

CDC Z4N071

Aerospace Medical Service Craftsman

Volume 1. Aerospace Medical Service Mission



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

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CONGRATULATIONS! You are now one step closer to becoming an Aerospace Medical Service Craftsman (AMSC). Many of you have worked in medical treatment facilities (MTF) that are gradually becoming smaller. Military healthcare system must maintain its ability to provide health services for the full range of military deployments and continue to maintain the health of members of the armed forces, their families, and all other beneficiaries. This is no small task. You as an AMSC play a significant role in achieving this goal.

This course, AMSC, is one volume that fulfills one of the requirements for your upgrade to 7-level. This volume, *Aerospace Medical Service Mission*, contains only three units that cover a variety of managerial responsibilities relevant to the craftsman.

Unit 1 covers specific issues facing the supervisors in the MTFs. Responsibilities range from managing logistics, to supervision, and training new personnel. While working on this unit, it is helpful to review the current 4N0X1 career field education and training plan (CFETP).

Unit 2 discusses information systems. It talks about manpower and resources to introduce you to how manning needs are developed and the basics to understand how you receive and maintain supplies and equipment necessary to complete your duties.

Unit 3 discusses patients with special considerations as well as covers patient care skills when planning and performing patient care. This section also brings to light the medical standards that apply to ALL military patients within the Aerospace Medicine Program.

To thrive in Military Health Service, you must always be forward thinking and willing to change as the civilian medical community changes. The future of our job depends on keeping an open mind and always providing the best healthcare possible to our patients. TRICARE and Health Maintenance Organizations (HMO) aren't going away anytime soon. Keeping a positive outlook and taking the initiative to seek opportunities to make things better is one way to keep the military healthcare system employed.

A glossary of abbreviations and acronyms is included at the end of this volume.

Code numbers on figures are for preparing agency identification only.

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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.

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This volume is valued at 12 hours and 4 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. Supervisors' Tools | 1-1 |
| 1-1. Medical Service Management..... | 1-1 |
| 1-2. Supervision..... | 1-11 |
| 1-3. Training..... | 1-29 |
| Unit 2. Overview of Information Systems..... | 2-1 |
| 2-1 Information Systems | 2-1 |
| 2-2. Components of Military Health System | 2-5 |
| Unit 3. Patient Considerations | 3-1 |
| 3-1. Special Patient Considerations..... | 3-1 |
| 3-2. Patient Care Skills | 3-7 |
| 3-3. Aerospace Medicine Program | 3-23 |
| <i>Glossary</i> | <i>G-1</i> |

Unit 1. Supervisors' Tools

| | |
|---|-------------|
| 1-1. Medical Service Management | 1-1 |
| 001. Equipment management..... | 1-1 |
| 002. Manpower considerations | 1-6 |
| 1-2. Supervision | 1-11 |
| 003. Performing daily operations..... | 1-11 |
| 004. Developing duty schedules | 1-12 |
| 005. Workcenter orientation..... | 1-19 |
| 1-3. Training | 1-29 |
| 006. Military medical scope of practice | 1-29 |
| 007. Maintaining the enlisted training and competency folder..... | 1-36 |

THIS UNIT PROVIDES INFORMATION AND GUIDELINES to help you prepare to be the best supervisor you can. Whether you are diagnosing a subordinate's development level, using a certain leadership style, conducting a counseling session, writing and conducting an Airmen Comprehensive Assessment (ACA) worksheet, or recommending an individual for a decoration, the tools in this unit will aid you as a supervisor and guide the Airman you train.

1-1. Medical Service Management

One task you will encounter as a noncommissioned officer (NCOIC) of a section in the medical treatment facility (MTF) will be managing your resources. The responsibilities will include manpower, money, and specifically equipment. It is a lot of responsibility, but as an Aerospace Medical Service Craftsman (AMSC), you must welcome this challenge, overcome it and try to obtain the goal of managing your resources.

001. Equipment management

As an AMSC you may be tasked to function as an equipment custodian in your section. Your duties and role as the manager for these resources are discussed in this lesson. A philosophy of cost containment is essential; your actions at the grass roots level determine how well you carry out the mission.

Equipment custodian responsibilities and procedures

Some responsible person in your section will be designated and appointed by the MTF commander as the property custodian. This may be you as an NCOIC or a coworker. Regardless of who is appointed, acceptance of and relief from custodial responsibility is a very serious matter and should be dealt with in a professional manner. There are different classifications of equipment you should understand.

| Equipment Classification and Description | | |
|--|--------------------------------------|--|
| Equipment Classification | Unit Cost | Life Expectancy/Examples |
| Medical investment equipment | \$250,000 or more | At least 5 years, and maintains its identity during use. |
| Medical expense equipment | At least \$3,300—less than \$250,000 | At least 5 years, and maintains its identity during use. Also included are items under \$3,000 that require additional local control as designated by the medical logistics flight commander. |

| Equipment Classification and Description | | |
|--|--|--|
| Equipment Classification | Unit Cost | Life Expectancy/Examples |
| Maintenance significant supply item | Less than \$3,000 requires some type of minor maintenance or inspection. | |
| Medical Supply (consumable) | | Medical items that lose their identity when used, and cannot be reused for their original purpose. Drugs, adhesive tape, and X-ray film are examples of consumable supply items. |
| Medical Supply (durable) | | Medical supply items that maintain their identity when used, and may be reused for their original purpose. Forceps, laboratory glassware, and stethoscopes are examples of durable supplies. |
| Nonmedical materiel | This materiel consists of two major categories: supplies and equipment. Nonmedical materiel used by AF MTFs consists primarily of office, janitorial supplies, and equipment. | |

Responsibility for Medical Equipment Management Office property

When you assume custodial responsibility, the base Medical Equipment Management Office (MEMO) provides you with a custody receipt/locator listing showing all property charged and due in to the custodians account. Before signing the listing, you and the current (losing) property custodian should perform a thorough inventory. All listed property should be shown to you. At the same time, obtain Medical Equipment Repair verification that required maintenance/calibration has been completed; also check for serviceability. Any property that is in your duty area but not listed should be identified and coordinated with the MEMO. Only after the inventory has been performed and all corrective actions documented should you sign for the property. Upon signing and dating the custody receipt/locator listing, the custodian assumes responsibility for all in-use items in the quantities indicated, and verifies the requirements for all due-ins on the listing. Remember, as custodian, the equipment becomes your administrative and financial responsibility, so don't take the word of the previous custodian—verify all items and their stock numbers.

The original signed listing is returned to MEMO; a signed copy of the custody receipt/locator listing is retained by the property custodian as a record of the equipment authorized, on hand, or due in. Items are issued to or turned in from the account on a signed AF Form 601, Equipment Action Request. The property custodian retains the Equipment Action Request, showing the action taken, until the item is correctly listed on the new custodial actions list or custody receipt/locator list. The AF Form 601 may then be destroyed.

The property custodian ensures, by spot check and periodic inventory, that all property in their account is properly charged to the account, is physically on hand, or appropriate action has been taken to effect settlement for missing or damaged items.

Before a property custodian is relieved from duty, transferred, separated from service, or absent from the account in excess of a 45-day period, the MEMO takes action to transfer the property or have it assigned to an authorized successor.

Report of Survey

When property is lost, damaged, or destroyed by an individual or an organization, the organization that has possession of the property will initiate a report of survey.

Remember as a noncommissioned officer (NCO), you are required to maintain control and effectively manage the property assigned to your sections accounts in accordance with Air Force Instruction (AFI) 23-111, *Management of Government Property in Possession of the Air Force*. This responsibility includes pecuniary liability for negligent loss, damage, or destruction. To prevent loss of assigned equipment, the following are some actions to take to manage your account:

- Manually and/or automatically track and record transactions affecting sections equipment under your functional control each duty day.
- Identify, report, disposition of serviceable, unserviceable, reparable, and excess materiel.
- Sign custody receipts or listings for property charged to anyone outside the duty section or organization.
- Report losses or irregularities relating to property to immediate commanders and Army and Air Force Post Offices (APO).

Ordering equipment

The office that manages the medical facility's equipment is the MEMO section of logistics. You prepare an AF Form 601 when any change is required in equipment assets under your control. It's very important that you realize the approval process for investment equipment can take several months, and it can take several more months to get the funding from your major command (MAJCOM).

When you wish to replace an old piece of equipment or buy a new piece, which you do not currently have, submit an AF Form 601 when the requirement is identified. Do not wait until the budget cycle; 601s drive your budget—don't let your budget drive your 601 requirements. A description of the change required, together with a complete justification, must be included. In the justification, discuss the following, among other things:

1. Where will this item be used and what function will it carry out?
2. What is the current and projected workload?
3. Who is or will be qualified to use the equipment?
4. How will equipment be maintained—by contract or biomedical equipment repair?
5. What are the savings or benefits?

These only represent a few of the areas you should address. Consult the Logistics personnel in your facility for local procedures.

Equipment transfer and turn-in

Equipment may be relocated between property custodians when approved by the MEMO. To transfer equipment, the property custodian losing the item completes an AF Form 601 stating "Relocation of Property" in the JUSTIFICATION block along with transfer from/to information.

Maintenance of equipment

As you learned in the 5-level career development course (CDC), it is not only your responsibility as an equipment custodian to manage the equipment inventory—it is also your responsibility to maintain it too. It is the supervisor's responsibility to ensure individuals on the unit are trained on how to use the equipment properly. The best resource for proper usage is the equipment manual.

Generally, the equipment is checked on a daily basis by a designated staff member. If during the inspection, a repair is identified fill out an AF Form 1297, Temporary Issue Receipt and turn it in to the Biomedical Equipment Repair Office. Make sure to also keep a copy for your own records. The most important thing to keep in mind is to make sure the equipment is safe to use. Remember to contact your Biomedical Equipment Repair Office or reference local policy if questions arise at any time.

Safety data sheets

AFI 90-821, *Hazard Communication (HAZCOM) Program*, establishes the minimum requirements for an effective hazard communication program for those activities that handle or use hazardous material. It contains the requirements for practices and procedures, assigns responsibilities, and provides guidance for managing the Air Force Hazard Communication Program (AFHCP). The purpose of AFHCP is to reduce the incidence of chemically induced occupational illnesses and injuries by informing employees of the hazards associated with, and proper preventive measures to be taken when using or handling, hazardous materials in the workplace. It applies to all United States civilian and military employees.

Product information

One of the tools used to communicate this process is the safety data sheet (SDS) formerly known as material safety data sheet (MSDS). An SDS is maintained for each product used in the workplace that contains hazardous chemicals. The SDS is provided by the product manufacturer and contains information such as the following in the table:

| Product Information /Hazard Sheet | |
|--|--|
| Hazard | Description |
| Product Information | This includes the product name, generic name, and (sometimes) its chemical formula. The name, address, and phone number of the manufacturer is also listed. |
| Specific Chemicals | Hazardous ingredients are listed separately. The concentration and exposure limit is usually listed, as is (are) the substance(s) volatility, flammability, or reactivity. |
| Physical Hazard | The data describes precisely why each chemical or substance is considered hazardous. |
| Flammable | If the item is flammable, the specific "flash point" is usually listed; if it is not flammable, it should specifically state so on the SDS. |
| Health Hazard Information | This includes symptoms of various exposures via individual routes of exposure, first aid procedures, and specific notes regarding medical treatment for overexposure to the substance. |
| Reactivity Data | The MSDS lists data that helps determine specifically how and where reactive products should be stored and handled. |
| Spills and Leaks | Detailed explanations, including a list of recommended personal protective attire, are provided. |
| Special Precautions and Special Protection Recommendations | Bioenvironmental Engineering (BE) maintains the SDS master file for the installation. For installations without a BE function, the commander selects a qualified representative to maintain the SDS master file. The master file must include SDS information for all hazardous materials used on the installation. The information is maintained in the Department of Defense (DOD) Hazardous Material Information System (HMIS) on microfiche, compact disk, or hard copy. |

Labeling

All materials contained on the SDS need to have appropriate labeling. Include the following information on the label:

- Identity of the hazardous material.
- Appropriate hazard warnings.
- Name, address, and phone number of the manufacturer, importer, or other responsible party.

Maintain the labels on the containers so they can be read easily. Should the labels become unreadable, replace them. When in doubt or you have questions about what is required for hazardous materials, contact your installation BE or representative.

Customer support listings

There are several Medical Logistic listings provided to property custodians to aid in the management of their custodian accounts. There are listings that show you the equipment you are responsible for maintaining and how much money you spend on issues. Take the time to review the supply listings provided to you and ensure you understand the usefulness of each.

As you can imagine, one of the top priorities for a property custodian is effective management of supplies and equipment. Medical Logistics provides several listings to aid the property custodian in the management of property.

Custody receipt/locator list

The purpose of this list is to indicate each specific item for which a custodian is responsible. The quantity and dollar value of assets on hand are shown in stock number sequence. The custodian's signature on this list indicates that possession of property is transferred. Before signing for an equipment account, MEMO provides you with a copy of this listing to help you perform your initial equipment inventory. After the inventory is completed and any necessary adjustments have been completed, you are given a new listing for your signature. MEMO maintains a signed copy of this list in the MEMO property custodian file. The second copy is given to you to file in your equipment folder.

Custodial actions list

The custodial actions list is an interim listing used to update the custody receipt/locator list. The list is produced each time Medical Logistics processes a change action affecting a custodian's account. The change may be an equipment issue, turn-in, transfer, or back order. The custodial actions list is distributed, certified, and filed in the same manner as the custody receipt/locator list. You may destroy custodial actions lists upon receipt of a new custody receipt/locator list incorporating the changes.

When you submit an AF Form 601 to the MEMO to record an equipment turn-in or transfer, normally you would receive a custodial actions list within five workdays. If not, contact the MEMO. This is another reason why it's important to maintain a file copy of the AF Form 601 that is submitted to the MEMO. Your signed copy of AF 601 serves as proof if any questions of liability arise.

Uses for customer support listing

To make the property custodian's task easier, it is important to know the usage for different listings issued by Medical Logistics. Let us take a look at some of these reports.

Log Back Order Report

This report is produced at the end of each month for customers who have supplies due out (owed) to their activity. Two copies of this report are distributed to each activity that has supplies or equipment on back order. The property custodian reviews the report for items requiring cancellation, follow-up status, quantity error, item error, and so forth. After reviewing the list and checking current on-hand supply levels, the property custodian returns an annotated copy to Medical Logistics by the seventh calendar day of the month if changes or cancellation of a due-in is required. One copy is kept for your records. Logistics uses your annotated list to a process cancellation request and any other appropriate changes. Be aware, there is no guarantee that Logistics will be able to cancel your due-out, but they will try.

Issue and Turn-in Summary Report

The using activity Issue/Turn-in Summary Report is produced for each activity supported by Defense Medical Logistics Standard Support (DMLSS) that had issue action during the month. This listing contains all the issues, reversals, and turn-ins for your using activity.

It is important to know that the Issue/Turn-in Summary Report contains the following four sections:

1. Section A—Issues.
2. Section B—Issue Reversal.
3. Section C—Turn-in.
4. Section D—Turn-in Reversal.

Issues

This portion of the list contains all issues and reversals of issues made during the month for each activity. It is produced by activity code in stock number/item identification (ID) sequence. The last page of each using activity contains a dollar value summary issued by refundable/reimbursable and nonrefundable/nonreimbursable for medical and nonmedical supplies and equipment. This is helpful in managing your account funds.

Turn-ins

This portion of the list contains all turn-ins and reversals of turn-ins processed during the month for your activity. The last page of the list contains a dollar value summary for items turned in. Located to the right, the refundable/reimbursable line is the dollar amount you were granted credit on your turn in. This money has been refunded to your account, and can be used to make new purchases. To determine the dollar value for noncreditable turn in, review the dollar amount to the right of nonrefundable/nonreimbursable line.

After reviewing this listing, you may destroy the daily issue/turn-in lists that were generated during the month. Retain the monthly summary in your files to aid in the management of your account.

002. Manpower considerations

The success of your MTF mission depends, to a great extent, on the people assigned to it. As supervisors in the MTF you must provide the highest quality healthcare services with the support of our subordinates. If the number of people assigned cannot satisfy patient needs, it becomes increasingly difficult to successfully accomplish the mission. Let's look at the system the Air Force has for allocating personnel resources and some of the specific responsibilities associated with this program.

You must thoroughly master manpower documents and reports procedures so that you will know and understand the process of positions and how positions for each section play a vital role in the mission of your MTF.

The term manpower refers to the number of people contributing to a need for a workforce. Familiarization with the terminology makes learning the specifics of the manpower program much easier. The following are some terms you will see often when dealing with manpower issues.

Man-hour

A man-hour is a unit of measuring work. It is equivalent to one person working at a normal pace for 60 minutes, two people working at a normal pace for 30 minutes, or a similar combination of people working at a normal pace for a period of time equal to 60 minutes.

Manpower authorization

A manpower authorization is a funded manpower requirement with details that defines the position in terms of its function, organization, location, skill, grade, and other appropriate characteristics that commands use.

Manpower requirement

A manpower requirement is a statement of manpower needed to complete a job, workload, mission, or program. There are two types—funded and unfunded. Funded manpower requirements are those that

have been validated and allocated. Unfunded requirements are validated manpower needs, but deferred because of budgetary constraints.

Manpower standard

This standard is a quantitative expression representing manpower requirements in response to varying levels of workload. A standard also includes a description of the workload, associated conditions on which the standard is built, a grade and skill level table, approved variances, and a process analysis summary.

Unit manpower document

The unit manpower document (UMD) is the primary manpower tool for managers. It is a quarterly computer product available to each base. Manpower spaces are shown by functional account with the authorizations displayed over fiscal quarters. Manpower authorizations define each position in terms of its function, organization, location, skill, grade, and other appropriate characteristics commands use. The information within the UMD provides a clear picture of the manning position within an MTF. It illustrates every funded, unfunded and contracted manpower requirement as validated by the medical annual planning and programming guidance. The following information explains the various sections within the UMD. Refer to figure 1-1 for an example of a unit manpower document and figure 1-2 for the manpower document callouts.

| Unit Manpower Document | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|-----------|----------------------|----|--------|---------|--------------|-----------------------|-----|---|-----------|-----|----------|------|------|------|------|------|-----|----------|------|------|------|-------------|------|------|------|---|---|---|---|---|
| M | 1 | 2 | 3 | 4 | A | C S P S M | | | | | | | | | | N | | | | | | | | | | | | | | | |
| A | | | | | P | 5 | E A R C S | | | | | | | | | | U | 6 | | | | | | | | | | | | | |
| C | POS | AFSC and TITLE | | | SEI | GRD | RGR | MNT | I | PEC | DTY | C | R | P | I | CRK1 | CRK2 | M | 99/1 | 99/2 | 99/3 | 99/4 | 00/4 | 01/4 | 02/4 | 03/4 | | | | | |
| MAC | FAS | UNIT | | | ILC | INSTALLATION | | | | | SCC | SUB | PAL2 | PAL3 | PAL4 | CBP | CCP | MET | IDENTITY | | | PPM | PARENT UNIT | | | | | | | | |
| OJ | 7 | PCB7 | 82 | MEG GP | 8 | VHVP | SHEPPARD AFB-WICH JAP | | | | | 48 | F | 02 | HP | SQ | SU | SQ | DMA | FC18 | | | 82 | TRG | WG | | | | | | |
| OSC: SG - SURGEON 9 FAC: 510000 - MEDICAL COMBUND 10 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CJ | 00235280J | MED CMDR, NURSE | | | 040CDE | CCL | COL | AN | 0 | 00087700B | 1 | C | | | | | | | | | | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | |
| CJ | 00235210J | HEALTH SERV ADMIN | | | 041A3 | CCL | COL | AN | 0 | 00087700B | 1 | C | | | | | | | | | | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | |
| CJ | 00347340J | HLTH SVC MNGT MGR | | | 4A000 | CMSGT | CMSGT | AN | | 00087700B | 1 | C | | | | | | | | | | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | |
| CJ | 00513600J | INFORMATION JYMN | | | 3A051 | CIV | CIV | AN | | 00087700B | 10 | 1 | C | | | | | | | | | | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| | | | | | | | | | | | | Officer | | | | | | | | | | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | | |
| | | | | | | | | | | | | Enlisted | | | | | | | | | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | | |
| | | | | | | | | | | | | Civilian | | | | | | | | | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | | |
| | | | | | | | | | | | | TOTAL: | | | | | | | | | | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | | |
| SUMMARY FOR: OSC: SG - SURGEON FAC: 510000 - MEDICAL COMBUND | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| OSC: SGRQ - QUALITY SVCS FAC: 511100 - QUALITY SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CJ | 01674090J | HLTH SVC MGT JYMN | | | 4A051 | CIV | CIV | AN | | 00087700B | 10 | C | MCA | | | | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | | | | | |
| CJ | 01281760J | HLTH SVC MGT JYMN | | | 4A051 | CIV | CIV | AN | | 00087700B | 10 | C | MCA | | | | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | | | | | |
| | | | | | | | | | | | | Officer | | | | | | | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| | | | | | | | | | | | | Enlisted | | | | | | | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| | | | | | | | | | | | | Civilian | | | | | | | | | | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | | |
| | | | | | | | | | | | | TOTAL: | | | | | | | | | | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | | |
| SUMMARY FOR: OSC: SGRQ - QUALITY SVCS FAC: 511100 - QUALITY SERVICES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| OSC: SGBT - EDUCATION & TRNG FAC: 570100 - EDUCATION & TRNG | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CJ | 01105140J | CLIN NURSE-STF DEV | | | T046N3D | CAPT | MAJOR | AN | 0 | 00087700B | | C | | | | | | | | | | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| CJ | 00022460J | EDUCATION & TRNG CPT | | | 3S271 | TSGT | TSGT | AN | | 00087700B | | C | | | | | | | | | | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | |
| CJ | 01106950J | MEDICAL SERVICE | | | 4N071 | TSGT | TSGT | AN | | 00087700B | | C | | | | | | | | | | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | |
| CJ | 03002710J | MEDICAL SERVICE | | | T4N051 | SMSGT | SMSGT | AN | | 00086761E | | C | | | | | | | | | | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | |
| CJ | 03002720J | MEDICAL SERVICE | | | T4N051 | SRA | SRA | AN | | 00086761E | | C | | | | | | | | | | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | |
| | | | | | | | | | | | | Officer | | | | | | | | | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | | |
| | | | | | | | | | | | | Enlisted | | | | | | | | | | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 4 | | |
| | | | | | | | | | | | | Civilian | | | | | | | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | |
| | | | | | | | | | | | | TOTAL: | | | | | | | | | | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | | |
| SUMMARY FOR: OSC: SGBT - EDUCATION & TRNG FAC: 570100 - EDUCATION & TRNG | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Figure 1-1. Sample unit manpower document.

| | |
|--|---|
| Position number (POS) Callout 1 | The POS identifies a manpower requirement that is a statement of manpower needed to accomplish a specified job, workload, mission, or program. For example, under Quality Services, two manpower requirements are needed to accomplish the work. Both are civilian Health Services Management Journeyman positions. The position number for the first position is 01674090OJ. |
| Air Force specialty code (AFSC) and title Callout 2 | The AFSC is a numeric code that identifies a particular task and may include an alpha prefix or suffix. The AFSC title identifies basic groupings of positions requiring similar skills and qualifications. |
| Special experience identifier (SEI) and grade (GRD) Callout 3 | SEIs are listed in the AFMAN 36-108. They identify special experience and training not otherwise reflected in the classification system and they provide a means to achieve greater flexibility in the management of personnel resources. GRD identifies the authorized (funded) military/civilian grade required for the position. Because of several constraints, primarily the budget, the Air Force and MAJCOMS seldom receive sufficient appropriations to fund all requirements. Due to these constraints, the actual authorized grades reflected on the UMD may not match the required grade called for by manpower standards. On the UMD military grades (COL, CAPT, TSgt) are displayed. Civilian grades are not normally reflected on the UMD; "CIV" is displayed to indicate the position is civilian. |
| Required grade (RGR) Callout 4 | The RGR shows the military grade that the work center earns according to the manpower standard. The required grade in many instances may not match the authorized grade because of various constraints. If it is a civilian position, "CIV" is indicated. |
| Program element code (PEC) Callout 5 | This alphanumeric code represents a subdivision of programmed cost data (i.e., people, equipment, and facilities) related to a weapons system or program. The first five characters are normally numeric (and the sixth is always alphabetic). The first character of the PEC identifies the Major Force Program (MFP). The numerical "8" (87700B) represents Training, Medical and other General Purpose Activities. |
| Fiscal quarters Callout 6 | Each position on the UMD is displayed over fiscal quarters. The fiscal year begins 1 October and ends 30 September. Fiscal quarters are as follows: 1 Oct – 31 Dec: First quarter. 1 Jan – 31 Mar: Second quarter 1 Apr – 30 Jun: Third quarter 1 Jul – 30 Sep: Fourth quarter Examples of dates found on the UMD: *99/1* is the first quarter of fiscal year 1999. *00/4* is the fourth quarter of fiscal year 2000. |
| MAJCOM code (MAC) and the personnel accounting symbol (PAS) Callout 7 | The MAC identifies MAJCOMs, separating operation agencies, direct reporting units, and other organizations or sub-organizations. "0J" represents the Air Education and Training Command (AETC). The PAS (7) is a sequentially assigned alphanumeric code representing a unit. "FCG7" represents the 82 nd Medical Group. |
| Installation or location indicator (ILC) Callout 8 | The ILC is an alpha code identifying the exact location of the unit or installation in geographic coordinates. |
| Organizational structure code (OSC) Callout 9 | The OSC is an alphabetic code, between two and seven characters in length that identifies the internal organizational structure of a specific unit. |
| Functional account code (FAC) Callout 10 | The FAC is a six-digit code identifying a particular function. HQ USAF controls the first four digits; the last two digits are controlled by the MAJCOM. |

Figure 1-2. Unit manpower document callouts.

Unit personnel management roster

The unit personnel management roster (UPMR) is a cross between an alpha roster and the UMD. It shows the authorized positions with such associated information as: position number, duty AF specialty code (DAFSC), authorized grade, functional account code (FAC), personnel accounting symbol (PAS), required security clearance, and rated codes. The UPMR also shows who is assigned to each position with personnel data items including: name, social security number (SSN), assigned DAFSC, primary Air Force specialty code (PAFSC), control Air Force specialty code (CAFSC), 2AFSC, current grade, estimated time of separation (ETS), excess/overgrade codes (if applicable), and technician identification sequence.

This document highlights any mismatches between what is authorized for each position and what the position occupant has for assigned data. Each position is authorized one occupant; however, under some circumstances a second individual could be assigned to a position for a limited period of time. This is known as an "Excess" condition. In situations where the person is graded higher than what is authorized, an overgrade situation occurs.

Authorization change request

The UMD is the official document the NCOIC and the hospital superintendent use to determine the appropriate use of personnel within the MTF. Due to the ever-changing requirements placed on our military medical system, changes to the manning may be necessary. These changes can be carried out by completing a request in letter form when you want to make a change to an authorization on your manning document. This is known as an authorization change request or ACR. Some changes that can be completed are changes to and Air Force specialty code (AFSC), move an authorization, or change a grade. Send your letter with the rationale for requesting the change through the Resource Management Office (RMO) to manpower.

Authorization change notification

An authorization change notification (CAN) is a letter or perhaps a phone call that you will receive from manpower when the ACR action has been completed. The official change is reflected on the UMD printed quarterly.

Manning assistance

There are times when your manning is just not sufficient to meet your needs for a temporary time period. There are ways to obtain manning assistance. AFI 36-2110, *Assignments*, describes the different types of manning assistance and AFI 65-601 Volume 1, *Budget Guidance and Procedures*, dictates that the requesting activity fund any manning assistance temporary duty (TDY). This does not, however, alter existing funding responsibilities for mission related travel; therefore, each request requires you to go through your squadron commander for approval, your request for manning assistance then goes to your RMO. The request should include the following information. While we recommend using the format below, keep in mind that each MAJCOM may have its own preferred format that you must follow.

- AFSC and title.
- Inclusive date needed for the manning assistance. Do not include travel dates.
- PAS code and duty location code.
- Fund citations and special remarks.
- If you have a volunteer include the individual's rank, name SSN, duty station, and phone number.
- Justification needed for this manning request.
- Point of contact.

Self-Test Questions

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

001. Equipment management

1. What are the two different classifications of equipment whose life expectancy is at least 5 years?

2. When should you sign the custody receipt/locator listing when assuming custodial responsibility?

3. What form is turned into Biomedical Equipment Repair when a repair is identified?
4. What is found on the custody receipt/locator list?
5. What is the purpose of the custodial actions list?
6. What document is submitted to MEMO to record equipment turn-in or transfer?

002. Manpower considerations

1. What is a unit for measuring work called?
2. What is a manpower authorization?
3. What is a manpower requirement?
4. How are manpower authorizations defined on the UMD?
5. What does the position number identify on the UMD?
6. How are civilian positions indicated on the UMD?
7. What months are included in the second fiscal quarter displayed on the UMD?
8. What is “excess condition?”
9. How can you fill a position temporarily?

1-2. Supervision

As an NCOIC, you manage resources: budget, unit equipment/supplies, staff, and time. There are many long-term objectives, which the good manager 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 out-weigh 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.

003. Performing daily operations

Do you feel like a prisoner to your in-basket and daily schedule? If only you had an opportunity to plan your week ahead of time! Well, don't lose heart. You can take charge today. You can become the master of your calendar and rule your "in-basket." It is not sufficient to simply create a plan, you must be able to articulate and implement whatever you plan. For a plan to work, each step must receive equal attention and a specific cycle of completion.

Planning

The first element of time management is planning. No one ever plans to fail—they just fail to plan. Planning is an integral part of the Aerospace Medical Service craftsman's daily schedule, and 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, culminating in an efficient and well-run unit. 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 the most useful and is found to be the most productive. Remember, whatever tool you use for planning it—should be your servant, not your master. When you plan ahead, you bridge the time span between where your unit is today and where you will be tomorrow. You will need to tailor it to your individual style and needs.

Set priorities

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 through 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 complete all necessary tasks in the 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 used. The following categories are examples of this basic tool.

| Categorizing Priorities | |
|-------------------------|--|
| <i>Categories</i> | <i>Description</i> |
| 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 the good manager must complete. These tasks do not have specific deadlines because they are continual. Some of these particular tasks are, but not limited to, the development, training, support, and motivation of his or her 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 complete these recurrent tasks, you can see that it is all too easy to ignore these tasks to complete the urgent A and immediate B priorities.

The beauty of time management is that through your planning and prioritizing, you control what can be completed, when it is completed and self-imposed through the use of the diary. Simply put, a manager might decide that one hour a week should be devoted to personnel issues and would then allocate a regular block of time to that activity. Of course, if the hospital is on fire, or World War III is declared, the manager may have to reallocate 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.

004. Developing duty schedules

Planning and prioritizing are primary mechanisms for guiding the efforts of your unit or clinic. The real test for you as a NCOIC is your ability to direct efforts on a daily basis, planning and prioritizing assignments in terms of the expected benefits. Scheduling can be one of the biggest nightmares you will encounter as a 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 any manager's day. There are four objectives to be met in the development of 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's and NCOIC's responsibilities

Nurse managers and NCOICs are the primary persons responsible for duty schedules within a unit or clinic. Their responsibilities are laid out 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 do not necessarily have to prepare the schedule. With training, most members of a unit can prepare schedules. Some people think of it as a puzzle and they enjoy making out duty rosters. 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 two to three schedule overlap is ideal for these two schedulers to work on together.

The NCOIC is responsible for scheduling of 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's responsibility

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 does the most and best he or she can to meet all current requirements before handing the schedule 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 Program*, 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 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 above and beyond you 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.

Unit operating instructions

The local MTF policy prevails and need not be repeated in your OI, nor do you need to repeat anything covered otherwise by regulations such as illness, civilian absenteeism, absent without leave (AWOL), convalescent leave, and so forth. However, you must be certain your staff knows of specific rules as they apply to your unit. These are some of the following items you may find in a local unit OI for basic duty schedules:

1. Preparation of 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.
2. Civilian Employees. (Be sure to review the union contract, if there is one, for this data.):
 - 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. Orientation Plans. (How long is orientation for individual skill levels?):
 - 3-Level personnel directly from tech school.
 - 5-Level personnel with no unit experience or personnel with 5 years of experience.
 - SSgt or TSgt's who have just cross-trained, but have management experience.
4. Special Requests. (Method for initiating requests.):
 - Holidays.
 - Weekends.
 - Days off.
 - Leave.
5. Mandatory Formations:
 - Mobility exercises.
 - Required training.
 - Details.
 - In-service, teaching.
 - Special projects.
 - Additional duties such as committee membership.
 - Classes, emergency medical technician (EMT), cardiopulmonary resuscitation (CPR).
6. On Call Procedures:
 - Is a beeper required for being on call?
 - Must individuals check in every four hours?
7. Tardiness:
 - If an individual calls 15 minutes prior to shift, they are not late.
 - Individuals who are tardy more than 3 times per schedule will be counseled.
8. Compensatory Time:
 - When individuals are called in for more than four hours during *on call* time.
 - Compensation will be given for mandatory formations during off duty time.
9. Split Shifts or Other Irregular Schedules:
 - 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).

Factors affecting duty schedules

While the previous paragraphs cover 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 they will need medical attention. In some instances, you as the NCOIC 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 following 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 holiday 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 unit's 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. When scheduling personnel, it is also important to have consistency. Members will normally be happy with a schedule showing consistency and predictability. In addition, develop your schedule to allow for planned classes, meetings, duties, TDYs, leaves, and emergencies. If you schedule an in-service or staff meeting make sure you have adequate staffing to cover the unit during those times. It may be necessary to schedule the timing of such meeting so that all staff members have an opportunity to attend. 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 usage 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.

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 and do not forget how it was when you had to live with a duty schedule made by someone else.

Maximum hours off between shifts

Arrange the schedule to allow for at least twelve 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 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 contributes to good personnel practices and maintains staff satisfaction. Because the policies and procedures you follow when developing duty schedules affect both the quality and quantity of the nursing care we provide, Dos and Don’ts of scheduling should always be considered.

| What to DO and Not to DO When Developing a Duty Schedule | |
|--|---|
| DO | <ul style="list-style-type: none"> • 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 be changed by the supervisor for emergency reasons only. • Schedule in time for supervisory, additional, and administrative duties of all personnel. |
| DON’T | <ul style="list-style-type: none"> • Avoid doubling 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, 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 while increasing 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: Arrives at work at 0600. Prepares the clinic for receiving patients. Obtains records if needed. Other administrative duties as needed. Lunch at 1030 or 1100. Released for the day at 1500.

2. Late technician duties: Arrives at work at 0730. Immediately begins patient care. Lunch at 1130 or 1200. After clinic closes for day, prepares record requests, straightens work areas, and replenishes supplies. Released for the day at 1630.

This is an oversimplification, 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 four, six, or eight-week schedule that provides even coverage, high quality, and high stability. The cyclic schedule is typically seen with twelve-hour shifts. The cost to maintain this type of schedule is low because it is easily done 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 six 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 appropriate mix of personnel are required to make it work. A two-week cyclic schedule has a repeated pattern of each staff member receiving every other weekend off (usually a three-day weekend). Having the ability to plan a schedule four, six, or even eight-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. The pattern of your cyclic schedule should be reviewed periodically to ensure it still meets the purpose, philosophy and objectives of your MTF and its mission. It also ensures it is practical in regard to the mix of your staff—that it continues to meet your patient care requirements and continues to use personnel effectively.

Flextime scheduling

This concept is beginning to catch on throughout the federal work force. You may even have some civilian employees in your medical facility that use 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 tenth day off. This keeps the length of the work day close to an 8-hour schedule while providing a three-day weekend every two 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 carrying out the mission effectively and efficiently, you can try almost anything.

Compressed work schedule

A newer concept is the compressed or four-day week schedule. This concept is usually used with clinic personnel working four ten-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 in-services and classes, and other training activities. The disadvantages are a greater potential for fatigue, and it requires more staff than eight or twelve 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. 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 for 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.

005. Workcenter orientation

Congratulations on your selection to the NCO ranks. Do you remember the day you met your first supervisor? Well, now you will soon be that first supervisor of a new Airman. There is an old saying that goes “If a truck ran over you today, who would do your job?” A good supervisor prepares the younger Airmen to someday fill his or her shoes. You should be preparing for that day by learning all you can now. There are so many things supervisors must take care of for their newly assigned airmen; i.e., safety briefings, identifying performance standards, on-the-job training (OJT), and orientations—the list seems endless! This section is designed to introduce you to the world of being a supervisor of Aerospace Medical Service personnel. While we will focus mainly on the 4N0X1 medics the information in this lesson applies equally to the shreds as well. Being a good supervisor requires integrity, time, patience, and sometimes; just having the courage to let subordinates make and learn from their mistakes.

Supervising newly assigned 4N0X1's

Leadership, management, and supervision are key elements in nearly every aspect of life. When you were child, your parents, guardians, or other adults provided these traits. Teachers, coaches, bosses, and even friends assume these roles at different times or for different activities. Your primary role focuses on supervision as you will soon be placed in a position to supervise less experienced Airmen. Leadership and management of personnel and resources are also important for you to learn. If you have not yet attended Airman Leadership School, you will soon have a class date. Also, at specified intervals during the rest of your career, you will be given the chance to attend other Professional Military Education (PME) schools. PME is designed to teach you the skills needed to be an effective leader and a manager.

Supervision can be defined as the process of reviewing, observing, and accepting responsibility for the actions and services provided by subordinates. As a technician team leader or a supervisor of 4N0X1 personnel, you must learn to direct people to the work that needs to be done, and inspect the work once it's finished. Of course before a worker can be put to the job, there are a few preliminary steps that need to be completed.

Orientation

When notified of the projected assignment of an apprentice Airman newly graduated from technical school, the flight NCOIC or element NCOIC determines and assigns an immediate supervisor. To prepare for the inbound Airman, the supervisor begins gathering and assembling the various records and documents required to create an Air Force Training Record (AFTR). The specific records required, as well as procedures for creating the training folder, are listed in the sections Master Training Plan (MTP) and 4N0X1 Career Field Education and Training Plan (CFETP). Some of these records include the following:

- 4N0X1 CFETP.
- AF Form 623a, On-the-Job Training Record—Continuation Sheet.
- Any locally developed overprints of the AF Form 797, Job Qualification Standard Continuation/Command (JQS).
- Any locally developed orientation checklists.
- AF Form 55, Employee Safety and Health Record.
- AF Form 931, Airmen Comprehensive Assessment.

NOTE: The AF 931 is never maintained in the training record; the ratee gets a copy, and the rater may keep a personal copy, but it does not go in the record. In addition to creating the training folder, the supervisor should also coordinate with the NCOIC and the unit training manager (UTM) to work out a training schedule.

Upon notification of the assignment, the NCOIC also coordinates with the orderly room to assign the individual a sponsor. The sponsor's job is to welcome the new arrival to the base, and help make the relocation process easier for all involved.

Sponsor's duties include the following:

- Writing a welcome letter.
- Serving as a point of contact for questions.
- Helping obtain a mailing address.
- Performing any other duties that can smooth the arrival.

Ideally, the sponsor is someone with similar interests and situations. For example, a single Airman living in the dorm may be an ideal sponsor for an incoming single Airman, but may not be able to help a staff sergeant with three kids. The reverse is also true. A 4N0X1 technician can introduce the arriving member to aerospace medical service duties, but may not be able to help a 4A0X1 medical service apprentice. Upon arrival to the base, the newly assigned Airman should contact his or her sponsor; the sponsor should then help the Airman get settled, then escort him or her to the duty section to begin orientation and inprocessing.

The orientation period now begins in earnest. The supervisor (or other designated individual) will take the new arrival to the orderly room to begin in-processing to the facility. The supervisor will also arrange for an appointment with the Military Personnel Flight to begin base in-processing.

Part of the in-processing procedure includes an orientation phase. This includes familiarization with the base, the facility, and work center (duty section). Most facilities will have newcomers' briefings. These include briefings ranging from the facility commander down to the various offices that the Airman will be dealing with on a day-to-day basis. When you're assigned to orientate an individual, be sure to introduce the young Airman to other work center personnel and those in the Airman's chain of command. Walk the individual through the work center, discuss and show him or her the physical layout of the duty section.

In addition to these areas, take the Airman on a tour of the facility and show the individual where the inpatient/outpatient units, clinics, lab, x-ray, pharmacy, and other important areas of your facility are located. Pay particular attention to fire and disaster evacuation plans and clinic/work center operating hours. Include a brief overview of what the Airman may be doing on the job, and so forth. The orientation period may vary from one individual to another, but it should always cover the essential information.

Most work centers, facilities, and bases, provide the Airman with an orientation checklist. Once this checklist is complete, give it to the supervisor to maintain in the individual's file or AFTR; forward checklists from the facility to the appropriate office of primary responsibility (OPR). As the newly graduated Airman's supervisor, there are a number of other areas you must address. As we proceed, we'll discuss the supervisor's role in explaining the Airman's duty schedule, work standards expected, and required safety related briefings and documentation. Before we go on to these areas, let's discuss the supervisor's role in evaluation of a newly assigned Airman arriving from technical training.

Evaluation of Aerospace Medical Service 4N0X1 formal course graduates

As the supervisor of a newly assigned surgical service apprentice, you will be asked to provide feedback to the Aerospace Medical Service Apprentice Course located at Fort Sam Houston, Texas. Providing feedback to the school is the only way you can help the school improve the quality of training. If graduates aren't learning what's needed to perform on-the-job, then you, as the supervisor, need to communicate this fact to the course.

There are various methods used to gather this data. These include the following:

- Field evaluation questionnaires (FEQ).
- Field interviews via telephone.
- TDY from training evaluators at the training group.

- Customer service information line (see your CFETP for details).
- Graduate assessment surveys (GAS).

If you are asked to participate in any of the above methods of evaluation, take your time, be accurate, and be specific. Make sure you accurately address the former student's knowledge and performance upon his or her first arrival at your facility. For example, if an Airman arrived in your duty section "gung-ho" and full of "yes ma'am, yes sir," the schoolhouse probably did a good job training military bearing and courtesies. If the Airman has lost those traits since being assigned, don't list "military skills" as needing improvement on the GAS—the Airman picked up these habits after arrival. On the other hand, if the Airman couldn't perform basic vital signs (temperature, blood pressure) without assistance then say so on the survey. Every survey, assessment, telephone call, letter, or other feedback received is evaluated by the training course for required action.

Evaluating training is your responsibility. After all, the technicians in the field are in the best position to determine who, what, and when something needs training. By the way—the same holds true for this CDC—if you have any comments, suggestions, questions, recommendations, or any other input, call, e-mail, or write the author. The numbers and addresses are listed on the inside cover of this volume.

Career field surveys

Have you ever heard of an Occupational Survey Report (OSR)? An OSR is a survey used to collect data for evaluation of career field training and to update training documents; specifically, the career field specialty training standard (STS) portion of your CFETP. The OSR specifically provides the training community with a comprehensive database to support anticipated training decisions for the career ladder. An OSR is completed by surveying personnel throughout the career field and is represented in terms of major commands, paygrade, and total active federal military service time. To compile data for the OSR report, the Occupational Measurement Squadron, located at Randolph AFB, TX, puts together a survey tool called a *job inventory*. The job inventory is a composition of all tasks specifically done by the 4N0X1 career field, and also lists any equipment commonly used by 4N0X1 personnel. The job inventory also asks background questions related to type of duty section, job satisfaction, and so forth. Upon compilation of the data, a thorough report is sent out to training personnel and to those who request a formal report.

If you or one of your coworkers is asked to participate in this survey, be accurate and honest. You may want to stress to your peers the importance of completing this survey. The results of this survey help determine some of your specialty knowledge test (SKT) questions and can affect your promotion. These surveys are only completed about every three years, so keep this in mind—the information provided to the training command will impact your career field for years to come.

Assigning personnel to work areas

As a 4N0X1 medical technician, shift work and "call" varies based on duty section and location. As a member of the Air Force, you are subject to duty 24 hours a day, including weekends and holidays. If so directed by a competent authority, you must report for duty at any hour and at any location and remain as long as necessary to get the job done unless excused earlier by a competent authority—the mission comes first. Duty schedules must provide adequate 4N0X1 coverage and distribute working hours so the best use is made of available personnel. The flight or element NCOIC is usually responsible for scheduling all enlisted personnel, but the task may be delegated to a mid-level supervisor. Once prepared, the schedule is also reviewed and approved by the OIC.

Policies

There are many rules and policies that the NCOIC must take into consideration when preparing duty schedules. One such policy is AFI 36-3003, *Military Leave Program*, which contains information pertaining to leave and administrative absence policy. The medical treatment facility and your duty section may also have written guidance operating instructions regarding scheduling. As NCOIC, or

designated scheduler, it's your responsibility to consult these resources and to know and follow appropriate guidelines for scheduling personnel.

Considerations

When preparing schedules, plan so that the most staff is available during peak workload periods; in most facilities this is during the "day shift." Also, distribute the staff according to experience and ability; ensure there are enough experienced staff members to not only cover the required tasks, but also to train and supervise inexperienced personnel.

Another consideration is equity. Always be fair; treat the entire staff the same. This means avoiding favoritism. Do not use schedules as tools for control or discipline. Trying to please everyone drives the scheduler crazy because it's impossible! If you remain consistently equitable to all staff, you will at least be respected.

Post your schedule as early as possible, at least two weeks in advance, and maintain a record book of past schedules. Keeping past schedules give you a record, so when a technician complains "You've put me on weekend duty for three months!" you've got documentation to prove otherwise—unless of course it's true! No matter how hard you try, you won't make everybody happy—about the only people happy with a call schedule are those whose names aren't on it! This is an area where judgment and equity are crucial.

Supervisors and trainers must judge carefully when deciding when a 4N0X1 is ready to lead a shift or be on call. The length of time in training is often used as a guideline, but this should not be the only guideline. Some technicians are capable of doing task by themselves in three months, others not for six months. Ability and expertise, as well as experience, maturity, and personal initiative, are all factors to consider; but it all boils down to the supervisor's judgment and how they perform when evaluated by the trainer/supervisor. If manpower allows, it's a good practice to schedule an inexperienced technician to work alongside an experienced one for time period they are in upgrade training (UGT).

If your section requires 12–24 hour coverage, avoid "doubling back" or scheduling people to return to duty after only an eight-hour interval away from duty. It's best to provide a 16-hour gap between duty shifts whenever possible. Avoid having anyone work three different shifts in a two-week period. Avoid split days off—give days off consecutively. Avoid having anyone work a double shift (16 hours in a row). Research has documented that after 12 hours, performance is significantly reduced. Use a forward rotation of your personnel. This means that they rotate from days to evening to nights, rather than a backward rotation, which means days to nights to evenings. The forward rotation is better because it works with the body's natural cycles.

Cyclic scheduling

One of the most equitable methods of distributing hours of work and time off is cyclic scheduling. In this type of scheduling, a basic pattern is established and then repeated over and over. Cyclic scheduling allows staff members to project their off-duty time into the future. This contributes to staff satisfaction and reduces the number of requests for special time off. Because of the military lifestyle, it doesn't always work, but you can adapt the framework. Many facilities have computer-generated templates that make scheduling much simpler than hand writing or typing a schedule. To give you an idea of the scheduling process, we've provided the following duty schedule example in the table on the following page. Refer to this example as we discuss the process. Place staff names in the wide left-hand column by date of rank. Record the days of the week on the top line, starting with whatever day the first of the month falls on; in the example it's Friday. Write the actual calendar dates in the row below the days. Mark all holidays for the month you are scheduling; then other personnel absences such as TDYs, leaves, PME classes, details, small arms training, and so forth. Develop and print a legend of codes used to designate scheduled events. Examples of legend codes are shown in the bottom left block of the example.

The following is a suggested procedure for completing a monthly duty schedule:

- Enter the days you know each individual won't be available for duty because of mandatory prior commitments such as PME, small arms training, TDY, and details.
- Enter projected and approved leave dates.
- Enter any special requests you intend to honor if at all possible.
- Enter holidays or military compensatory holidays. (Civilians are off on the actual holiday, or they work it. They don't have compensatory time.)
- Complete the evening shift, one technician at a time, in turn, all the way across the schedule with appropriate time off before and after the evening tour.
- Enter the night shift personnel in the same fashion.
- Enter the "Call" shifts, ensuring adequate coverage for each period required.
- Enter projected compensatory time for the call shift.
- Enter the day shifts, one technician at a time, with days off, etc., all the way across the schedule.
- Add up, and enter in the bottom of each daily column the total number of technicians on each shift.
- Ensure each day is covered by at least the locally established minimum staff for each shift.
- Adjust deficiencies by moving "comp days" and requested time off first. If possible; honor leave requests. Mandatory military duties may not routinely be canceled or moved.
- Sign the completed schedule. Forward it to the OIC for review and signature.

Post the schedule in the designated conspicuous area. See figure 1-3 for an example of a daily schedule.

| OCTOBER | F | S | S | M | T | W | T | F | S | S | M | T | W | T | F | S | S |
|---|-----|-----|-----|-----|---|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|----|
| 2004 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 13 | 15 | 16 | 17 |
| MSgt Stienkamp | D | O F | O F | D | D | D | D | D | O F | O F | H | D | D | D | D | O F | OF |
| TSgt Peoples | D | O F | O F | D | D | D | A D | D | O F | O F | H C | D | D | D | H O | O F | OF |
| SSgt K. Devalle | D | O F | O F | D | D | D | D | O F | C | O F | H | L V | L V | L V | L V | O F | OF |
| SSgt Hess | D | O F | C | O F | D | D | D | D | O F | O F | H | D | D | D | D | O F | OF |
| SrA Cabigas | E | O F | O F | E | E | E | E | E | O F | O F | H | E | E | E | E | O F | OF |
| SrA VanDoren | D | O F | O F | D | D | D | D | D | O F | C | H | O F | D | D | D | O F | OF |
| A1C Saucedo | O F | C | O F | D | D | O F | D | D | O F | O F | H | D | D | D | D | O F | OF |
| A1C Frerichs | D | O F | O F | D | D | D | D | D | O F | O F | H | D | D | D | D | O F | OF |
| A1C M Charles | D | O F | O F | E | E | E | E | E | O F | O F | H | D | D | D | D | O F | OF |
| # ON DAYS | 7 | | | 6 | 6 | 6 | 7 | 6 | | | | 6 | 7 | 7 | 6 | | |
| D = Days E = Evenings C = Call H = Holiday HC = Holiday Call OF = off HO = holiday comp day LV = leave TY = TDY DT = Detail AD = Administrative Day | | | | | | | | | | | | | | | | | |
| Raines B MSgt Mote B. Maj NCOIC OIC | | | | | | | | | | | | | | | | | |

Figure 1-3. Daily schedule.

Schedule contents

Local policy determines the specific information listed on the surgery schedule. Most lists have the following as a minimum:

- Date and day of the operation.
- Time of the operation.
- Designated exam room.
- Patient identification information:
 - Name.
 - Hospital register number or SSN.
 - Age.
 - Sex.
 - Military status or rank (E-3, O-5, Capt, Amn).
 - Patient location or nursing unit designation.
- Operation to be performed (entries may be abbreviated to save space).
- Primary physician/nurse.

Copies of the duty schedule are distributed or transmitted to several key personnel and functional areas within the MTF. Specific distribution is determined locally, but usually includes the following:

- Commander and executive staff.
- Administrative staff.
- MTF commander.
- Chief of hospital services.
- Chief of surgical services.
- Chiefs of all appropriate specialties.
- Concerned nursing units.
- Chief nurse.
- Patient administration.

Additional copies may also be sent to other persons or areas determined by local policies, such as the laboratory and the radiology department. With the proliferation of computerized information systems in Air Force hospitals, many clinics are now developing and distributing the surgery schedule via computer.

Counseling the 4N0X1 technician

One of the most important aspects of supervision, and one that is often overlooked, is counseling. Counseling is a very important part of being a good supervisor. Now let's take a look at some of the areas where you can be of value as a counselor to your Airmen.

Reporting to duty expectations

As the trainer or supervisor, stress the nature and the seriousness of the trainees' responsibilities when on-call. Ensure they know their time reporting limits and geographical area. Stress the need for adequate rest and physical conditioning to handle the sometimes demanding rigors of call. Ensure they know what behaviors and activities are allowed and which are not allowed (i.e., no consuming of any alcohol within 30 minutes prior to arriving for work at hospital).

Training progression

Periodically evaluate and appraise the trainee of the progress in training—this includes dating and initialing the appropriate STS elements in the CFETP. Too many trainers and supervisors let a trainee go for months with no feedback, then hand the trainee a CFETP with all items dated and "closed out."

They often tell the trainee to initial next to the date without explaining what the trainee is indicating by the initials. It is critical that trainees understand that by placing their initials after an item on an STS, they are certifying that they know how to do (and are completely trained on) the specific item.

Mentoring

Mentoring is basically leading or guiding your subordinates to reach their full potential; it is a form of positive counseling. It helps fulfill your responsibility to “train-up” the next generation of Air Force leaders—your replacements. Mentoring counseling is often conducted in conjunction with feedback sessions. Topics you should discuss include those covered in this section, as well as items like promotion requirements, PME eligibility, unit/base/community involvement, medical and physical fitness, equal opportunity, assignment policies and procedures, personal and financial planning, and numerous other subjects to help the subordinate become a well-rounded Air Force member. These are just some examples of the areas you may want to focus on during counseling. Put yourself in your subordinate's place—if your supervisor doesn't discuss these issues with you, who will?

Career ladder progression

By now you should have an idea of where you want to go in your career in the Air Force. I hope your supervisors have taken the time to counsel you on your career ladder progression in the aerospace medical service career field in the past. If not, you should take this opportunity to be a better example than your predecessors. From the time they are assigned to you, counsel your Airmen on how to progress in rank and skill level in the 4N0X1 career field. Stress the importance of what they do now can impact their lives and career for years to come. The CFETP is the best source on career ladder progression. It contains a very detailed chart, references on career paths and progression for our entire career field; including the shred specialties. Go over the guidance in the CFETP on career ladder progression with your Airmen in great detail. Make sure that they are aware of all the opportunities that are available to them not only within the career field, but those that will be available to them as they reach higher pay grades. You will find this will not only help them, it will also help you remain focused on what you want to do as an NCO and 4N0X1 technician in the Air Force. Also, don't get caught up in “Air Force bashing” or “this base is horrible.” This sets a bad example for your Airmen and has caused a lot of good people to leave the military over the years. Teach your Airmen that every assignment is what he or she makes it. This goes back to the principle that the choices they make now can affect them in years to come.

Career job reservation

One area often neglected by supervisors is explaining the reenlistment process, especially the career job reservation (CJR). According to AFI 36-2606, *Reenlistment in the United States Air Force*, paragraph 1.14, the purpose of the CJR is to “prevent surpluses and shortages in the career force.” However, there is a specific time-frame during which first-term Airmen may apply for the CJR. Four year first-term enlistees may apply on the first duty day of the month during which they complete 35 months on their current enlistments, but no later than the last duty day during which they complete 43 months. Similarly, six-year first-term enlistees may apply on the first day of their 59th month of enlistment, but no later than the last day of their 67th month.

Airmen continue to receive eligibility notifications until they apply or are no longer eligible. Since there are few exceptions to these timeframes, it is vital for Airmen to apply for the CJR to remain eligible, or they could forfeit their eligibility. Refer to the AFI for further information regarding specific exceptions to the time-frames just described. Encourage any subordinates to apply for a CJR even if they fully intend to separate from the Air Force after the first enlistment. Without an approved CJR, a first-term Airman can't reenlist. Approval of a CJR does not mandate reenlistment; it simply keeps the option open. Also, make sure that your Airmen have been notified that they need to get a CJR using the guidance above. I had an Airman who made plans to get out, go home, live with family, get a job and go back to school. Unfortunately, every one of his plans fell through and he needed to reenlist. The problem was he had never gotten his CJR. The only thing that saved him was a glitch in the computer system and he was never notified that he needed to get his CJR. If he had

turned down his CJR, he would not have been allowed to reenlist. Why burn a bridge if you don't have to?

Supervising civilians

Along with supervising Airmen you may enter into a situation where you will be required to evaluate the performance of civilians that work in your department. Let's take a few minutes to review some of the details associated with supervising civilians.

All active duty personnel have job descriptions. Federal civilian employees are no different except that their descriptions are known as position descriptions; as such, they are more complex and very detailed. Position descriptions are broken down into specific performance elements that describe each duty. If you are ever assigned to supervise a civilian employee, consult with your civilian personnel office for specific job descriptions and duties. You are required to receive training from your local civilian personnel office upon being assigned to supervise a civilian employee.

It would also be wise to seek out an experienced civilian supervisor. To get an idea just how complicated civilian supervision can be, read the section on civilian personnel in Air Force Pamphlet (AFPAM) 36-2241, *Professional Development Guide*.

Like civilian job descriptions, civilian performance standards are more complicated to manage. Each performance element in the position description is described as to exactly how the duty is to be completed. Objective standards must be set that allow for fully successful performance. Don't be afraid to take on the responsibility of supervising a civilian employee—the experience, while complicated at times, can be very educational and rewarding.

Self-Test Questions

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

003. Performing daily operations

1. SSgt Johnson is constantly working from one project to another and is unable to bring his units current status in line with the future goals of the organization. What aspect of time management does he need to incorporate?
2. TSgt Smith has recently been assigned as the NCOIC of a clinic. She has a firm grasp of the organizations goals. What other information can TSgt Smith use to align the units progression to meet the organization's goals?
3. Which aspect of time management can TSgt Smith use that offers her a clear direction to complete all the necessary tasks?
4. SSgt Mays is the shift leader of the special care unit and works 8-hour day shift. SSgt Mays is constantly stressed, over whelmed, and always has a "hot" project or suspense that needs to be met. What prioritizing tool could SSgt Mays use to make more efficient use of his time?

5. SSgt Aerans is in charge of providing in-service training quarterly, but is routinely running around at the last minute to set up the necessary training. How could SSgt Aerans complete this task better?

004. Developing duty schedules

1. When developing a duty schedule, what four objectives should be met?
2. Who is responsible for final approval of the enlisted duty schedule?
3. You over hear SrA Jones complaining that she never gets the days off she wants. How could you help her to change her outlook?
4. What references and guidance does the scheduler use to prepare a duty schedule?
5. When scheduling civilian personnel, what document should be reviewed and what information would it contain pertaining to scheduling?
6. As the scheduler of the inpatient surgical unit, why is it necessary to have open lines of communication with the surgery suite and surgical clinic?
7. What schedule provides a continual rotation, but the least amount of flexibility?
8. As the NCOIC of the Pediatric Clinic, the flight chief has tasked you to produce a schedule that incorporates overlap between shifts, increases staffing at the busiest times, and offers staff the opportunity to attend in-service training. What scheduling technique could you possibly use to fulfill this opportunity?

005. Workcenter orientation

1. Define the term *supervision*.
2. Who determines and assigns an immediate supervisor to a newly assigned Airman?
3. What is the sponsor's job?
4. List some of the actions you can take to help orient a new assignee?
5. What is the purpose of supervisors providing feedback to the Aerospace Medical Service Apprentice Course?
6. List the methods used to collect data regarding the training that trainees receive.
7. What is an OSR?
8. What tool is used to collect the data needed to compile an OSR?
9. Who is responsible for scheduling enlisted personnel for duty?
10. Who reviews and approves the duty schedule?
11. Where can you find information pertaining to leave and administrative absence policy that must be taken into consideration when preparing duty schedules?

12. List what you need to consider when planning a schedule.
13. Why should you *not* schedule someone to work a double shift (16 hours)?
14. List at least five things that are found on a typical daily schedule.
15. What is the best source of information on career ladder progression?
16. Why should all first term Airmen apply for a CJR?
17. What are civilian job descriptions called?

1-3. Training

During career progression, Aeromedical Medical Service Journeymen find themselves at a crossroads in their jobs. Advancement to the 5-skill level brings new duties and responsibilities. This section addresses various aspects of medical service management as well as on-the-job training responsibilities. OJT is simply training conducted during job performance. This section includes lessons that address the military medical scope of practice and maintaining the enlisted training and competency folder.

006. Military medical scope of practice

Training is *not* a “formal-course-only” program! Formal courses (i.e., the Aerospace Medical Service Apprentice Course, these CDCs, and so forth) *begin* the training process for a specific skill level. Individuals are prepared to meet the challenges of the job after successfully completing a formal course, but in no way are armed with the experience that can only be attained during duty performance. This is where the role of the on-the-job trainer comes in. Hence, training is completed through formal courses and OJT. In this lesson we discuss different levels of the military medical scope of practice, from career knowledge, job qualification and job description.

The effectiveness of any training program involves monitoring the effectiveness of the process. Three key areas to consider here are the career knowledge by the member, current qualification and certification of the job, and job proficiency through UGT status.

Career knowledge

This aspect of training is simply evaluating the person's knowledge of his or her responsibilities within the AFSC. Additionally, members should have a general understanding of responsibilities for others in the AFSC as it applies to various skill levels and positions.

| Education and Training Requirements | Grade Requirements | |
|---|--------------------|--|
| | Rank | Special Duty |
| Upgrade to Journeyman (5-Skill Level) <ul style="list-style-type: none"> • Certified in all STS Core Tasks • Minimum NREMT certification • QTPs for assigned position • Complete all duty position training requirements | A1C/SrA | <ul style="list-style-type: none"> • 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) <ul style="list-style-type: none"> • Minimum NREMT certification • QTPs for assigned position • Complete all duty position training requirements | SSgt | <ul style="list-style-type: none"> • 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) <ul style="list-style-type: none"> • NREMT certification | CMSgt | <ul style="list-style-type: none"> • MAJCOM level assignments • MAJCOM Functional Manager |
| Chief Enlisted Manager (CEM) 4N000 <ul style="list-style-type: none"> • CLC | CMSgt | <ul style="list-style-type: none"> • Air Force Career Field Manager (AFCFM) • Medical Group Superintendent |

Figure 1-4. 4N0X1 Career Path.

The 4N0XX CFETP is a comprehensive document containing complete information regarding education and training requirements applicable to the AFSC. The CFETP provides personnel with a clear path to success and defines training requirements needed at various points during an individual's career. Each enlisted specialty has a CFETP designed specifically for the career field. Figure 1-4 shows an at-a-glance career progression from Airman Basic (AB) to Chief Master Sergeant (CMSgt). Study this graphic carefully as you may see questions on it later.

Job proficiency qualification

Certification and qualification are two different things. Certification involves the official authenticating by a governing body in regard to an individual's ability to perform a certain set of skills. An example of this is National Registry of Emergency Medical Technicians (NREMT) certification.

Qualification is simply an assessment of an individual's ability to perform a certain job. In other words, ensuring he or she is qualified to do what they are supposed to do. The AMSC is usually qualified to perform the job responsibilities of the NCOIC of a duty section. Following established training guidelines specified by the CFETP, Part 1 ensures most qualifications are met.

The *first part* of the CFETP contains five sections. These sections provide information necessary for the overall management of the specialty. Figure 1-5 shows the lay out for part I of the CFETP.

CFETP Part I

| Section | Title | Contents |
|-----------|------------------------------------|---|
| Section A | General Information | Explains how everyone will use the plan. |
| Section B | Career Progression and Information | Career progression information pertaining to the specialty is included in this section. In addition, information regarding skill level progression, training decisions, Community College of the Air Force (CCAF), and the career field path can be found in Section B. |
| Section C | Skill Level Training Requirements | Explains the purpose and training requirements for each skill level. |
| Section D | Resource Constraints | Anytime a resource or training constraint that would hinder the training process mandated by the CFETP is identified, it's listed in this section. Constraints may include such factors as a lack of necessary funds, manpower, equipment, facilities, etc. |
| Section E | Transitional Training Guide | This final section of Part I is used only when two or more career fields are merging to become a single specialty. In the event of such a merger, Section E serves as a transitional training guide for the process. |

Figure 1-5. CFETP Part I.

Job description

Being proficient in a job is paramount to the success of a mission. A job description is a brief summary of jobs or tasks performed by the position. These tasks are in direct correlation to the STS items found in the master task list (MTL). Each individual job or task is not listed in the job description, but an overall snapshot of the primary duties expected to be performed within each job. You commonly see a job description on the front of the enlisted Performance Report (EPR). Because the job description does not list each task performed the MTL is the tool the supervisors use to ensure that the appropriate training is completed.

Some of the duties that are expected by the AMSC include providing medical training to agencies and personnel other than medical. Training includes areas such as national registered emergency medical technician and self-aid buddy care. Also included are scheduling in-service training in new procedures, techniques, and equipment and providing required basic life support training for both medical and non-medical personnel.

Supervisors monitor the proficiency of all subordinates and initiate action when upgrade to the next skill level is appropriate. Working with the unit-training manager, supervisors ensure all criteria are met when initiating skill level upgrade for a member. This information is directly taken from the CFETP, Part 2.

The *second part* of the CFETP contains six sections. The majority of Part II contains the STS for the specialty. The contents of Part II are designed to provide formal course developers and field supervisors with the information necessary to identify, plan, and conduct training. The following table shows the lay out for part II of the CFETP.

| CFETP, Part 2 | | |
|---------------|-----------------------------|---|
| Section | Title | Contents |
| Section A | Specialty Training Standard | <p>The STS has multiple applications. First, the introductory portion contains general instructions and an endorsement by the USAF Surgeon General. A proficiency code key is also included, which serves as a guide for formal course developers when constructing lessons. The codes determine the level of training to be provided for each specific STS item. Items that do not have a code assigned for a specific level of training are only trained on the job when required by the member's current duty position. The proficiency coding of STS items defines the contract that the schoolhouse has with the field.</p> <p>The various attachments to the STS list all of the knowledge and task items that apply to the specialty, shredouts, and special experience identifiers (SEI). Additionally, items identified as core tasks (applicable to everybody in the AFSC), wartime course tasks (items taught in a formal course during a time of war to reduce formal training time as much as possible), and items that have an available Qualification Training Package (QTP) are listed in the STS. The final portion of the STS contains a list of training references approved for use by formal course developers and field supervisors when conducting training.</p> |
| Section B | Course Objective List | This section contains information on how to obtain a listing of course objectives taught by the various formal career field courses. Supervisors can also use this information when determining whether-or-not Airmen have satisfied all training requirements. |
| Section C | Support Materials | Contains a listing of all published Qualification Training Packages (QTP). QTPs are standardized training aids that are mandated for use at the unit level—when applicable to a member's current duty position. All tasks that have an available QTP are identified in the STS. |
| Section D | Training Course Index | Contains an index of mandatory and optional courses that supervisors can use to determine available training support resources. |
| Section E | MAJCOM Unique Requirements | MAJCOMs with unique requirements not addressed by the CFETP may have the information placed in this section upon approval of the career field manager. |
| Section F | Documentation of Training | <p>Is divided into two subparts:</p> <p>Part 1, Air Force Training Record (AFTR), contains the OJT record for each member. Supervisors are responsible to document training completion in the members training records</p> <p>Part 2, Work Center Training Binder ensures all initial and on-going work center training meets required standards. Each work center will maintain a training binder (electronic or hard copy) that is accessible by all work center personnel.</p> |

Recommending people for training

Various methods are used to determine if and when someone needs training. The training a person needs can involve AF or job-specific topics. Supervisors are the key people who must make these determinations.

AF training usually affects all personnel on a prescribed timetable. Training involving safety and policy issues are often mandated on an annual (or more frequent) basis. Examples of AF training topics include annual fire extinguisher training, Air Force Occupational and Environmental Safety, Fire Prevention, and Health (AFOSH), OPSEC (operations security)/COMSEC (communications security)/COMPUSEC (computer security), and so forth. Supervisors often receive an automatic notification from various AF program monitors when personnel are due for such recurring training.

Job-specific training encompasses a wide range of requirements. For enlisted members, skill level upgrade training is a prime example. Entering subordinates into the UGT process for 5-and 7-level training is an important role of the supervisor. Although the Air Force establishes a *minimum* of 12-months for UGT (for both 5- and 7-level), supervisors must work closely with unit

and base training personnel when members are ready for upgrade training to a higher skill level. Other job-specific training includes, but is not limited to, the following:

1. CPR recertification.
2. NREMT recertification.
3. QTP training.
4. Unit-specific training (infection control, patient sensitivity, and so forth.).
5. Duty section-specific training (training on new equipment, procedures, and so forth.).

Retrain opportunities

The overall objective of the retraining program is to balance the career force of each AFSC needed. Additionally and most rewarding, the program allows individual Airmen a choice of career fields from which to pursue an Air Force career and provide a method to return Airmen disqualified from their current AFSC to a production status. Members assigned in the continental United States (CONUS) apply for retraining no earlier than the first duty day of the month when they complete 35 months of their current enlistment (59 months for six-year enlistees), but no later than the last day of the 43rd month of their current enlistment (67 months for six-year enlistees). Members assigned overseas apply between the 9th and 15th month before their date of estimated return from overseas (DEROS) and will enter their Career Airman Reenlistment Reservation System (CAREERS) window (35th – 43rd month for four-year enlistees; 59th – 67th month for six-year enlistees) on or before their DEROS.

Phase I is a voluntary phase announcing the start of the fiscal year program. Air Staff provides the list of AFSCs with significant overages and shortages. The objective is to retrain volunteers from overage AFSCs into AFSCs with shortages. Phase II is an involuntary phase and occurs if retraining objectives are not met through the voluntary phase then the involuntary retraining phase becomes necessary. All eligible Airmen who are vulnerable for involuntary retraining are formally notified and selected for an AFSC by HQ AFPC. Airmen who possess a secondary or additional AFSC in a shortage skill are returned to those skills if it is in the best interest of the Air Force.

When you hear formal training, what is the first thought that comes to mind? In most cases, the first thought may be enlisted professional military education (EPME) such as Airman Leadership School (ALS), Noncommissioned Officer Academy (NCOA) Intermediate Leadership Experience (ILE), Senior Noncommissioned Officer Academy (SNCOA) Advanced Leadership Experience (ALE) or for officers Squadron Officer School (SOS), is that right?

Well despite popular belief there is more formal training than just PME. Almost every course you complete in the Air Force that has training rip, a quota, an allocation of funds, training line number (TLN), and potential Community College of the Air Force (CCAF) credits are considered some form of formal training. However, keep in mind most courses that are unit funded may be considered “just training” and not formal training.

Air Force developmental education (DE) programs expand knowledge and increase understanding of the role of air, space and cyberspace power in times of peace and war. Air Force education programs prepare Air Force personnel to anticipate and successfully meet challenges across the range of military operations and build a professional corps. Further, they positively impact both recruitment and retention efforts. Education is one of three core concepts that make up the Continuum of Learning (CoL) which encompasses the deliberate developmental path over the course of an Air Force career. The other two core concepts of the CoL are training and experience. The CoL ensures the Air Force synchronizes force development efforts so personnel receive the right education at the right time throughout their careers. Air Force EPME is a time-in-service (TIS)-based model that ensures targeted delivery of institutional competencies (IC) throughout the Continuum of Learning across an enlisted Airman’s career. Basic EPME requirements will be developed in three phases across an Airman’s career according to the following table.

| Course | Delivery | Time required |
|--|-----------------------------------|--|
| Phase 1 | Resident Airman Leadership School | At least 3 years but no more than 6 years time in service |
| Phase 2 | Distance Learning | At least 7 years, but no more than 12 years time in service |
| Phase 3 | Distance Learning | At least 12 years, but no more than 18 years time in service |
| NOTE 1: Airmen must complete and pass Phase 2 & 3 via distance learning (DL) within one year of enrollment. | | |
| NOTE 2: Air National Guard (ANG) members must complete Phase 1 DL within 3 to 6 years TIS. Members with 4 to 6 years have priority. | | |

Comprehensive EPME requirements build upon the basic EPME requirements and encompass required competencies at the designated proficiency levels. In the EPME model, the resident ALS, the resident NCOA ILE and the resident SNCO ALE courses provide educational opportunities to achieve higher proficiency levels. AF/A1DL establishes Total Force production targets to ensure a deliberate and methodical process to provide a supply of ILE/ALE candidates to meet present and future mission demands, these timeframes are shown in the following table.

| Total Force Component | Minimum Requirements | TIS Eligibility | Selection Process |
|--|---|---|--|
| Regular AF | Complete & pass resident ALS Complete & pass EPME Phase 2 DL | Minimum 8 years TIS; no more than 12 years TIS | 1. TSgts. 2. TSgt-selects. 3. Non-selects to TSgt across AFSCs; from highest WAPS score descending until class seats have been filled. |
| Air National Guard (ANG) | Complete & pass ALS (resident or DL) Complete & pass EPME Phase 2 DL | Minimum of 8 years and not more than 14 years TIS | TSgts are eligible. |
| Air Force Reserve (AFR) | Complete & pass ALS (resident or DL) Complete & pass EPME Phase 2 DL | Minimum of 8 years and not more than 14 years TIS | TSgts are eligible; AFRC internal selection process. |
| NOTE: For Regular AF, Air Force Personnel Center (AFPC)/DPSIT controls the eligibility list and selects attendees based on AFI 36-2301, <i>Developmental Education</i> , and any additional guidance provided by AF/A1DLE. AFPC/DPSIT will coordinate with Pacific Air Forces (PACAF)/A1K and United States Air Forces in Europe (USAFE)/A1K to establish eligibility list and determine scheduling processes that ensure compliance and meet unique overseas requirements. | | | |

Training inservice

Training is conducted at the unit level in many ways. Commander's calls, computer-based programs, nursing in-service training, and one-on-one sessions are key examples. When an individual or agency other than the supervisor conducts required training, the supervisor is responsible for (1) ensuring members who need the training are scheduled to attend and (2) documenting training completion in the members training record.

When a supervisor conducts training, a few key points should be considered:

1. Always prepare the lesson plan or demonstration *before* the session is conducted.
2. Research to ensure the material being presented is accurate and current. Training references approved for use by field supervisors and formal (schoolhouse) course developers are listed in Part II, Section A, Attachment 9 of the 4N0XX CFETP.

3. Evaluate learning by asking questions, administering tests, or observing trainee performance.
4. Document training completion in each individual's training record.

Evaluating training effectiveness

Supervisors conduct an initial evaluation on initial formal school graduates and reassigned personnel within 60 days of assignment. Trainees need to be counseled during the training process to keep them informed as to their own personal progress. Trainees should be regularly informed as to their status in meeting prescribed training timelines, as well as, strengths and weaknesses detected during the training process. All counseling sessions should be documented in the member's training record. When you receive an initial formal school graduate, you are required to evaluate the effectiveness of the training received. For this evaluation, you use information in the CFETP and the proficiency codes listed in the 3-skill level column. By conducting this evaluation, you determine what the trainee already understands. In turn, this allows you to adjust the training program to the level of the person's current abilities. Initial technical school graduates require a new training record that documents their training requirements.

Use the CFETP to identify any mandatory forms to use when documenting training. Most AFSCs require the use of the AF Form 623 and a CFETP. The AFCFM is the person who decides which documents to use for recording accomplished training. These requirements are identified in the CFETP. When conducting an initial evaluation on a reassigned individual, match the individual's qualifications to the work center requirements. Evaluate the person on the previously qualified tasks, and if the individual is still qualified, then no further action is required. Decertify those tasks the individual cannot perform, enter the decertification remarks on the AF Form 623A, and enter the trainee into qualification training. The required tasks the trainee cannot perform are called individual training requirements.

Job inventory

One of the tools used to improve training effectiveness involves conducting a job inventory (JI). The Occupational Analysis (OA) section conducts reviews on all enlisted Air Force specialties (AFS) on a periodic basis (typically a 3-year cycle) and upon request from the career field manager (CFM). They develop, administer, and analyze occupational surveys sent out to the career field that provides objective information about USAF career fields. The OA mission provides the AFS with a warfighter expert for collecting and analyzing factual data critical to the effective employment of quality Airmen. They also aid optimizing personnel utilization, training, and promotion decisions. The JI focuses on training analysis—analyze training documents to ensure their relevancy to tasks performed by AFSC members.

Because of the critical uses of occupational analysis data, all Air Force members (active duty, ANG, and AFR under Air Force authority) must complete occupational JIs. Civilians are strongly encouraged to participate in occupational JIs for which they have been identified. 4N0X1s at all levels will ensure all selected members of their organizations complete and return JIs and related JIs promptly and accurately. Failure of Air Force personnel to complete and return occupational JIs may negatively impact Air Force training, testing, and proper use of personnel. Once JI is complete, the Occupational Analysis team will communicate the results of the occupational review to parties which include those in testing, training, and career field management. Briefing will encompass discussion of results and assistance in understanding, interpreting, and applying the occupational analysis data.

Graduate assessment survey

After graduation, a one-page survey, the graduate assessment survey (GAS), is emailed to the supervisor for feedback on how the trainees are progressing within the Air Force. This survey provides a snapshot of the first duties of the trainees and shows if they are progressing satisfactorily in their unit training/indoctrination program. For courses that have a large number of graduates per year, this may be the only survey the supervisor receives. This is because more detailed surveys are sent to a random sampling of graduates' supervisors. Therefore, use the GAS to make comments and

ask questions. When the survey is complete, send the survey back to the OPR. Supervisors may receive a personal visit from one of the training evaluators from a training group. These visits are used to evaluate graduates who have graduated from a technical school four to six months earlier. Sometimes evaluations are done over the telephone to save the cost of TDY funds. Third-party interviews, such as those by training managers, or interviews conducted by any other technologically advanced means of direct communication (conference calls) may be used. Data is obtained through discussions with the graduate, the immediate supervisor, and others having knowledge of the graduate's performance, such as his or her trainer or coworkers.

007. Maintaining the enlisted training and competency folder

The enlisted training and competency folder contains the 4N0XX CFETP. This plan is a comprehensive document containing complete information regarding education and training requirements applicable to the AFSC. The CFETP provides personnel with a clear path to success and defines training requirements needed at various points during an individual's career. Each enlisted specialty has a CFETP designed specifically for the career field IAW AFI 36-2201, *Air Force Training Program On-The-Job Training Administration*. In this lesson the focus is why training is required, when and why each step is important in developing a competent medical technician.

Identify training needs

As new personnel in process a base and duty sections, you as a supervisor or trainer must find out what they can or cannot do according to experience. Everyone learns at a different pace and have preferences based on how training is received. Training needs is essentially developed by reviewing your MTP against your trainees AFTR. Then, identifying any gaps that exist to ensure your medical technicians receive the right training at the right time.

The style of how you present training is also important for full comprehension. For example, a visual learner might prefer to have images of tasks while learning and an auditory learner would prefer to have discussions on a particular task rather than a PowerPoint lecture with no trainee participation. There are also tactile learners who prefer to practice hands-on with what is being trained. Since you can't predict who will have what style its best to conduct training using a mixture of all three to meet everyone training needs.

Recommend people for training

Once training needs are identified and gaps exist, utilize the duty schedule to balance the needs of the mission and training of personnel. Everyone can't be all trained at the same time without planning and help from other knowledgeable trainers. Review your AFTR to identify and sort out the level of everyone's training competency, then plan out a monthly/quarterly schedule of topics that will meet the need of training those who have gaps in training tasks needed for duty section mission requirements.

Components of electronic training records

The 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. It is required for Airmen in the grades of Airman Basic through Technical Sergeant (or personnel in combat ready duty positions, if required by the AFCFM) and SNCOs in

retraining status, or as directed by the AFCFM. SNCOs who hold a skill level commensurate with their grade and duty Air Force specialty code are considered qualified and do not require training records unless directed by the AFCFM.

The following information gives an overview of why, when and why each step in a trainees AFTR is important in providing quality and timely training throughout an Airmen's career as a 4N0X1. You are now at the level of responsibility to ensure this is managed properly in workcenters across any clinic or hospital.

Required maintenance

The entire CFETP is constructed during a conference called Utilization and Training Workshop (U&TW). The U&TW is chaired by the career field manager and is attended by the MAJCOM Medical Service functional managers, subject matter experts (SME) from various facilities around the world, and personnel from formal training courses at the schoolhouse. Data compiled from the OSR is used as a guiding tool for determining training needs.

Once the content of the CFETP is established, it is voted on by the MAJCOM Medical Service functional managers and approved by the CFM with the endorsement of the USAF Surgeon General who approves the CFETP. Only when changes are made to the CFETP can changes be made to the AFTR. In the Medical Service specialty, the CDC writer/manager is tasked with ensuring the content is constructed in the Air Force-approved format for publication. The final product is then sent to higher headquarters for publishing and distribution worldwide.

The Air Force requires each specialty to review and update its CFETP annually. The CFM and MAJCOM Medical Service functional managers in conjunction complete this with personnel from the various formal courses. Any changes are officially constructed, voted on, approved, and published for distribution in the same manner as the original publication.

The importance of schoolhouse participation is driven by the fact that the STS portion of the CFETP serves as a contract between the schoolhouse and the field on what is taught in formal resident courses, as well as in the 5-level CDCs.

To implement the contract, the schoolhouse and CDC writer incorporates classroom lessons that teach medical technicians based on everything developed after the U&TW. Each 4N0X1 trainer at the unit level utilizes AFTR and each of the component elements below as a documentation tool to keep track of all the CFETP requirements.

AFTR elements

AFTR is an enterprise-wide Internet application designed to streamline and standardize training management by consistently applying information from AFI 36-2201. It has been mandated for use by all enlisted career fields within the Air Force Medical Service (AFMS) to document all training actions and competency-related issues. AFTR components managed by the supervisor involve the following: The MTL is a comprehensive list identifying all day-to-day mission requirements, core tasks, in-garrison and contingency tasks, and additional duties performed by work center personnel. The MTL consists of the current STS, AF Form 623 Parts II and III, AF Forms 797, Job Qualification Standard Continuation/Command JQS and 1098, Special Task Certification and Recurring Training, tasks, and tasks required to meet deployment and/or UTC requirements.

The MTP employs a strategy for ensuring the completion of all work center job requirements by using an MTL and serves as a guide for supervisors, trainers, and certifiers to ensure that personnel are trained in an effective and efficient manner to meet training and mission requirements.

The MTP will include when tasks on the MTL should be trained (priority/milestones), how they will be trained (resources/method), and approximately how long it should take to train on individual tasks or set of tasks. Refer to AFI 36-2201 for guidance in developing the MTP. The duty task list (DTL) is

a list of all tasks required for a given duty position. The supervisor creates the DTL by selecting tasks from the MTL.

Training record

All training is documented in the training record by way of AFTR. This is the electronic version of the former Enlisted Training and Competency Folder. The training record is made up of the AF Form 623 Parts I, II and III; AF Forms 623a, 797, 803, Report of Task Evaluations and 1098; and the JQS. Refer to AFI 36-2201 for guidance in documenting training on the various forms contained within the training record. All enlisted personnel (CMSgt and below) with a medical AFSC will have an active training record within AFTR. AFTR provides the capability to upload training-related documents into a training record. The following table lists the documents (as applicable) that will be uploaded into every 4N0X1X training record.

| AFTR Document Upload | |
|---|--|
| <ul style="list-style-type: none"> • Current NREMT card (for SMSgt and below and CMSgt assigned to 4N0 positions on standard UTCs). • Current Basic Life Support Card. • AF Form 2096, Classification/On-the-Job Training Action. • CDC Answer Score Sheets, if enrolled in CDCs. (Maintain until completion of UGT). • Independent Duty Medical Technician (IDMT) (4N0X1C) training documents that will be uploaded: • Current IDMT certification letter signed by the MTF SGD/SGH. • Completed IDMT Initial Orientation/Certification. [Attachment 5 from IDMT User Guide located on the Knowledge Exchange (Kx)]. • Most recent IDMT Sustainment Training Documentation. (Attachment 6 from IDMT User Guide located on the Kx or AF Form 1098 overprint). • Aeromedical Evacuation Technicians (X4N0X1) training documents that be uploaded: • Most recent AF Form 4023, Aircrew Training Progress Report. • Most recent AF Form 4024, Aircrew Training Accomplishment Report. • Most recent AF Form 4025, Aircrew Summary/Close-Out Report. | |

Guidance for AFMS-required training record documentation also includes (but is not limited to):

- AFI 41-106, *Medical Readiness Program Management*.
- AFI 44-102, *Medical Care Management*.
- AFI 44-119, *Medical Quality Operations*.
- AFI 46-101, *Nursing Services and Operations*.

Review the following table for additional description of AFTR component elements and their importance.

| Component Elements | Why | When | Why each step is needed |
|---------------------------|---|---|--|
| JQS | Documentation of task completion based on performance standard. | Workcenters with more than 1 personnel. | Provides AFMS with competent deployable military medics. |
| Enroll | Attaches task to each trainee. | Initial skills evaluation and needs assessment. | Provides training on areas not known to trainee. |
| MTP | 100% task coverage. | Workcenters with more than 1 personnel. | Balance training and mission requirements while ensuring completion of all work center duty position requirements. |

| Component Elements | Why | When | Why each step is needed |
|--------------------|--|---|--|
| MTL | This part of the plan is used to identify specific tasks applicable to the member's duty section. It identifies all day-to-day mission (duty position, skill levels) requirements, core tasks, in-garrison and contingency tasks, and additional duties performed within the duty section. | Work centers with one person assigned only require a master task list, unless otherwise directed by the AFCFM. Positions such as First Sergeant and Group/Unit Superintendents, Career Assistance Advisors, etc. do not require a MTL and are exempt from this requirement. Additionally, MTLs are not required for SNCOs working in staff functions above wing level. This does not apply to SNCOs in retraining status. | Creates milestones for tasks and CDC completion (identify the projected timeframe the trainee will complete all required tasks, deployment/UTC tasks, and each set of CDCs as required). |
| DTL | Identifies workcenter specific task, but also includes TR's and timelines for completion. | Workcenters with more than 1 personnel. | Balance training and mission requirements. |
| Profile I | List trainees' demographic information. | Workcenters with more than 1 personnel. | Accurate user information in each unit. |
| 623 I | Trainee acknowledgement and identification. | Initial AFTR account and upon upgrade of skill level. | Accurate user information in each unit. |
| 623 II | Enrollment documentation of CDCs. | 5/7 UGT | Keeps historical record of every CDC set completion date and testing scores. |
| 623 III | Documents EPME training | Completion of ALS, NCOA, AFTC. | Keeps historical record of formal training requirements for trainers. |
| 623a | Document training progression involving CDC, task, skills evaluation, job description/orientation, needs assessment and interruptions in training. | All 4N0X1 personnel within 60 days of arrival. If enrolled in CDCs or in UGT every 30 days. | Keeps historical record of trainee/trainer comments on progression. |
| 797 | Documents task that are not listed in CFETP. | For applicable duty sections. | Provides additional area to document training tasks not elsewhere available. |
| 1098 | Documents QTP and Readiness Skills Verification (RSV) training requirement. | Biannually for QTPs and every 20 months for RSVs. | Provides validation of wartime core tasks regardless of assigned duty section. |
| 803 | Documents trainees' competence to the "go level." | As deemed by UTM. | Validates duty section training program. |
| User files | Provides filing of training certifications. | All E-1 to E-8/enlisted 4N0X1. | Keeps current record of required certifications that validates ability to perform AFSC tasks. |

Self-Test Questions

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

006. Military medical scope of practice

1. Name two aspects by which training is completed.
2. The effectiveness of training involves monitoring what three key areas?
3. SrA Jones is interested in applying for a special duty assignment but is unsure what she is eligible for. As her supervisor how can you assist her in this process?
4. As a SMSgt, what two special duty assignments can you fill?
5. How many parts is the CFETP divided into, and what is incorporated in each part?
6. What information will you find in part II, section A of the CFETP?
7. Who is responsible for documenting training completion in the members training records?
8. What is the overall objective of the retraining program?
9. What is the purpose of Air Force EPME?
10. When you receive an initial formal school graduate, how do you evaluate the effectiveness of the training received?

007. Maintaining the enlisted training and competency folder

1. How are changes to AFTR made and with whose approval?
2. How often is the CFETP reviewed and by whom?

3. Who is mandated to have an active training record within AFTR?
4. What documents are maintained in the user file of the AFTR?
5. Why is an MTP required and when is it completed?
6. Which document indicates items required for various skill levels and duty positions within the duty section?

Answers to Self-Test Questions

001

1. Medical Investment and Medical Expense.
2. Only after the inventory has been performed and all corrective actions are documented should you sign for the property.
3. AF Form 1297, Temporary Issue Receipt.
4. The quantity, dollar value of assets and stock number sequence.
5. An interim listing to update the custody receipt/locator listing process a change action affecting a custodian's account.
6. AF Form 601, Equipment Action Request.

002

1. Man-hour.
2. A funded manpower requirement with details that define the position in terms of its function, organization, location, skill, grade, and other appropriate characteristics that commands use
3. A statement of manpower needed to complete a job, workload, mission, or program.
4. In terms of their function, organization, location, skill, grade, and other appropriate characteristics that commands uses.
5. A manpower requirement.
6. CIV is displayed.
7. 1 Jan – 31 Mar.
8. Each position is authorized one occupant, however under some circumstances a second individual could be assigned to a position for a limited period of time.
9. Through a manning assistance request.

003

1. Planning can help you bridge the time span between where your unit is today, and where the unit will be in the future.

2. She can incorporate historical unit data with planning to determine the unit's progression to meet the organization's goals.
3. She must prioritize the tasks to complete all of the necessary tasks.
4. He can categorize his priorities in an A, B, and C method. Budgeting each level of priority having no more than 10 percent of A priorities, then evenly split B and C priorities.
5. SSgt Aerans must use ongoing time management to meet the continual deadlines of training.

004

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 are the primary persons responsible for duty schedules within a unit or clinic.
3. Offer SrA Jones the responsibility of creating a schedule in order to gain a new perspective for the scheduler's responsibilities.
4. AFIs, OIs, and local guidance.
5. Union contracts must be reviewed. There may be restrictions for full time, the number of hours per week they could work, specific guidelines for weekends and holidays per schedule, permanent shifts and the lines of authority in the absence of the nurse manager or NCOIC.
6. 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.
7. A cyclical/12-hour schedule provides personnel with a continual rotation, but is somewhat inflexible.
8. The compressed work schedule offers the best possibility to complete this task. With a compressed work schedule you are able to overlap time between shifts, improving interpersonal relationships, increase staffing at the busy times, and offer staff an opportunity to attend in-service training.

005

1. The process of reviewing, observing, and accepting responsibility for the actions and services provided by subordinates.
2. The flight NCOIC or element NCOIC.
3. To welcome the new arrival to the base, and to help make the relocation process easier for all involved.
4. Introduce the young Airman to other work center personnel and those in his or her chain of command. Walk the individual through the work center, discuss with and show him or her the physical layout of the OR, recovery room, and central supply. Take him/her on a tour of the facility and show where the nursing units, clinics, lab, x-ray, pharmacy, and other important areas of your facility are located. Pay particular attention to fire and disaster evacuation plans, clinic operating hours, a brief overview of what he or she may be doing on the job, etc.
5. Providing feedback to the school is the only way you can help the school improve the quality of training.
6. (1) Field evaluation questionnaires.
(2) Field interviews via telephone.
(3) TDYs from training evaluators at the training group.
(4) Customer service information line (see your CFETP for details).
(5) Graduate assessment surveys.
7. A survey used to collect data for evaluation of career field training and to update training documents; specifically, the career field STS portion of your CFETP. It specifically provides the training community with a comprehensive data base to support anticipated training decisions for the career ladder.
8. A job inventory.
9. The flight or element NCOIC is usually responsible for scheduling all enlisted personnel, but the task may be delegated to a mid-level supervisor.
10. The OIC.
11. AFI 36-3003/410.

12. Plan so that the most staff is available during peak workload periods. Distribute staff according to experience and ability; ensure there are enough experienced staff members to not only cover the required tasks, but also to train and supervise inexperienced personnel. Another consideration is equity. Post your schedule as early as possible. Maintain a record book of past schedules.
13. Research has documented that after 12 hours, performance is significantly reduced.
14. Any five of the following:
 - (1) Date and day of the operation.
 - (2) Time of the operation. Usually, a specific time is allocated to only the first cases of the day in each operating room; all others are scheduled "to follow" or simply, "TF."
 - (3) Designated operating room number or letter (OR 4, OR D) for the procedure.
 - (4) Patient identification information.
 - (5) Name.
 - (6) Hospital register number or Social Security Number.
 - (7) Age
 - (8) Sex.
 - (9) Military status or rank (E-3, O-5, Capt, Amn).
 - (10) Patient location or nursing unit designation.
 - (11) Operation to be performed (entries may be abbreviated to save space).
 - (12) Primary physician/nurse.
15. The CFETP.
16. Without an approved CJR, the member can't reenlist. Approval of a CJR doesn't mandate reenlistment; it simply keeps the option open.
17. Position descriptions.

006

1. Through formal courses and on-the-job training.
2. You monitor the career knowledge by the member, current qualification and certification requirements for the job, and job proficiency through upgrade training.
3. Reviewing the CFETP with SrA Jones is the best way to educate her in the process of special duty assignments for which she may be eligible. The CFETP contains a clear career path and defines the training requirements needed at various points.
4. MAJCOM functional manager and group superintendent.
5. Two parts. Part I provides information necessary for the overall management of the specialty. Part II is largely made up by the STS, and is designed to provide formal course developers and field supervisors with the information necessary to identify, plan and conduct training.
6. The STS.
7. The supervisor.
8. Balance the career force of each AFSC needed.
9. Air Force EPME is a TIS-based model that ensures targeted delivery of ICs throughout the Continuum of Learning across an enlisted Airman's career.
10. For this evaluation, you use information in the CFETP and the proficiency codes listed in the 3-skill level column.

007

1. The USAF Surgeon General endorses and approves the CFETP, and only when changes are made to the CFETP can changes be made to AFTR.
2. Annually. The CFM, MAJCOM functional managers, and various formal course personnel complete this task.
3. All enlisted personnel (CMSgt and below) with a medical AFSC will have an active training record within AFTR.

4. Current NREMT card (for SMSgt and below and CMSgt assigned to 4N0 positions on standard UTCs). Current Basic Life Support Card. AF Form 2096. CDC Answer Score Sheets, if enrolled in CDCs. (Maintain until completion of UGT). IDMT (4N0X1C) training documents that will be uploaded: Current IDMT certification letter signed by the MTF SGD/SGH. Completed IDMT Initial Orientation/Certification. [Attachment 5 from IDMT User Guide located on the Kx]. Most recent IDMT Sustainment Training Documentation. (Attachment 6 from IDMT User Guide located on the Kx or AF Form 1098 overprint). Aeromedical Evacuation Technicians (X4N0X1) training documents that be uploaded: Most recent AF Form 4023. Most recent AF Form 4024. Most recent AF Form 4025.
5. It provides 100 percent task coverage and it's required for workcenters with more than 1 personnel.
6. The MIL.

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 Air Force Career Development Academy (AFCDA).

1. (001) What is one classification of equipment whose life expectancy is at *least* 5 years?
 - a. Nonmedical material.
 - b. Medical Investment.
 - c. Medical Supply.
 - d. Durable supply.
2. (001) When assuming custodial responsibility, when should you sign the custody receipt/locator listing?
 - a. 7–10 duty days.
 - b. 10–14 duty days.
 - c. As soon as you are appointed as the equipment custodian .
 - d. Only after the inventory has been performed and all corrective actions documented.
3. (001) When do you submit an AF Form 601, Equipment Action Request, for a piece of equipment that needs replacing?
 - a. At the end of the month.
 - b. At the end of the year.
 - c. When the need for new equipment is identified.
 - d. When “fall-out” money is available for new equipment.
4. (001) Which equipment management list indicates each specific item the custodian has signed to accept responsibility?
 - a. Custody receipt/locator.
 - b. Back order equipment.
 - c. Equipment support.
 - d. Equipment turn-in.
5. (001) How many days does it normally take for an equipment turn-in or transfer to be processed?
 - a. 5.
 - b. 14.
 - c. 20.
 - d. 30.
6. (002) One man-hour is equivalent to one person working at a normal pace for how many minutes?
 - a. 20.
 - b. 30.
 - c. 60.
 - d. 90.
7. (002) The description of the workload, associated conditions, a grade and skill level table, approved variances, and a processes analysis summary is the definition of a manpower
 - a. authorization.
 - b. standard.
 - c. requirement.
 - d. unit measure.

8. (002) A funded manpower requirement is defined as a
 - a. base requirement.
 - b. mission requirement.
 - c. validated and allocated requirement.
 - d. function, organization, location, skill, grade, and other appropriate characteristics.
9. (002) What is a manpower requirement?
 - a. A statement of manpower needed to complete a job, workload, mission, or program.
 - b. A funded manpower requirement to complete a job, workload, mission or program.
 - c. The standard quantitative expression representing manpower requirements.
 - d. The standard qualitative expression representing manpower requirements.
10. (002) Information found in which document provides a clear picture of the manning positions within a medical treatment facility (MTF)?
 - a. Unit manpower.
 - b. Manpower request.
 - c. Mission support plan.
 - d. Manpower requirement.
11. (002) What is the numeric code that identifies a particular task that may include an alpha prefix or suffix?
 - a. Air Force specialty code (AFSC).
 - b. Program element code (PEC).
 - c. Position number.
 - d. Job number.
12. (002) What annotates special experience and training *not* otherwise reflected in the classification system?
 - a. Individuals required grade.
 - b. Functional account code (FAC).
 - c. Organizational structure code.
 - d. Special experience identifier (SEI).
13. (002) Each position in the unit manning document (UMD) is displayed over fiscal quarters. When does the fiscal year start and end?
 - a. 1 June through 30 May.
 - b. 1 Jan through 31 Dec.
 - c. 1 Sept through 30 Aug.
 - d. 1 Oct through 30 Sept.
14. (002) Who authorizes a change to manpower requests?
 - a. Logistics officer.
 - b. Group superintendent.
 - c. Resource Management Office.
 - d. Medical treatment facilities (MTF) commander.
15. (003) SSgt Johnson is constantly working from one project to another and is unable to bring his units current status in line with the future goals of the organization. What will help you bridge the time span between where your unit is today and where the unit will be in the future?
 - a. Planning.
 - b. Brainstorming.
 - c. Delegating.
 - d. Scheduling.

16. (003) TSgt Smith has recently been assigned as the noncommissioned officer in charge (NCOIC) of a clinic. She has a firm grasp of the organizations goals. There is other information TSgt Smith can use to align the units progression to meet the organization's goals? TSgt Smith can incorporate
- a. planning to determine the unit's progression to meet the organization's goals.
 - b. current unit data with planning to determine the unit's progression to meet the organization's goals.
 - c. historical unit data with planning to determine the unit's progression to meet the organization's goals.
 - d. the unit's progression to meet the organization's goals.
17. (003) SSgt Mays is the shift leader of the special care unit and works 8-hour day shift. SSgt Mays is constantly stressed, over whelmed, and always has a "hot" project or suspense that needs to be met. What prioritizing tool could SSgt Mays use to make more efficient use of his time?
- a. Budget each level of priority having no more than 30% of D priorities, then evenly split E and F priorities.
 - b. Budget each level of priority having no more than 20% of D priorities, then evenly split E and F priorities.
 - c. Budget each level of priority having no more than 15% of D priorities, then evenly split E and F priorities.
 - d. Budget each level of priority having no more than 10% of A priorities, then evenly split B and C priorities.
18. (003) What priority category must be completed by the end of the duty day?
- a. A urgent.
 - b. B immediate.
 - c. C lowest.
 - d. D rapid.
19. (003) What categoring priority must be addressed within the next two days?
- a. Category A urgent.
 - b. Category B immediate.
 - c. Category C lowest.
 - d. Category D highest.
20. (003) What categoring priority may be delegated out to other persons within the unit?
- a. CategoryA urgent.
 - b. Category B immediate.
 - c. Category C lowest.
 - d. Category D highest.
21. (004) Who is responsible for final approval of the enlisted duty schedule?
- a. Noncommissioned officers in charge (NCOIC).
 - b. Nurse managers and NCOICs.
 - c. The base commander.
 - d. The base superintendent.

22. (004) What references and guidance does the scheduler use to prepare a duty schedule?
- a. Air Force Instructions (AFI), operating instructions (OI), and local guidance.
 - b. Clinical nursing skills guidebook.
 - c. Lippincott nursing manual.
 - d. AFIs and local guidance.
23. (004) Considering factors affecting duty schedules, the inpatient surgical intensive care scheduler should have open lines in communication with other inpatient units to
- a. update admission statuses.
 - b. check intravenous therapy supplies.
 - c. verify the levels of blood units on hand.
 - d. relay patient census and plan for heavy workloads.
24. (005) Who determines and assigns an immediate supervisor to a newly assigned Airman?
- a. The flight noncommissioned officer in charge (NCOIC) or element NCOIC.
 - b. Element NCOIC.
 - c. First Sergeant.
 - d. Commander.
25. (005) The sponsor's job is to
- a. help make the relocation process easier for your children.
 - b. help make the relocation process easier for your spouse.
 - c. welcome the new arrival to the unit, and to help make the relocation process easier for all involved.
 - d. welcome the new arrival to the base, and to help make the relocation process easier for all involved.
26. (006) What document contains complete information regarding education and training requirements for an Air Force specialty code (AFSC)?
- a. Specialty training standard (STS).
 - b. AF Form 156, Student Training Report.
 - c. Career field education and training plan (CFETP).
 - d. AF Form 623a, On-the-Job Training (OJT) Continuation Record.
27. (006) When upgrading to a 7-skill level, what is the *minimum* number of months needed in training?
- a. 9.
 - b. 12.
 - c. 18.
 - d. 24.
28. (006) What is the overall objective of the retraining program?
- a. Assigning Airmen to stateside locations.
 - b. Assigning Airmen to overseas locations.
 - c. Balancing the medical force of each Air Force specialty code (AFSC) needed.
 - d. Balancing the career force of each AFSC needed.
29. (006) The Air Force enlisted professional military education (EPME) EPME is a time-in-service (TIS)-based model that ensures
- a. targeted delivery of institutional competencies (IC) throughout the Continuum of Learning (CoL) across an enlisted Airman's career.
 - b. optional delivery of ICs throughout the CoL across an enlisted Airman's career.
 - c. the CoL across an enlisted Airman's career.
 - d. the CoL across the first enlistment of an enlisted Airman's career.

30. (006) When you receive an initial formal school graduate, to evaluate the effectiveness of the training received you use information in
- a. the Career Field Education and Training Plan (CFETP) and the proficiency codes listed in the 5-skill level column.
 - b. the CFETP and the proficiency codes listed in the 3-skill level column
 - c. AFI 36-2201.
 - d. AFI 36-2202.
31. (006) In the Aeromedical Medical Service Journeymen field, what are the methods by which training is completed?
- a. Formal courses and on-the-job training.
 - b. Informal courses and on-the-job training.
 - c. Temporary duty assignments.
 - d. Manning assists.
32. (006) In the Aeromedical Medical Service Journeymen field, the effectiveness of training involves monitoring what key areas?
- a. Qualification and certification.
 - b. Upgrade training courses, job proficiency.
 - c. Career development courses, qualification.
 - d. Career knowledge, current qualification and certification, and job proficiency.
33. (007) When referring to tasks applicable to the member's duty section, which document would you need?
- a. Career field Education and Training Plan (CFETP).
 - b. Job Qualification Standard (JQS).
 - c. Specialty Training Standard (STS).
 - d. Master Task List (MTL).
34. (007) When new personnel arriving to your duty section, which document would you initiate to maintain a 100-percent task coverage of all training requirements?
- a. Career Field Education and Training Plan (CFETP).
 - b. Master Training Plan (MTP).
 - c. Maintenance record.
 - d. Six-part folder.
35. (007) When there are approved changes to the Career Field Education and Training Plan (CFETP), who is the approval authority?
- a. MTF commander.
 - b. US Air Force Surgeon General.
 - c. Education and Training Flight.
 - d. Major command (MAJCOM) functional managers.
36. (007) What Air Force Training Record (AFTR) component is used to document training progression involving tasks and skills?
- a. 623 II.
 - b. 623a.
 - c. 803.
 - d. 1098.

37. (007) Who is mandated to have an active training record within Air Force Training Record (AFTR)?
- a. E-9 and below.
 - b. E-8 and below.
 - c. E-7 and below at Air Force levels.
 - d. E-6 and below at base levels.
38. (007) Which document below is maintained in the user file of the Air Force Training Record (AFTR)?
- a. National Registry of Emergency Medical Technicians (NREMT) card.
 - b. AF Form 2099, Request for Community College of the Air Force Transcript.
 - c. AF Form 803, Report of Task Evaluations.
 - d. 5-level upgrade training card.

Please read the unit menu for unit 2 and continue ➡

Unit 2. Overview of Information Systems

| | |
|--|------------|
| 2–1. Information Systems | 2–1 |
| 008. Electronic documentation of patient care | 2–1 |
| 009. Individual medical readiness program | 2–3 |
| 2–2. Components of Military Healthcare System | 2–5 |
| 010. Patient care management | 2–6 |
| 011. Managed care..... | 2–8 |
| 012. TRICARE options | 2–11 |

THIS UNIT HIGHLIGHTS THE TOOLS medical technicians use to document and track the results of our assessment or that of doctors, nurses, and other medical professionals. Medics are on the front line in ensuring the protection and usage of these resources remains a valuable footprint in our Military Healthcare System (MHS).

2–1. Information Systems

As a 4N0 you will be inputting data into a computer system practically everyday. More than likely it will be patient care related but it could also be reports, evaluation, memos, or in-service lessons. This section focuses on different types of information systems used to track the health status of military personnel. Proper knowledge of why and when you use these systems is essential to protecting patient information from harm in the current and future years to come.

008. Electronic documentation of patient care

Much of the information 4N0X1's document during patient care is saved and stored to a computer system. Working with computers as often as we do in our jobs, you've probably already begun to realize how much storage space we need on our computers. Storage is needed for all of our software programs and the work we generate. Since storage on older computer systems decreases with time, more advanced systems replace current ones and they sometimes coexist until the transfer of information is complete.

Background

Tri-service use of an electronic record documentation was not available in the past decade, but current technological advances has replaced and improved its uses in DOD medical facilities. In the past, medical facilities used different computer systems in every aspect of care for War Fighters and their families, whether in a deployed environment or at home station. Wherever patients were seen, different electronic health record systems were used without any standardization. Several initiatives have come to the forefront and there focus is capitalizing on current best practices and regulatory requirements that will benefit every aspect of care from bedside to the War Fighter and families, as well as, senior leadership in meeting the challenge of balanced quality care across the enterprise. The capability to produce standardized documentation across the Enterprise will not only facilitate best practices by following clinical practice guidelines, but will also drive consistent data usage and storage for local and centralized reporting and coding.

Tri-service Initiative

The first Tri-service Initiative began with the Integrated Inpatient Product Team (IIPT) that is operated by the MHS. Each service is not in full control but share responsibilities and support as needed in their medical facilities. However, the Services are accountable for coordination of clinical personnel for incorporation of clinical standards and content into the standard content. They are also accountable for deployment of the standard content to the inpatient facilities. This deployment of material includes all training the site is to receive in relation to the content. Based on the goals of initiatives, our current electronic health record aim is to fully standardize and optimize the use of best

practices, minimize training, decrease variance so the MHS can maximize use of its Information Technology investment.

Composite Health Care System

The Composite Health Care System (CHCS) is the system that was *used before* Armed Forces Health Longitudinal Technology Application (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 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.

Armed Forces Health Longitudinal Technology Application

AHLTA is the electronic medical record for *outpatient* visits. 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 Department of Defense 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 are 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 system. The only way it can be deleted is if it is a critical error (sexually transmitted disease (STD), human immunodeficiency virus (HIV), etc.) and it takes DOD approval to change this.

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. Electronic records allow worldwide documentation of inpatient care for all service members and their beneficiaries. It's also used to assist injured service members returning from Theater to Landstuhl Regional Medical Center in Germany for acute care. Information captured in this system 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 Veterans Affairs (VA) facilities. It also helps reduce the majority of paper-based inpatient documentation at DOD military treatment facilities. The use of the electronic health record allows for standardization of processes and sharing of documentation across DOD and VA treatment facilities.

Key features and benefits

The features and benefits of electronic medical record tracking far outweigh old methods used to capture medical data. The following are some key points of why the tri-service medical community has decided to standardize these important resources:

- Ensures real-time monitoring of patient vital signs.
- Ensures data sharing between health care facilities.
- Enhances continuity of admission, discharge, transfer, laboratory results, and radiology text interpretation.
- Enhances the delivery of patient care interoperability with the VA.

- Ensures continuity of care to ill and injured service members.
- Increases clinical and administrative efficiency.

Limitations

Although technology ensures medical documentation services are standardized when a patient visits their facility, there are some limits as the full feature of any system will take time and resources to capture all its abilities. Consider this as you work each step of the way with following limitations:

- Data within clinical notes, flowsheets, etc. can only be configured to flow one way—meaning notes must be completed in a certain order for info to populate the next note.
- Limited interfaces with older systems.
- Limited interfaces with VA clinical information systems.
- Initially, MTFs were allowed to modify/customize an electronic health record content to meet workflow/clinical needs. This led to a different version at every MTF.

009. Individual medical readiness program

Military treatment facilities have been directed to use DOD and AFMS data systems to identify and describe their enrolled population by age, gender, beneficiary category and assess their healthcare needs. Aeromedical Services Information Management System (ASIMS) has two primary purposes—(1) ensure all individual medical readiness (IMR) requirements are current and (2) ensure all AF members have been provided necessary or recommended preventive services.

Individual medical readiness requirements

The IMR program combines the many changes that have occurred over the past several years within the AFMS and MHS. The outcome of IMR Preventive Health Assessment and Individual Medical Readiness (PIMR) should be a medically fit and ready force. It is very likely that someday you may be part of the primary care management team, whether as part of Flight Medicine or another primary care clinic. Along with commanders and the individual service members, you have a crucial role in ensuring success of this program. The IMR software is an automated way of recording, verifying, and storing vital information about individual medical readiness metrics, preventive health assessment (PHA) exams, individual medical readiness, physical examination standards, and clinical preventive services standards.

Individual medical readiness objectives

The primary purpose of IMR is to provide “real-time” medical readiness assessment of IMR requirements to commanders, individuals, and primary care managers (PCM) so they can manage and optimize the readiness status of their assigned or enrolled AF personnel. While IMR is covered in the PHA process, the assessment of an individual’s medical readiness is a continuous process and is independent of the recurring PHA cycle or assessment. As individual IMR services become due, members must be scheduled to complete them to maintain their full readiness status. For example, if individuals complete their PHA in January and become due for a required immunization in March or become pregnant in June, their IMR status will be immediately reflected in the ASIMS program. For IMR status to be kept current in ASIMS, these items must be updated continuously year round, as you know medical conditions do change. The vast majority of information for the IMR portion of PIMR is imported into the software from other computer systems or a central server. The rest is manually entered into the ASIMS system as needed.

Individual status

The IMR status for each individual is coded as follows:

1. Green—Immunizations complete and up-to-date. [PHA within last 18 months. Dental class 1 or class 2. Lab requirements are current. No deployment-limiting profile.]
2. Yellow—Items out-of-date and/or needing attention.

3. Red—Immunizations missing or out of date. [PHA more than 18 months ago. Dental class 3 or class 4. Lab requirements are missing. Deployment-limiting profile.]

Immunizations

Immunizations requirements (including tuberculosis [TB] skin testing) are established and fed automatically to PIMR. When a required immunization or TB skin test becomes due, the IMR status changes to RED until it is completed or the requirement is deleted. The Air Force Complete Immunizations Tracking Application (AFCITA) is an automated database program that records, verifies, and stores clinical and readiness information about immunizations. Data can be accessed for people within your MTF, at field locations, and for immunizations that were given at other military installations. AFCITA downloads data on AF personnel weekly and Defense Enrollment Eligibility Reporting System (DEERS) Prime files on a monthly basis. This enables names, SSNs, units, and more to be automated and accessed electronically. As a medical technician in any clinic within an MTF, you may have the opportunity to check and update AFCITA.

To gain access to this program, you will need to see your local AFCITA program manager (your allergy and/or immunization clinic should be able to help you or direct you to the correct person). You must have an account established before you will be able to login. You also need to have the program loaded on to the computer you will be using. Ensure you have assistance as you are learning to maneuver through this database; we will only be covering the basics here.

Dental classification

Dental classification is managed through the Dental Classification Management System (DCMS) to PIMR automatically. A dental classification of 1 or 2 will be reflected as IMR GREEN, 3 or 4 will be reflected as RED.

Physical profile

All deployment limiting profiles will be managed within the ASIMS software. Providers will initiate the profile as indicated in AFI 48-123, *Medical Examinations and Standards*, and USAF Medical Standards Directory with guidance in AFI 10-203, Duty Limiting Conditions.

Medical readiness lab test

The following lab tests are required at the indicated frequency and must be recorded in PIMR:

- G6PD—once.
- DNA—once.
- Blood type—once.
- Sickledex—once.
- HIV—within 5 years.

If these lab tests have not been completed and are not in the PIMR software, this area will show as RED until the requirements have been met. The data must be entered manually into the PIMR software to change the RED to GREEN.

Self-Test Questions

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

008. Electronic documentation of patient care

1. What Tri-service Initiative was created and is now operated by the MHS to standardize electronic documentation of inpatient care?

2. How does the IIPT initiative aim to standardize documentation?
3. Why is AHLTA forecasted to replace all functions of CHCS?
4. The electronic health record has been standardized by tri-service military personnel to take advantage of what key benefits?
5. As a medical technician who uses electronic medical records in a tri-service facility, why are features still different across MTFs?

009. Individual medical readiness program

1. What is the purpose of the IMR software?
2. What is the purpose and outcome of IMR readiness objectives?
3. How often are IMR requirements scheduled to be considered in GREEN status?
4. What does IMR status RED represent?

2-2. Components of Military Healthcare System

The MHS mission is to support the Department of Defense (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. 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 AMSC, 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.

010. Patient care management

The AFMS continues to operationalize our AFMS Population-Based Health Plan. With this plan, there are two main areas of priority:

1. Reengineer primary care services known as primary care optimization (PCO).
2. The need to recapture care from the private sector. Both of these priorities are being met through population health management.

Population health management starts with four basic questions:

1. Who is in our population?
2. What are the population’s evidence-based health risks or needs?
3. What are the best, evidence-based ways to address these problems?
4. How are we doing, when it comes to addressing these problems?

So how do you find out whom your population is, and what is the current state of their health to provide the right care to the right people at the right time? Let’s begin with the patients to whom you will be caring for through population health management.

Population health management

As a manager of health, it is up to you to remain vigilant about the health of our population, while helping maintain the viability of each MTF and the AFMS. Once you can show the value of the MHS through the focus on improving the measures of your population’s health, the choice to use the MHS will clearly be evident by the TRICARE Prime enrollments.

Who is eligible for TRICARE Prime? All active duty military personnel are eligible and most are automatically enrolled in TRICARE Prime at their nearest MTF. Family members of an active duty sponsor must initiate the enrollment process. When enrolling into TRICARE Prime, the eligible beneficiary makes the choice about which PCM will care for him or her and his or her family.

The PCM assignment is the cornerstone for Population Health. The PCM is responsible for managing the health of a group of individuals throughout the continuum of care. Completion of a health stratification survey is an essential part of enrollment process. The Health Evaluation Assessment Review (HEAR) survey is one of the health stratification surveys used to assist the PCMs in managing care for their enrolled population. The survey provides information related to the patients health risks and needs, projects demand services: including the need for prevention, case management, and disease management programs. Once you are able to obtain the populations health information through the survey, the data is collected, analyzed, and used to complete the demand forecasting used to determine the gap relative to the capacity of the MTF.

Demand management

All survey information is compiled to make use of interventions designed not only to reduce unnecessary and/or potentially preventable health care use but also to encourage the appropriate use of health care. When demand management is implemented, it will reflect the activities of a health system designed to create a healthy environment, decrease morbidity and mortality, and encourage the use of effective decision-support and self-management tools. Effective implementation is completed when the patients are actively involved in their healthcare, which enables beneficiaries to use health care recourses appropriately.

With demand management, it takes two parts of the equation to make a successful MHS work, the PCM and the patient being treated. The MHS goals for demand management are simple: to assess, monitor, and encourage the demand for needed preventative services in the population and community; manage the demand for health care secondary to adverse environmental and lifestyle behaviors and inappropriate utilization of health resources; and ensure processes and services are in place to deliver preventative services to individuals and communities.

The AMSC is a vital team member of the PCM and the demand management process. The PCM is one part of the equation that makes demand management work; the patient is the receiving part of the equation. As a member of the PCM, you encourage efficient use of the health services available to the patients. Encourage appropriate health promotion, early condition identification and disease prevention interventions. Educating your population is the greatest tool you can offer them. You need to be aware how you can eliminate delays for the patient seeking medical advice where appropriate and use the resources your MTF has in place: health care information line (HCIL) or nurse triage lines. Educate your patients on self-care programs, patient-based preventative care tools: Put Prevention into Practice (PPIP), Preventative Health Care Application (PHCA), *Take Care of Yourself Handbook*, and age-specific self-care books. The demand management concept is based on teaching the patients about prevention. The more tools you can offer your patients to prevent illness will create the need for the patient to complete the puzzle.

Condition management

Through the demand management process, you will be able to assess the individual patient's needs and tailor the patient's healthcare needs to the patient's condition. Not all patients need the same care or treatment plans. This is where condition management begins. Condition (or disease) management is a system that coordinates and improves all of the services provided to patients with a given set of medical condition.

Condition management targets high-cost, high-volume, and complex diseases/conditions, using performance metric tools to focus on key processes and outcomes. A successful condition management program employs nationally accepted best practices and evidence based medical practice. Condition management is an effective and efficient process for rapidly improving the health of populations affected by acute medical conditions or suffering from chronic diseases and the related medical cost. When properly executed, condition management is patient (enrollee) focused, proactive, and promotes efficiency and the delivery of high-quality medical services. It reduces unwarranted variability in provider practice patterns (provide continuity), improves clinical outcomes, satisfies accreditation requirements and improves the satisfaction of the patient and the clinical staff.

With an efficient condition management program, you can be assured that the medical forces are proficient in modern medical processes and the community is integrated with necessary patient care enhancing the quality of life for all beneficiaries. When you as a PCM team member can promote patient-provider collaboration, use standard clinical pathways and guidelines to reduce unwarranted variations in the management of a medical condition—efficient effective use of resources and patient care is evident.

011. Managed care

Without vision and the willingness to implement change when necessary, the AFMS would become extinct or no longer useful to our beneficiaries. What was once innovative or useful may seem outdated or even archaic today. The following information discusses the history and changes made by the AFMS to ensure we are never stuck in a paradigm. It shows the vision of our leadership and their ability to work without blinders to advance what we do best: health care!

Evolution of managed care

Prior to World War II, the armed forces were small and quite stable. Some men spent their entire careers in the same regiment. Nearly all the soldiers and sailors lived on or near Army posts or Navy bases and almost everyone could easily obtain medical care for their families.

Today, retirees who on average require more medical care than their active duty counterparts, make up more than 50 percent of those eligible for care. But, as more and more MTFs close, health care for many retirees became harder to obtain. The demand for health care began to exceed the current system's capability to deliver the health care needed by beneficiaries.

In response to the challenge of maintaining medical combat readiness while providing the best health care for all eligible personnel, DOD introduced TRICARE as a regionally managed care program. So let's discuss how the concept of "managed care" began for the military.

In the beginning

In the mid 20th century, physicians introduced prepaid group practices into the American medical care system. Prepaid group practice is an arrangement in which an association of three or more physicians provide a defined set of services to a person over a specified time period in return for a fixed periodic prepayment made before the service(s) were rendered. With the advent of the prepaid group practice, patients now had a choice between two systems of patient care: fee for service or prepaid group practice.

The corporate practice of medicine was advanced by the federal government through the enactment of Medicare (health care financing for the elderly) and Medicaid (health care financing for the poor) laws in 1965. Medicare and Medicaid laws laid the groundwork for increased corporate control of medical care delivery by third-party payers through government-mandated regulations of fee for service and indemnity payments for health care services. This legislation also prompted the development of investor-owned hospital chains and stimulated the growth of university medical centers. As the corporate practice of medicine grew, the federal government took notice.

More federal support for the corporate practice of medicine resulted when the Health Maintenance Organization (HMO) Act in 1973 passed with its ensuing amendments.

This Act enabled managed medical care plan to increase in numbers and expanded enrollments through health care programs financed by grants, contracts, and loans. Strong support for the HMO concept came from business; the executive, legislative, and judicial branches of government; and several states where managed care was growing.

Managed care organizations

Managed care plans continue to evolve; there is no single definition for the term-managed care. Originally, HMOs, preferred provider organizations (PPO), and traditional forms of indemnity health insurance were distinct. Today you may find it hard to distinguish the difference between products that bill themselves as HMOs, PPOs, or managed care overlays to health insurance. The aspects of HMOs that strongly resemble the type of care found within the AFMS.

TRICARE is the DOD's managed health care program for active duty service members, service families, retirees, and their families and survivors. TRICARE is a blend of the military's direct care system of hospitals and clinics and the Civilian Health and Medical Program of the Uniformed

Services. It represents the best features from the variety of health care delivery alternatives demonstrated by the DOD in the late 80s and early 90s.

History

In response to the challenge of maintaining medical combat readiness forces while providing the best health care for all eligible personnel, the DOD introduced TRICARE. TRICARE is a regionally managed health care program for the following:

- Active duty.
- Retired members of the uniformed services.
- Family members of active duty and retirees.
- Survivors of all uniformed services who are not eligible for Medicare.

NOTE: TRICARE is *not* applicable for parents and parents-in-law who are dependants of a military sponsor.

TRICARE brings together the health care resources of the Army, Navy, and Air Force and supplements them with networks of civilian health care professionals to provide better access and high-quality service while maintaining the capability to support military operations. TRICARE has been implemented throughout the US, Europe, Latin America, and the Pacific as a way to improve overall access to health care for beneficiaries. TRICARE continually strives towards improving beneficiary medical care by doing the following:

- Providing faster, more convenient access to civilian health care.
- Creating a more efficient way to receive health care.
- Offering enhanced services, including preventive care.
- Providing choices for health care.
- Controlling escalating costs.

TRICARE offers eligible beneficiaries many choices for their health care needs. The three most common are TRICARE Prime, TRICARE Extra, and TRICARE Standard.

The main challenge for most eligible beneficiaries is deciding which TRICARE option is best for their particular situation. *Active Duty personnel* are enrolled in TRICARE Prime and pay no fees. *Active duty family members* pay no enrollment fees, but they must choose a TRICARE option and apply for enrollment in TRICARE Prime. There are no enrollment fees for active duty families in TRICARE Prime.

Goals

The TRICARE program was founded with the following goals:

- Provide medical services and support to the Armed Forces prior to and during military operations.
- Improve beneficiary access to care.
- Assure a high-quality, consistent and efficient health care benefit for all MHS beneficiaries at a reasonable cost.
- Provide more choices for all non-active duty participants.
- Contain overall DOD health care costs.
- Obtain maximum enrollment into the TRICARE Prime option of eligible beneficiaries.

Principles

Some of the principles that guide the design and implementation of the TRICARE program are:

1. Provide medical services and support to members of the Armed Forces.

2. Implement managed care.
3. Designate regional health service areas and lead agents.
4. Central oversight with local accountability and execution.
5. Improve access to health care.
6. Efficient use of MHS resources.
7. Achieve a uniform standard of quality.
8. Provide specialized treatment services.
9. Achieve effective use of information systems.

Provide medical services and support to members of the Armed Forces

TRICARE will do its part to ensure a combat-ready force. In addition, it will enable DOD to retain a healthy force capable of meeting its broad-ranging mission requirements.

Implement managed care

TRICARE is the military's managed care program. It will ensure accountability for health care spending and provide beneficiaries access to high-quality care. For other than active duty beneficiaries, the program will provide more freedom to choose among alternative sources of health care.

Designate regional health service areas and lead agents

The TRICARE program restructures the geographic MHS into Health Services Regions; each administered by a *lead agent*. These regions were established to ensure there were adequate numbers of beneficiaries to support cost-effective volumes of care under TRICARE support contracts and regional access to tertiary care provided primarily by MTFs.

| Region | Location/Title | Contractor |
|--------|---------------------------------------|---|
| 1 | Northeast | Sierra HMO |
| 2 | Mid-Atlantic | Humana |
| 3 | Southeast | Humana |
| 4 | Gulf South | Humana |
| 5 | Heartland | Humana |
| 6 | Southwest | Health Net Federal Services (HNFS) |
| 7 | Central | TriWest |
| 8 | Central | TriWest |
| 9 | Southern California | HNFS |
| 10 | Golden State | HNFS |
| 11 | Northwest to include Alaska | HNFS |
| 12 | Hawaii | Contractor through lead agent (Not HMO) |
| 13 | TRICARE Europe | Contractor through lead agent (Not HMO) |
| 14 | TRICARE Pacific | Contractor through lead agent (Not HMO) |
| 15 | TRICARE Latin America & Canada (TLAC) | Contractor through lead agent (Not HMO) |

Central oversight with local accountability and execution

Health care is delivered locally; therefore, it must be managed locally. Consequently, MTF commanders will have the tools, flexibility, and authority to make appropriate decisions about delivery of care. Within their delivery areas, lead agents (within their region) and medical group commanders (within their MTF) will be accountable for the health care costs, quality, and access. Their responsibilities are interwoven between the civilian networks and the direct care system.

Improve access to health care

Each regional military health care plan, comprised of military and civilian provider networks, must have attributes of size, composition, mix of providers and geographical distribution that together will adequately address the health care need of all DOD beneficiaries with emphasis on those who choose to enroll.

Efficient use of MHS resources

MTFs are the hearts of the military health care delivery system, providing about seventy-five percent of all care system-wide PCMs and health care finders will direct enrolled patients to the MTF, or where care is not available, to civilian providers under a managed care support contract. This will optimize the use of military health care system direct care resources and minimize out-of-pocket cost for beneficiaries. MTFs and TRICARE Managed Care Support contractors will implement standardized, strong utilization management programs to reduce unnecessary care and ensure access to the appropriate level of care.

Achieve a uniform standard of quality

The DOD strives for uniform standards of quality, which applies equally to health care in the direct care system and any care purchased from civilian providers under managed care support contracts.

Provide specialized treatment services

Those clinical services involving high-technology and high-cost procedures will be available to DOD beneficiaries at designated facilities, both within and among health services regions.

Achieve effective use of information systems

One key to the success of the TRICARE program is the effective use of information systems; both the integration of present systems and the rapid fielding of new integrated, open systems. Without timely information regarding access, utilization, and cost, the maximum benefits of TRICARE cannot be realized.

012. TRICARE options

Formerly known as Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), TRICARE is the DOD health benefits program to all uniformed services personnel. Those eligible for TRICARE include active duty members and their family members, military retirees and their family members, and survivors of deceased military personnel. TRICARE provides three separate healthcare plans: TRICARE Prime, TRICARE Standard, and TRICARE Extra.

TRICARE Prime

TRICARE Prime is a voluntary HMO option. Members of this plan pay an annual enrollment fee (except active duty and their families who enroll for free) and enroll for a year at a time. Normally enrollees in this plan receive their care from within the Prime network of civilian and military providers.

Key features of TRICARE Prime include the following:

- Requires enrollment for one year (in most situations).
- No enrollment fee for active duty members and their families.
- Annual enrollment fee for all others.
- Guaranteed access to timely medical care.
- Priority for care in military hospitals and clinics.
- Primary care managers provide and guide care.
- Small fee per visit to civilian providers (no fee for active duty or their family members), excluding fees prescription and Program for Persons with Disabilities.

TRICARE Standard

TRICARE Standard is the regular CHAMPUS option with a new name. It is a fee-for service program, meaning that each service used outside the MTF requires a fee. It pays a share of the cost of covered health care services that you obtain from an authorized *non-network civilian health care provider*. There is no enrollment for this plan. Patients pay the normal TRICARE Standard deductibles for outpatient care, and your cost-sharing percentages will be the same as for regular CHAMPUS. Currently TRICARE will pay 80 percent of the approved allowable cost for outpatient care for active duty families and 75 percent for retirees, their families and all other eligible beneficiaries. Key features of TRICARE Standard include the following:

- Broadest choice of providers.
- Most widely available.
- No enrollment fee.
- May use TRICARE Extra.
- Nonavailability statement for civilian inpatient care may be required for areas surrounding MTFs.

TRICARE Extra

TRICARE Extra is very similar to TRICARE Standard with one notable exception. Patients must use a provider listed on the network of civilian health care professionals. Under this option, individuals select a provider from a network of civilian health care professionals who participate in the TRICARE Extra program. These carefully chosen providers have agreed to share an approved rate for medical treatment and procedures. This provider network is set up much like the PPO. There is no enrollment or an annual fee. You do have to satisfy an annual deductible for outpatient care, just as you would under TRICARE Standard. TRICARE pays an additional five- percent of the health care services when patients use the *network providers* offered through TRICARE Extra. Raising TRICARE's cost share to 85 percent for active duty family members and 80 percent for retirees and their family members and other eligible beneficiaries.

Key features of TRICARE Extra include the following:

- No enrollment fee.
- No additional charges over and beyond the allowable rate.
- Providers always file claims for the patient.
- May use TRICARE Standard.

As the AFMS evolves and expands to meet the ever-changing needs of the beneficiaries, TRICARE will continue to develop new avenues. TRICARE for Life is one of the newest programs being evolved in the AFMS and TRICARE. As of 1 Oct 01, all Medicare-eligible military (excluding active duty family members' beneficiaries become eligible for "all other" TRICARE benefits). For the seniors to receive TRICARE for Life services, the law requires that all Medicare-eligible beneficiaries, regardless of when they turn 65 years old, be enrolled in Medicare Part B.

Under the TRICARE program, service centers are established at, or near each military installation to assist beneficiaries in obtaining care and services as necessary. As part of the valued PCM, you can only enhance the health care given when you know the options available to your patients. Use all your resources to educate your patient to obtain the best medical care they can have.

Self-Test Questions

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

010. Patient care management

1. What are the four basic questions population health management starts with?
2. Who is eligible for TRICARE Prime and how is the enrollment completed?
3. The HEAR survey provides what specific patient information about the populations health?
4. Once implemented, what does demand management reflect?
5. What does condition management target?

011. Managed care

1. Who, on average makes up more than 50 percent of those eligible for care?
2. Define Medicare.
3. TRICARE is a blend of what systems?
4. What are the three most common choices for eligible beneficiaries?
5. What nine principles guide the design and implementation of the TRICARE program?

012. TRICARE options

1. What are the key features of TRICARE Prime?
2. What was the former name of TRICARE Standard?
3. Under TRICARE Standard, what are the allowable costs for outpatient care for both active duty families, and all other beneficiaries?
4. What is the newest TRICARE program implemented for retired members over 65, and what are the requirements for these members to enroll?

Answers to Self-Test Questions**008**

1. Integrated Inpatient Product Team.
2. Based on the goals of initiatives our current electronic health record aim is to fully standardize and optimize the use of best practices, minimize training, decrease variance so the MHS can maximize use of its Information Technology investment.
3. CHCS is primarily used for scheduling appointments and for some order entry procedures. In the future, AHLTA will take over all CHCS functions with added ability to code each patient visit. 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.
4. Real-time monitoring of patient vital signs; Data sharing between health care facilities; Continuity of Admission, Discharge, Transfer, laboratory results and radiology text interpretation; Enhances the delivery of patient care interoperability with the Veterans Affairs; Ensures continuity of care to ill and injured service members; Increases clinical and administrative efficiency.
5. Initially, MTFs were allowed to modify/customize an electronic health record content to meet workflow/clinical needs.

009

1. An automated way of recording, verifying, and storing vital information about individual medical readiness metrics, Preventive Health Assessment (PHA) exams, individual medical readiness, physical examination standards, and clinical preventive services standards.
2. The primary purpose of IMR is to provide “real-time” medical readiness assessment of IMR requirements to commanders, individuals and primary care managers (PCM) so they can manage and optimize the readiness status of their assigned or enrolled AF personnel.
3.
 1. Green—Immunizations complete and up to date. [PHA within last 18 months. Dental class 1 or class
 2. Lab requirements are current. No deployment-limiting profile.]

4. Red—Immunizations missing or out of date. [PHA more than 18 months ago. Dental class 3 or class 4. Lab requirements are missing. Deployment-limiting profile.]

010

1. (1) Who is in our population?
(2) What are their evidence-based health risks or needs?
(3) What are the best, evidence-based ways to address these problems?
(4) How are we doing, when it come to addressing these problems?
2. All active duty military personnel are eligible and most are automatically enrolled at their nearest MTF. Family members of an active duty sponsor must initiate the enrollment process.
3. It provides information related to the patients health risks and needs, projects demand services: including the need for prevention, case management, and disease management programs.
4. It will reflect the activities of a health system designed to create a healthy environment, decrease morbidity and mortality, and encourage the use of effective decision-support and self-management tools.
5. It targets high-cost, high-volume, and complex diseases/conditions, using performance metric tools to focus on key processes and outcomes.

011

1. Retirees.
2. Medicare (health care financing for the elderly).
3. It is a blend of the military's direct care system of hospitals and clinics and the Civilian Health and Medical Program of the Uniformed Services.
4. TRICARE Prime; TRICARE Extra; and TRICARE Standard.
5. (1) Provide medical services and support to members of the Armed Forces.
(2) Implement managed care.
(3) Designate regional health service areas and lead agents.
(4) Central oversight with local accountability and execution.
(5) Improve access to health care.
(6) Efficient use of MHS resources.
(7) Achieve a uniform standard of quality.
(8) Provide specialized treatment services.
(9) Achieve effective use of information systems.

012

1. Requires enrollment for one year (in most situations); no enrollment fee for active duty members and their families; annual enrollment fee for all others; guaranteed access to timely medical care; priority for care in military hospitals and clinics; primary care managers provide and guides care; small fee per visit to civilian providers (no fee for active duty or their family members), excluding fees prescription and Program for Persons with Disabilities.
2. CHAMPUS.
3. TRICARE will pay 80 percent of the approved allowable cost for outpatient care for active duty families and 75 percent for retirees, their families and all other eligible beneficiaries.
4. TRICARE for Life.

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.

Do not return your answer sheet to AFCDA.

39. (008) Why is Armed Forces Health Longitudinal Technology Application (AHLTA) forecasted to replace all functions of Composite Health Care System (CHCS)
- a. CHCS is primarily used for scheduling appointments and for some order entry procedures. In the future, AHLTA will take over all CHCS functions with added ability to code each patient visit. 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.
 - b. CHCS is primarily used for scheduling appointments and for some order entry procedures. In the future, AHLTA will take over some CHCS functions with added ability to code each patient visit. 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.
 - c. AHLTA was created by the Integrated Inpatient Product Team (IPT) initiative to replace CHCS.
 - d. CHCS was created by the IIPT initiative to replace AHLTA.
40. (008) To what extent is Armed Forces Health Longitudinal Technology Application (AHLTA) used for patient care?
- a. It is not used for all aspects of patient care, including x-ray entry, and coding.
 - b. It is not used for all aspects of patient care, only order entry, and coding.
 - c. It is used for all aspects of patient care including order entry, and coding.
 - d. It is used for some aspects of patient care including order entry, and coding.
41. (008) What Tri-service Initiative was created operated by the Military Healthcare System (MHS) to standardize electronic documentation of inpatient care?
- a. Integrated Inpatient Product Team.
 - b. TRICARE Prime.
 - c. Integrated Outpatient Product Team.
 - d. TRICARE Standard.
42. (008) How does the Integrated Inpatient Product Team (IIPT) initiative aim to streamline documentation?
- a. Minimizes variances and increase training by 50 percent.
 - b. Improves access to training and care by 80 percent.
 - c. Optimizes the use of best practices, maximize training, decrease variance.
 - d. Standardizes and optimizes the use of best practices, minimize training, decrease variance.

-
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43. (009) What is the purpose of the individual medical readiness (IMR) software?
- a. An automated way of recording, verifying, and storing vital information about individual medical readiness metrics, Preventive Health Assessment (PHA) exams, individual medical readiness, physical examination standards, and clinical preventive services standards.
 - b. An automated way of recording, verifying, and storing vital information about individual medical readiness metrics, PHA exams, individual medical readiness, and physical examination standards.
 - c. Clinical preventive service standards.
 - d. Physical examination standards.
44. (009) The purpose and outcome of individual medical readiness (IMR) objectives are to
- a. provide “real-time” medical readiness assessment of IMR requirements to immediate supervisors so they can accurately plan duty schedules of their Air Force (AF) personnel.
 - b. provide “real-time” medical readiness assessment of IMR requirements to commanders, individuals and primary care managers (PCM) so they can manage and optimize the readiness status of their assigned or enrolled AF personnel.
 - c. optimize the Military Health Service (MHS) readiness status.
 - d. optimize the Department of Defense (DOD) readiness status.
45. (009) What does individual medical readiness (IMR) status RED represent?
- a. Preventive health assessment (PHA) less than 18 months ago.
 - b. Dental class 1 or class 2.
 - c. Immunizations complete and up to date. [PHA within last 18 months. Dental class 1 or class 2. Lab requirements are current. No deployment-limiting profile.]
 - d. Immunizations missing or out of date. [PHA more than 18 months ago. Dental class 3 or class 4. Lab requirements are missing. Deployment-limiting profile.]
46. (009) What does individual medical readiness (IMR) status GREEN represent?
- a. Preventive health assessment (PHA) less than 18 months ago.
 - b. Dental class 1 or class 2.
 - c. Immunizations complete and up to date. [PHA within last 18 months. Dental class 1 or class 2. Lab requirements are current. No deployment-limiting profile.]
 - d. Immunizations missing or out of date. [PHA more than 18 months ago. Dental class 3 or class 4. Lab requirements are missing. Deployment-limiting profile.]
47. (009) What does individual medical readiness (IMR) status Yellow represent?
- a. Preventive health assessment (PHA) less than 18 months ago.
 - b. Dental class 1 or class 2.
 - c. Immunizations complete and up to date. [PHA within last 18 months. Dental class 1 or class 2. Lab requirements are current. No deployment-limiting profile.]
 - d. Immunizations missing or out of date. [PHA more than 18 months ago. Dental class 3 or class 4. Lab requirements are missing. Deployment-limiting profile.]
48. (010) Reengineering primary care services known as primary care optimization (PCO) and the need to recapture patient care from the private sector are being completed through
- a. TRICARE.
 - b. Managed Care.
 - c. Population Health Management.
 - d. Military Health Service Management.

49. (010) What tool is used to assist primary care managers (PCM) in managing care for their enrolled population?
- Health Evaluation Assessment Review.
 - Primary Care Managers review.
 - Occupational Survey Report.
 - Job inventory Survey.
50. (010) To assess, monitor and encourage the demand for needed prevention services in the community are the goals for what kind of population health management?
- Demand.
 - Condition.
 - Community wellness.
 - Occupational fitness.
51. (010) The demand management concept is based on what foundation?
- Referring patients for specialty health care.
 - Assessing already ill patients.
 - Curing patients through treatment.
 - Teaching patients about prevention.
52. (010) Who is eligible for TRICARE Prime?
- Active duty military and family members of an active duty sponsor.
 - Active duty military and spouse of an active duty sponsor.
 - Active duty military only.
 - Active duty, reserve, and air national guard.
53. (010) The Health Evaluation Assessment Review (HEAR) survey provides what specific information about the population's health?
- Cholesterol result risks.
 - Patients health risks and needs.
 - Dependents health risks and needs.
 - Diabetes screening risks.
54. (011) What classifies health care financing for the poor?
- TRICARE for Life.
 - TRICARE Standard.
 - Medicare.
 - Medicaid.
55. (011) With which Health Maintenance Organization (HMO) does Region 2, the Mid-Atlantic area of the United States, have a contract to manage the TRICARE?
- Sierra Health Maintenance Organization (HMO).
 - Health Net Federal Services.
 - Lead agent.
 - Humana.
56. (011) Which is the *most* common choice for eligible beneficiaries?
- TRICARE Prime, Extra, Standard.
 - CHAMPUS health insurance.
 - Bluecross and Blueshield.
 - Medicare.

57. (012) When was TRICARE for Life made available?
- a. 1 Sept 96.
 - b. 30 Oct 99.
 - c. 30 Sept 00.
 - d. 1 Oct 01.
58. (012) What is one of the key features of TRICARE Prime?
- a. No enrollment fee for active duty members and their families.
 - b. Wait list for care in military hospitals and clinics.
 - c. Semi-annual enrollment fee for all dependents.
 - d. Large fee per visit to civilian providers.
59. (012) What was the former name of TRICARE Standard?
- a. Medicare.
 - b. Medicaid.
 - c. Blue Cross.
 - d. Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).
60. (012) Under TRICARE Standard, what are the allowable costs for outpatient care for both active duty families and all other beneficiaries?
- a. 80 percent of the approved allowable cost for outpatient care for active duty families and 75 percent for retirees, their families, and all other eligible beneficiaries.
 - b. 70 percent of the approved allowable cost for outpatient care for active duty families and 65 percent for retirees, their families and all other eligible beneficiaries.
 - c. 60 percent of the approved allowable cost for outpatient care for active duty families and 80 percent for retirees, their families and all other eligible beneficiaries.
 - d. 50 percent of the approved allowable cost for outpatient care for active duty families and 100 percent for retirees, their families and all other eligible beneficiaries.

Please read the unit menu for unit 3 and continue ➡

Student Notes

Unit 3. Patient Considerations

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|--|-------------|
| 3–1. Special Patient Considerations..... | 3–1 |
| 013. Diabetic..... | 3–1 |
| 014. Caring for unconscious and immobile patients..... | 3–4 |
| 3–2. Patient Care Skills..... | 3–7 |
| 015. Performing medication administration | 3–7 |
| 016. Performing wound closure..... | 3–10 |
| 017. Determining patient needs | 3–12 |
| 018. Emergency cardiac care..... | 3–15 |
| 3–3. Aerospace Medicine Program | 3–23 |
| 019. Maintaining medical standards | 3–23 |
| 020. Deployment Availability Working Group Overview..... | 3–27 |

IN THIS UNIT we will cover patients with special considerations as well as specific patient care skills when planning and performing patient care. When caring for these patients, whether it is inpatient, outpatient, or in the field, you as part of the health care team need to be aware of certain criteria. We will discuss each case individually and bring to light the significant clinical needs of the patients of each category.

3–1. Special Patient Considerations

We have already covered the medications used to treat the diabetic patient in your 5-level CDCs. We will now learn about the disease process and the affects the disease has on the body. The primary consideration for the diabetic patient is diabetic neuropathies.

013. Diabetic

Over a period, diabetes can damage nerves throughout the body. Neuropathies lead to the numbness, pain, and weakness of the extremities of the diabetic patient. These problems are not limited to the extremities and may also occur in the organ systems of the body. The neuropathies may occur at any time, but the longer the individual is diabetic, the greater the risk. Patients with additional risk factors, such as high blood pressure, overweight, and over the age of 40 are more apt to develop the neuropathy problems. The cause of the neuropathy is different with each individual based on the type of diabetes and the length of time they are diabetic.

Research shows nerve damage is likely to be a combination of factors. These factors include metabolic dysfunctions that include uncontrolled high blood glucose, low levels of insulin, long duration of diabetes, and abnormal blood fat levels. The neurovascular factors can lead to damaged blood vessels that carry oxygen and nutrients specifically to the nerves. Autoimmune factors can cause inflammation in the nerves, or mechanical injury to the nerves (carpal tunnel syndrome). Additional controllable risk factors such as smoking or alcohol use are causes for the neuropathy.

The symptoms of the neuropathy depend on the type of neuropathy and which nerves are affected. Many of the patients experience both pain and numbness to the affected area. Mild cases may go unnoticed for a long period. Patients must be educated about these symptoms, to take note of them, and report them to the healthcare team at each visit. Symptoms include the following:

1. Numbness, tingling, or pain in the toes, feet, legs, hands, arms, and fingers.
2. Wasting of muscles of the feet or hands.
3. Indigestion, nausea, or vomiting.
4. Diarrhea or constipation.

5. Dizziness or faintness due to a drop in postural blood pressure.
6. Problems with urination (frequency or inability).
7. Erectile dysfunction or vaginal dryness.
8. General weakness.

In addition to the symptoms listed above, weight loss and depression are often noted along with the neuropathy. There are four main types of neuropathies: peripheral, autonomic, focal, and proximal. Each affects different parts of the body in different ways. Peripheral neuropathy can cause either pain or loss of feeling in the toes, feet, legs, hands, and arms. Autonomic neuropathy causes changes to organ systems like the digestive, sexual responses, and perspiration as well as the nerves that serve the heart. Proximal neuropathy can cause pain in the thighs, hips or buttocks that may lead to weakness in the legs. Focal neuropathy results in the sudden weakness of one nerve or a group of nerves causing weakness or pain at the nerve site. Any nerve in the body may be affected by focal neuropathy.

Peripheral neuropathy

Peripheral neuropathy affects the farthest extremities. Symptoms of peripheral neuropathy include numbness or insensitivity to pain or temperature, tingling, burning or prickling sensation, sharp pains, or cramps, extreme sensitivity to even a light touch to the area, and a loss of balance and coordination. The symptoms are often worse at night. Peripheral neuropathy may also cause muscle weakness, and lead to changes in a patient's gait.

Foot deformities such as hammertoes and the collapse of the midfoot (flattened arches) may occur. Blisters and sores appear on the numb areas of the foot because the pressure or injury goes unnoticed. This is why the importance of proper foot care must be stressed. Proper foot care instructions include the following:

1. Patients should inspect feet daily. The feet should be inspected each time a patient visits the health care provider even when the visit is unrelated to a problem with the feet. When the patient is at home, he or she should use a mirror to inspect the bottom and all sides of their feet.
2. Patients should be educated that a healthcare provider or podiatrist should be the ones to remove any calluses or corns from their feet. Patients should not try to remove them by using any commercial preparation or sharp instrument.
3. At the sign of inflammation or infection, notify the healthcare provider immediately. Do not wait. Infection may spread quickly to the bone if not treated promptly.
4. Patients should avoid cutting toenails with scissors. Nails should be trimmed only with a file and with great care to prevent injury.
5. Patients should avoid using heat treatment on feet. The patient with peripheral neuropathy may be unaware of burning until the damage to the skin has occurred.
6. Teach the patient to avoid socks or stockings with elastic tops or round garters. These often decrease the circulation in the legs and feet.
7. Recommend propping feet up several times a day to encourage good blood return to the heart, and avoid crossing their legs at the knees when sitting.
8. Patients should be instructed to avoid going barefoot to prevent the possibility of injury to the feet.
9. Instructions should be clear to keep feet dry and warm and to wear clean socks and proper fitting shoes. New shoes should be broken in gradually to avoid blisters and possible skin injury.

Autonomic neuropathy

Autonomic neuropathy affects the nerves of the autonomic nerve system. These nerves control the heart, regulate blood pressure, digestion, respiratory system, urinary system, sensory organs, and the sexual responses. With autonomic neuropathy, the system that restores blood glucose levels to normal after a hypoglycemic episode may be affected. The result is a loss of the warning signs (sweating and palpitation) of hypoglycemia and the body does not recover without intervention.

When the heart and circulatory systems are affected, the nerves interfere with the body's ability to adjust blood pressure and heart rate. The result is a sharp drop in blood pressure with position changes, or the heart rate remaining high instead of rising and falling in response to normal function or exercise.

Damage to the digestive system may occur. Nerve damage of the digestive system may cause the stomach to empty too slowly (gastroparesis), and lead to persistent nausea, vomiting, bloating, and loss of appetite. Gastroparesis can make the blood glucose levels to fluctuate widely due to the abnormal digestion of the food. Nerve damage to the esophagus may make swallowing difficult, while nerve damage to the bowels can cause constipation alternating with frequent, uncontrolled diarrhea especially at night. With such digestive problems, weight loss may become a problem.

With the urinary tract, autonomic neuropathy may prevent the bladder from emptying completely. When this occurs, urine lies stagnant in the bladder to allow for bacteria to grow and spread to the kidneys. The nerve damage to the urinary system may cause the bladder to lose control resulting in urinary incontinence.

Neuropathy can also gradually decrease sexual response in both men and women. The neuropathy does not affect the sex drive; neuropathy affects the ability for a man to have an erection and a woman's ability to secrete lubrication during arousal.

Autonomic neuropathy can affect the nerves that control sweating. With an inability to sweat, the body cannot regulate its temperature properly or produce signs commonly seen with many severe body reactions (hypoglycemia symptoms). Nerve damage can also produce profuse sweating at night or while eating.

Finally, the autonomic neuropathy affects the sensory organs, primarily the eyes. Autonomic neuropathy can affect the pupils making them less responsive to changes in the light. As a result, individual affected find it difficult to drive at night.

Not every diabetic patient is affected with autonomic neuropathy nor is a patient affected with each aspect of the autonomic neuropathy. With any part of the body, a patient may incur focal neuropathy, which is sudden and affects an individual or a group of nerves.

Focal neuropathy

Focal neuropathy is painful and unpredictable and most often seen in older patients. The focal neuropathy most often affects the nerves in the head, the torso, or leg. Focal neuropathy may cause an inability to focus the eye, double vision, aching behind one eye, paralysis to one side of the face (Bell's palsy), severe pain in the lower back or pelvis, pain in the front of the thigh, chest or abdominal pain that is sometimes mistaken for heart disease, heart attack, or appendicitis. With focal neuropathy, it tends to improve by itself over weeks or months and does not cause long-term damage.

Proximal neuropathy

Proximal neuropathy for many is the worst and most disheartening. It is sometime called lumbosacral plexus neuropathy or femoral neuropathy. The pain generally starts in the thighs, hips, buttocks, or legs, affecting one side of the body.

This neuropathy causes weakness in the legs, producing the inability to rise from a seated position without any help.

Patients may also start walking incorrectly to compensate for the weakness in the one leg. This can lead to significant gait problems, and muscle contractures. Proximal neuropathy is more common in type II diabetics and in the older people of this category.

For patients suffering with proximal neuropathy, treatment for the weakness and pain is usually needed. The length of recovery and the type of treatment is dependent on the type of nerve damage. With any diabetic neuropathy, the first treatment is to bring the blood glucose levels within the normal range. Good glucose control may help prevent or delay the onset of further problems. Treatment also includes pain relief and other medications as needed depending on the type of nerve damage.

As the health care team member who has the most contact with the patient, the Aerospace Medical Service Craftsman is expected to continue his or her own education in the disease process that affect the patient population you deal with. Not every AFMS craftsman will encounter long-term diabetic patients, but may only encounter young diabetic children. In either case you must have the knowledge to educate the patient or the parents of the patient on any aspect of their care. The health care provider and nurse you work with will also be able to enhance the knowledge you have and to reinforce the teachings you give to the patients.

Diabetic patients are not the only patients with special considerations you will need to care for. Patients with known or sudden seizure activity have special precautions that are considered when performing patient care.

014. Caring for unconscious and immobile patients

Patients, who are unconscious or immobile due to illness or injury, generally need one-on-one care. These patients may sometimes need assistance when it comes to breathing adequately. An artificial airway may be required at that time. In nearly all circumstances, *airway management* is the highest priority for clinical care. This is because if there is no airway, there can be no breathing. Without adequate breathing there will be no oxygenation of the blood and circulation will eventually cease.

An artificial airway is placed when an immobile or unconscious patient needs assistance to ensure proper ventilation. The two common airways used are the endotracheal and tracheostomy airway supports.

Endotracheal tube

The endotracheal tube (ETT) was established for the unconscious individual that is unable to breathe on his or her own. The endotracheal tube is the most common for the neonatal and pediatric patients even for long-term care. A healthcare provider often under emergency conditions inserts the tube. The tube is generally removed after 48–72 hours, but may be left in place for up to a week. Long-term complications of endotracheal intubation include tracheal stenosis. The granulation tissue and fibrosis can occur at the tip of the tube or the site of the cuff. The pressure from the cuff may also cause a mucosal ulcer between five and seven days. In some cases, an acute complication of prolonged intubation can be tracheal rupture. Proper placement, and continued care of the ETT can help to alleviate these complications in the neonatal and pediatric patients.

Ensuring proper placement of the ETT is verified by auscultation or by chest X-ray. The ETT is secured into place by taping around the ends of the tube. The tape should be tight enough to prevent migration of the tube, but must allow one finger to be placed under the tube at any point. The tube is then marked at the patient's lips.

Suctioning of the ETT should be performed PRN (as needed) or at intervals ordered by the healthcare provider. When performing suctioning, aseptic technique will be used. The suction catheter should be less than half of the endotracheal tube. When suctioning, the catheter should be occluded for 5 second intervals, and the patient's oxygen saturations should be monitored at all times. When performing

repeated suctioning, allow for the patient to regain adequate oxygen levels. The patient may be hyperventilated prior to each suctioning procedure.

Over suctioning should be avoided to decrease potential damage to the patient's airway. While performing ETT suctioning, you may need to clean out the patient's oral pharyngeal airway also. After suctioning the oral pharyngeal airway, never place the suction device back into the trachea. This allows for infection opportunity directly into the trachea and lungs.

If ventilator support will be necessary for an extended period of time, a tracheostomy is usually performed.

Tracheostomy

The tracheostomy is performed for individuals needing long-term airway support and helps to prevent the aspiration of secretion. Tracheal tubes are either cuffed or uncuffed (fig. 3-1). Patients on a positive-pressure ventilator to treat respiratory failure must have a cuffed tracheostomy. The cuff may be foam or soft balloon cuff. With the soft balloon cuff, the pressure is checked at least every eight hours. The patient is never left unattended when the cuff is deflated due to the danger of fluid aspiration.

With a tracheostomy, suctioning is required to remove secretions from the lower respiratory air passage. As with the endotracheal suctioning, aseptic technique is to be used to prevent potential infection. The step-by-step procedure to suction the tracheal tube is similar to the skill involved in suctioning the upper airway, keeping in mind some precautions. When every there is noisy, moist or labored respirations, this is an indication that mucus has accumulated in the respiratory tract causing extra stress on the cardiopulmonary system. When performing suctioning, provide oxygen before the procedure and maintain aseptic technique throughout the procedure. When applying suction to a tracheal tube, it should be for no longer than 10-15 seconds at a time; allow the patient to regain adequate oxygenation between suctioning procedures. To prevent tracheal stenosis and erosion, ensure the tracheal tube placement is in the midline position, and evaluate the skin around the stoma site with each dressing change and suctioning procedure.

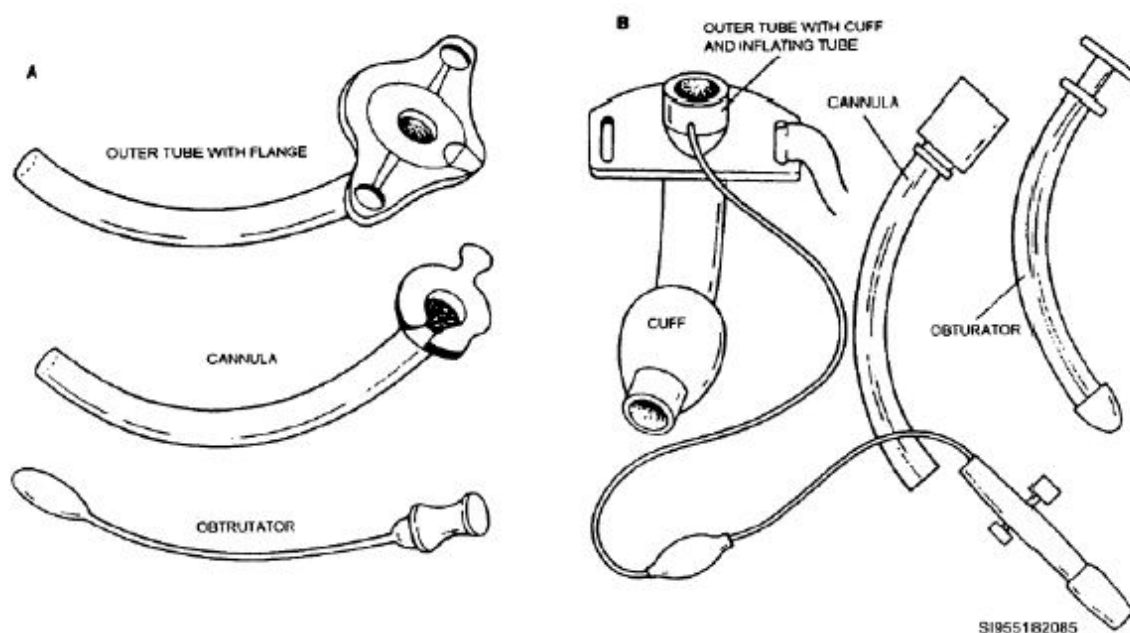


Figure 3-1. Cuffed and uncuffed tracheostomy tube.

Self-Test Questions

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

013. Diabetic

1. What additional risk factors contribute to diabetic neuropathy?
2. Name the four main types of neuropathies and give a brief description of each.
3. Why is it important for all diabetic patients to perform daily foot care?
4. With autonomic neuropathy, how are the heart and circulatory systems affected?
5. Which type of neuropathy is most often seen in older patients?
6. What is the primary treatment used to prevent or delay diabetic neuropathy?

014. Caring for unconscious and immobile patients

1. With an unconscious patient, what is the highest priority of patient care the healthcare team should concentrate?
2. When an unconscious patient is unable to breathe on his or her own, what is established?
3. Match the conditions in column A to the type of artificial airway in column B. The answers of column B can be used more than once.

Column A

- ____ (1) Most common for long-term pediatric and neonatal patients.
- ____ (2) Cuffed tube used in conjunction with positive pressure ventilation.
- ____ (3) Cuff may cause mucosal ulceration in five to seven days.
- ____ (4) Soft balloon cuff pressure is checked every 8 hours.
- ____ (5) Primarily used for long-term ventilatory support.
- ____ (6) Usually removed after 48–72 hours.
- ____ (7) Long-term complication of tracheal stenosis.

Column B

- a. Tracheostomy.
- b. Endotracheal tube.

3-2. Patient Care Skills

As an AMSC, you can expect more responsibility not only as a supervisor, but also as a member of the healthcare team. Through experience and knowledge, you are able to not only perform, but teach patient care tasks. You should know how to interpret and perform tasks self sufficiently.

015. Performing medication administration

As you learned in the journeyman course the important steps to medication administration not only include the nursing process for drug administration, but more importantly they include making sure the patient is receiving the right dose.

Now that you are a craftsman, you should understand the basics of medication administration. Your responsibility is to know your role when administering and calculating medications. One small error in calculation can potentially harm a patient. Once the order is written you will begin the calculation process. To calculate medication dosages, the first thing to make sure is the measurements are the same. Another important rule to remember is to write the problem in equation form using the appropriate formula to calculate. Lastly, have someone else verify your calculations for accuracy. Remember, the most common method used to calculate medication dosages is using the basic calculation method which is the ordered dose divided by the supplied dose.

Medication reconciliation

Before you administer a medication there are important safety precautions. As defined by the Joint Commission, medication reconciliation is the process of comparing a patient's medication orders to all of the medications that the patient has been taking. This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions. Medication reconciliation should be done at every transition of care in which new medications are ordered or existing orders are rewritten. Transitions in care include changes in setting, service, practitioner or level of care.

The medication reconciliation process comprises of the five following steps.

1. Develop a list of current medications.
2. Develop a list of medications to be prescribed.
3. Compare the medications on the two lists.
4. Make clinical decisions based on the comparison.
5. Communicate the new list to appropriate caregivers and to the patient.

This means that there are two parts to address medication reconciliation: Part A and B.

Part A

Clinician/pharmacist reviews medication profile with the patient to assure it is correct and up-to-date.

- Discontinue all non-active medications.
- Renew all expired medications. If the patient already has these medications, the pharmacist places them on hold.
- Prescribe new medications not on the medication profile including over-the-counter (OTC), herbal, and traditional medications. All prescriptions will contain the indication for prescribing (to address health literacy).

Part B

Patients will receive a copy of their medication profile using the Patient Wellness Handout or other printed report.

- The medication profile will contain medications with the status of active, hold, or returned to stock.

- Medications that are expired and not current therapy and discontinued should not appear on the profile.
- Consider printing a copy of the Patient Wellness Handout for the patient containing their medication profile.
- The medication profile is to be reviewed with the patient.
- Document the medication reconciliation process using the patient education code.

Standards

The following are the standards of the medication reconciliation process:

- Emphasize the importance of maintaining an accurate and updated medication profile.
- Provide the patient/family with a copy of the patient's medication profile.
- Discuss the content of the medication profile with the patient/family. Emphasize that the profile should consist of all medications including prescription, over the counter medications, herbals, traditional, and medications dispensed at a non-international health specialist (IHS) pharmacy.
- Emphasize the need for patients to provide clinicians with a copy of their complete medication profile anytime there is a transition of care when possible.

Approved drug list

The approved drug list (ADL) contains the items approved by the Pharmacy and Therapeutics (P&T) Function for stock and use by sections and providers within your facility. Each section or provider will have its own specific ADL that must be adhered to and is covered by inspection checklist. In most cases, the ADL will also cover stock levels on approved items. When an area feels that their stock levels are inadequate or that they need to stock a certain drug that is not on their ADL, they must submit a change to their list through appropriate channels.

Expired or unserviceable medications

All deteriorated, outdated, or mislabeled medications will be removed from wards/clinics and returned to the pharmacy. Outdated and unused compounded sterile products (CSP) must be returned to the pharmacy for disposal or possible reuse. Depending on your military hospital or clinic guidance, this may be initiated by either pharmacy or ward/clinic personnel. It is important that suspended or expired stock is physically segregated from other stock and identified as suspended or expired. Using these items could cause harm to our patients.

Controlled temperature storage

Ward/clinic personnel should monitor their drug storage areas carefully to ensure that product potency is retained through the manufacturer's labeled expiration date. Controlled temperature storage areas throughout the MTF, such as refrigeration or freezer units, should be monitored at least once daily and the results documented on a temperature log. Proper monitoring of temperatures is crucial because medications may become unstable or deteriorate if not stored properly; the temperature for refrigerators in wards and clinics should be between 35 and 46 degrees Fahrenheit (° F). Inspections must confirm compliance with appropriate storage conditions, separation of drugs and food, and proper use and maintenance of refrigeration logs.

Conversions

Depending on the route of administration and the strength of the medication supplied, the dosage may be ordered in different measurements. The conversion must be completed before calculating the amount of the dose. Basic conversions never change, and are readily referenced in most nursing manuals. As you see in the following chart, when the decimal point is moved either to the right or

left, the value of the number changes. Conversions must be made before inputting the information into the medication calculation formula.

| Kilo (k) | Hecto (h) | Deca (da) | Units (gm / L) | Deci (d) | Centi (c) | Milli (m) | | | Micro (p) |
|-------------|--------------|--------------|-------------------|-------------|--------------|--------------|--------|---------|--------------|
| 1000 | 100 | 10 | 1 | 0.1 | 0.01 | 0.001 | 0.0001 | 0.00001 | 0.000001 |

When you use the above scale, you can figure out the conversions for these base values in grams, meters, and liters. Other measurements and values may need to be converted as well. See the measurement conversion chart below for some common measurement equivalencies.

| Abbreviations | | Measurement Conversions | | |
|--|------|-------------------------|---|----------|
| Kilograms | Kg | 1 kg | = | 2.2 lb |
| Gallons | Gal | 1 gal | = | 8 pts |
| Yards | Yd | 1 gal | = | 3.8 L |
| Inch | In | 1 yd | = | 3 ft |
| Ounces | Oz | 1 in | = | 2.5 cm |
| Liter | L | 1 oz | = | 30 cc |
| Gram | g/gr | 1 L | = | 1.06 qts |
| Milligram | Mg | 1 qt | = | 4 C |
| Cubic centimeter | Cc | 1 qt | = | 32 oz |
| Tablespoon | Tb | 1 tsp | = | 5 ml |
| Teaspoon | Tsp | 1 Tb | = | 15 ml |
| Quart | Qt | 1 pt | = | 2 L |
| Pint | Pt | 1 pt | = | 16 oz |
| REMEMBER: 1 medicine cup is equal to 1 oz/ 30 cc/2 Tb/ 8 drams. | | | | |

Calculation formula

Basic calculation method:

$$\frac{\text{Ordered}}{\text{Supplied}} \times \text{Quantity} = \text{The amount needed for the dosage required.}$$

Sample order 1: Administer Valium 2 mg

The Valium is supplied as 10 mg/5ml.

The answer you need to determine is how many ml is equal to 2 mg.

$$\frac{\text{Ordered}}{\text{Supplied}} \times \frac{2 \text{ mg}}{10 \text{ mg}} \times 5 \text{ ml} = \text{total ml to be given to the patient}$$

Reduce the fraction:

When reducing, remember that like values cancel each other out leaving you with the whole numbers.

$$\frac{10 \cancel{\text{mg}}}{10 \cancel{\text{mg}}} = 1$$
$$\frac{10}{10} \div \frac{10 = 1}{10 = 1} = 1$$

The answer is 1 ml.

Sample order 2: Administer 25 mg/kg. The patient weighs 185 pounds (lbs).

The medication is supplied 250 mg/ml.

Steps 1- label all the parts:

$$\frac{\text{Ordered} \quad 25 \text{ mg/kg}}{\text{Supplied} \quad 250 \text{ mg/ml}}$$

The total amount ordered is based on the patient's weight. For every kg the patient weighs, you will administer 25 mg's of the medication. This weight must first be converted from pounds to kilograms. You know there are 2.2 lbs for every kilogram. You will divide 185 by 2.2 to convert the pounds to kilograms and then multiply by 25.

$$185 \div 2.2 = 84 \text{ (kg)} \times 25 \text{ (mg)} = \text{total mg ordered } 2,100 \text{ mg}$$

The total order is: administer 2,100 mg

$$\frac{\text{Ordered} \quad 2100 \text{ mg}}{\text{Supplied} \quad 250 \text{ mg}} \div \frac{250}{250} = \frac{7.5}{1} = 8.4 \text{ ml}$$

Remember to always verify the order, use the basic calculation method and have someone else double check your work. This will ensure your calculations will come out correctly.

016. Performing wound closure

The body defenses are automatic responses to disease and the invasion of microorganisms into the body. Some of the microorganisms may be a result to an external cause of injury. With injuries come wounds. As you learned in the 5-level CDC the physiological response for the body's healing process of wounds is done in three different wound closure treatments: primary, secondary, and tertiary-intention healing. The choice of wound closure will depend on how the injury occurred and to what extent is the wound. The one that we will focus on is the primary intention closure.

Primary intention closure

When a wound with little tissue loss or damage, such as a surgical incision, is made *primary intention closure* is used. The wound edges are approximated and leaving only a slight chance for infection. The closure is done by suturing or the use of staples. There are no open areas or dead space left in the wound. There are instances where you will use skin closure strips to reinforce the sutures or staples.

Skin closure strips

Skin closure strips (Steri-strips) are basically small strips of sterile, adhesive surgical taped mounted on a piece of cardboard. These strips are made from several different materials (including nylon, rayon, and polypropylene) and come in different widths and lengths.

The most common size strips are 1/8, 1/4, or 1/2 inch wide, and 1 1/2 to 4 inches long. The strips are supplied in pre-sterilized peel-pack packages, a feature that allows for aseptic presentation on the sterile field.

You may use skin closure strips in place of sutures or staples to approximate the edges of skin to achieve a fine closure with minimal scarring. Skin closure strips are often used along with skin sutures and or staples to close small gaps in the tissue between the sutures or staples.

Additionally, the skin strips are used to hold skin edges together after the removal of sutures or staples several days postoperatively. You can also use skin closure strips to approximate skin over subcuticular skin closures (hidden stitches), approximate skin edges on minor lacerations, and close the skin on pediatric patients. Skin closure strips provide an excellent alternative to staples and sutures for closing the skin on low-stress areas of the body.

Before skin strips are applied, you may need to apply benzoin or adhesive spray to make the skin tacky and help the strips adhere better. You may also need to cut the strips in half. The simplest way to do this is to leave all the strips on the card they were packaged on and cut the card in half. Both ends of most packing cards have perforated tabs that can be removed to expose just the ends of the strips. Before using the strips, you should always remove at least one of these tabs to facilitate removal of the strips from the card.

Local anesthesia administration

With any wound closure, a local anesthetic will need to be administered first. The goal of the local anesthetic is to prevent pain. A common local anesthetic is Xylocaine. Xylocaine is injected by needle and syringe (*local infiltration*) to provide comfort for the patient being sutured. The anesthetic is injected into the skin and subcutaneous tissues to block nerve impulses from the area to the brain. When injecting the anesthesia, the physician must be careful not to inject the Xylocaine into the vein. Injecting a local anesthetic intravenously can cause cardiovascular collapse or convulsions.

A *digital block* is a nerve block used to anesthetize a finger. To perform this, an anesthetist injects the anesthetic agent along the nerve path, not into the nerve. Once the agent is injected, it takes longer to take affect but the area stays anesthetized longer. Topical anesthetics include prescription products and over-the-counter products. Topical anesthetics can provide local relief to the skin.

To ease the pain of injections or needle sticks, *topical anesthetics* can also numb the skin before needle insertion, though it can take a while for the numbing effect to work. Emla cream is an example of a topical agent that is used in the MTF.

Pediatric patients are good recipients of this agent, as well as, adult patients who get very anxious when it comes to needle sticks. This cream is applied to the area of the skin where the needle stick will place. This usually will occur at least thirty minutes beforehand.

Before any local anesthetic can be administered, there are some steps that need to be followed.

1. Ensure informed consent has been obtained from the patient for the procedure to take place.
2. Instruct the patient on what will occur throughout the process.
3. Gather your supplies to include drawing up your local anesthetic.
4. Expose and drape operative area (if applicable).
5. Clean operative area with Betadine swabs or wipes.

Once these steps are completed, you may now administer your local anesthetic. After the local anesthetic is administered, allow a few minutes for the medication to take effect.

017. Determining patient needs

Upon release from the inpatient unit, clinical follow-up is provided by a completely different healthcare team than who took care of the patient while admitted into the hospital. The nursing process does not exist solely for the inpatient care of patients, but the clinical setting as well. To plan the appropriate care, the patient's needs must be assessed. This is done through customer evaluation. How you as the front line member of the healthcare team approach and interact with the patients becomes a factor in this evaluation and determining the patient needs.

Sometimes, the way a patient feels affects how they treat you, but it should never affect how you treat the patient. Since the AMSC works the front line of patient care, it all begins with you. A good example is when Chief Master Sergeant (CMSgt) Yuk complains of having a splitting headache, runny nose, itchy eyes, and is irritable due to lack of rest. As he makes his way to the family practice counter, you may greet him with a smile "good morning chief, how may I help you?" CMSgt Yuk responds in a less than pleasant voice, "I feel terrible and I need to see a doc ASAP!" How you respond to this patient may be what is evaluated through the customer complaint/comment cards that were filled out.

Customer evaluation

Everyone you come into contact with has a right to considerate and respectful treatment. It is the responsibility of each healthcare team members to know how you can ensure your customer's rights are preserved and their interactions with medical staff are as pleasant as possible. More of the "customer service evaluations" are seen in the clinical areas of the hospital because more patients are seen in this setting than on the unit. The individual evaluations set up within your healthcare facility will be determined through hospital operating instructions. The basic customer evaluation is seen in the form of customer comment cards. Some healthcare facilities determine a particular day of the month to have all patients seen in the clinical areas to fill out a "comment card." On the inpatient side of the hospital, it may be determined that all patients are to fill out a customer comment evaluation prior to release. In either case, patient care and determining these customers' (patients) needs are carried out to plan appropriate patient care in the future. We can all learn how to improve customer service skills by building rapport as well as discovering how to make a great first impression. These are the foundations that your professional patient care skills can be built upon.

Building rapport

Rapport is difficult to describe, but you know when you see it or feel it. Building rapport means building a harmonious relationship with others. For your patients and their families, this includes the sense of safety and security. There are many different personal touches that build a good rapport with the patients, beginning with the face-to-face contact. This contact will include both non-verbal and verbal communication.

Face to face contact

Throughout the nursing process, assessment of the patient is continual. You use both verbal and nonverbal questions to gather as much information as possible. You must patiently listen to the patient's (and sometimes the family's) concerns and respectfully answer questions.

| Nonverbal Responsiveness | |
|--------------------------------------|--|
| Response | Action |
| A pleasant facial expression | Smiling Raised eyebrows Good eye contact |
| Acknowledging the patient's presence | Nodding "Good morning. May I help you?" "Hello, I'll be with you in a moment." |

| Nonverbal Responsiveness | |
|-----------------------------|---|
| Response | Action |
| Calling the patient by name | "Sergeant Garcia, the provider will be with you shortly." "Mrs. Glover, the report is ready." "Lt Polvich, it's nice to see you again." |
| Using courtesy words | "Thank you for waiting." "When you have completed these forms please let me know." "Please have a seat." |

Problem resolution

If you have problems with getting paid, you would expect the finance staff to solve the problem. When you arrived at the accounting and finance office, the first person you saw didn't know the answer so they directed you to another office to see a second individual. The second person wasn't able to help. At what point would you say, "That's okay, I'll just live with the problem."

Customers expect you to stay with a problem until it's resolved. If you can't solve the problem, they want you to find someone in the organization to help them. Give the customer updates about what's happening to solve the problem and follow-up with the customer until "they" say the problem is resolved.

As a Craftsman, that is your responsibility to all patients you encounter. If you are unable to solve the problem, don't provide the same resolution the accounting and finance office provided. It is all about your integrity to do what is right for the patient. This also includes doing what it takes to recover from a mistake. That is, you apologize and take action to make things right in the customer's eyes. Nothing hinders communication faster than having customers tell you about a situation that you refuse to accept responsibility for or that you complain or blame others. It's always best to apologize and take action to right the wrong.

First impressions

Studies show that the most important thing you can do to build relationships is to use a customer's name. Remember to address your customers properly. Use the proper rank (or title) when addressing active duty and retired military personnel. Address all other individuals as Mr., Mrs., Ms., or the appropriate title.

Learn to give instructions willingly, clearly, and logically. Even though you may have given the same set of instructions 99 times in any given day, your current customer has heard the instructions only once. Be clear, concise, complete, but not curt. Instructions are not specific to directional instructions; they also include instructing the patient on special tests, procedures, and medications. Never assume the provider will give the patient all instructions necessary to complete the course of treatment ordered. As the AMSC, you are responsible to understand information regarding medications' actions and side effects as well as test procedures. This ties into the problem resolution aspect of patient care. Don't just send the patient to the laboratory to receive directions; learn the procedures and instruct the patient as you provide them the equipment necessary to complete the test.

When customers share personal information within your hearing, you can assume that they want you to hear it. They may make comments like, "Ever since my husband was deployed to Bosnia, my child has been sick." or "My wife just had a baby and I need to get this paperwork processed before she leaves the hospital." or "I'm afraid that I will have to take these tests over if my records are lost." To ignore such comments with no response shows the patient the perspective that you really don't care. React to such personal shared comments with an appropriate response that lets the customer know you heard and that you identify with the feeling or situation. Empathize; customers want to know that

you identify with their feelings. Look for ways to show or state you understand their needs, frustrations, or disappointments.

You must avoid being overly familiar when responding to a patient. There's a fine line between responding to personal comments and being too familiar in responding with a remark inappropriate for the professional relationship. For example, if a customer mentions a death in the family, you wouldn't respond with something so personal as to bring tears, but you would express sympathy.

Another appropriate response is to agree selectively. We all like for others to agree with us. Find something about a situation or comment with which you can agree. Obviously, if someone says, "This policy is stupid—you're totally incompetent," you can't agree with the statement that you are incompetent. However, you can agree that the policy is confusing to many people. Rather than clash with a customer's statement, look for a part of the comment to which you can respond positively.

Complaints and conflicts resolution

Conflict and complaint resolutions usually begin with choosing the right words to use to diffuse an already difficult situation. All words have both a denotative and connotative meaning. The denotative meaning refers to the dictionary definition—the neutral meaning of the word. The connotative meaning refers to the meaning of the word in a given context or by common use. Refer to the following list of neutral words and phrases, along with their negative or positive connotations.

| Neutral | Positive | Negative |
|----------------------|--|---------------------|
| House | Home | Shack |
| Situation | Challenge | Problem |
| Your inquiry | Your question | Your complaint |
| You didn't notice... | You may have inadvertently overlooked... | You neglected to... |

When communicating with customers, word choice can make the difference between a satisfied customer and an upset customer. Make sure your words, phrases, statements, and questions frame the positive, rather than the negative, approach to issues and situations.

Some of the following comments are negative because of a particular word. Other comments are negative in their approach—they frame the negative rather than the positive way to look at a situation. For each comment, a positive substitute is given.

| Never Say | Try to Substitute Positive Words and Statements |
|---|--|
| "Okay, what's your complaint?" | "How may I help you?" |
| "So what did you want to know?" | "What questions do you have for me?" |
| "You failed to notify us." | "We did not receive any notice from you." |
| "You'll have to wait if you want help with that." | "I can help with that in a moment." |
| "We can't get it to you until Friday." | "We can get it to you on Friday." |
| "It's against regulations for you to do that." | "Let's explore our options. What we can do is...." |
| "What's the problem?" | "How may I help you?" |

Remember, customer satisfaction with quality care is the capstone of the AFMS strategic plan. The way we provide help and support to others influences their feelings and how they relate to us. Treating everyone with courtesy and respect should be the norm and not the exception!

Patient advocate

A patient advocate acts as a liaison between the patient and healthcare provider. The patient advocate is a vital instrument to both patient and physician in the optimal delivery of healthcare. Most facilities have a central office with a patient advocate that represents the entire facility. Each duty section is

required to have a patient advocate representative as well, but ultimately we are all patient advocates. Anytime a patient brings a concern to your attention, it is your responsibility to take action. Even though it may not be your clinic's responsibility, you need to take ownership and ensure the patient's concern is addressed whether it is with another section or the facilities' patient advocate. I know we have all had that patient who just was not happy with any care that was provided in your section. Take a step back and put yourself in their shoes. What if it was you, or your family member and you felt like no one cared whether your service was satisfactory or not? The important things to remember are to provide the best possible care you can, control what you can control and never lose your cool. Patients are not angry with you, they are angry with the situation at hand. Our responsibility as the patient advocate is to help resolve the issue at the lowest level because ultimately providing quality patient care is our number one priority.

018. Emergency cardiac care

Not all military nursing happens in the traditional hospital or clinical setting. With the rise in ops-tempo and deployments, you are bound to be involved in the realm of contingent patient care. Patient care in a contingency setting will vary depending on Expeditionary Medical Support (EMEDS) package you are assigned to during deployment. As you learned in the first volume, there are over 2,000-unit type code (UTC) billets for the deployable Air Expeditionary Force (AEF) and EMEDS components.

All patient care begins with assessment and triage. In the traditional hospital or clinical setting, you will generally take care of the most critical patient first. Within the field or contingency setting, you don't have a lot of personnel or resources to care for many critical patients. During wartime or field triage, your primary focus is to return the greatest number of warriors back to fight and second save life and limb of the critically injured.

During the initial assessment, the element of assessing the ABCs is a critical step for any patient care. If you are in a field setting the ability to assess arrhythmias is non-existent. While caring for patients in the EMEDs, monitoring a patient's rhythm is more common. There are three life-threatening arrhythmias covered in this lesson: ventricular fibrillation, pulseless ventricular tachycardia, and asystole. Pulseless electrical activity (PEA) is not necessarily classified as an arrhythmia, but it is necessary to understand the causes as a cardiac emergency. In order to understand the life threatening arrhythmias, you have to be able recognize normal sinus rhythm and understand why each segment is important.

Normal sinus rhythm

In a normal heart rhythm, the sinoatrial (SA) node generates an electrical impulse that travels through the right and left atrial muscles producing electrical changes which is represented on the electrocardiogram (ECG) by the P wave. The P wave is normally small smooth and slightly round in shape and present before all QRS complexes. The P wave represents atrial depolarization (the electrical representation of the muscle contraction of the atria). When the P wave is absent or in an abnormal position, the impulse is originated outside the SA node.

The electrical impulse then continues to travel through specialized tissue (internal nodal pathways) leading the electricity to the atrioventricular (AV) node. The AV node conducts electricity at a slower pace than the SA node. This electrical activity will create a pause (PR interval) before the ventricles are stimulated. This interval represents the time it takes for the electrical activity to leave the SA node, travel through the atria and then to the AV node. The PR segment (the flat line between the P wave and the QRS complex) represents the delay at the AV node. This pause is helpful since it allows blood to be emptied into the ventricles from the atria prior to ventricular contraction to propel blood out into the body. The repolarization of the atria is not seen on the ECG because the electrical activity of the ventricle is more powerful and is seen as the electrical activity in the QRS complex.

The ventricular contraction is represented electrically on the ECG by the QRS complex. The QRS complex represents ventricular depolarization. The width of the QRS complex should be noted when identifying the rhythm. The normal width of the QRS complex should be $<.12$ seconds (approximately 2.5 blocks on the ECG graph). A complex wider than three blocks shows there is a possible heart block.

Following the depolarization of the ventricles (QRS complex) is the ST segment. The ST segment is the straight line between the QRS complex and the T wave. The ST segment represents the time between the completion of the ventricular depolarization and the beginning of the resting phase of the ventricles.

The ST segment is *isoelectric*, meaning it is neither elevated or depressed in a normal rhythm. If the ST segment is elevated, the indication is there has been myocardial injury.

If the ST segment is depressed below the baseline, the indication is a sign of myocardial ischemia. Following the ST segment is the T wave. The T-wave represents the electrical changes in the ventricles as repolarizing. Because of the large muscle mass of the ventricles, the re-polarization of these muscles is electrically noted on the ECG as the T wave.

The last segment of normal sinus rhythm recognition is the QT interval. The QT interval begins at the onset of the QRS complex and to the end of the T wave. It represents the time between the start of ventricular depolarization and the end of ventricular repolarization. It is useful as a measure of the duration of repolarization. The QT interval will vary depending on the heart rate, age and gender. It increases with bradycardia and decreases with tachycardia. Men have shorter QT intervals (0.39 sec) than women (0.41 sec). Electrolyte balance, drugs, and ischemia also influence the QT interval. The cardiac cycle after a short pause repeats itself, and so on. Therefore, on an ECG in normal sinus rhythm, p-waves are followed after a brief pause by a QRS complex, then a T-wave. Figure 3-2 demonstrates a normal sinus rhythm.

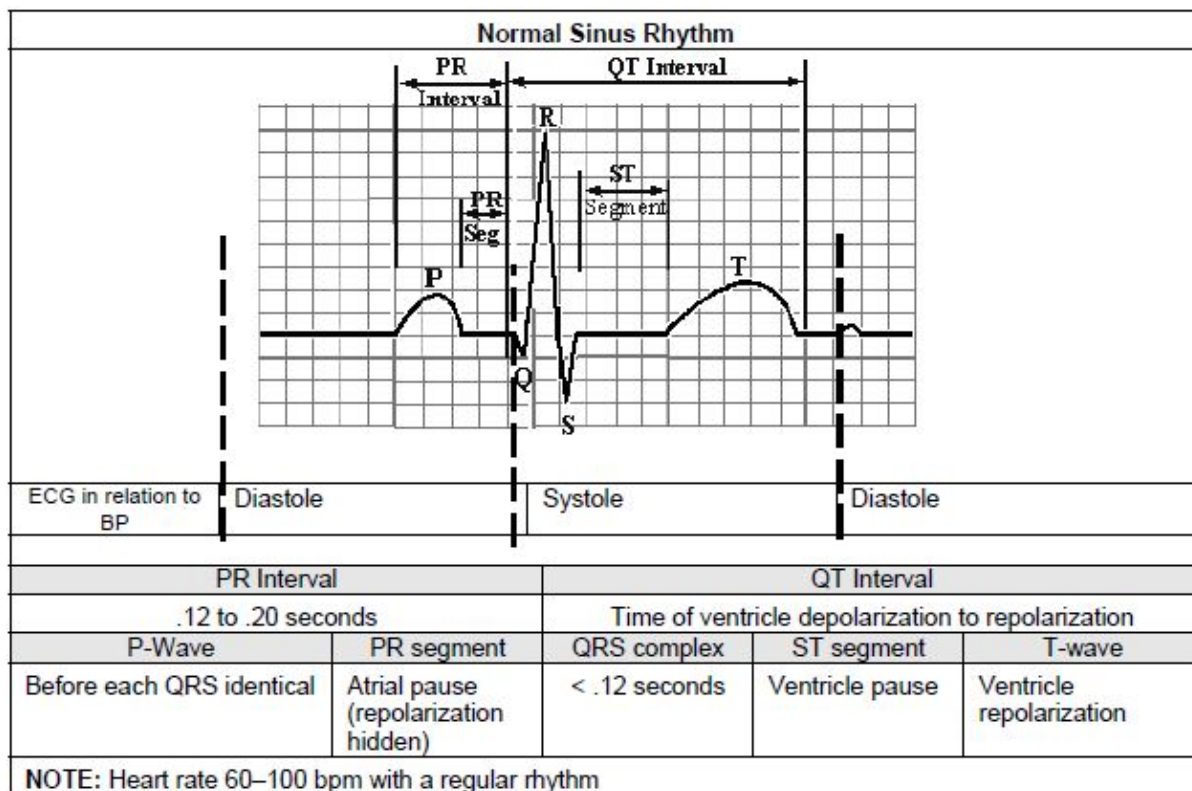


Figure 3-2. Normal sinus rhythm.

Normal sinus rhythm not only indicates that the rhythm is being generated by the SA node and traveling in a normal fashion in the heart, but also that the heart rate, i.e. the rate at which the SA node is generating impulses is within normal limits. There is no one normal heart rate, but this varies by age. It is normal for a newborn to have a heart rate up to 150 beats per minute, while a child of five years of age may have a heart rate of 100 beats per minute. An adult heart rate is even slower; about 60–80 beats per minute.

The electrical activity of the heart is made visual through the ECG; this represents the muscle contractions of the heart in motion produces. Unfortunately there are times when the contraction of the heart muscle does not work in the proper order, or function correctly. When these things happen, they are identified as an arrhythmia.

Causes of arrhythmia

Some of the causes of arrhythmias are simply history of coronary artery disease, heart valve disorders, or other cardiac conditions. Individuals with imbalances of blood chemistries are also at higher risk for arrhythmias and complications from arrhythmias. This blood chemistry imbalance could be from heat exhaustion or trauma, both are common occurrences in the field environment. There are five probable causes for arrhythmia that will be covered:

1. Intrinsic mechanisms.
2. Extrinsic mechanisms.
3. Hypertrophy patterns.
4. Intraventricular conduction defects (IVCD).
5. Preexcitation syndromes.

Intrinsic mechanisms

The intrinsic mechanism of the heart deals with functions within the heart. The problem would arise from direct damage to a portion of the electrical conduction system producing necrosis or ischemia. Necrosis of the heart tissue is commonly known as myocardial infarction (MI). This is when individual cells, groups of cells, or localized areas of tissue have died. With cardiac ischemia the heart tissue is not dead, the blood flow (and thus oxygen) is restricted to a part of the body. Intrinsic mechanisms are also from an imbalance in the activity of the autonomic nervous system. The imbalance is seen when there is an increased sympathetic or the parasympathetic quality in the heart. The heart wall may become distended causing the heart chambers to be stretched. Congestive heart failure (CHF) is one of the results of this problem, in addition to irritation or inflammation of the conduction system (pericarditis).

Extrinsic mechanisms

Extrinsic mechanisms are causes external to the heart. Cardiac drugs such as digoxin, lidocaine, epinephrine, and isoproterenol all have extreme effects on the heart. These effects were covered in the cardiac drug section already. Along with the drugs, trauma, or heat exhaustion can stress the heart and cause arrhythmias.

Hypertrophy patterns

Hypertrophy is seen when the wall of a chamber(s) of the heart become enlarged or thickened. This is not the same result as with CHF. Hypertrophy can occur either in the atrias or the ventricles. With either case the ECG will present differently to determine which of the chambers are being affected.

Intraventricular conduction defects

IVCD is when a delay of the supraventricular impulses through the intraventricular conduction pathways. This delay occurs at the Bundle of His and is noted through a widened QRS complex greater than 0.10 seconds. These blocks are categorized as either right or left bundle branch blocks. The electrical conduction from the AV node is blocked at either the right or the left side of the bundle

branch, preventing the proper activity of the ventricles. This block is not necessarily just one sided, it may occur on both sides as referred to as a 2° heart block or there may be a complete heart block referred to as a 3° heart block.

Pre-excitation syndromes

These arrhythmias are associated with congenital defects that result in a shortened PR interval. The cause is generally due to an abnormal conduction between the atria and the ventricles. There are two primary arrhythmias in this category, the first being Wolff-Parkinson White Syndrome (WPW).

Wolff-Parkinson White Syndrome

A congenital accessory pathway links the atria and ventricles electrically bypassing the AV node, known as the Bundle of Kent. This pathway allows rapid conduction so expect a short PR interval and then a slurred QRS upstroke—this results from the co-activation of ventricle by the accessory path and the AV nodal path. Individual who are predisposed to WPW are individuals with atrial fibrillation, and re-entrant tachycardias.

Lown-Ganong-Levine Syndrome

Lown-Ganong-Levine Syndrome (LGL) is denoted by the impulses originating in the SA node traveling through the accessory pathways that connect the atria to the distal AV node or the Bundle of His. This pathway causes depolarization of both ventricles since the accessory pathways connect at distal points of the AV node and the Bundle of His. The conduction through the ventricles is normal. LGL is characterized with a PR interval less than or equal to 0.12 seconds with a normal QRS complex duration. Predisposition to LGL is seen in individuals with a history of supraventricular tachycardia.

Life threatening arrhythmias

Not all arrhythmias are life threatening, most are treated with medications and routine follow up care. There are three life threatening arrhythmias that you must be able to identify and have an understanding what the cause could be and how to provide initial treatment. These include ventricular fibrillation (VF), pulseless ventricular tachycardia (VT), and asystole. Keep in mind PEA is a cardiac emergency. The patient will have a heart rhythm without a pulse. The causes and recognition of these causes will be discussed at the end of the lesson.

Ventricular fibrillation

VF occurs when the electrical signals in the ventricles fire in an uncontrolled manner. This causes the lower chambers to quiver; therefore the heart is unable to pump any blood. When you look at a bowl of jello and how it moves in no certain pattern, this is the same movement as the heart in VF. Sudden loss of cardiac output with subsequent tissue hypoperfusion creates large-scale tissue ischemia; brain and myocardium are the most susceptible. VF is the primary cause of sudden cardiac death (SCD).

VF can be initiated by ischemic heart disease when a premature ventricular contraction (PVC) overcomes a lowered fibrillation threshold. Fibrillation is caused by simultaneous presence of arrhythmias, conduction disturbances. This abnormal conduction is often seen on an ECG as an R-on-T extrasystole phenomenon. If the abnormal conduction is infrequent the perkinje fibers of the ventricles are able to overcome the arrhythmia and the SA node “restarts” the heart. The next beat begins with the proper conduction from the SA node to the AV node down to the Bundles of His and across the perkinje fibers. If the heart degrades to VF, the only source of correction is electricity to restart the heart. This is completed through the use of the defibrillator. With this advanced cardiac life support, medications are also used in conjunction with the defibrillator. The following is a classic snapshot of what VF looks like on the monitor strip. Keep in mind, there is electrical conduction through the heart, it is just erratic, and produces no rhythmic contractions between the ventricles or the atria’s. See figure 3-3 for a display of ventricular fibrillation.

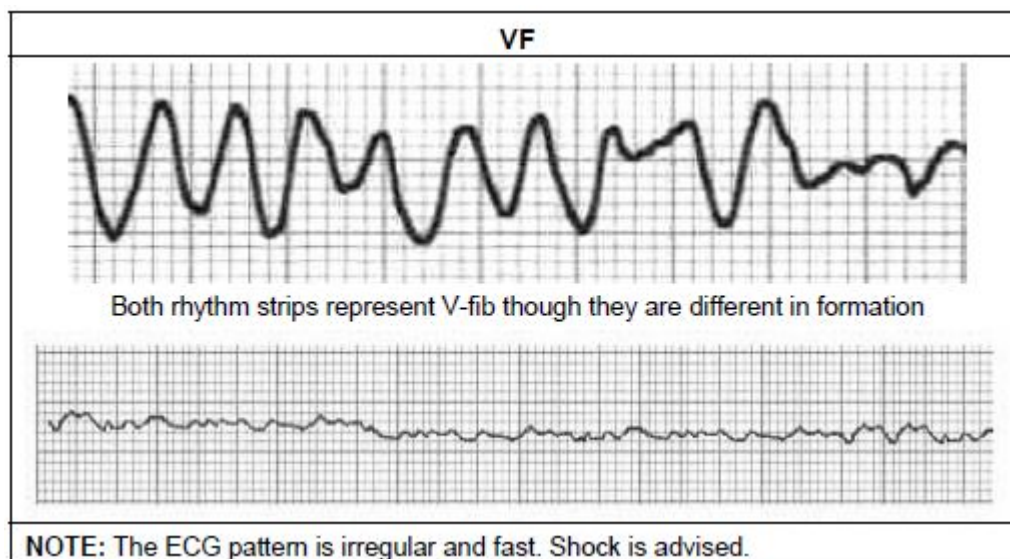


Figure 3-3. Ventricular fibrillation.

The R on T phenomenon can produce fibrillation with the spread of the abnormal conduction to the whole myocardium. This implies that initial fibrillation reached sufficient critical mass. The strip below is just one example of R on T phenomenon that results in VT that often precedes the onset of VF in these cases; VT degenerates into VF. Figure 3-4 demonstrates R on T phenomenon.

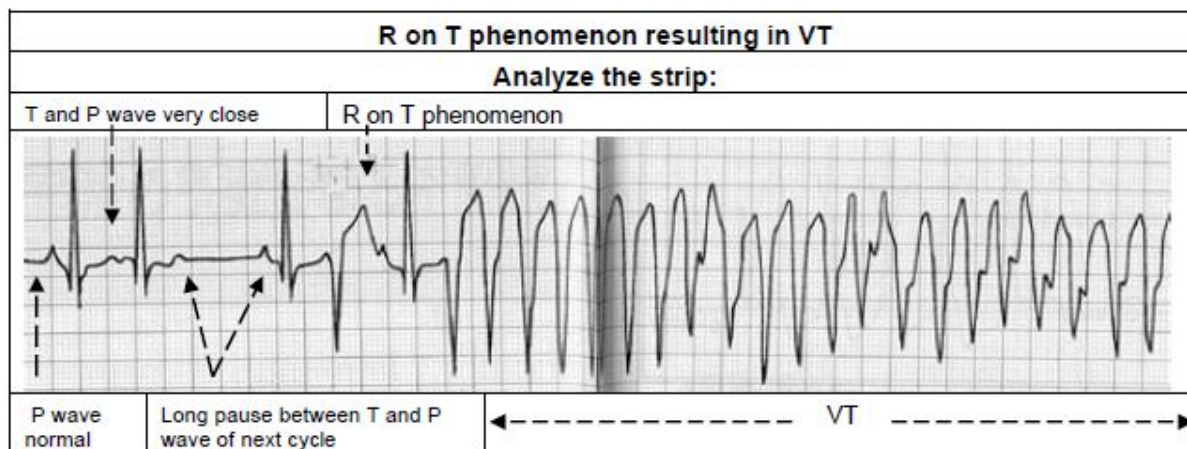


Figure 3-4. R on T phenomenon.

In addition to the R on T phenomenon, more common are the disturbance PVCs can have on the heart. When the heart continues to produce PVCs or premature atrial contractions (PAC) consecutively the results can also be the same as R on T; the abnormal conduction can spread throughout the whole myocardium. There are some predisposing conditions that contribute to a higher possibility of fibrillation. Some of the contributing factors of a lowered fibrillation threshold and myocardial ischemia include the following:

- Increased catecholamine levels due to treatment using antidepressant.
- Improper sympathetic stimulation due to treatment using isoproterenol and norepinephrine and smoking.
- Electrolyte imbalances.
- Hypoxia or acid-base disturbances.

- Toxic responses due to pro-arrhythmic drugs due to treatment using calcium-channel and β blockers.
- Hyperthermia/hypothermia.
- Pro-arrhythmic conditions, such as prolonged QT syndromes, inherited and acquired during treatment with antihistamines, antibiotics and diuretics.

In the absence of ischemic heart disease, VF may occur as secondary to antiarrhythmic drugs, prolonged QT syndromes, pre-excitation syndromes, and systemic hypoxemia. Ventricular tachycardia often precedes onset of VF in these cases; VT degenerates into VF.

If the person does not receive immediate medical attention to include defibrillation and a normal rhythm is not restored quickly, the patient will suffer brain and heart damage and die.

Why is it important to defibrillate early? When defibrillation is done within the first minute, the survival rate is close to 90 percent. Survival then decreases by 2 to 10 percent per minute. By 10 minutes, chances of survival are almost none. This rapid decrease is primarily due to the depletion of the heart's energy stored by the fibrillating heart. When cardiopulmonary resuscitation (CPR) is performed during this time, survival rates do improve. However, EARLY defibrillation remains the critical step to successful revival of VF and pulseless V-Tach.

Pulseless ventricular tachycardia and ventricular tachycardia

Do not confuse pulseless ventricular tachycardia (pulseless VT) with VT. With VT the heart's electrical activity is fast because ectopic pacemakers (other than the SA node) arise within the ventricles, but the heart is still able to eject blood to the body. The victim has a rapid pulse and may be conscious and breathing. An automated or semi-automated defibrillator cannot tell the difference between the two. That is why it is critical to check the pulse. When a heartbeat begins in the ventricles, the disturbance will usually spread throughout the myocardium and the result is usually fatal.

With pulseless VT, the heart's electrical activity is racing, the muscles may not be able to keep up and remain contracted. If they do not relax, the heart cannot fill with blood, and consequently no blood will be ejected. Shock is advised in hopes it will stop the ectopic pacemakers within the ventricles and the SA node will take over and regain control. Always ensure to check the victim's pulse prior to administering any electricity to the heart. The treatment for pulseless VT is the same as VF. Figure 3-5 below demonstrates ventricular tachycardia.

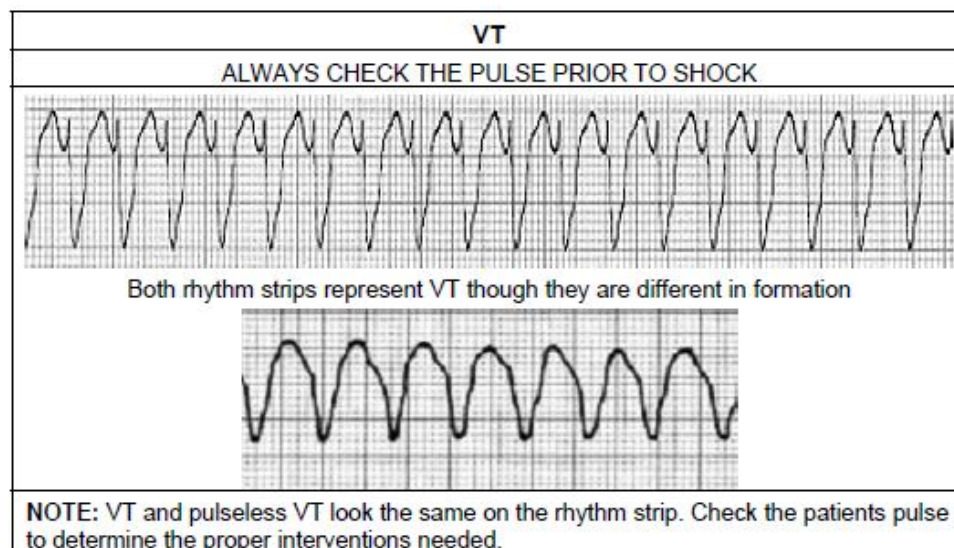


Figure 3-5. Ventricular tachycardia.

1. How do you define medication reconciliation?
2. What are the benefits of ensuring medication reconciliation is done?
3. The ADL is approved by what function?

4. What must be done first before inputting information into the calculation formula?
5. How many milliliters are there in a teaspoon?
6. What is the basic method of calculating drug dosages?
7. How do you convert kilograms to pounds?

Use the following scenario for questions 8 and 9:

Mrs. Smith has an order to receive 5 mg/kg of medicine each day. Mrs. Smith weighs 154. The medicine is supplied in 500mg/ml.

8. How much does Mrs. Smith weigh in kg?
9. How many milliliters does the patient receive?

016. Performing wound closure

1. Why is the primary intention closure used when a surgical incision is made?
2. What is a digital block?
3. What must occur before a local anesthetic can be administered?

017. Determining patient needs

1. How are customer needs assessed?
2. Why is building rapport important?

3. What should you do if you cannot solve the patient's problem?
4. What is a patient advocate?

018. Emergency cardiac care

1. Explain the normal flow of electrical conduction through the heart.
2. Why is the repolarization of the atria *not* seen on an ECG?
3. What are likely causes of extrinsic mechanisms of arrhythmias?
4. Why is it important for early defibrillation when treating VF or pulseless VT?

3-3. Aerospace Medicine Program

Aerospace Medicine is the assemblage of a team of highly qualified and committed personnel, using facilities and business processes to successfully execute the Aerospace Medicine Program (AMP), as described in Air Force Policy Directive (AFPD) 48-1, Aerospace Medicine Enterprise.

Responsibilities for elements of the AMP are outlined in AFI 48-101, *Aerospace Medicine Enterprise*. This "Team Aerospace" is comprised of personnel and activities that include, but may not be limited to, Flight Medicine, Public Health (PH), Bioenvironmental Engineering (BE), Health Promotion (HP), Aeromedical Evacuation (AE), Medical Readiness, Optometry, and Hyperbaric Medicine as well as education, research and development activities related to the successful completion of this program.

Previous training provided you with the groundwork to complete the specific tasks involved with aerospace medicine and the understanding of the basic "nuts and bolts" of the AMP as a whole. The next progressive step is to take on leadership roles. As the AMSC, you will provide health care and management for flying and special operational duty personnel, deployment readiness, occupational health examinations, and many others, all of which are geared toward ensuring personnel on the installation (or while deployed), are performing at maximum efficiency to carry out their AF mission. This is much more than routine healthcare—the AMP is a world where you must consider the impact medical care and treatment may have on the mission—as well as your patients' health and readiness. In a sense, the mission is the focus as a result of the treatment of the patient.

019. Maintaining medical standards

Medical standards are derived from law, DOD Instructions and DOD Directives. These standards primarily exist for two very important reasons. First, medical standards are in place to ensure the basic health and fitness of all military members, to fulfill its obligation as an instrument of US National Policy.

Second, standards ensure personnel are not placed at undue risk based on conditions that may not be conducive to certain military occupations. Your role as an experienced AMSC, who is facing the challenges of leading the enlisted force for an element of Team Aerospace, cannot be overemphasized. Understanding how the application of medical standards impacts all military members, their respective units and the carrying out of that unit's mission, will lead to your success as an operationally minded medic.

Conducting medical record reviews

To track medical standards, personnel medical records needs to be reviewed for disqualifying defects in accordance with AFI 48-123, Medical Examinations and Standards. This is completed by conducting a medical record reviews prior to any medical appointment regardless of appointment type. The focus is identifying and preventing illness to ensure a healthy working environment. The general responsibility of the AMSC is the follow these steps:

1. Ensure member has a current AF Form 422, Notification of Air Force Member's Qualification Status on file.
2. Ensure member has a current preventive health assessment (PHA) on file.
3. Ensure member has followed up on any previous appointment responsibilities to include but not limited to 5-day blood pressure checks, lab work or any referral requests made by the provider.

Our role is to identify if follow up care is still required and ensure the patient follows through with their medical responsibilities. The ultimate goal is to make sure the patient is medically qualified to perform their duties.

Another type of medical records review involves security clearances. Each of us requires a security clearance to perform our job in the Air Force. There are three different categories of classified information.

1. Confidential: Applied to information or material the unauthorized disclosure of which could be reasonably expected to cause damage to the national security.
2. Secret: Applied to information or material the unauthorized disclosure of which reasonably could be expected to cause serious damage to the national security.
3. Top Secret: Applied to information or material the unauthorized disclosure of which reasonably could be expected to cause exceptionally grave damage to national security.

As an aerospace medical technician, your primary classification would be a secret clearance, but in general, two things determine the level of security required—your AFSC and your assignment. AFI 48-123 lists the standards applicable to all USAF personnel as well as some specialized jobs and circumstances members may find themselves. With every patient visit, remember to continually ask yourself the question, *“What is the impact on the unit's ability to do its mission as a result of my action?”* Repeated referral to this instruction and remembering the operational impact will lead to your successful execution of this important AMP role. The application of standards does not simply mean making sure a physical examination reflects someone's qualification, or disqualification from an AFSC, a special duty assignment, or overseas permanent change of station (PCS) move. Applying these medical standards is vital during every visit an Active Duty (AD) or Air Reserve Component (ARC) member makes to your clinic, regardless of flying or special operations duty status.

The quick identification of members not meeting the medical standards listed for a given circumstance can affect duty performance, retention within an AFSC, or perhaps their very career.

In AFI 48-123, each of the chapters cover the medical standards for specific physical examinations such as initial, periodic, separation and retirement, medical hold, profiles, waivers and examinations exclusive to the ARC not on extended active duty. Within each of the chapters, the AFI is organized by body system, and the standards for each are listed in the respective attachments.

The medical standards and disqualifying medical conditions are more stringent for those individuals who are on flying status due to the significant operational necessity of their mission. Since flying standards are more stringent than those for retention in the Air Force, it can be safely assumed that if one meets flying standards, they also meet the standards required for retention in the service.

However, one may not assume that if a member is disqualified for flying, they are also disqualified from further retention in the Air Force—but you should be asking that question just the same.

To ensure a medically fit force, you are required to understand a disease process and be able to apply the applicable medical standards for that disease. You will have to recognize them during patient visits as well as during a record review.

The responsibility of applying the medical standard process does not solely belong to the AMSC. You must take the initiative to learn, understand, and become proficient with these medical standards.

Medical Board

To maintain a fit and vital force, the Secretary of the Air Force relies on disability laws to remove active duty and ARC (Air Force Reserve and Air National Guard) members who can no longer perform their military duties because of a mental or physical defect. The Medical Evaluation Board (MEB) is the first step in the Air Force disability evaluation process to determine who is not worldwide qualified.

In addition to Force Health Management the AMSC can also pick up on a 4T profile that meets the criteria for MEB/Physical Evaluation Board (PEB).

When performing a medical records review, keep in mind this one-year standard for a 4T profile. The medical standard of one year can also be accumulative. However, it is not necessary or advisable to wait a full year before initiating an MEB if the condition is likely to remain or reasonably expected to last beyond the 12 months period. There are also circumstances when an MEB must be completed immediately following an event. For example, a patient suffering a seizure must have an MEB within 90 days of diagnosis.

Once an individual with a 4T profile is identified as needing an MEB, the process is completed according to AFI 41-210, *Patient Administration Functions, TRICARE Operations and Patient Administration Functions*, chapter 10. A 4T profile precludes reassignment and precludes worldwide assignment and deployment (mobility) until the MEB or PEB processing is completed or the condition is resolved. For active duty members, it does not necessarily preclude retraining.

When the MEB/PEB process is complete, the patient's primary care provider will assign a permanent limitation based on the board results. The local profiling officer is the final approval for this new revised physical, upper extremities, lower extremities, hearing, eyes, psychiatric (PULHES) for all active duty members who are returned to duty with or without an assignment limitation code-C (ALC-C) by AFPC/DPAMM. Additionally, the profile should indicate when the next in-lieu-MEB review is due at HQ AFPC/DPAMM. Profiles for members returned to duty following MEB/PEB with ALC-C require semi-annual review.

If a member is returned to unrestricted worldwide service by MEB/PEB (without ALC-C action), do not assume that the member's condition is compatible with mobility, deployment or overseas assignments. For example, if an individual has a PULHES (physical, upper extremities, lower extremities, hearing, eyes, p(s)ychiatric) with a "3" coded in the lower extremities, they are able to perform their primary responsibilities of their career field, but unable to stand longer than six hours at a time. Two specific outcomes from an MEB/PEB are individuals who are returned to duty with an ALC -C or are recommended for temporary disability retirement limitations (TDRL) with or without a limited assignment status (LAS).

Integrated Disability Evaluation System

The Integrated Disability Evaluation System (IDES) is the joint DOD-VA process that helps the Air Force, Army, Navy, and Marine Corps determine whether wounded, ill, or injured Airmen are able to continue to continue active duty service. In the Air Force, the case is referred to the IDDES by DPAMM.

Timelines

Prior to integrating the services into one medical evaluation board, timelines for a member from case initiation, to VA rating could take as long as three years. The new process goal is to shorten the timeline with a joint, continuous, and efficient process. To achieve this, the DOD created the IDDES timeline that the process is required to meet. Monitoring and updating the Veterans Tracking Application (VTA) will ensure you are following the timelines.

Responsibilities

The MTF commander appoints a mature and experienced administrator as the MEB clerk and PEBLO. By its name, you may think that PEBLO must be a commissioned officer, but actually, most PEBLOs are mature responsible enlisted or civilian personnel. At the larger hospitals, the PEBLO is designated on published orders. At non-PEBRHs, the PEBLO need not be on orders, but must be identified in each request for one-time PEB referral authority.

Provider

Upon notification, the provider will complete and sign the VA Form 21-0819, VA/DoD Joint Disability Evaluation Board Claim, forward to the Physical Evaluation Board Liaison, who will then send it to the VA via the MSC.

MEB clerk

The MEB recorder provides the following administrative support functions for the MEB:

1. Assembles and provides all pertinent reports and records, and schedules cases for board hearings.
2. Completes AF Form 618, Medical Board Report; obtains signatures from the board members and the approval authority; and assembles the attachments to AF Form 618.
3. Ensures the evaluatee or next of kin (NOK) has an opportunity to read the medical board report and narrative summary (NARSUM).
4. Assists the evaluatee in resolving any questions concerning the content of the report or summary, and advises the evaluatee or NOK that he or she may submit a signed statement for consideration by the disposition authority if the evaluatee takes exception to the content of the MEB report or NARSUM.
5. Obtains evaluatee or NOK signature on AF Form 618, forwards the completed MEB package to the disposition authority, and makes proper distribution of that authority's responses.

Physical Evaluation Board Liaison Officer

The Physical Evaluation Board liaison officer (PEBLO) is not necessarily an AMSC; it may be a civilian or an individual of another AFSC (4A0, or 4E0) with guidance found in AFI 36-3212, *Physical Evaluation for Retention, Retirement, and Separation*. The PEBLO is responsible for ensuring all disability cases referred to the PEB are complete, accurate, and fully documented. They also counsel members or NOK on the PEB findings and recommended disposition as documented on AF Form 356, Findings and Recommended Disposition of USAF Physical Evaluation Board. This individual manages all of the profile serial code 37 in conjunction with Military Personnel Flight (MPF) and the tracking through PIMR. The PEBLO will counsel patients concerning their rights in the disability process. During this counseling the PEBLO will ensure all members undergoing disability evaluation fully understand the process.

The PEBLO counsels them on at least two occasions: when the case enters the disability evaluation system at the referring facility, and again when the PEB completes its action. The PEBLO will not

speculate about the possible case disposition or percentage of disability when counseling the patient. When a patient requests a formal hearing, the PEBLO counsels them at the referring facility, then the appointed military counsel counsels them before and after the hearing.

Counseling varies, depending on the circumstances in each case. Information in this attachment, as well as other parts of this instruction, will answer most questions.

In addition, HQ AFPC/DPPD prepares and distributes a “Disability Counseling Guide for PEB Liaison Officers” to assist in counseling. However, the PEBLO or PEB counsel should contact HQ AFPC/DPPD if they need help. Lastly, the PEBLO will maintain coordination with the member, medical facility, MPF, and HQ AFPC/DPPD.

Assignment limitation code-C

When a member has been evaluated by an MEB/PEB and is returned to duty as “fit,” HQ AFPC/DPAMM will review the case to determine the code. An ALC-C is annotated for AD or DAC-42 if the member is ANG. The code needs to be placed in the Personnel Data System (PDS) which is done at the MPF.

This code will prevent reassignment without prior HQ AFPC/DPAMM or ARC/SGP medical clearance. The intent of the ALC-C (DAC-42 for ANG) is to protect members from being placed in an environment where they may not receive adequate medical care for a possible life-threatening medical condition and to prevent the assignment of non-worldwide qualified personnel to overseas locations. This will further ensure the safe and effective accomplishment of the Air Force mission.

Medical reviews are conducted periodically for all ALC-C, as specified by DPAMM. This is dependent on the diagnosis. The reviews are usually due during the member’s birth month.

HQ AFPC/DPAMM is the authority to assign or remove the ALC-C on active duty members and the appropriate ARC/SGP is the authority to assign or remove the ALC-C or DAC-42 for ARC members. Active duty and ARC medical facility commanders are responsible for tracking and keeping wing commanders updated on those members of the command who are on ALC-C or DAC-42 and will assure timely medical review during the birth month of the member or as specified by HQ AFPC/DPAMM during the year indicated. The AD or ARC medical facility is the focal point for the management of ALC-C or DAC-42 reviews for all members assigned to the installation including those geographically separated.

A couple of common medical diagnoses associated with an ALC-C are obstructive sleep apnea requiring continuous positive airway pressure (CPAP) device and asthma. Asthma is defined to include recurrent bronchospasm, or reactive airway disease, unless due to a well-defined avoidable precipitant cause. Just because an individual has either of these diagnoses, does not mean they will automatically require separation. The only mandatory step to be taken is for the individual to complete the MEB/PEB process to determine a need for an ALC-C or a permanent change in their profile.

All of the information needed to retire or discharge AF members who are unfit to do their military duties because of physical disability as determined by an MEB is found in AFI 36-3212, *Physical Evaluation for Retention, Retirement, and Separation*. The AFI outlines procedures for examining, and discharging or retiring members from the TDRL. An MEB finding that places a member on TDRL requires individual to be reassessed at least once every 12 months. This instruction describes how to retire or discharge AF members who are unfit to do their military duties because of physical disability. It outlines procedures for examining, and discharging or retiring members from TDRL.

020. Deployment Availability Working Group Overview

The Deployment Availability Working Group (DAWG) is a working group formed with members in the military treatment facility (MTF) that reviews personnel medical conditions. Their purpose is to review patients with medical records with a duty limiting condition (DLC) that impacts mobility,

retention, or long-term physical fitness of an Airman. The group also identifies personnel not deployment eligible and tracks progress of the medical condition. For the DAWG to do their job, there needs to be a system or process in place to notify them of the DLC. Currently there are two ways the DAWG is notified; through a trigger event, or profile reviews.

Trigger events

A trigger event is a condition or occurrence that may indicate a member has a health condition that is inconsistent with retention standards or deployability. The provider identifies the trigger event.

Trigger events include, but are not limited to, the following:

1. Provider identification of duty limiting condition(s) or deployment limitation(s).
2. Although not an all-inclusive list, Chapter 5 of AFI 48-123, *Medical Examinations and Standards* specifies conditions that require evaluation for continued military service.
3. Commander requests evaluation due to poor duty performance or deployment concerns stemming from a potential medical or mental health condition.
4. DPANM may identify conditions via an annual or modified review in lieu of medical board (RILO) and direct the MTF to submit an initial RILO package.
5. PCS, TDY, or deployment cancellation or curtailment for a medical or mental health reason. After recognizing a trigger event, the provider must notify the MTF PEBLO and Medical Standards Management Element (MSME). Once notified, the PEBLO will put together a package referred to as an Initial Review in Lieu of Medical Board (IRILO).

Unfitting

Conditions that are not eligible for referral to the disability evaluation system are referred to as an unfitting condition.

Unsuited

Unsuited conditions are different from unfitting conditions because they are handled using administrative action. Unsuited conditions are listed in AFI 36-3208, *Administrative Separation of Airmen*, and do not qualify for disability processing.

Initial Review in Lieu of Medical Board paperwork

Preliminary review of a trigger event requires an IRILO. The IRILO should meet the next scheduled DAWG meeting; however, it should not exceed 45 days once the case is referred to the PEBLO or MSME. The following IRILO documents are required to meet the DAWG:

1. NARSUM.
2. Commander's letter.
3. Medical records.
4. Consults or special examination.
5. Updated profile.
6. Other relevant information.

Profile

The physical profile system classifies individuals according to physical abilities, functional abilities, and long-term availability for worldwide duty. The MSME reviews all profiles and refers Airman's case, as medical condition requires. However, before you learn about the different types of profiles and classifications, you need to understand the profile lingo.

Duty limitation

A duty limitation is a recommendation resulting from a medical evaluation, which, if applied explicitly, limits or restricts an Airman's ability to perform primary and/or additionally assigned duties, deploy (mobility), or participate in fitness activities.

Duty limiting condition

A medically related condition (injury or illness) that results in a duty limitation is a DLC.

Duty restriction

A duty restriction is a recommendation resulting from a medical evaluation, which, if applied explicitly, restricts the activities that an Airman may perform in carrying out any and/all required or directed Air Force duties or responsibilities. While maintaining physical fitness is a responsibility of all Airmen, fitness activities are not included in the definition of duty restrictions.

Functional (or physical) limitation

A functional limitation is the *inability* of an Airman to perform specific physical movements or actions based on an assessment of the Airman's injury or illness by a medical professional.

Functional (or physical) restriction

On the other hand, the restriction is a report of an Airman's injury or illness, based on evaluation by a medical professional, that describes specific physical activities or functions that are *recommended* for the Airman to avoid allowing recovery or reducing risk of further injury.

Mobility restriction

A mobility restriction is a recommendation resulting from a medical evaluation, which, if applied explicitly, limits or restricts an Airman's participation in deployment or mobility actions.

Assignment availability codes

An assignment availability code (AAC) is not a medical code, but a personnelist code. It is an Assignment Deferment and Availability code that is updated in the Military Personnel Data System (MilPDS). It precludes an Airman from moving while suitability to remain on active duty is evaluated, or during a period of observation or rehabilitation. There are personnel codes for Airmen going through some type of administrative actions, and there are also medical codes for Airmen going through evaluation. There are two codes reviewed by the DAWG that are related to the MEB.

| Two Codes Reviewed by the DAWG Related to the Medical Evaluation Board | | | |
|---|-------------------|--|--|
| Code | Title | Description | Deferment Period or Effective Date |
| 31 | Medical Deferment | Temporary disqualification for worldwide duty, including PCS (nonmobility profile) | Date of availability on AF Form 469, Duty Limiting Condition Report, section IV (not to exceed 12 months from date medical problem incurred), or expiration of medical hold imposed by HQ AFPC/DPAMM. |
| 37 | Pending MEB | Member deferred from PCS reassignment pending results of MEB or PEB | Regardless of date of availability on AF Form 469, Duty Limiting Conditions Report, no assignment action is taken until Airman is returned to duty through AFPC/DPAMM and code 37 is removed as Airman may be unfit for retention. |

Forms

There are two forms used to record evaluation or diagnosis of disqualifying defects: the AF Form 469, Duty Limiting Condition Report and AF Form 422, Notification of Air Force Members Qualification Status.

AF Form 469, Duty Limiting Condition Report

The AF Form 469, Duty Limiting Condition Report is used to describe physical limitations and recommend duty restrictions to the commander when there is a potential risk to an Airman's health, safety and well-being, the safety of the mission, or the ability of the Airman to effectively complete the mission. It is also used to notify the commander of limitations related to the AF Fitness Program (FP). In general, the AF Form 469 describes what an Airman is unable to do. Duty limitations are entered on the AF Form 469. The profile is only good for a maximum of 365 days. The only time a profile is valid for longer than 365 days is when the member has met the MEB.

AF Form 422, Notification of Air Force Member's Qualification Status

The AF Form 422 is primarily used to annotate if someone is qualified for the following:

- Initial qualification,
- Retirement or separation.
- Military retraining.
- PCS.
- PME.

It may also be used for to document exercise prescriptions, and to describe what an Airman is qualified to do based on medical assessment. The AF Form 422 is also used to convey descriptions of physical capabilities, which are used for establishing suitability for continued military duty. Both forms are updated annually during the PHA. The forms are also updated when a duty or mobility restriction exists for 6 months and the condition is not expected to improve in the near future.

Guidelines for profiles

If a member requires a profile that meets the following guidelines, the case is presented to the DAWG:

1. Fitness assessment exemptions with AC exemptions (not including pregnancy profiles).
2. Fitness assessment exemptions for 365 days.
3. If a member is not qualified for their current AFSC, or qualified to retrain to another AFSC.
4. Cases previously reviewed by the DAWG that requires follow-up.
5. Mobility restriction for over 90 days.
6. If a member is on an AAC 31 that reaches 300 days cumulative for a single condition.

Quarters management

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. A quarters' patient is treated on an outpatient basis, and is to remain in their home during the quarters' period. Quarters' periods generally last 24–72 hours depending on the providers prescribed rest/recovery period.

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 on-going 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 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, Task Performance Checklist, or a locally created form. Disclose only the minimum information necessary and account for the disclosure in the Protected Health Information Management Tool (PHIMT) 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 to the member so he/she may give the quarters' sick slip to their supervisor. Develop local procedures for program management, including, but not limited to these:

- Notifying PH for communicable disease tracking.
- Mechanism for 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—Commander's Support Staff (CSS) to make the quarters notification. Once received by the member's unit, the medical quarters' data is manually entered into the AFPC 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 commanders, CSS, 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 email notification to the commander/designated unit monitor. The member can obtain a copy of his or 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.

Membership

There are members of the MTF that must be present and accounted for during the DAWG meeting; their knowledge and expertise make them essential to the member's evaluation. These members include the Chief of Aerospace Medicine, Chief of Staff, senior profiling officer (SPO), all available profile officers, MSME, PEBLO, a PCM representative, and exercise physiologist (EP). If mission requires, other individuals, such as the Department of VA, mental health, women's health, and so forth can be assigned or invited to the meetings.

Those who are not assigned to the MTF staff may attend, but only for those portions of the meeting that do not address protected health information (PHI). For PHI-related portions of the meeting, DAWG attendance by non-MTF staff is limited to unit commanders or personnel designated by commanders to receive PHI. These personnel may only attend portions of the DAWG applicable to Airmen under their designated command structure.

DAWG evaluation

During the meeting, the members of the DAWG have a heavy burden. They evaluate individual's medical conditions to ensure they can safely meet the requirements of the Air Force. The following items are some of the criteria members take into considerations when evaluating active duty member's medical conditions:

1. Is timing appropriate for IRILO referral? Verify the member's hospitalization or treatment progress appears to have medically stabilized (and the course of further recovery is relatively predictable). In cases where there is no definitive diagnosis, but the preponderance of clinical evidence suggests a probable underlying cause in which the treatment progress, and/or progression of the condition, appears to be reasonably predictable, IRILO processing may proceed without a definitive diagnosis.
2. Is the case appropriate for IRILO referral? Only unfitting conditions are eligible for referral. Unsuiting conditions must be distinguished from unfitting conditions because they are handled using administrative action.
3. Is the member unable to reasonably perform the duties of his or her office, grade, rank, or rating due to a physical or mental condition which is not likely to resolve or improve such that he or she can perform the duties of his or her office, grade, rank or rating within 12 months?
4. Is this a chronic condition, which imposes unreasonable requirements on the military to either maintain or protect the member?
5. Is this a chronic condition that may preclude or limit the member's ability to safely and effectively deploy to field conditions?
6. Has an IRILO package been directed by DPAMM?
7. Is this a condition with 12 months of cumulative AAC 31 status for the same or related issue(s)?
8. Is the member refusing required professional, medical or dental care, which would be necessary to achieve fitness for continued military service?

DAWG determinations

The DAWG review takes into account all available and appropriate information related to the case and then makes a determination. The disposition of the DAWG review may include case dismissal, IRILO referral (for profile review) or refer for adjudication (for IRILO review).

Case dismissal

The DAWG can decide the Airman is fit for continued military service and mobility based on the information considered. Although the case is dismissed, it does not mean the Airman cannot meet the DAWG review again in the future for the same condition if the Airman's status changes. A note is placed in the Airman's medical record indicating that the condition was reviewed for possible MEB and found to be fit without need for IRILO or MEB. Lastly, the AF Form 469, Duty Limiting Condition Report is updated appropriately and the case dismissed to routine medical care.

Initial Review in Lieu of Medical Board referral

During a profile review, if there is any doubt that the Airman is fit for continued unrestricted duty, the case becomes an IRILO. Once the DAWG determines that the case warrants IRILO, it is incumbent upon the PEBLO to ensure that all requirements for the IRILO package are completed.

Refer for adjudication

When the case is referred for adjudication, the PEBLO acquires the required documents, prepares them and ensures they are signed by the Chief, Medical Staff (SGH) or the Chief, Aerospace

Medicine (SGP). This step is a final quality review and is completed within 30 days of the DAWG initially reviewing the case.

Medical standards recommendations

AFPC/DPANM reviews the IRILO packages and advises the PEBLO of the disposition. The notification comes via the AFPC/FL4 and is sent to the PEBLO. The types of determinations are return to duty, direct an MEB, and Continued Military Medical Observation and Care.

Return to duty

If the member is returned to duty (RTD), the PEBLO is notified by DPAMM via the AFPC/FL 4. In turn, the PEBLO notifies the PCM and the MSME. A disposition of RTD does not mean the Airman cannot be considered for an IRILO again for the same condition if the condition changes or deteriorates enough to warrant re-consideration.

Direct MEB

If DPAMM directs an MEB, the PEBLO is notified via AFPC/FL4. The PEBLO will then notify the PCM, the DAWG chair, and the SGH. The PCM will complete the VA Form 21-0819, VA/DoD Joint Disability Evaluation Board Claim form and return it to the PEBLO. The date the provider signs the VA Form 21-0819 is the date that the member officially enters into the IDES.

Continued Military Medical Observation and Care

Although infrequently used, continued military medical observation and care is also a type of determination. This would also be listed using an AFPC/FL4 and it would provide further directions such as 'Re-evaluate in 6 months.'

Self-Test Questions

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

019. Maintaining medical standards

1. Medical standards exist for what two purposes?
2. What two things determine a member's security clearance?
3. When are medical standards applied?
4. What circumstance warrants an MEB be completed immediately following the event and how long after the event must it be completed?
5. Who is the final approval authority for the new PULHES for all active duty who are returned to duty?

6. What are two specific outcomes from a MEB/PEB?
7. What is the primary responsibility of the PEBLO?
8. What is the primary purpose of ALC-C?

020. Deployment Availability Working Group Overview

1. What is the purpose of the Deployment Availability Working Group?
2. What is a trigger event?
3. What AFI specifies conditions that require evaluation for continued military service?
4. Who can request medical evaluations due to poor duty performance or deployment concerns due to medical concerns?
5. Once identified, how long does a Review in Lieu of MEB have to meet the DAWG?
6. What cases are not qualified for disability processing?
7. What is a duty limitation?
8. What is an Airman's inability to perform actions due to an injury or illness?
9. What assignment availability code cannot to exceed 12 months?
10. What assignment availability code is used for members pending a MEB?

11. When would you use an AF Form 469, Duty Limiting Condition Report?
12. When should an AF Form 422, Notification of Air Force Member's Qualification Status be used?
13. What kind of fitness exemptions are required to meet the DAWG?
14. Who is required to be part of the DAWG?
15. What are the determinations the DAWG can make?
16. If the DAWG refers the case for adjudication, how long does the quality review have to be completed?
17. What recommendations can DPAMM make?

Answers to Self-Test Questions

013

1. High blood pressure, overweight, and over the age of 40.
2. (1) Peripheral can cause either pain or loss of feeling in the toes, feet, legs, hands and arms. (2) Autonomic—it affects the nerves of the autonomic nerve system—causes changes to organ systems like the digestive, sexual responses, and perspiration as well as the nerves that serve the heart. (3) Proximal neuropathy can cause pain in the thighs, hips or buttocks that may lead to weakness in the legs. The pain generally starts in the thighs, hips, buttocks, or legs, affecting one side of the body. (4) Focal neuropathy results in the sudden weakness of one nerve or a group of nerves causing weakness or pain at the nerve site.
3. Peripheral neuropathy can lead to changes in a patient's gait causing foot deformities such as hammertoes and the collapse of the midfoot (flattened arches). Blisters and sores appear on the numb areas of the foot because the pressure or injury goes unnoticed.
4. The nerves interfere with the body's ability to adjust blood pressure and heart rate. The result is a sharp drop in blood pressure with position changes, or the heart rate remaining high instead of rising and falling in response to normal function or exercise.
5. Focal neuropathy.
6. To bring the blood glucose levels within the normal range.

014

1. Airway management.
2. Endotracheal tube.

3. (1) b.
- (2) a.
- (3) b.
- (4) a.
- (5) a.
- (6) b.
- (7) b.

015

1. The process of comparing a patient's medication orders to all of the medications that the patient has been taking.
2. To avoid medication errors such as omissions, duplications, dosing errors, or drug interactions.
3. By the P&T Function for stock and use by sections and providers within your facility.
4. Conversions.
5. 5.
6. The basic calculation method:
$$\frac{\text{Ordered} \times \text{Quantity}}{\text{Supplied}} = \text{The amount needed for the dosage required .}$$
7. Multiply 2.2 by the weight in kilograms.
8. 70 kg.
9. 0.7 ml.

016

1. Because there is little tissue loss or damage,
2. A nerve block that anesthetize the finger.
3. Obtain informed consent from the patient for the procedure to take place, instruct the patient on what will occur throughout the process, gather your supplies to include drawing up your local anesthetic, expose and drape operative area (if applicable), clean operative area with Betadine swabs or wipes.

017

1. Through customer evaluation.
2. Builds harmonious relationship with patients as well as a sense of safety and security.
3. Find someone in the organization who can.
4. Liaison between patient and healthcare provider.

018

1. The SA node generates an electrical impulse that travels through the right and left atrial muscles: the P wave represents atrial depolarization. The electrical impulse then continues to travel through specialized tissue (internal nodal pathways) leading the electricity to the AV node: the ventricular contraction is represented electrically on the ECG by the QRS complex. The T-wave represents the electrical changes in the ventricles as re-polarizing.
2. Because the electrical activity of the ventricle is more powerful and is seen as the electrical activity in the QRS complex. Because of the large muscle mass of the ventricles, the re-polarization of these muscles is electrically noted on the ECG as the T wave."
3. Cardiac drugs such as digoxin, lidocaine, epinephrine, and isoproterenol, trauma or heat exhaustion can stress the heart are extrinsic causes of arrhythmias.
4. When defibrillation is done within the first minute, the survival rate is close to 90 percent. Survival then decreases by 2 to 10 percent per minute. By 10 minutes, chances of survival are almost none. This rapid decrease is primarily due to the depletion of the heart's energy stored by the fibrillating heart. When CPR is performed during this time, survival rates do improve. However, EARLY defibrillation remains the critical step to successful revival of VF and pulseless V-Tach.

019

1. (1) To ensure the basic health and fitness of all military members to fulfill its obligation as an instrument of US National Policy. (2) To ensure personnel are not placed at undue risk based on conditions that may not be conducive to certain military occupations.
2. AFSC and assignment.
3. During every visit an AD or ARC member makes it to your clinic, regardless of flying or special operations duty status.
4. A patient suffering a seizure; 90 days.
5. Local profiling officer.
6. Return to duty with assignment limitation code and recommend for Temporary Disability Retirement Limitations.
7. To ensure all disability cases referred to the PEB are complete, accurate, and fully documented.
8. To protect members from being placed in an environment where they may not receive adequate medical care for a possible life-threatening medical condition and to prevent the assignment of non-worldwide qualified personnel to overseas locations.

020

1. To review patients with medical records with a DLC that impacts mobility, retention, or long-term physical fitness of an Airman.
2. It is a condition or occurrence, which may indicate a member, has a health condition that is inconsistent with retention standards or deployability.
3. AFI 48-123, *Medical Examinations and Standards*.
4. The commander.
5. Within 45 days.
6. Unsuiting.
7. A duty limitation is a recommendation resulting from a medical evaluation, which, if applied explicitly, limits or restricts an Airman's ability to perform primary and/or additionally assigned duties, deploy (mobility), or participate in fitness activities.
8. Functional (or physical) limitation.
9. Code 31.
10. Code 37.
11. This form is used to describe physical limitations and recommend duty restrictions to the commander when there is a potential risk to an Airman's health, safety, and well being; the safety of the mission, or the ability of the Airman to effectively accomplish the mission. Additionally, the AF Form 469 is used to convey limitations related to the AF Fitness Program (FP). In general, the AF Form 469 will describe what an Airman is unable to do.
12. For initial qualification; retirement or separation; military retraining; PCS; and PME.
13. Fitness assessment exemptions with AC exemptions (excluding pregnancy) and fitness assessment exemptions for 365 days.
14. SGP, SGH, SPO, all available profiling officers, MSME, PEBLO, a PCM representative, and EP.
15. Case dismissal, IRILO referral, and refer for adjudication.
16. Within 30 days.
17. Return to duty, direct an MEB, and Continued Military Medical Observation and Care.

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 AFCDA.

61. (013) A 45-year old patient presents to the emergency room with pain to her extremities. She complains the pain is worse at night? Which type of neuropathy does she have?
 - a. Autonomic.
 - b. Peripheral.
 - c. Proximal.
 - d. Focal.
62. (013) What additional risk factors contribute to diabetic neuropathy?
 - a. High blood pressure.
 - b. Low insulin levels.
 - c. High cholesterol.
 - d. Lupus.
63. (013) Which of the following is a type of neuropathy and a brief description of it?
 - a. Peripheral can cause either pain or loss of feeling in the toes, feet, legs, hands and arms.
 - b. Somantic causes changes to organ systems like the digestive, sexual responses, and perspiration as well as the nerves that serve the heart.
 - c. Medial neuropathy can cause pain in the shoulders, neck, arms that may lead to weakness in the upper body.
 - d. Frontal neuropathy results in the sudden weakness of one muscle group of tendons causing weakness or pain at the site.
64. (013) Why is it important for all diabetic patients to perform daily foot care?
 - a. Because the pain goes unnoticed with increased age.
 - b. Brittle toenails develop due to poor circulation.
 - c. Redness and swelling develop due to poor circulation.
 - d. Blisters and sores appear on the numb areas of the foot because the pressure or injury goes unnoticed.
65. (014) Why do you suction a tracheostomy tube?
 - a. Promote a positive outlook for the patient's family.
 - b. Clear the upper airway from any foreign body.
 - c. Remove secretions from the lower respiratory air passage.
 - d. Clear out the vocal cords for better speech understanding.
66. (014) When an unconscious patient is unable to breathe on their own, what is established?
 - a. Suctioning.
 - b. Tracheal tube.
 - c. Nasal cannula.
 - d. Endotracheal tube.

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-
67. (015) When you convert the units 0.001 grams, it would equal to one
- milligram.
 - centigram.
 - microgram.
 - decigram.
68. (015) What are the benefits of ensuring medication reconciliation is completed?
- Eliminating narcotic drug errors.
 - Increasing supply resources.
 - Decreasing manning issues.
 - Avoiding medication errors.
69. (016) When you gather supplies to approximate a wound, what can be used in place of sutures or staples?
- Skin closure strips.
 - Pressure dressing.
 - Occlusive dressing.
 - Band aid.
70. (016) Why is the primary intention closure used when a surgical incision is made?
- Little tissue loss or damage.
 - Wound size and location.
 - Improve tissue recovery.
 - High tissue loss or damage.
71. (016) In reference to doing a closure, what is a digital block?
- Minimizes the loss of blood.
 - Increases wound healing timeframes.
 - A tissue block that anesthetize the joint.
 - A nerve block that anesthetize the finger.
72. (017) A patient checks into your clinic for same day surgery; what can you do to improve your customer service skills and make the patient feel at ease?
- Never show empathy or concern.
 - Ask your peers what works for them.
 - Build rapport and make a good first impression.
 - Take as many classes on your off time to improve your customer service skills.
73. (017) You notice a patient looking lost at the main entrance of the hospital. You approach and ask if he needs assistance. The patient proceeds to complain about a previous visit with their provider. When attempting to resolve this issue, at what level should you initiate resolution?
- Lowest.
 - Squadron commander.
 - Hospital commander.
 - Wing commander.
74. (017) How are customer needs assessed?
- Customer evaluation.
 - Employee evaluation.
 - Anonymous survey.
 - Initial feedback.

75. (017) Why is building rapport at your job important?
- Increases brainstorming.
 - Lowers external customer expectations.
 - Improves internal and external relations.
 - Builds harmonious relationship with patients.
76. (017) What should you do if you *cannot* solve the patient's problem?
- Find someone in the organization who can.
 - Contact patient administration.
 - Refer to front desk personnel.
 - No actions are required.
77. (018) Why do you let the provider know if a QRS complex is wider than three blocks?
- Because of a possible heart block.
 - Because of ventricular repolarization.
 - Because the left atria is pacing the heart.
 - You do not need to; the ventricles are normal.
78. (018) Why do you need to know if your patient is dehydrated or on drugs prior to performing an electrocardiogram (ECG)?
- Because it elevates the P wave.
 - Because it decreases the P wave.
 - Because it gives an abnormal reading.
 - It could influence the QT interval.
79. (018) What is the first node that generates an electrical impulse that travels through the right and left atrial muscles?
- Atrioventricular.
 - Sinoatrial.
 - Tricuspid.
 - Mitral.
80. (018) Why is the repolarization of the atria *not* seen on an electrocardiogram (ECG)?
- Conduction of atria is weaker.
 - Conduction of ventricle is less powerful.
 - Electrical activity of the atria is more powerful.
 - Electrical activity of the ventricle is more powerful.
81. (018) What are likely causes of extrinsic mechanisms of arrhythmias?
- Heat exhaustion.
 - Hypertension.
 - Hypolemia.
 - Synovitis.
82. (019) Which is a responsibility of the Physical Evaluation Board Liaison Officer (PEBLO)?
- Obtains evaluatee or Next of Kin (NOK) signature on AF Form 618, Medical Board Report, forwards the completed Medical Evaluation Board (MEB) package to the disposition authority, and makes proper distribution of that authority's responses.
 - Completes AF Form 618, Medical Board Report; obtains signatures from the board members and the approval authority; and assembles the attachments to AF Form 618, Medical Board Report.
 - Counseling members or next of kin on the Physical Evaluation Board (PEB) findings and recommended disposition as documented on AF Form 356.
 - Assists the evaluatee in resolving any questions concerning the content of the report or summary.

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83. (019) What is the intent of the assignment limitation code?
- a. Protect members from being placed in an environment where they may not receive adequate medical care for a possible life-threatening condition and to prevent the assignment of non-worldwide qualified personnel to overseas locations.
 - b. Tracks members who are not worldwide qualified due to medical reasons and refers them to the servicing military treatment facility (MTF) for Medical Evaluation Board (MEB) processing.
 - c. A personnel tool used by Military Personnel Flight (MPF) to ensure members with disabling illnesses/injuries are listed and evaluated every 12 months.
 - d. Works in concert with the Overseas Medical Clearance Program to ensure dependents do not get stationed in locations without the proper medical facilities.
84. (019) Which is a responsibility of the Medical Evaluation Board (MEB) clerk?
- a. Schedules cases for board hearings.
 - b. Ensuring accurate and complete case records are sent to the Physical Evaluation Board (PEB).
 - c. Requesting commander's letter and keeping member's commander/first shirt apprised of the member's case status.
 - d. Advising the patient administration or hospital services office of the final disposition of all cases where the member underwent PEB processing in an outpatient status.
85. (019) What two things determine a member's security clearance?
- a. Rank and base.
 - b. Citizenship and place of birth.
 - c. Air Force specialty code (AFSC) and assignment.
 - d. Background clearance and date of birth.
86. (019) When are medical standards applied?
- a. Annually at every visit an Active Duty (AD) or Air Reserve Component (ARC) member makes it to your clinic.
 - b. Bi-annually at every clinic visit.
 - c. Every visit an AD or ARC member makes it to your clinic.
 - d. Semi-annual at every visit an AD or Air National Guard (ANG) member makes it to your clinic.
87. (020) Which conditions are *not* eligible for referral to the disability evaluation system?
- a. Unfitting.
 - b. Unsuiting.
 - c. Duty limiting.
 - d. Duty restriction.
88. (020) What is a recommendation resulting from a medical evaluation, which, if applied explicitly, limits or restricts an Airman's ability to perform primary and/or additionally assigned duties, deploy (mobility), or participate in fitness activities?
- a. Unfitting.
 - b. Unsuiting.
 - c. Duty limiting.
 - d. Duty restriction.
89. (020) What is the *maximum* number of days that the AF Form 469, Duty Limiting Condition Report and AF Form 422, Notification of Air Force Member's Qualification Status is good for?
- a. 90.
 - b. 120.
 - c. 180.
 - d. 365.

90. (020) An Airmen should be referred to the Deployment Availability Working Group (DAWG) if a mobility restriction goes over how many days?
- a. 90.
 - b. 120.
 - c. 180.
 - d. 365.

Glossary of Abbreviations and Acronyms

| | |
|----------------|---|
| ° F | degrees Fahrenheit |
| AB | Airman Basic |
| AAC | assignment availability code |
| ACA | Airmen Comprehensive Assessment |
| ACR | authorization change request |
| AFMS | Air Force Medical Service |
| AFSC | Air Force specialty code |
| ALC | assignment limitation code |
| AD | active duty |
| ADL | approved drug list |
| AE | aeromedical evacuation |
| AEF | Air Expeditionary Force |
| AFCITA | Air Force Complete Immunizations Tracking Application |
| AFHCP | Air Force Hazard Communication Program |
| AFI | Air Force Instruction |
| AFMS | Air Force Medical Service |
| AFPAM | Air Force Pamphlet |
| AFPC | Air Force Personnel Center |
| AFPD | Air Force Policy Directive |
| AFTR | Air Force Training Record |
| AFR | Air Force Reserve |
| AFS | Air Force specialty |
| AFSC | Air Force specialty code |
| AFTC | Air Force Training Course |
| AFTR | Air Force Training Record |
| AHLTA | Armed Forces Health Longitudinal Technology Application |
| ALC-C | assignment limitation code-C |
| ALE | advanced leadership experience |
| ALS | Airman Leadership School |
| AMP | Aerospace Medicine Program |
| AMSC | Aerospace Medical Service Craftsman |
| ANG | Air National Guard |
| APO | Army and Air Force Post Office |
| ARC | Air Reserve Component |
| ASIMS | Aeromedical Services Information Management System |
| AV | atrioventricular |
| BE | Bioenvironmental Engineering |
| CAFSC | control Air Force specialty code |
| CAL | custodian action list |
| CAN | change notification |
| CAREERS | Career Airman Reenlistment Reservation System |
| CCAF | Community College of the Air Force |

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|----------------|---|
| CDC | career development course |
| CDR | Central Data Repository |
| CFETP | Career Field Education and Training Plan |
| CFM | career field manager |
| CHCS | Composite Health Care System |
| CHAMPUS | Civilian Health and Medical Program of the Uniformed Services |
| CHF | congestive heart failure |
| CJR | career job reservation |
| CISD | critical incident stress debriefing |
| CMSgt | chief master sergeant |
| CoL | Continuum of Learning |
| CONUS | continental United States |
| CPAP | continuous positive airway pressure |
| CPR | cardiopulmonary resuscitation |
| CSS | Commander's Support Staff |
| CSP | compounded sterile product |
| DAFSC | duty Air Force specialty code |
| DAWG | Deployment Availability Working Group |
| DCMS | Dental Classification Management System |
| DD | Department of Defense |
| DE | development education |
| DEERS | Defense Enrollment Eligibility Reporting System |
| DEROS | date of estimated return from overseas |
| DL | distance learning |
| DLC | duty limiting condition |
| DMLSS | Defense Medical Logistics Standard Support |
| DOD | Department of Defense |
| DTL | duty task list |
| ECG | electrocardiogram |
| EMEDS | Expeditionary Medical Support |
| EMT | emergency medical technician |
| EP | Exercise Physiologist |
| EPME | enlisted professional military education |
| EPR | Enlisted Performance Report |
| ETS | estimated time of separation |
| ETT | endotracheal tube |
| FAC | functional account code |
| FEQ | field evaluation questionnaires |
| FP | fitness program |
| GAS | graduate assessment surveys |
| HCIL | health care information line |
| HEAR | Health Evaluation Assessment and Review |
| HIV | human immunodeficiency virus |
| HMIS | Hazardous Material Information System |

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|----------------|--|
| HMO | Health Maintenance Organization |
| HNFS | Health Net Federal Services |
| HP | Health Promotion |
| HQ | Headquarters |
| IAW | in accordance with |
| IC | institutional competencies |
| ID | identification |
| IDES | Integrated Disability Evaluation System |
| IHS | international health specialist |
| IPT | Integrated Inpatient Product Team |
| ILE | intermediate leadership experience |
| | |
| IMR | individual medical readiness |
| IRILO | initial review in lieu of medical board |
| IVCD | intraventricular conduction defects |
| JI | job inventory |
| JQS | job qualification standard |
| Kx | Knowledge Exchange |
| LAS | limited assignment status |
| LGL | Lown-Ganong-Levine Syndrome |
| MAJCOM | major command (USAF) |
| MEB | Medical Evaluation Board |
| MEMO | Medical Equipment Management Office |
| MHS | Military Healthcare System |
| MI | myocardial infarction |
| MI LPDS | Military Personnel Data System |
| MPF | Military Personnel Flight |
| MSDS | material safety data sheet |
| MSME | medical standards management element |
| MTF | medical or military treatment facility |
| MTL | master task list |
| MTP | Master Training Plan |
| NARSUM | narrative summary |
| NCO | noncommissioned officer |
| NCOA | Noncommissioned Officer Academy |
| NCOIC | noncommissioned officer in charge |
| NREMT | National Registry of Emergency Medical Technicians |
| NOK | next of kin |
| OA | occupational analysis |
| OB | obstetrical |
| OJT | on-the-job training |
| OI | operating instruction |
| OIC | officer in charge |
| OPR | office of primary responsibility |

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|----------------|--|
| OSR | Occupational Survey Report |
| OTC | over the counter |
| PAC | premature atrial contractions |
| PACAF | Pacific Air Forces |
| PAFSC | primary Air Force specialty code |
| PAS | personnel accounting symbol |
| PCM | primary care manager |
| PCS | permanent change of station |
| PEA | pulseless electrical activity |
| PEB | Physical Evaluation Board |
| PEBLO | Physical Evaluation Board liaison officer |
| PDS | Personnel Data System |
| PH | Public Health |
| PHA | preventive health assessment |
| PHCA | Preventive Health Care Application |
| PHI | protected health information |
| PHIMT | Protected Health Information Management Tool |
| PIMR | Preventive Health Assessment and Individual Medical Readiness |
| PME | professional military education |
| PPIP | Put Prevention into Practice |
| PPO | preferred provider organization |
| PRN | as needed |
| P&T | pharmacy and therapeutics |
| PULHES | physical, upper extremities, lower extremities, hearing, eyes, p(s)ychiatric |
| PVC | premature ventricular contractions |
| QTP | quality training package |
| RILO | review in lieu of medical board |
| RMO | Resource Management Office |
| RSV | readiness skills verification |
| RTD | returned to duty |
| SA | sinoatrial |
| SCD | sudden cardiac death |
| SDS | safety data sheet |
| SEI | special experience identifier |
| SKT | skills knowledge test |
| SME | subject matter expert |
| SNCOA | Senior Noncommissioned Officer Academy |
| SPO | senior profiling officer |
| SOS | Squadron Officer School |
| SSN | social security number |
| STS | specialty training standard |
| STD | sexually transmitted disease |
| TB | tuberculosis |
| TDRL | temporary disability retirement limitations |

| | |
|-----------------|---|
| TDY | temporary duty |
| TIS | time in service |
| TLAC | TRICARE Latin America & Canada |
| TLN | training line number |
| TSgt | technical sergeant |
| UGT | upgrade training |
| UMD | unit manpower document |
| UPMR | unit personnel management roster |
| USAF | United States Air Force |
| USAFE | United States Air Forces in Europe |
| UTM | Unit Training Manager |
| U&TW | Utilization and Training Workshop instead of unit and training workshop |
| UTC | unit type code |
| VA | veteran affairs |
| VF | ventricular fibrillation |
| VT | ventricular tachycardia |
| VTA | Veterans Tracking Application |
| WPW | Wolff-Parkinson White Syndrome |

Student Notes

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