe, and cost-effective care.
 - Build trust, improve quality and safe care.
100. (048) What is the purpose of utilization management (UM)?
- Evaluate issues that may result in inefficient healthcare delivery or that may have an impact on resources and services.
 - Monitor and resolve issues that may result in inefficient healthcare delivery or that may have an impact on resources.
 - Document inefficient healthcare delivery that impact resources and services.
 - Identify, monitor, evaluate, and resolve issues.

Student Notes

Glossary of Abbreviations and Acronyms

ACLS	advanced cardiac life support
ACN	authorization change notice
ACR	authorization change request
ADL	advanced distributive learning
ADLS	Advanced Distributive Learning System
ADSM	active duty service member
ADT	admission, discharge, transfer
AE	aeromedical evacuation
AEF	air and space expeditionary force
AET	aeromedical evacuation technician
AETC	Air Education and Training Command
AF	Air Force
AFCDA	Air Force Career Development Academy
AFCFM	Air Force career field manager
AFCITA	Air Force Complete Immunization Tracking Application
AFDD	Air Force Doctrine Document
AFECD	Air Force Enlisted Classification Directory
AFI	Air Force Instruction
AFMOA	Air Force Medical Operations Agency
AFMS	Air Force Medical Service
AFOMS	Air Force Occupational Measurement Squadron
AFPAM	Air Force pamphlet
AFPC	Air Force Personnel Center
AFS	Air Force specialty
AFSC	Air Force specialty code
AFTC	Air Force Training Course
AFTH	Air Force theater hospital
AFTR	Air Force training record
AHA	American Heart Association
AHLTA	Armed Forces Health Longitudinal Technology Application
AIM	alternate input method
AIMWTS	Aircrew Information Management Waiver Tracking System
AIT	allergy/immunization technician
AMSC	aerospace medical service craftsman

AQE	Aptitude Qualification Examination
ARC	Air Reserve Component
ASIMS	Aeromedical Services Information Management System
ATH	air transportable hospital
ATLS	advanced trauma life support
BH	behavioral health
BLS	basic life support
BMET	biomedical equipment repair technicians
BW	biological warfare
CAC	common access card
CAFSC	control Air Force specialty code
CAL	Custodian Action List
CAREERS	Career Airman Reenlistment Reservation System
CASF	contingency aeromedical staging facility
CBRNE	Chemical, Biological, Radiological, Nuclear and High-Yield Explosive
CCAF	Community College of the Air Force
CCT	critical care technician
CDA	Corporate Dental Application
CDC	career development course
CDR	Central Data Repository
CEM	chief enlisted manager
CEU	continuing education unit
CFETP	Career Field Education and Training Plan
CFM	career field manager
CHCS	Composite Health Care System
CISD	critical incident stress debriefing
CJR	career job reservation
CLR	clearly legible report
CM	case management
CNM	certified nurse midwife
CONUS	continental United States
CPG	clinical practice guidelines
CPR	cardiopulmonary resuscitation
CRL	custodian receipt/locator list
CW	chemical warfare
CWDE	chemical warfare defense equipment

DAFSC	duty Air Force specialty code
DCMS	Dental Classification Management System
DCS	Direct Care System
DEA	Drug Enforcement Administration
DEERS	Defense Enrollment Eligibility Reporting System
DEROS	date eligible for return from overseas
DM	disease management
DMAA	Disease Management Association of America
DME	durable medical equipment
DMHRSi	Defense Medical Human Resource System Internet
DMLSS	Defense Medical Logistics Support System
DNR	do not resuscitate
DOD	Department of Defense
DODI	Department of Defense Instruction
DODMERB	Department of Defense Medical Examination Review Board
DOR	date of rank
DOS	date of separation
DRG	diagnosis-related groupings
DTL	duty task list
E/M	evaluation and management
EAID	Equipment Authorization Inventory Data
ECAT	Electronic catalog
ECOMS	Executive Committee of the Medical Staff
EMEDS	expeditionary medical support
EMT	emergency medical technician
EOC	end of course
EPR	enlisted progress report
ERAA	equipment review and authorization activity
ETCA	Education and Training Course Announcements
FOMC	Flight and Operational Medicine Clinic
FOMT	Flight and Operational Medicine Technician
FOUO	For Official Use Only
FTA	first term Airman
GAS	Graduate Assessment Survey
GPC	government-wide purchase card
GPM	group practice manager

HA	health assessment
HBMT	hyperbaric medical technician
HCI	health care integrator
HDMT	hemodialysis medical technician
HHS	Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HQ	Headquarters
HRR	health risk review
HSI	Health Services Inspection
HST	home station training tasks
IAW	in accordance with
IBT	immunization back-up technician
ICD-9-CM	International Classification of Diseases, 9 th Revision, Clinical Modification
ID	identification
IDMT	independent duty medical technician
IMR	individual medical requirements; individual medical readiness
JC	Joint Commission
JI	job inventory
JQS	job qualification standard
LP	local purchase
LPN	licensed practical nurse
MAJCOM	major command
MCSC	managed care support contractors
MEMO	Medical Equipment Management Office
MEPRS	Medical Expense and Performance Reporting System
MHS	Military Health System
MHSPHP	Military Health System Population Health Portal
MILPDS	Military Personnel Data System
MLFC	medical logistics flight commander
MM	medical management
MOPP	mission-oriented protective posture
MSME	Medical Standards Management Element
MTF	medical treatment facility
MTL	master task list
MTP	master training plan
NCO	noncommissioned officer

NCOIC	noncommissioned officer in charge
NCORP	noncommissioned officer retraining program
NDAA	National Defense Authorization Act
NREMT	National Registry of Emergency Medical Technicians
NREMT-B	National Registry of Emergency Medical Technicians-Basic
NSN	national stock number
NT	neurology technician
OB	obstetrical
OI	operating instruction
OIC	officer in charge
OJT	on-the-job training
OPHSA	Office for Prevention and Health Services Assessment
OSI	Office of Special Investigation
OSR	occupational survey report
PA	Privacy Act
PAFSC	primary Air Force specialty code
PAR	population-at-risk
PC	primary care
PCA	permanent change of assignment
PCK	proficiency code key
PCM	primary care manager (or management)
PCMH	patient centered medical home
PCS	permanent change of station
PEPP	Physical Examination Processing Program
PHA	preventive health assessment
PHI	protected health information
PHSO	Population Health Support Office
PIMR	PHA Individual Medical Readiness
PL	Public Law
PME	professional military education
POC	point of contact
PIIP	Put Prevention into Practice
PRBC	packed red blood cells
PV	prime vendor
QRP	Quality Retraining Program
QTP	qualification training package

RM	referral management
RN	registered nurse
ROFR	right of first refusal
ROS	Report of Survey
ROTC	Reserve Officer Training Corps
RSVP	Readiness Skills Verification Program
SABC	self-aid and buddy care
SEI	special experience identifier
SERE	Survive, Evasion, Resistance, and Escape
SKT	specialty knowledge test
SME	Squadron Medical Element
SMSgt	senior master sergeant
SNCO	senior noncommissioned officer
SOC	Special Operations Command
SOD	special operations duty
SSgt	staff sergeant
STS	specialty training standard
TAFMSD	total active federal military service date
TB	tuberculosis
T-Con	telephone consult
TDY	temporary duty
TMA	TRICARE Management Activity
TR	training reference
TSWF	Tri-Service Workflow
UCMJ	Uniform Code of Military Justice
UGT	upgrade training
UHM	unit health monitor
UM	utilization management
UMD	unit manning document
UPMR	unit personnel management roster
UR	utilization review
URL	uniform resource locator
USAF/SG	United States Air Force/Surgeon General
USAFMS	United States Air Force Medical Service
USC	United States Code
UT&W	utilization and training workshop

UTC	unit type code
UTL	unit task list
UTM	unit training manager
VA	Veterans Affairs
WAPS	Weighted Airman Promotion System
WII	wounded, ill, and injured

Student Notes

Student Notes

AFSC 4N051
A4N051 01 1505
Edit Code 05