

# **CDC A4P051**

## **Pharmacy Journeyman**

### **Volume 2. Pharmacy Administration**



**Air Force Career Development Academy**  
**The Air University**  
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CAREER Development Course (CDC) A4P051, *Pharmacy Journeyman*, is designed to satisfy the 5-skill level CDC subject and task knowledge requirements specified in the Specialty Training Standard. You are about to begin a volume consisting of many different subjects that will aid you in your day-to-day pharmacy operations. This, along with the information that you received in Volume 1, will help you understand how your pharmacy is operated and why you follow certain procedures. This volume has three units and is set up as follows.

Unit 1, Military Treatment Facility Accreditation and Inspections, is a study of how hospitals, clinics, and pharmacies are accredited by The Joint Commission (TJC), The Accreditation Association for Ambulatory Health Care (AAAHC). Medical facilities are held to a high set of standards, and you need to understand how these standards affect the pharmacy and you as a pharmacy technician. We will also discuss methods we use to achieve quality in the service we pass along to our patients, as well as, ways we ensure medications are used properly and efficiently by looking at ourselves through the self-inspection program. This unit concludes with a thorough look at the new Air Force Unit Effectiveness Inspections.

Unit 2, Pharmacy Forms, Files, and Administrative Reports, covers several subjects from forms and files to the collection and reporting of medical expense and performance data. We start off with the categories and disposition of forms and files, and then we go into the particular forms and files that are used in the pharmacy. From there we discuss pharmacy practice responsibilities, to include several different reports and reporting methods. The last topic that we discuss is pharmacy administrative reports, which covers the Medical Expense and Performance Reporting System (MEPRS).

Unit 3, Medical Readiness Concepts and Controlled Substances, introduces force health protection prescriptions products we dispense to deploying members. We will also look at home station medical response principles and the role pharmacy technicians' play. Additionally, this unit covers point of dispensing procedures in the event we have to respond to a mass treatment or prophylaxis event. This volume will conclude with an extensive look at managing controlled substances. Proper managing of controlled substances will be very important throughout your pharmacy career. We will look at procedures for both inpatient and outpatient settings to include filling order, documentation, disposal, and inventories for controlled substances.

A glossary is included for your use.

Code numbers on figures are for preparing agency identification only.

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This volume is valued at 9 hours and 3 points.

## ACKNOWLEDGEMENT

PREPARATION of this volume was aided by the cooperation and courtesy of The Joint Commission Resources, *2014 Comprehensive Accreditation Manual for Hospitals* (CAMH), pg. HM-7. Permission to use this information is gratefully acknowledged. The figure from unit 1 has been reproduced by permission.

Figure 1-1. Example of a standard, rational, element of performance, and scoring.  
(Reprinted with Joint Commission permission, *2014 Comprehensive Accreditation Manual for Hospitals*, pg. HM-7).

## 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.

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# Unit 1. Military Treatment Facility Accreditations and Inspections

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**H**AVE YOU EVER wondered why pharmacies operate the way they do or why so much time is spent on documentation? Then you should understand that pharmacies undergo constant review of policies, programs, and procedures while also implementing new ones. The goal of these reviews and new programs is the constant push toward excellence. A way to strive for excellence is to develop procedures or programs which consistently produce services at a high level—in other words, standardization. Can you imagine the difficulties and disorganization that would occur if everyone in your section, every section in the hospital, and every hospital in the Air Force were allowed to conduct business according to their own standards for performance? The results would be disastrous. This unit will discuss organizations formed to meet health care standardization throughout the Air Force to include methods used to monitor and improve the performance of each organization.

## 1–1. Accreditation Awarding Agencies

The Air Force Medical Service (AFMS) presently uses the Air Force Inspection System (AFIS) and two civilian agencies to periodically evaluate its medical facilities. The main objective is to assess the quality of care provided and compliance with applicable standards. This section will discuss The Joint Commission (TJC) and the Accreditation Association for Ambulatory Health Care (AAAHC). One of your roles as a pharmacy journeyman is to assist your officer in charge (OIC) and your noncommissioned officer in charge (NCOIC) to consistently maintain policies and procedures that are patient focused and meet the intent of TJC and AAAHC standards. The accreditation and inspection processes can be complicated. Most hospitals devote offices or individuals to keeping facilities in compliance, so realize you will not be an expert on TJC or AAAHC entirely upon completion of this unit. However, you will have a firm understanding of the general principles associated with their activities.

### 201. Principles of The Joint Commission accreditation

The mission of TJC is to continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value. It does this through a voluntary accreditation process. The accreditation process adds credibility to an institution's medical practices. This means the institution, as a whole, is willing to accept a set of standards as the minimum requirements for providing quality patient care.

TJC is a civilian agency that surveys and accredits medical facilities that provide in-patient care. TJC uses the word “survey” instead of “inspection” or “evaluation.” TJC accreditation survey is a critical event for your military treatment facility (MTF). The primary purpose is to assess the quality of care provided to patients. Air Force Instruction (AFI) 44–102, *Medical Care Management*, states all Air Force medical facilities must follow TJC guidelines and standards. TJC develops the pharmacy standards with input from the American Society of Health-Systems Pharmacists (ASHP). TJC's comprehensive accreditation manual, also referred to as the CAM, contains these standards.

### Comprehensive accreditation manuals

The comprehensive accreditation manuals provide organizations with information about the accreditation process. The two manuals include the *Comprehensive Accreditation Manual for Hospitals* (CAMH) and the *Comprehensive Accreditation Manual for Ambulatory Care* (CAMAC). If you're in a facility that *does* admit patients (hospital), you will use the CAMH. If you work in a facility that *does not* admit patients (clinic), you will use the CAMAC as your guide. The difference between the guides is based on the type of care provided in your facility. Both the CAMH and CAMAC include the latest standards and compliance information along with materials that support your facility's continuous operational improvement and its accreditation efforts.

If you work in a hospital, TJC is your accrediting body and you will use the CAMH. If you work in a clinic, the AAAHC is the civilian accrediting agency and you will use the CAMAC.

### The Joint Commission's accreditation survey

During a Joint Commission accreditation visit, a survey team evaluates your organization's performance of functions and processes aimed at continuously improving patient outcomes. The survey process focuses on assessing performance of important patient-centered and organization functions that support the safety and quality of patient care, treatment, and services. This assessment evaluates your organization's compliance based on tracing of patient care delivery, on-site observations and interviews by the surveyors, and documents your organization provides. Tracing is the tracking of patients or patient records through all sections where they receive medical care and administrative support.

TJC began conducting all surveys on an unannounced basis in 2006. This change shifted focus from survey preparation to continuous operational improvement. The accreditation process also encourages organizations to incorporate the standards into routine operations to achieve and maintain excellent operational systems on an ongoing basis. TJC surveyors tailor the inspection to each organization's mission, so it is consistent and supports the organization's efforts to improve performance. TJC determines the length of the survey, using the information the organization provides on the application, which describes the organization's size and scope of services. In addition, TJC surveyors may conduct some survey activities during evening, night, and weekend shifts for full surveys of three or more days and a sample of two-day surveys in health care organizations that provide 24-hour care or off-shift care. However, these off-shift visits do not occur before the opening conference at the start of the survey.

In this next section, you will learn general principles of the accreditation process. As stated earlier, TJC has revolutionized its accreditation survey process.

### Components of survey criteria

For TJC to see the "big picture" of an organization's performance and improvement activities, it needs to be able to objectively measure the organization's past, current, and future performance. This section examines a few key components of that survey criteria. You can think of these components as measuring tools because TJC measures your facility against the benchmarks detailed in the accreditation manual. These components include sections, chapters, standards, rationales, and elements of performance (EP). The first components addressed are sections, chapters, and standards.

### Sections, chapters, and standards

TJC has reorganized its *Comprehensive Accreditation Manual* into two sections—*Accreditation Requirements* and *Accreditation Process Information*. These two functional areas have 27 functional chapters, which contain TJC's standards and explain the entire accreditation process. The following table shows the two basic sections along with the 27 functional chapters. Under the functional chapters, the individual standards are listed along with the rationales and elements of performance (rationales and EP will be discussed later in this lesson).



Please review the following table containing TJC sections and functional chapters before continuing to read.

<b>The Joint Commission CAMH (Two Sections)</b>	
<b>Section 1 Accreditation Requirements</b>	<b>Section 2 Accreditation Process Information</b>
Accreditation Participation Requirements (APR)	The Accreditation Process (ACC)
Environment of Care (EC)	Standards Applicability Grid (SAG)
Emergency Management (EM)	Sentinel Events (SE)
Human Resources (HR)	The Joint Commission Quality Report (QR)
Infection Prevention and Control (IC)	Performance Measurement (PM) and the ORYX Initiative
Information Management (IM)	Staffing Effectiveness Indicators (SEI)
Leadership (LD)	Required Written Documentation (RWD)
Life Safety (LS)	Early Survey Policy Option (ESP)
Medication Management (MM)	Primary Care Medical Home Certification Option (PCMH)
Medical Staff (MS)	
National Patient Safety Goals (NPSG)	
Nursing (NR)	
Provision of Care (PC), Treatment, and Services	
Performance Improvement (PI)	
Record of Care (RC), Treatment, and Services	
Rights and Responsibilities of the Individual (RI)	
Transplant Safety (TS)	
Waived Testing (WT)	

### *Standards*

Standards are statements that define the performance expectations and/or structures or processes that must be in place for a hospital to provide safe, high-quality care, treatment, and services. Standards establish a set of expectations against which current and future performance can be measured. TJC sets standards that are reasonable, achievable, and surveyable. Its purpose is to encourage the development of effective and efficient processes for patient care, governance, and management. How well an organization performs its primary tasks has a large bearing on patient outcomes, the cost of providing effective and appropriate services, and the eventual health status of the population served.

A hospital's compliance with TJC standards is either compliant or not compliant. Facilities seeking accreditation must comply with standards to receive or continue to receive TJC's accreditation.

### *Pharmacy standards*

Let's take a moment to talk about a few pharmacy standards and a couple of roles the pharmacy has in the accreditation process. Pharmacy standards are throughout the chapters of the accreditation manual. The integration of pharmacy standards throughout the manual reflects the new Joint Commission's focus on "interdisciplinary health care," so let's examine this for a minute. If you were looking for this type of health care in your facility, you would be looking to see how all areas of the health care team interact to produce positive patient outcomes. TJC evaluates pharmacy operations independently, but it also looks at how pharmacies function with other departments to provide safe, quality patient care.

Proper medications management is an important part of patient care. TJC focuses on this particular area when surveying the medical facility.

The guidelines state the following:

- Medication management is often an important component in the palliative, symptomatic, and curative treatment of many diseases and conditions.
- Effective and safe medication management involves multiple services and disciplines working closely together.

A well-planned and implemented medication management system supports patient safety and improves the quality of care by doing the following:

- Reducing practice variation, errors, and misuse.
- Monitoring medication management processes with regards to efficiency, quality, and safety.
- Standardizing equipment and processes across the hospital to improve the medication management system.
- Using evidence-based good practices to develop medication management processes.
- Managing critical processes associated with medication to promote safe medication management throughout the hospital.

An effective medication management system includes mechanisms for reporting potential and actual medication-related errors and a process to improve medication management processes and patient safety based on this information. TJC believes the most effective feedback and improvement systems usually operate in hospitals that have a nonpunitive culture.

One of the functional chapters listed above is *Medication Management*. We will use the *Medication Management* chapter to teach you how TJC applies its standards during the accreditation process. Remember, standards are expectations that organizations must meet for accreditation purposes. Failure to meet standards results in recommendations or contingencies, both of which require corrective action. Failure to meet key factors may result in a revisit and can affect the MTF accreditation decision.

The following tables shows the standards listed in TJC's 2014 CAMH.

TJC Standards in 2014 CAMH	
Planning	
<ul style="list-style-type: none"> <li>• Patient-specific information is readily accessible to those involved in the medication management system.</li> <li>• High-alert and hazardous medications are safely managed.</li> <li>• Safe use of look-alike/sound-alike medications is addressed.</li> </ul>	
Selection and Procurement	
<ul style="list-style-type: none"> <li>• Medications available for dispensing or administering (including stock medications) are selected, listed, and procured based on criteria.</li> </ul>	
Storage	
<ul style="list-style-type: none"> <li>• Medications are properly and safely stored.</li> <li>• Emergency medications and/or supplies, if any, are consistently available, controlled, and secured.</li> <li>• A process is established to safely manage medications brought into the hospital by patients or their families.</li> </ul>	
Ordering and Transcribing	
<ul style="list-style-type: none"> <li>• Only medications needed to treat the patient's condition are ordered, provided, or administered.</li> <li>• Medication orders are written clearly and transcribed accurately.</li> </ul>	

TJC Standards in 2014 CAMH	
Preparing and Dispensing	
<ul style="list-style-type: none"> <li>• All prescriptions or medication orders are reviewed for appropriateness. Medications are prepared safely.</li> <li>• Medications are labeled.</li> <li>• Medications are dispensed safely.</li> <li>• The hospital has a system for safely providing medications to meet patient needs when the pharmacy is closed.</li> <li>• Medications dispensed by the hospital are retrieved when recalled or discontinued by the manufacturer or the Food and Drug Administration for safety reasons.</li> <li>• The hospital has a process to address medications that are returned to the pharmacy or the hospital.</li> </ul>	
Administration	
<ul style="list-style-type: none"> <li>• Medications are safely and accurately administered.</li> <li>• Self-administered medications are safely and accurately administered.</li> <li>• Investigational medications are safely controlled and administered.</li> </ul>	
Monitoring	
<ul style="list-style-type: none"> <li>• The effects of medication(s) on patients are monitored.</li> <li>• The hospital responds to actual or potential adverse drug events and medication errors.</li> </ul>	
Evaluation	
<ul style="list-style-type: none"> <li>• The hospital evaluates its medication management system.</li> </ul>	

### *Rationale, elements of performance, and scoring*

After reading through each standard, you may notice that some of them are only basic statements that are open to interpretation. To help avoid multiple interpretations of standards, TJC provides a rationale for some of them.

A rationale is background, justification, or additional information about a standard. A rationale is included for those standards needing additional text describing the purpose of the standard. In some cases the rationale for a standard is self-evident; therefore, not every standard has a written rationale. A rationale is not scored.

Let's look back at a few medication management standards and match a couple of them with their rationales.

Medication Management Standards	
<b>Storage Standard</b>	<p>Medications are properly and safely stored.</p> <p>Rationale for Storage Standard:</p> <ul style="list-style-type: none"> <li>• Appropriate medication storage increases patient safety. Medication storage is designed to assist in maintaining medication integrity, promote the availability of medications when needed, minimize the risk of medication diversion, and reduce potential dispensing errors. (<b>NOTE:</b> The following elements of performance also apply to emergency medications.)</li> </ul>
<b>Preparing and Dispensing Standard</b>	<p>The hospital safely manages returned medications. Medications may be returned when allowed under law or regulation and hospital policy. Previously dispensed but unused, expired, or returned medications in the hospital must be accounted for, controlled, and disposed. The pharmacy is responsible for controlling and accounting for all unused medications returned to the pharmacy.</p>

Notice that without the rationales the standards are vague and open to misinterpretation; the addition of the rationale provides clarity and focus to the standard.

Before we move on to the accreditation survey findings report, we will look at EPs and how they are scored.

Elements of Performance	
EPs are statements that detail the specific performance expectations and/or structures or processes that must be in place for an organization to provide high-quality care, treatment, and services. EPs are scored and determine a hospital's overall compliance with a standard. Take a look at the following, which is one of our standards from above, its rationale, and add the EP so you can begin to see the whole picture.	
Preparing and Dispensing Standard	
<b>Rationale for Preparing and Dispensing Standard</b>	The hospital safely manages returned medications. Medications may be returned when allowed under law or regulation and hospital policy. Previously dispensed but unused, expired, or returned medications in the hospital must be accounted for, controlled, and disposed of. The pharmacy is responsible for controlling and accounting for all unused medications returned to the pharmacy.
<b>Elements of Performance for Preparing and Dispensing Standard</b>	<ul style="list-style-type: none"> <li>• The hospital determines under what circumstances unused, expired, or returned medications will be managed by the pharmacy.</li> <li>• When the hospital accepts unused, expired, or returned medications, it has a process for returning medications to the pharmacy's control that includes procedures for preventing diversion.</li> <li>• The hospital determines if and when outside sources are used for destruction of medications.</li> <li>• The hospital implements its process for managing unused, expired, or returned medications.</li> </ul>

Notice the EPs breakdown the standard. In this way the EPs survey the standard at different levels and aspects, making sure the standard is properly evaluated for compliance or noncompliance.

### Scoring of standards and elements of performance

The Joint Commission framework for scoring is in two parts:

- Scoring for standards is listed as **compliant** or **not compliant**.
- The EPs will be scored on the following scale in the table below:

The following is the numerical score description:

- 0—Insufficient compliance.
- 1—Partial compliance.
- 2—Satisfactory compliance.
- NA—Not applicable.

A simple count of the standards or EPs that are scored **not compliant** is the basis for accreditation decisions.

The basis on the scoring of a specific standards EP is the determination as to whether your MTF is compliant with a given standard. Remember, an EP is a specific performance expectation related to a standard detailing the specific structures or processes that must be in place for a hospital to provide quality care, treatment, and services. EPs are score as a 0 or 2; however, a score of 1 for partial compliance is also possible, depending on track record.

Now, let's put all of the pieces together and look at the medication management storage standard as it appears in the accreditation manual (fig. 1-1).

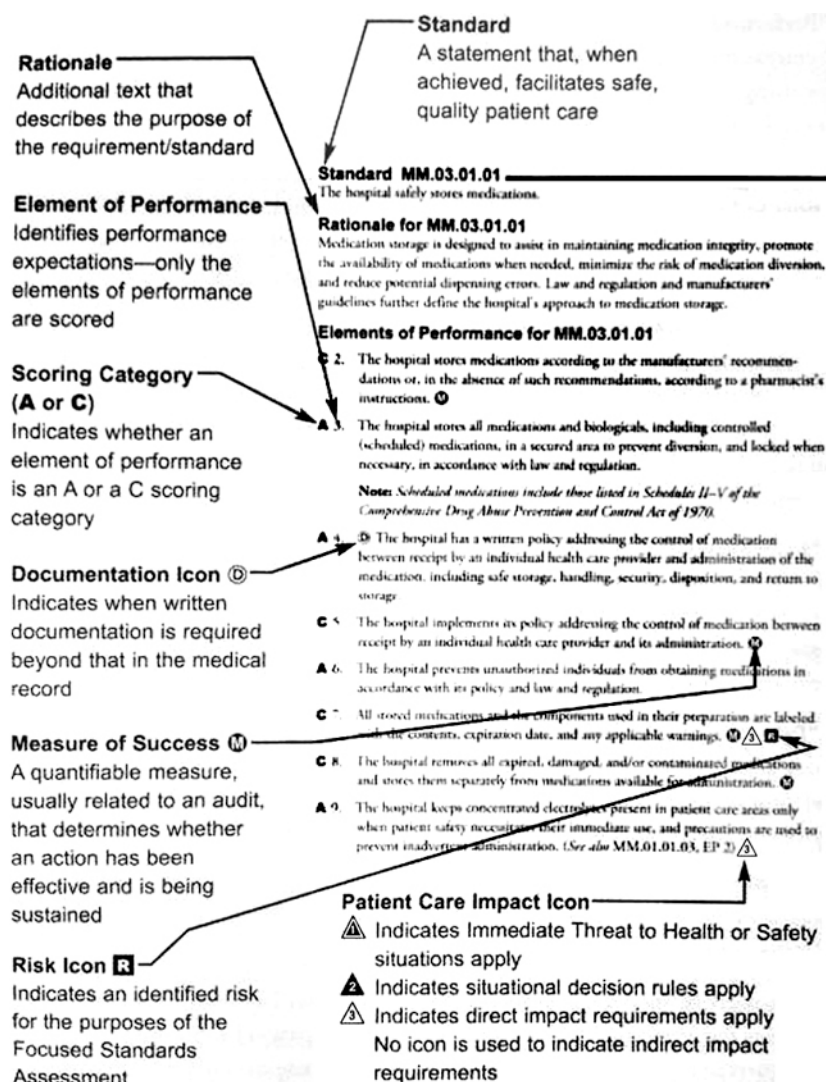


Figure 1–1. Example of a standard, rationale, element of performance, and scoring.  
(Reprinted with Joint Commission permission, 2014 Comprehensive Accreditation Manual for Hospitals, pg. HM–7).

### The accreditation survey findings report

Following evaluation of an organization's performance of functions and processes, the surveyor (or survey team) reviews the results of integrated individual findings. Then, with the use of laptop-based–decision-support software, the surveyor (or survey team) produces the organization's accreditation survey findings report. The surveyor (or survey team leader) meets with the organization's commander prior to the closing conference and provides him or her with a copy of the report. The surveyor (or survey team) uses the report contents in making his or her closing conference presentations. Shortly after a survey, an organization's report of survey findings is posted on the organization's secure extranet site. The report includes, as appropriate, requirements for improvement and supplemental findings.

If an organization does not receive any requirements for improvement, the organization's accreditation decision is rendered at the same time the organization's accreditation survey findings report is available, and it is effective the day after the completion of the survey. If an organization receives requirements for improvement, then the organization's accreditation decision is rendered following the submission of an acceptable Evidence of Standards Compliance (ESC) report.

**NOTE:** An ESC report is a document a surveyed organization submits within 45 days of its survey, which details the action(s) it took to bring itself into compliance with a standard or clarifies why the organization believes it did comply with the standard for which it received a requirement for improvement.

### **Duration of accreditation award**

An accreditation award is continuous until the organization has its next full survey, which is usually three years, unless accreditation is revoked. An organization may request a full accreditation survey more frequently than when it is due to have a survey. TJC, at its discretion and in accordance with its mission, determines whether to honor the request. An organization should send such a request to TJC account representative.

### ***Continuous compliance***

TJC expects an accredited organization to be in continuous compliance with all applicable standards and EPs. It may ask an organization to supply, in writing, information about compliance with standards. It may also survey an organization at any time with or without notice in response to complaints, media coverage, or other information that raises questions about the adequacy of patient health and safety protections. TJC might also conduct a survey if an organization fails to respond to a request for more information.

TJC may view an organization's failure to permit a survey as the organization no longer wanting to participate in the accreditation process. In such a case, TJC begins proceedings to deny accreditation to the organization.

### ***Continuing accreditation***

An organization's accreditation cycle is continuous, as long as the organization does both of the following:

- Has a full, unannounced survey within 36 months of its last survey.
- Continues to meet all accreditation-related requirements as required.

TJC's quality report is accessible to the public through TJC's Quality Check website and details all graded areas of a survey. This report is crucial to patients needing to know if a particular hospital can meet their medical needs.

### **The change to the Accreditation Association of Ambulatory Health Care**

In recent years the majority of Air Force MTFs have evolved from large bedded facilities, such as hospitals and medical centers, to smaller clinics providing mostly outpatient or ambulatory care. With this change to our facilities also came a change in accreditation criteria. As of now, our MTF clinics receive accreditation by the AAAHC instead of TJC. AFMS bedded facilities will continue their longstanding partnership with TJC by maintaining the commission's standards and receiving its accreditation.

TJC's inspections focus towards hospitals that have a fair number of support people to handle large administrative workloads—our clinics are not. The AAAHC focuses towards outpatient clinics and ambulatory surgery centers and has been accrediting the Coast Guard clinics for several years. Because they are a well-respected organization with standards that are equal to TJC, many in Air Force leadership consider them a perfect fit with our clinics. Let's continue the next lesson with the AAAHC.

## **202. Accreditation Association of Ambulatory Health Care principles**

The mission of the AAAHC is to remain the preeminent leader in developing standards to advance and promote patient safety, quality, value, and measurement of performance for ambulatory health care through peer-based accreditation processes, education, and research. The AAAHC, also known as the Accreditation Association, is a civilian agency founded in 1979 to assist ambulatory health care

organizations improve the quality of care provided to patients. Currently, the AAAHC is the leader in ambulatory health care accreditation, and just like TJC, its accreditation process is voluntary.

In many ways the AAAHC follows the same principles as TJC, but in other ways they are very different. For this lesson we will compare and contrast the two agencies; this will reinforce your knowledge of TJC while teaching you the new material on the AAAHC's accreditation principles. Remember you learned TJC has a comprehensive accreditation manual (CAM) with set standards. Well, the AAAHC has standards, too, but they are contained in a handbook called *AAAHC Accreditation Handbook for Ambulatory Health Care*.

### Purpose

The standards in the AAAHC's handbook encourage the voluntary attainment of high-quality care in organizations providing health care services in ambulatory settings. The standards describe characteristics the accreditation association believes to be indicative of an accreditable organization. All organizations seeking accreditation, regardless of name, mission statement, or primary service provided, must meet the same high standards described in this handbook.

Most AAAHC standards are in general terms to allow an organization to achieve compliance in the manner that is most compatible with its particular situation and most conducive to the attainment of high-quality patient care, meaning organizations can choose the best way to meet the standards. Where the acceptable methods of achieving compliance with a standard are limited, the standard is written in specific terms to define in more detail the criteria for meeting the standard. In comparison, TJC uses rationales and EPs to define certain standards while the AAAHC defines the criteria for the standard within the standard itself.

### Application

Regardless of the type of organization, the applicable portions of the eight core standards (listed below) apply to the organization seeking an accreditation survey.

Accreditation Association of Ambulatory Health Care Core Standards	
Rights of Patients and Responsibilities	Quality Management and Improvement
Governance	Clinical Records and Health Information
Administration	Infection Prevention and Control and Safety
Quality of Care Provided	Facilities and Environment

In addition to the eight core standards, the AAAHC has 17 adjunct standards that apply to services an organization provides.

Selected Accreditation Association of Ambulatory Health Care Adjunct Standards	
Anesthesia Care Services	Behavioral Health Services
Surgical and Related Services	Teaching and Publication Activities
Pharmaceutical Services	Research Activities
Pathology and Medical Laboratory Services	Overnight Care and Services
Diagnostic and Other Imaging Services	Occupational Health Services
Dental Services	Immediate/Urgent Care Services
Other Professional and Technical Services	Emergency Services
Health Education and Health Promotion	Radiation Oncology Treatment Services
Medical Home	

Let's look at an example on how to apply core and adjunct standards. If your clinic is one of the facilities surveyed by the accreditation association, the facility must be in compliance with all core standards and any adjunct standards that apply to the services your facility provides. Likewise,



civilian ambulatory surgical centers and office surgery practices located off-base must meet the core standards, plus the adjunct standards on anesthesia and surgical services, as well as, all other relevant adjunct standards if they wish to be accredited by the AAAHC. This agency recognizes some of their standards, listed as adjunct standards, do not apply to every facility seeking their accreditation. As a pharmacy technician, you need to be familiar with the pharmaceutical standards listed below.

### *Pharmaceutical services adjunct standards*

Pharmaceutical services overall standard is that pharmaceuticals are available by an accreditable organization to meet the needs of the patients and dispensed in accordance with ethical and professional practices and legal requirements. Such an organization has the following sixteen characteristics as shown in the following table:

Pharmaceutical Services Adjunct Standards	
Characteristics	
<ul style="list-style-type: none"> <li>Pharmaceutical services are provided or made available in a safe and effective manner.</li> <li>Pharmaceutical services are provided in accordance with ethical and professional practice and applicable federal and state laws.</li> <li>Staff demonstrates knowledge of applicable state and federal pharmaceutical laws.</li> <li>Records and security are maintained to ensure the control and safe dispensing of drugs, including samples, in compliance with federal and state laws.</li> <li>Staff informs patients concerning safe and effective use of medications consistent with legal requirements and patient needs.</li> <li>Measures have been implemented to ensure prescription pads are controlled and secured from unauthorized patient access, and pre-signed and/or postdated prescription pads are prohibited.</li> <li>All medications, including vaccines and samples, are checked for expiration dates on a regular basis and expired items are disposed of in a manner that prevents unauthorized access, protects safety, and meets state and federal requirements.</li> <li>All injectable medications drawn into syringes or oral medications removed from the packaging identified by the original manufacturer must be appropriately labeled if not administered immediately.</li> </ul>	<ul style="list-style-type: none"> <li>The organization must have policies in place for safe use of injectables and single-use syringes and needles that at minimum include the CDC or comparable guidelines for safe injection practices.</li> <li>Pharmaceutical services provided by the organization are directed by a licensed pharmacist or, when appropriate, by a physician or dentist who is qualified to assume professional, organizational, and administrative responsibility for the quality of services rendered.</li> <li>Providers or other health care professionals who prescribe, dispense, administer, and provide patient education on medications have easy access to current drug information and other decision-support resources.</li> <li>If look-alike or sound-alike medications are present, the organization identifies and maintains a current list of these medications, and actions to prevent errors are evident.</li> <li>Procedures are established by the organization for maintenance, cleaning, distribution, and use of devices such as nebulizer units, intravenous infusion pumps, or any other mechanical device used in the medication delivery process.</li> <li>A pharmacy owned or operated by the organization is supervised by a licensed pharmacist.</li> <li>Pharmaceutical services made available by the organization through a contractual agreement are provided in accordance with the same ethical and professional practices and legal requirements that would be required if such services were provided directly by the organization.</li> <li>Patients are not required to use a pharmacy owned or operated by the organization.</li> </ul>



### **Medicare certification**

Medicare is a federal program and thus must follow many established mandates. It is governed by the Social Security Act and certain standards must be met for reimbursement purposes; therefore, AAAHC includes these standards in the certification process. The following are requirements for Medicare certification:

- Adverse reactions are reported to the physician or provider responsible for the patient and are documented in the record.
- Orders given orally for drugs and biologicals are followed by a written order, signed by the prescribing physician.
- Blood and blood products are administered only by physicians or registered nurses.

Now that we've covered some of the standards, let's look at the process.

### **Principles governing accreditation and survey process**

To initiate the survey process, interested organizations submit a complete application for survey along with supporting documentation the application lists. The application provides the accreditation association with a profile of the organization that requests an accreditation survey. The answers to the questions do not weigh toward achieving or not achieving accreditation. They provide descriptive information that is helpful to the accreditation association surveyors and staff in understanding the organization and its practices. Surveyors review the application and supporting documents prior to conducting the on-site survey and may seek verification and clarification of certain items during the survey.

The AAAHC uses health care professionals and administrators who are actively involved in ambulatory health care settings to conduct accreditation surveys. These individuals volunteer their time to serve as surveyors. Each accreditation survey tailors to the type, size, and range of services the organization seeking accreditation offers. A careful review of the information provided in the application for survey and supporting documents submitted by the organization determines the length of the on-site visit and the number of surveyors the accreditation association uses. This is also referred to as the scope of survey.

The survey executes in accordance with the procedures the surveyors and organization discuss before the on-site survey. These procedures enable the surveyors to gather information with minimal disruption of the daily activities of the organization survey. Before the survey, the surveyors will ask the organizations to have specific documents and other information available to the surveyors during the on-site visit. They will also submit other documents directly to the Accreditation Association in advance of the survey. Surveyors may, however, ask to see additional documents or may request additional information during the on-site survey. If applicable, it will be necessary for the surveyor(s) to observe procedures that the organization conducts, such as a surgery, diagnostic imaging, or dental services.

At the conclusion of the on-site survey, the surveyors hold a summation conference at which they present their findings to representatives of the organization for discussion and clarification. As the surveyors are "fact finders" for the accreditation association and do not render the final accreditation decision, the surveyors do not provide information regarding the organization's accreditation decision during this conference. Members of the organization's governing body, medical staff, and administration can take this opportunity to comment on or rebut the findings as well as express their perceptions of the survey.

After completion of the on-site survey, Accreditation Association staff members review the survey report, surveyor recommendations including the survey team's overall recommendation regarding accreditation, and any other relevant information; then they make an independent recommendation regarding accreditation to the Accreditation Committee of the AAAHC. The committee carefully

reviews each survey report, surveyor and staff recommendations, and any other relevant information before making a decision.

### **Receiving and maintaining accreditation**

The AAACH awards accreditation to organizations demonstrating substantial compliance with the standards and are in adherence with the AAAHC accreditation policies. The accreditation period is three years and organizations must maintain compliance with all applicable AAAHC standards. The AAAHC reserves the right to amend its standards and policies from time to time, if it provides all accredited organizations with notice of such amendments or includes such amendments in the most recent edition of the handbook. To avoid a lapse in accreditation status, organizations must undergo full, regular surveys at least once every three years.

In the last two learning objectives, you learned about two different civilian accrediting agencies, TJC and the AAAHC as well as their practices and policies for accreditation.

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## **Self-Test Questions**

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

### **201. Principles of The Joint Commission accreditation**

1. What is the mission of The Joint Commission?
2. What does the accreditation process add to an institution's medical practices?
3. What does TJC evaluate during a survey visit?
4. What determines the length of a Joint Commission survey?
5. What does TJC need to objectively measure to see the "big picture" of an organization's performance and improvement activities?
6. The Joint Commission organized its accreditation standards to address what two functional areas?
7. List the characteristics of TJC standards?
8. How does TJC evaluate pharmacy operations?
9. What chapter of TJC's CAMH addresses medication storage?

10. What does TJC provide to help avoid multiple interpretations of its standards?
11. What Joint Commission survey components detail specific performance expectations, are scored, and determine a hospital's overall compliance with a standard?
12. How long can a pharmacy be awarded accreditation by TJC?

**202. Accreditation Association of Ambulatory Health Care principles**

1. What is the mission of the Accreditation Association for Ambulatory Health Care?
2. AAAHC developed its standards to encourage high-quality care in what type of health care setting?
3. Regardless of the type of organization, how many AAAHC core standards are applied to an organization seeking an accreditation survey?
4. In addition to the core standards, how many adjunct standards does AAAHC have?
5. Describe the overall standard AAAHC places on an accreditable organization.
6. What must be reported to the physician responsible for the patient and documented in the record?
7. AAAHC selects what type of individuals to conduct their accreditation surveys?
8. When an organization demonstrates substantial compliance with AAAHC standards, it is granted accreditation status for what period of time?

## 1-2. Internal Inspection Programs

In the last section, you learned about external inspection agencies that come to our facilities to accredit and/or assess your ability to complete the mission in providing patient care. This section covers internal inspections and unit effectiveness inspections (UEI) which are conducted by the Major Command Inspector Generals (MAJCOM/IG) and Air Force Inspection Agency (AFIA). Internal inspections programs allow a manager to identify and correct operational deficiencies at their level. The goal of this section is to provide you with information and guidance that can be used in any pharmacy or MTF to which you work. Remember, your MTF will likely have specific guidance covering inspections so familiarize yourself with any additional guidance your facility has prior to conducting any inspection. The first internal inspection program we'll cover is your own self-inspection program.

### 203. Self-inspection programs

Self-inspection assesses the services you provide, how well you provide them, and your conformance to standards, while also planning for improvements. The self-inspection process is the basis for all other review processes—a strong self-inspection program virtually guarantees the pharmacy will do well during inspections by outside agencies. Pharmacy supervisory personnel regularly review inspection checklists and document the results to ensure compliance with all items. If you are in a supervisory position, your first act upon arrival at a new assignment is to conduct a comprehensive inspection and provide a written report of the results to your supervisor. The report identifies weak and strong areas, general observations, and challenges. Demonstrating you have a handle on the operation will establish your credibility.

#### Purpose

The primary purpose of the self-inspection program is to identify problems at the lowest management level, implement solutions, and provide a feedback system to track problems until they resolve. From the last section you know the premise for TJC, the AAAHC, and the UEI and the need to be prepared when these agencies arrive. The primary way to ensure readiness for any inspection is to constantly evaluate and measure your programs against set standards; hence the need for a self-inspection.

#### Philosophy

The inspector general (IG) reports consistently show commanders who emphasize critical self-assessments achieve the best results.

#### Inspections

Personnel from any level within the organization can manage the program by completing the inspections.

Personal commitment and integrity at all echelons are essential for successful self-inspection programs. Identifying your own discrepancies may be difficult, but it is necessary to correct them. Supervisors can use self-inspections more frequently than directives specify to critically examine functions in their areas.

#### Inspection references and tools

Inspections can be for many things, such as safety or reliability of products or equipment, but in this lesson we focus on compliance. As in the lesson concerning TJC and the AAAHC, you have standards you must comply. In this lesson, you will learn you must comply with AFIs. AFIs are written so all personnel know and understands the standards with which we all must comply. Checklists are tools that AFIs can generate; they contain small pieces of data from AFIs or other documents with which compliance is necessary. The Air Force now uses the Management Internal Control Toolset (MICT) system to document self-assessment. MICT is accessible through the Air Force portal website and provides commanders with real-time status of any inspectable program. Other valuable inspection data sources are cross-feed information and special interest items.

### ***Checklists and guides***

Self-inspection programs should tailor to each unit's structure and mission and contain mechanisms that ensure adequate coverage of the organization's mission, resources, training, and people programs. Mechanisms may consist of periodically administering checklists, quality control reviews, internal audits, functional inspections, management information systems, numerical summaries, and analysis programs. The uses of checklists and inspection guides alone do not guarantee better management practices or mission success. Normally, Air Force/major command (MAJCOM) checklists and guides provide only basic standards for compliance. To properly conduct a self-inspection with a checklist, personnel should review all parent instructions used to construct that checklist. If, while conducting your inspection you find a need for more guidance than a checklist item provides, refer back to the parent instruction.

### ***Cross-feed information***

MAJCOMs provide several forms of valuable information that units use to prepare for inspections and improve their self-inspection programs. This information includes inspection reports from other bases, the IG's periodic analyses report (which summarizes inspection reports and describes common deficiencies within the command), audit reports, and the IG briefs. Units establish a system to receive and review applicable portions of these reports, changing unit procedures or implementing recommendations as necessary, and updating self-inspection checklists.

### ***Special interest item***

A special interest item (SII) is a tool to focus management attention, gather data, and assess the status of specific programs and conditions in the field.

### ***Office of primary responsibility***

The Secretary of the Air Force Inspector General (SAF/IG) is the primary office of responsibility (OPR) for inspection programs. Guidance for this program is contained in AFI 90-201, *The Air Force Inspection System*, but this instruction directs each MAJCOM to establish self-inspection program guidelines for their subordinate units. In this way, MAJCOM commanders can focus attention to critical areas within their commands. Furthermore, MAJCOM supplements to AFI 90-201 give the same guidance in establishing self-inspection at the wing/base level. The intent is to provide commanders (command level down to the local level) with a tool for internal assessment of unit health and to complement external inspections and assessments. So when we say the SAF/IG is the primary OPR for self-inspections programs, remember the program only begins there. There will also be OPRs at the MAJCOM and wing/base levels as well.

Some duties of the OPR for the self-inspection are:

- Ensures that self-inspection programs meet the requirements of AFI 90-201 along with any MAJCOM, wing, or local supplemental requirements and ensures the inspections are conducted in an efficient manner.
- Establishes procedures to foster effective self-inspections.
- Assists subordinate units in establishing effective self-inspection programs.
- Provides units with cross-feed, SII, and other information needed to update subordinate unit programs.
- Annually reviews wing staff agency and group-level self-inspection programs.

### ***Key personnel within the self-inspection program***

There are also OPRs at the group and squadron/division levels, but they are generally called self-inspection managers. Your squadron/division level inspection manager reports inspection data up to the group inspection manager; all group inspection data flows up to the wing/base OPR. Let's look at some additional duties of these self-inspection managers and other key personnel within the program.

### *Self-inspection manager*

The commander appoints this individual in writing to ensure the appropriate monitoring and completion of the unit's self-inspection programs.

### *Self-inspection manager responsibilities*

Self-inspection managers are very important and are the first level in identifying potential items of concern. The self-inspection manager does the following:

- Ensure the unit commander is briefed on the status of the self-inspection program. This briefing should be properly documented and placed in the self-inspection book.
- Ensure self-inspection checklists are maintained by each subordinate unit or staff element.
- Distribute cross-feed information and related documents to subordinate self-inspection monitors. Ensure cross-feed items are thoroughly reviewed for similar discrepancies or commendable programs.
- Conduct periodic staff assistance visits (SAV) to make certain all personnel understand the goals, objectives, and administrative management of the self-inspection program.
- Publish or provide an annual schedule to review the subordinate activity's inspection program.
- Maintain self-inspection binder or electronic files to include results from evaluations, inspection, and cross-feed items, as well as documents related to the management of the program.
- Track self-inspection discrepancies in MICT.
- Prepare quarterly progress reports on corrective action for significant deficiencies until the problem is corrected. Forward reports to the wing/base commander through designated chain of command.

### *Self-inspection monitor*

The commander appoints this individual in writing to assist the manager in ensuring the appropriate monitoring and completion of the unit's self-inspection programs. Self-inspection monitors generally perform their duties at the shop level (such as the pharmacy) and report inspection data up through their self-inspection managers.

### *Self-inspection monitor responsibilities*

Self-inspection monitors are very important and are the first level in identifying potential risk areas. If you are appointed as a self-inspection monitor, you are a representative for your unit. The self-inspection monitor does the following:

- Brief his or her appointing authority and self-inspection manager on identified discrepancies from local or higher headquarters inspections and their unit's status on those areas.
- Monitor discrepancies entered in MICT until corrective action is complete.
- Review all cross-feed information and related documents for updating self-inspection checklists and circulate to appropriate staff to ensure potential problem areas are fixed before they become problems.
- Ensure self-inspection checklists are reviewed annually.
- Prepare quarterly progress reports on corrective actions for significant deficiencies until the problem is corrected. Forward reports to the self-inspection manager.

### **Inspecting your work areas**

A thorough, comprehensive self-inspection is the most important aspect of the program. Only the most knowledgeable and professional individuals should conduct the inspections, but those knowledgeable individuals should keep in mind that eventually they will be moving on; in other

words, they need to train their replacements. Learning the inspection process takes time and effort, so whenever a self-inspection takes place, another member of the pharmacy team should be part of the process so he or she can become familiar with it.

Remember, a totally honest and objective approach will identify problems or potential problems in sufficient time to correct them before they have a negative impact on the unit and its mission. Document tracking procedures for monitoring discrepancies until discrepancies are totally corrected.

### **Frequency**

Self-inspections are annual requirements. However, commanders may direct self-inspections more frequently if deemed necessary.

### **Documentation**

Document discrepancies and enter them into MICT. Discrepancies must identify the root cause and not merely the symptom; these corrective actions are in the quarterly progress reports until the item is correct and closed. Each discrepancy must have an estimated completion date (ECD) established and a quarterly management review by the self-inspection monitor to ensure correction. When an item is correct, flag it for review at the next inspection to ensure the corrective action is continuing to work.

### **Tracking inspection results/discrepancies**

The proper tracking of inspection results is just as important as proper documentation. If your facility properly tracks its inspection findings, the data can be used to look for trends not only in individual work centers but throughout the MTF, and in some cases, your entire wing. As mentioned earlier, MTFs across the Air Force have begun using MICT to complete this task. MICT is an Air Force program of record used by Airmen to complete self-assessment of program management and compliance with higher headquarters directives.

## **204. Unit effectiveness inspections**

The UEI integrates elements of compliance and readiness with new inspection elements to create a new IG) inspection of unit effectiveness. Conducted by MAJCOM IGs, AFIA, and Air Force Intelligence, Surveillance, and Reconnaissance Agency (AFISRA), the UEI is a continual evaluation of performance throughout the inspection period—a “photo album” versus a snapshot. The inspection period begins immediately after the close-out of the previous UEI report. The UEI inspects the following four major graded areas (MGA)—managing resources, leading people, improving the unit, and executing the mission.

UEIs validate and verify a wing commander’s (CC) inspection report (CCIR) for accuracy, adequacy and relevance, and provide an independent assessment of the Wing’s resource management, leadership, process improvement efforts and ability to execute the mission. A UEI is a years-long, continual inspection of the unit’s effectiveness, and helps the wing commander understand the areas of *greatest risk from undetected noncompliance*.

Using a risk-based methodology, the MAJCOM/IG follows the UEI sequence of events in the conduct of a UEI (fig. 1–2). The wing CC and MAJCOM CC receives a final report and grade. This report includes two grades: one grade on the wing’s effectiveness and another grade on the adequacy of resources provided to the wing.



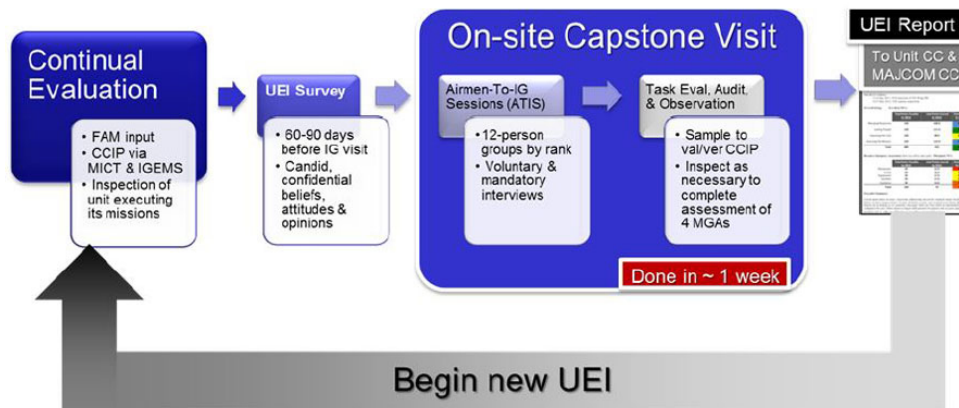


Figure 1-2. Unit effectiveness inspection cycle.

### Unit effectiveness inspection process

UEIs function in accordance with HQ USAF Program Action Directive (PAD) 13-01, *Implementation of the Secretary of the United States Air Force Direction to Implement a New Air Force Inspection System*, and AFI 90-201.

MAJCOM commanders develop a battle rhythm to facilitate UEI sampling, which enables continual evaluation of all wings and gained wings. They also hold wing CCs accountable for CCIR accuracy.

MAJCOM/IGs continually evaluate unit effectiveness. With the purpose of the UEI in mind, they build base-specific sample strategy with input from higher headquarters, MICT data, survey results, virtual inspections, and available IG resources. Additionally, they work with leadership to identify a MICT program manager to assist wings in MICT and verify functional area manager (FAM) checklist standardization.

MAJCOM FAMs coordinate with the MAJCOM/IG to identify areas of interest and/or emphasis items for the UEI by monitoring data from each wing through MICT and trend analysis. FAMs also identify and provide inspector augmentees with functional expertise.

### UEI methodology

Use the following guidance to assist the MAJCOM/IG in developing sound inspection policy for conducting the UEI:

- The MAJCOM/IG assembles a team to perform the inspection and submit upon completion. The inspection team consists of a sufficient number of IG inspectors and augmentees to conduct UEI inspections under the authority of the MAJCOM/IG.
- When non-IG inspections synchronize by the MAJCOM Gatekeeper, the MAJCOM/IG Team Chief coordinates with the non-IG inspection team leader to minimize any adverse effects on the unit's mission and to prevent any unnecessary duplication of effort or use of installation resources.
- The UEI primary focus is not on detecting noncompliance; rather, the UEI validates and verifies the commander's own compliance detection program, identifies areas for the wing CC where he or she has significant *risk of undetected noncompliance*. To identify areas where there may be risk of undetected noncompliance, the MAJCOM IG team develops a sampling strategy for each wing to inspect mandatory items.
- MAJCOM/IGs establishes a 24-30 month UEI cycle for each Active Duty and Reserve wing and a 48-60 month UEI cycle for Air National Guard wings. Inspectors complete all elements of the UEI within this timeframe.
- The continual evaluation phase of the UEI begins immediately after the previous UEI report is signed.



### **UEI survey**

The MAJCOM/IG administers an online survey to the wing to capture candid, confidential beliefs, attitudes, and opinions about matters relevant to the four UEI MGA. The purpose of the survey is threefold: (1) to gather data since the last on-site evaluation, (2) to assist in determining the inspection team composition, and (3) to develop the sampling strategy for the capstone—on-site evaluation.

Prior to the capstone event, the MAJCOM/IG sends the wing CC instructions on completing the survey and making sure all wing members have access and ample time to complete the survey. The survey is available to wing personnel approximately 90 days prior to the capstone event.

MAJCOM/IG personnel close out the survey on a date that provides wing personnel ample opportunity to complete the survey while also allowing MAJCOM/IG personnel ample time to analyze survey results before the capstone event.

Survey results help inspection teams understand Airmen's attitudes, beliefs, and perceptions to more precisely target a sample strategy for the on-site capstone visit. MAJCOMs use the SAF/IG-approved survey and may add up to five MAJCOM-unique questions to help prepare for their on-site inspection. The survey results and analysis are for IG use only.

The IG assures the survey participants that results will not go to their chain of command, and survey administrators honor that promise. Wing CCs will not receive copies of survey results.

Any significant trends shape the on-site sampling strategy for the UEI. Team chief out-brief will include feedback to the wing on select significant trends and proposed courses of action without compromising participant confidentiality.

### **On-site capstone visit**

The on-site visit is the capstone event of the UEI and the catalyst for generating a UEI report. The capstone event is intended to last approximately one week, during which time the IG validates and verifies the commander's inspection program (CCIP), conduct Airmen-to-IG-Sessions, and independently assess unit effectiveness through task evaluations, audits, and observation. An accurate and trusted CCIP is the cornerstone of the AFIS. The validation and verification of CCIP is the most important part of a UEI. If the inspection team believes CCIP is not accurate, adequate, or relevant, then the wing's grade is INEFFECTIVE.

Inspection teams have a handoff plan in place in the event a complainant comes forward during the on-site inspection. All inspectors have contact information immediately available to contact an appropriately-trained complaints resolution IG member. Wing performance plays a part in determining the scope and depth of the on-site IG visit. Excellent performance throughout the UEI period may reduce the depth and scope of the inspection sample. Conversely, questionable performance may require a broader or deeper inspection.

### **UEI reports**

The UEI report covers the entire UEI period. Once the MAJCOM/IG submits the report, the wing immediately enters into the next UEI cycle. The UEI report specifically includes two distinct grades. One grade is the wing's grade; the other is the "adequacy of resources" grade. The adequacy grade provides a MAJCOM/CC an assessment of the support the wing receives from higher headquarters (HHQ) staffs. The report does not reveal any survey data below the wing level.

### **UEI ratings**

MAJCOM/IGs use the five-tier grading system to determine UEI assessments.

#### ***Outstanding***

Given for a UEI score between 85 and 100, this rating indicates the wing meets/exceeds the criteria for a HIGHLY EFFECTIVE rating AND most or all of the following are consistently true:

- Mission activities, programs, and processes execute in an increasingly cost-effective manner.

- Results of long-term commitment to continuous process improvement are evident.
- Leader's decisions and priorities demonstrate genuine care for their Airmen.
- Leaders engage to help Airmen achieve their own goals as well as the unit's goals.
- Widespread evidence of high proficiency, unit pride, and cohesion.
- Programs and processes are institutionalized and produce highly reliable results.
- Programs are nearly deficiency-free, and efforts to benchmark and share lessons learned with other wings are evident.
- Effective Management Systems are in place and are used to maximum effectiveness at all levels.

### *Highly effective*

Given for a UEI score greater than 65 and less than or equal to 85, this rating indicates the wing exceeds the criteria for an EFFECTIVE rating AND most or all of the following are consistently true:

- Mission activities, programs, and processes are executed in a highly effective and efficient manner; personnel demonstrate high proficiency.
- CCIP is institutionalized, used to measure and report improvements in all four MGAs, and provide actionable feedback to HHQ on policy, guidance, and resource adequacy.
- Continuous process improvement efforts are widespread and have improved efficiency.
- Most programs and processes are measured and repeatable and produce reliable results.
- Risk-based criteria are habitually applied when allocating resources and making decisions.
- Programs have very few deficiencies and necessary waivers are in effect.
- Deliberate efforts to train, communicate, and engage Airmen are evident.
- Effective processes are in place to improve Airmen's quality of work and home life.
- Management Systems are mature and continuous improvement crosses across multiple programs.

### *Effective*

Given for a UEI score greater than 35 and less than or equal to 65, this rating indicates most or all of the following are generally true:

- Requirements are met in all mission areas (Primary, Air and Space Expeditionary Force (AEF), Mission Assurance Command and Control (C2), and personnel are proficient.
- CCIP provides the command chain an accurate, adequate, and relevant picture of unit performance.
- Resources are managed in an effective and compliant manner.
- Leaders treat Airmen with respect and provide a healthy and safe work environment.
- Continuous process improvement efforts are evident.
- Critical programs and processes are measured and repeatable.
- Risk-based criteria are often considered when allocating resources and making decisions.
- Programs have few significant deficiencies and many necessary waivers are in effect.
- Management Systems are present and continuous improvement occurs.

### *Marginally effective*

Given for a UEI score greater than 15 and less than or equal to 35, this rating indicates the wing does not meet the criteria for an EFFECTIVE rating, and some or all of the following are consistently true:

- Requirements are met in some but not all mission areas (Primary, AEF, and Mission Assurance C2).
- Unit personnel meet minimum performance criteria but with limited proficiency.
- CCIP provides the command chain an accurate, though limited, picture of unit performance.
- Some key processes and activities are not carried out in a competent or compliant manner or are personality-dependent.

- Little to no evidence exists of continuous process improvement efforts.
- Resources and programs are not well-managed.
- Risk and resource scarcity are not deliberately considered in decision-making processes.
- Deficiencies exist that significantly increase risk to Airmen, the mission, or the Air Force.
- Management systems have some elements that are not working in a cohesive process.

### *Ineffective*

Given for a UEI score between 0 and 15, this rating indicates the wing does not meet all of the criteria for an EFFECTIVE rating, and some or all of the following are consistently true:

- Wing does not demonstrate ability to meet mission requirements.
- Evidence exists of systemic noncompliance or widespread disregard for prescribed procedures.
- The number and severity of deficiencies preclude or seriously limit mission accomplishment.
- CCIP does not provide an accurate, adequate, or relevant picture of unit performance.
- Leaders do not treat Airmen with respect or do not provide a healthy and safe work environment.
- Resources and programs are grossly mismanaged.
- Management systems are not evident.

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## Self-Test Questions

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

### **203. Self-inspection program**

1. What is the primary purpose of the self-inspection program?
2. According to IG reports, how can commanders achieve the best results?
3. How should self-inspection programs be tailored?
4. What are two examples of cross-feed items?
5. Who is the OPR for self-inspection programs?
6. Who conducts periodic staff assistance visits to make certain all personnel understand the goals, objectives, and administrative management of the self-inspection program?
7. How frequently *should* self-inspections occur, and how frequently *can* they occur?

8. What is the database which all work centers within the MTF can log and track their inspection data?

#### **204. Unit effectiveness inspections**

1. Under whose authority are UEIs conducted?
2. What does a UEI validate?
3. What is the UEI cycle for active duty wings?
4. What is the highest score a wing can receive on a UEI?
5. What UEI rating is given for a score of 15 or less?

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### **Answers to Self-Test Questions**

#### **201**

1. To continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value.
2. Credibility.
3. Performance of functions and processes aimed at continuously improving patient outcomes.
4. Organization size and scope of services.
5. The organization's past, current, and future performance.
6. Accreditation Requirements and Accreditation Process Information.
7. They are reasonable, achievable, and surveyable.
8. Independently.
9. Medication management.
10. A rationale.
11. EPs.
12. Three years.

#### **202**

1. To remain the preeminent leader in developing standards to advance and promote patient safety, quality, value, and measurement of performance for ambulatory health care through peer-based accreditation processes, education, and research.
2. Ambulatory.
3. Eight.

4. Seventeen.
5. Pharmaceutical services are provided or made available to meet the needs of the patients and are provided in accordance with ethical and professional practices and legal requirements.
6. Adverse reactions.
7. Health care professionals and administrators who are actively involved in ambulatory health care settings.
8. Three years.

**203**

1. To identify problems at the lowest management level, implement solutions, and provide a feedback system to track problems until they are resolved.
2. By emphasizing critical self-assessments.
3. They should be tailored to each unit's structure and mission and contain mechanisms that ensure adequate coverage of the organization's mission, resources, training, and people programs.
4. Inspection reports from other bases, the Inspector general's periodic analyses report, audit reports, and TIG briefs.
5. SAF/IG.
6. The self-inspection manager.
7. Annually. However, commanders may direct self-inspections to be conducted more frequently if deemed necessary.
8. MICT.

**204**

1. MAJCOM/IGs.
2. A wing commander's inspection report for accuracy, adequacy and relevance, and provide an independent assessment of the wing's resource management, leadership, process improvement efforts, and ability to execute the mission.
3. 24–30 months for active duty.
4. Outstanding.
5. Ineffective.

**Complete the unit review questions before going to the next unit.**

## Unit Review Exercises

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

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

1. (201) What is the mission of The Joint Commission, and how is it carried out?
  - a. To improve the quality of care and services provided in healthcare settings; imposed accreditation.
  - b. To improve the quality of care and services provided in healthcare settings; voluntary accreditation.
  - c. To continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value; imposed accreditation.
  - d. To continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value; voluntary accreditation.
2. (201) How do pharmacies prepare and dispense medication to meet compliance with the Joint Commission's Medication Management standard?
  - a. All medication orders are reviewed for appropriateness.
  - b. By allowing non-pharmacy personnel access to the pharmacy.
  - c. By sending patients to civilian hospital pharmacies that are open.
  - d. Pharmacies must remain open 24 hours a day to provide medications with consistent quality.
3. (201) Which of The Joint Commission (TJC) compliance Numerical Score Description ratings represent "insufficient compliance" with an element of performance and serves as a determination as to whether your military treatment facility (MTF) is compliant with a given standard?
  - a. 0.
  - b. 1.
  - c. 2.
  - d. N/A.
4. (202) The Accreditation Association for Ambulatory Health Care (AAAHC) scores the pharmacy by using how many different characteristics?
  - a. 13.
  - b. 14.
  - c. 15.
  - d. 16.
5. (203) The primary purpose of the self-inspection program is to identify problems at the
  - a. flight level only.
  - b. squadron level only.
  - c. lowest management level.
  - d. highest management level.

6. (203) According to the Inspector General (IG) reports, commanders achieving the *best* results are commanders who emphasize
  - a. outcome.
  - b. leadership.
  - c. management.
  - d. critical self-assessment.
7. (203) In a military treatment facility, how often must self-inspections be conducted?
  - a. Monthly.
  - b. Quarterly.
  - c. Biannually.
  - d. Annually.
8. (204) The Unit Effectiveness Inspection (UEI) integrates elements of compliance and readiness to measure unit
  - a. compliance.
  - b. effectiveness.
  - c. ineffectiveness.
  - d. noncompliance.
9. (204) What is the number of months for the Unit Effectiveness Inspection (UEI cycle) timeframe for Active Duty and Reserve wings?
  - a. 6–12.
  - b. 12–24.
  - c. 24–30.
  - d. 30–48.

## **Student Notes**



## Unit 2. Pharmacy Forms and Files & Administrative Reports

<b>2-1. Maintaining forms and files.....</b>	<b>2-1</b>
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**P**HARMACY PROCEDURES DON'T just happen— they are planned, organized, coordinated, directed, and evaluated. A variety of people from the medical group (MDG) commander to you manage the activities taking place in your pharmacy. It is a team approach to provide pharmacy care to our patients. It takes a lot of time to manage a pharmacy, provide quality care, and meet the standards expected. Regardless of your rank or position in the pharmacy, you assist your fellow Airman, civilian contactors, and supervisors, all the way up to the pharmacy flight commander. To complete this, you must comply with the standards, regulations, and policies inherent to any treatment facility, military or civilian. This unit will help you with many of the administrative functions you need to efficiently and effectively run a pharmacy. Administration involves a lot of paperwork, reports, and documentation, but nonetheless necessary. This unit covers those necessary forms, files, and reports.

### 2-1. Maintaining Forms and Files

Every business or corporation has some means of communicating policy and guidelines from the bosses down to the front-line workers. Although verbal communication is easier and faster, most people like to have communication that affects them presented in black and white. This approach to communication avoids misinterpretations and holds both the message sender and receiver accountable. The Air Force communicates important news, policies, and regulations through written documents called publications. These publications come in two types: directive and non-directive. Directive publications are necessary to meet the requirements of law, safety, security, or other areas where common direction and standardization benefit the Air Force. Air Force personnel recognize these directive publications as policy directives and memorandums, mission directives, operating instructions, manuals, and arguably the best known, Air Force Instructions or AFIs, just to name a few. Air Force personnel *must* comply with these publications. Non-directive publications are informational and suggest guidance that you can modify to fit the circumstances. Complying with publications in this category is expected but not mandatory. Air Force personnel recognize these non-directive publications as pamphlets, doctrine documents, directories, handbooks, and catalogs, just to name a few. Personnel use these publications as reference aids, “how-to” guides, or as sources of official information.

You were given an introduction to AFIs in volume one. Many of these instructions direct the use of particular forms within your pharmacy, while others provide guidance on how to maintain your files. Before we complete our look at pharmacy forms and files, let's look at the how the Air Force categorizes these forms and files (records) and their disposition.

#### 205. Pharmacy files and disposition

AFI 33-364, *Records Disposition—Procedures and Responsibilities*, lists ten different categories of records. For the purpose of your pharmacy career development courses (CDCs), we will cover three of these categories; they are federal records, personal papers, and temporary records.

#### Federal records

Federal records vary widely to include books, papers, maps, photographs, electronic media, or other documentary materials, regardless of physical form or characteristics, that the Air Force makes or

receives under Federal law or during the course of its public business. These records are kept as evidence of the Air Force's organization, functions, policies, decisions, procedures, operations, or other activities and because of the material's informational value (this area applies to pharmacy forms and files).

Collections of official records are known as official files. Removal and destruction of official records must be according to the Air Force Records Information Management System (AFRIMS) Records Disposition Schedule (RDS) or other directives.

### **Personal records**

Not all correspondence you transmit is property of the United States government. Sometimes you may have personal correspondence you owned before joining the Air Force. Personal papers that relate solely to an individual's private affairs include:

- Papers that the individual created before entering government service.
- Private materials that the individual brought into, created, or received in the office but are not related to government business and work-related circumstances.
- Work-related personal papers not used for transacting government business.

Correspondence that is "personal" or "private" but relating to the conduct of public business is maintained and disposed of in accordance with 44 US Code, Chapter 31, *Records Management by Federal Agencies*.

### **Work-related personal papers**

Work-related personal papers include diaries, journals, personal calendars, and appointment schedules that contain work-related information but exist for the official's personal use (such as reminders and personal observation on work-related topics) and not for transacting government business.

### **File personal papers separately from the pharmacy records**

Typically, you should file personal papers separately from official pharmacy records. At a later date, the Air Force may designate some of these materials as official records, depending on the circumstances surrounding their creation, maintenance, use, or disposition.

### **Personal copies of records and non-record materials**

When personnel leave the Air Force, they might want to take copies of particular MTF papers, working papers, and nonrecord materials, especially if they plan to continue working in the same field or write memoirs. With agency approval, Air Force personnel may take nonrecord copies of documents and copies of materials they drafted, reviewed, or otherwise acted upon. Most personnel keep extra copies of such documents from the beginning of their Air Force careers.

### **Temporary records**

Temporary records are any record the Archivist of the United States deems to have insufficient value to warrant preservation by the National Archives. Temporary records are disposable after a fixed period of time or after an event and according to the AFRIMS RDS.

### **Disposition of records**

Disposition is a comprehensive term that includes destruction, salvage, or donation; transfer to a staging area or records center; transfer from one organization to another; and actions taken with inactive records. These actions may include erasure of data, transfer to a records center, or transfer to the National Archives. The disposition of records is directed by AFI 33-364 and includes *disposition instructions*, which can be located at the AFRIMS RDS website.

### **Disposition instructions**

These instructions are precise and specify the date or event for cutoff, transfer, retirement, or destruction of records. The instructions also provide specific guidance to different organizational levels (Air Force, USAF Headquarters, and organizational activities below USAF Headquarters to

which disposition instructions apply to them). In most cases, disposition instructions exist, such as “Destroy after 2 years,” or “Destroy after 10 years”—these would be placed in your inactive files after the current year, until the number of years is up. Some of the instructions state, “Destroy after 3 months,” “When superseded,” or “When no longer needed” —for these types of statements, just follow the directions. Regardless of the disposition instructions, unless otherwise stated, *retention periods begin after the file cutoff date rather than the dates of individual records in a file*. In the past, many have misunderstood this file cutoff date and retention period. To help clear this up, let’s move on to our next subject, *records staging*, where you can learn about the file cutoff date and retention period in correlation to records staging more effectively.

### ***Records staging***

With work space at a premium, the pharmacy cannot always maintain the paperwork it receives, processes, and generates. At some point in time, you may need to store this paperwork elsewhere; otherwise, your pharmacy would be wall-to-wall paperwork. The process of gathering, arranging in proper order, storing, and disposing of this paperwork is called *records staging*. Pharmacies that cannot maintain their records for a long time stage their records. This staging process transfers your records to another, larger staging area where the personnel at the staging facility destroy upon expiration of the remainder of the retention period; the staging facility coordinates with your unit’s functional area records manager (FARM) and base records manager (BRM).

Because each of our pharmacies’ workloads, records generation, and storage space is different, each pharmacy, in coordination with its FARM, will decide how long to hold its records in-house, whether to stage them, and/or when to stage them. In accordance with AFI 33–364, work areas can retain small volumes of records with a retention period of two through eight years in the current pharmacy files area until eligible for disposal or retirement. If your pharmacy needs space for *current records*, the records manager (RM) responsible for the supervision of the staging area may approve transfer of your *non-current* records to the larger staging area early. Although each facility is different, most staging activities accomplish this annually. Now that you know what staging is; let’s readdress the file cutoff date and retention period of your records.

### ***Record file cutoff date and retention period***

To reiterate, AFI 33–364 states: “Regardless of the disposition standards, unless otherwise stated, retention periods begin after the file cutoff date, rather than the dates of individual records in a file.” *Retention period* refers to “the length of time the Air Force keeps a record before disposing of it according to the disposition instructions. Records not authorized for a specific disposition have a retention period of permanent.” The *cutoff date* is the point in time, determined by the disposition instructions, to be when your retention period begins. Depending on the type of records and volume size, AFRIMS refers to cutoff dates at the end of each calendar or fiscal year, as applicable.

An example of a disposition instruction would be as follows:

<b>TABLE &amp; RULE: T 41–14 R 01.00</b>	<b>DATE CREATED: Unknown</b>
<b>TITLE: Prescription Records</b>	<b>DATE MODIFIED: 16/Jun/2005</b>
<b>AUTHORITY: N1–AFU–90–3</b>	
<b>COLUMN B CONSISTING OF:</b>	
DD Form 1289, DOD Prescription Form; AF Form 781, Multiple Item Prescription	
<b>COLUMN C WHICH ARE:</b>	
At pharmacies	
<b>COLUMN D DISPOSITION:</b>	
<b><i>Destroy after 3 years.</i></b>	

**NOTES**

**212** Electronic copies created using electronic mail and word processing: Destroy paper after recordkeeping copy has been created and filed or when no longer needed for revision, dissemination, or reference, whichever is later.

**213** Electronic systems that replace temporary hard copy records: Destroy on expiration of the retention period previously approved for the corresponding hard copy records.

**214** Electronic systems that supplement temporary hard copy records where the hard copy records are retained to meet recordkeeping requirements: Destroy when the agency determines that the electronic records are superseded, obsolete, or no longer needed for administrative, legal, audit, or other operational purposes.

The above disposition instruction tells you the what, when, and how: It is the year 2015; on 1 January 2016, all files with a *disposition instruction of one year or more* get moved to the inactive files for the *number of years that is on that specific instruction*. You will place all AF Forms 781s, Multiple Item Prescription, in the inactive files and destroy them in January 2019 (the year of active files [in this case, 2015] does not include in the count; you only begin the count once the files are inactive). For disposition instructions of all of your pharmacy forms and files, always refer to the applicable AFIs and work closely with your facility's RM for proper records storage and disposition. Your RM will help you to reconcile proper cutoff dates and retention periods for your pharmacy records.

If your facility decides to box and move files to a staging center, you must follow the guidelines in AFI 33-364 regarding packing and shipping requirements.

**File boxes**

At the appropriate time, you gather applicable records up and either dispose of them or store them. Now, we can't just take this paperwork and hand it to the records staging personnel. Make sure the paperwork is in sequence, boxed up, and labeled. Let's learn how the Air Force wants us to stage this paperwork.

The following is a list of the sizes or types of boxes that may be used to retire, ship, or transfer Air Force records to a federal records center, staging area, or other organization:

- 14¾ inches by 12 inches by 9¾ inches (tuck bottom).
- 14¾ inches by 12 inches by 9¾ inches.
- 15 inches by 12 inches by 10 inches.

You can obtain these boxes from your normal supply source.

**Prepare your records for packing**

Make sure all records you pack together in one box have the same disposition date, and follow the same rules for storage. Let's use your outpatient prescription files as an example. Group the prescriptions by item numbers and cutoff date (e.g., prescription forms in numerical sequence for numbers 100001 through 198872 for the month of January).

The records you pack in the staging boxes should be loose enough to allow others to remove files freely or add more files later. Place records in boxes in an upright position, in the same numerical sequence listed on the Standard Form (SF) 135, Records Transmittal and Receipt, with the label facing the numbered end of the box.

Do not place folders on top of folders. If your box contains only a few legal-size files mixed with letter-size files, fold the bottom edge of the legal-size files to fit the width of the box.

You can fill the box to capacity; the standard shipping container holds 1 cubic foot of records. If you fill the standard shipping containers to capacity, no packing material is necessary. If you have a partially filled box, use crumpled, wadded paper, or other suitable packing material to prevent movement during shipment (**NOTE:** Wood shavings, shredded paper, wax paper, additional file

material, and surplus file folders are not suitable packing material). Do not send partially filled boxes to the federal records center. Hold a series of records until a cubic foot of material becomes available.

### *Sealing your boxes*

Seal boxes going to a federal records center, or postal shipments going to any location, with one-inch filament tape. Call your records staging office to find out the specific type and stock number to order this tape.

### *Marking your boxes*

On the top of each box, indicate the shipper's and addressee's names and addresses when shipping to a federal records center or through postal channels to any location. You may omit this information if you deliver your boxes directly to the Washington National Records Center in Maryland.

If your shipment is not to a federal records center, enter the box number and total number of boxes, in consecutive numerical sequence, in the upper right-hand corner or unstitched front end of each box. You can also use the appropriate label printed on the tuck-bottom box (i.e., if a shipment includes three boxes, number them 1/3, 2/3, 3/3). Use a felt-tip pen or its equivalent to mark the boxes or use tuck-bottom boxes with a printed label on the front of the box. Mark the accession number and box number with numerals. If you pack boxes in several locations so you can combine them later into a single shipment, you may assign numbers in pencil (remove these numbers before starting to number the complete shipment).

Okay, now we have the boxes packed and sealed, we must now complete some paperwork.

### **Using Standard Form 135, Records Transmittal and Receipt, and SF 135A, Records Transmittal and Receipt**

You use SF 135 to identify records for retirement to a federal records center or staging area. You use the SF 135A when you need more than one page. These forms serve as follows:

- As a packing list for transferred or retired records.
- As a medium for controlling the location, retrieval, reference, and disposition of records in staging areas and federal records centers.
- As a receipt for retired records.
- As identification and accountability for lost, destroyed, or withheld records that personnel normally would have retired.

See AFI 33-364, *Records Disposition—Procedures and Responsibilities*, for instructions on filling out this form. Contact your section records manager for appropriate guidance in staging your pharmacy records.

## **206. Pharmacy forms and files**

AFI 33-360, *Publication and Forms Management*, defines a form as a tool used for the collection, recording, and/or extraction of information whereby a predetermined set of data fields have been established and defined to meet a definitive Air Force purpose or objective. You have already been introduced to several forms in technical school and this CDC. This lesson completes the introduction of pharmacy forms and files, provides you guidance for proper filing/disposition of these forms, and provides a brief review of all forms covered so far. Let's start the lesson with outpatient prescription files.

### **Outpatient prescription files and forms for controlled and non-controlled drugs**

In later units, you will learn that providers within your MTF use the provider order entry (POE) function of the Composite Healthcare Computer System (CHCS) to prescribe medication to their patients instead of writing a paper prescription (AF Form 781, Multiple Item Prescription; and DD Form 1289, Prescription Form). Of course, CHCS will sometimes experience problems, and your

providers will temporarily resort back to the paper prescription. Pharmacy personnel must fill out these military prescription forms, along with their civilian equivalent.

There are three categories of outpatient prescription files: drugs listed as Schedule II; drugs listed as Schedules III, IV, and V; and finally drugs listed as non-controlled legend drugs. All three prescription types require separate prescription forms (i.e., Schedule II drugs are required to be on a separate prescription from those in Schedules III, IV, and V; and non-controlled drugs are required to be written separately from all schedule drug classes). The filing system for these prescriptions is similar; however, you file each of the three prescription types separately in chronological sequence by prescription number and date. Retain the AF Form 781 and civilian prescriptions for three years and then you destroy them.

### Air Force Form 2380, Pharmacy Manufacturing Control Data

When compounding, use the AF Form 2380 (figs. 2-1 and 2-2) to initiate each individual batch that you prepare.

PHARMACY MANUFACTURING CONTROL DATA					ATTACH LABEL HERE	
PRODUCT		LOT NUMBER				
Atenolol Suspension 2mg/ml		1417701				
INGREDIENTS		MFG	LOT NUMBER	AMOUNT	WEIGHED BY	CHECKED BY
1	Atenolol 100mg	Sandoz	CJ4463	2 tablets	51	5
2	Glycerin	Humco	534184	2 mls	51	5
3	Ora Sweet SF	Paddock Labs	3344172	100 ml QSAD	51	5
4						
5						
6						
7						
8						

AF FORM 2380  
JUN 71

Figure 2-1. Sample AF Form 2380, Pharmacy Manufacturing Control Data (front).

LABELING 90 days refrigerated/ 7 days @ room temperature; shake well			
CONTAINERS UTILIZED Amber vial		TYPE Tight-light resistant	SIZE 4 oz
SPECIAL SPECIFICATIONS N/A			
THEORETICAL YIELD 102 mls	ACTUAL YIELD 102 mls	REASON FOR DISCREPANCY (if any) N/A	
MANUFACTURED BY SSgt James Leonard (51)		TIME 1:29 PM	CONTROL ACTION N/A
REMARKS			
DATE 15 Jul 2015	PREPARED BY SSgt James Leonard (51)	DATE 15 Jul 2015	CHECKED BY Greg Splitter, RPh

Figure 2-2. Sample AF Form 2380, Pharmacy Manufacturing Control Data (back).

### Quality control data

AF Form 2380 provides a record of the manufacturer's quality control data (including any expiration dates) and amounts for each product used as an ingredient in the preparation.



**Lot number**

The AF Form 2382, Pharmacy Bulk Compounding Chronological Control Log, assigns the pharmacy lot number.

**Form retention**

Destroy the form after three years or when it is no longer needed, whichever is sooner.

**Air Force Form 2381, Pharmacy Master Formula**

Initiate this form (fig. 2-3) on all medications manufactured (compounded) in bulk quantities.

**Formula**

As the title of the form indicates, use the AF Form 2381 to record the formula (also referred to as the recipe) you follow each time you compound the item. This form contains the medication ingredients, ingredient amounts, directions, container requirements, and any special considerations for compounding.

**Lot number**

Each time a batch is prepared, the assigned lot number and the amount compounded are recorded on the back of the form.

**Form retention**

Destroy AF Form 2381 when it is superseded, becomes obsolete, or is no longer needed.

PHARMACY MASTER FORMULA		COST		ATTACH LABEL HERE
		12oz 1oz 2oz 4oz	8oz 16oz 32oz	
PRODUCT		Atenolol Suspension 2mg/ml		
INGREDIENTS				AMOUNT
1	Atenolol 100mg			2 tablets
2	Glycerin USP			2 ml
3	Ora-Sweet Sugar Free			100 ml
4				
5				
6				
7				
8				
9				
10				
11				
12				
DIRECTIONS FOR MANUFACTURE				
<p>***Atenolol was not found to be stable in Ora-Sweet***</p> <ol style="list-style-type: none"> <li>1. Grind tablets to a fine powder in a mortar and pestle.</li> <li>2. Levigate with Glycerin USP to form a paste (increase amount slightly if needed).</li> <li>3. Add Ora-Sweet SUGAR FREE in increasing amounts while mixing thoroughly.</li> <li>4. Transfer contents of the mortar to a measuring cylinder.</li> <li>5. Rinse the mortar and pestle with base solution and pour into graduated cylinder.</li> <li>6. Add base solution to the graduated cylinder to achieve total volume indicated above.</li> <li>7. Transfer contents of the graduated cylinder into an appropriate size amber bottle.</li> <li>8. Shake well to mix.</li> </ol> <p>LAST REVIEWED: 19 July 2014</p>				
LABELING				
90 Days Refrigerated/ 7 Days @ Room Temperature; Shake Well				
SPECIAL CONTAINER REQUIREMENTS				
Tight-light resistant containers				
THEORETICAL YIELD				
DATE	PREPARED BY	DATE	CHECKED BY	
31 May 2015	Amy Hammond, CPhT	31 May 2015	Gregg Splitter, RPh	
AF FORM 2381 JUN71				

Figure 2-3. Sample AF Form 2381, Pharmacy Master Formula (front).

### Air Force Form 2382, Pharmacy Bulk Compounding Chronological Control Log

This form along with AF Forms 2381 and 2380, serves to fulfill information requirements for bulk compounding of pharmaceutical preparations.

#### Lot number

Use this as a central register for assigning individual lot numbers to each preparation compounded.

#### Number information

This locally devised number reflects when the product was compounded in your pharmacy. Pharmacies can log their compounded products two different ways, but they both involve using calendar dates. You can use either the Julian calendar date (fig. 2-4) or the Gregorian calendar date along with the batch number compounded that day.

JULIAN DATE CALENDAR PERPETUAL													
Day	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Day
1	001	032	060	091	121	152	182	213	244	274	305	335	1
2	002	033	061	092	122	153	183	214	245	275	306	336	2
3	003	034	062	093	123	154	184	215	246	276	307	337	3
4	004	035	063	094	124	155	185	216	247	277	308	338	4
5	005	036	064	095	125	156	186	217	248	278	309	339	5
6	006	037	065	096	126	157	187	218	249	279	310	340	6
7	007	038	066	097	127	158	188	219	250	280	311	341	7
8	008	039	067	098	128	159	189	220	251	281	312	342	8
9	009	040	068	099	129	160	190	221	252	282	313	343	9
10	010	041	069	100	130	161	191	222	253	283	314	344	10
11	011	042	070	101	131	162	192	223	254	284	315	345	11
12	012	043	071	102	132	163	193	224	255	285	316	346	12
13	013	044	072	103	133	164	194	225	256	286	317	347	13
14	014	045	073	104	134	165	195	226	257	287	318	348	14
15	015	046	074	105	135	166	196	227	258	288	319	349	15
16	016	047	075	106	136	167	197	228	259	289	320	350	16
17	017	048	076	107	137	168	198	229	260	290	321	351	17
18	018	049	077	108	138	169	199	230	261	291	322	352	18
19	019	050	078	109	139	170	200	231	262	292	323	353	19
20	020	051	079	110	140	171	201	232	263	293	324	354	20
21	021	052	080	111	141	172	202	233	264	294	325	355	21
22	022	053	081	112	142	173	203	234	265	295	326	356	22
23	023	054	082	113	143	174	204	235	266	296	327	357	23
24	024	055	083	114	144	175	205	236	267	297	328	358	24
25	025	056	084	115	145	176	206	237	268	298	329	359	25
26	026	057	085	116	146	177	207	238	269	299	330	360	26
27	027	058	086	117	147	178	208	239	270	300	331	361	27
28	028	059	087	118	148	179	209	240	271	301	332	362	28
29	029		088	119	149	180	210	241	272	302	333	363	29
30	030		089	120	150	181	211	242	273	303	334	364	30
31	031		090		151		212	243		304		365	31

Figure 2-4. Julian date calendar (perpetual).

The Julian calendar determines the day of the year for a given date. The day of the year ranges from 1–365 for a perpetual year to 1–366 for a leap year. A compounded product given a lot number of 14-034-02 would mean that this particular item was compounded in the year 2014 (14), on February 3 (034—the 34<sup>th</sup> day of the year), and was the second batch of compounded product done that day (02).

The Gregorian calendar is the calendar in which the United States and most of the world uses on a daily basis. A compounded product that was made as the second batch of the day, on the same day as above, 3 February 2014, might have a lot number that looks like this: 140203-02. To reiterate, this is a locally devised number, so your lot numbers may look like the ones presented or some variation of those numbers.

#### Form retention

Destroy AF Form 2382 after three years or when it is no longer needed, whichever is sooner.



**Inpatient prescription files and forms for controlled and non-controlled drugs**

Unlike the outpatient setting, inpatient providers can't use the POE function of CHCS. Some facilities now use Essentris® to send medication orders electronically to the pharmacy instead of writing a paper prescription. Just like CHCS, Essentris® will sometimes experience problems, and your providers may have to resort back to paper prescriptions.

**Air Force Form 3066, Doctor's Orders**

Providers use AF Form 3066, Doctor's Orders, or an automated product to provide special instructions to the nursing staff, order lab tests and radiological imaging exams, direct dietary needs, and prescribe medication for inpatient use. Unlike outpatient prescription forms (AF Form 781, Multiple Item Prescription; DD Form 1289, DOD Prescription, and their civilian equivalents), all medication, both controlled and non-controlled, are written on the same AF Form 3066. The pharmacy does not maintain this form in storage so you do not need retention information.

**Requisition forms**

These forms are forms such as DD Form 1150, Request for Issue or Turn-In. The inpatient units and clinics use this form or a locally prepared request form to request issues of bulk quantities of drug items from the pharmacy. *Your facility may use an electronic ordering system through CHCS or some local database in place of this form.* In either case, you can destroy bulk orders for non-controlled drugs after one year. You can destroy bulk orders for controlled substances after three years.

**Air Force Form 582, Pharmacy Stock Record**

The AF Form 582 is a valid Air Force form and still available; however, you will rarely use it due to the continuing advances in our pharmacy computer systems. After CHCS was fully implemented in 1995, the Air Force approved this system as a valid and reliable medium for controlled substance management, but the AF Form 582 is still relevant for contingency operations or deployed locations where CHCS is not available. The form or its automated equivalent is used to track the perpetual inventory (receipts, issues, and amounts on hand) for all scheduled medication and any other drugs your MTF commander has designated as controlled.

When you receive controlled substances from supply, enter the receipt information into CHCS under the narcotic system menu (NSM). Enter the item, quantity, and supply document number, and the inventory automatically updates. Annotate on the signed issue list from medical logistics that CHCS is up to date, and then kept on file in accordance with the AFRIMS RDS or other directives.

If you must use the paper-based AF Form 582, prepare a separate form for each item. Since you will not be using the automated CHCS system, you will increment and decrement all amounts manually; the balance column reflects the actual amount on hand. The Air Force mandates that you maintain the AF Form 582s and issue receipts for three years.

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**Self-Test Questions**

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

**205. Pharmacy files and disposition**

1. What types of records include all books, papers, maps, photographs, electronic media, or other documentary materials, regardless of physical form or characteristics, that the USAF makes or receives under Federal law or during the course of its public business?
2. What types of information are considered to be personal papers?

3. With agency approval, Air Force personnel who retire may take what types of documents?
4. What is *records staging*, and how often is it usually completed?
5. What is the term for “the point in time, determined by the disposition instructions, to be when your retention period begins”?
6. According to AFI 33-364, *Records Disposition—Procedures and Responsibilities*, what is the size of the tuck bottom box that you may use to package records for disposition?
7. When packing your records for disposition, how should you pack them, and what order should they be packed in?
8. When filled to capacity, what quantity of records can the standard shipping container hold?
9. How should you seal and mark your boxes when they are being shipped to a federal records center or through postal channels to any location?
10. What are the purposes of the SF 135 and SF 135A?

#### **206. Pharmacy forms and files**

1. What are the three types of outpatient prescription files?
2. When should an AF Form 2380 be initiated?
3. What information is recorded on an AF Form 2380?
4. When should an AF Form 2380 be destroyed?
5. When should an AF Form 2381 be initiated?

6. What is an AF Form 2381 used for?
7. When should an AF Form 2381 be destroyed?
8. What is an AF Form 2382 used for?
9. When should an AF Form 2382 be destroyed?
10. What AF form is used to track perpetual inventory for all scheduled medications or any other drugs designated as controlled by the MTF commander?
11. When should an AF Form 582 be destroyed?

## **2-2. Pharmacy Administrative Reports**

The Department of Defense (DOD) is one of the largest and most complex organizations in the world. The DOD annually reports billions of dollars in assets. Each fiscal year (FY) the DOD recognizes several hundred billions of dollars in revenues, financing sources, and incurred expenses.

One of the mechanisms used by the DOD in its quest for making sound financial decisions is the Medical Expense Performance Reporting System or (MEPRS). This high-profile MTF reporting system channels all of the way up the chain of command from the MTF to the Defense Health Agency (DHA) Secretary. Along the way, each leader has the opportunity to review the MTF data to gain a clear, concise understanding of AFMS treatment facilities.

### **207. Medical expense and performance reporting system**

The scope of the DOD operations is similar to that of many large corporations. Obviously, it is critical that leaders at every level have tools capable of assisting them with making those tough financial decisions. For the MTF, MEPRS is that tool.

#### **Purpose and use**

The purpose of MEPRS is to report manpower and expense requirements for MTFs; this tri-service resource management reporting system provides a means of comparing MTF costs and productivity. By using a common or uniform method, the three military services (Army, Navy, and Air Force) have a way of determining, budgeting, defending, and allocating basic manpower requirements. By using this system, long-range planning is greatly improved.

As mentioned in the introduction to this unit, the chain of command for MEPRS is from the MTF to the Defense Health Agency (DHA) Secretary. Using MEPRS makes sure that each MTF capture its activity using a standard process for reporting up the chain. Many of the activities report through CHCS; these activities have a functional cost code (FCC), which we will discuss later in this lesson. Before we go any further, let's first make sure that you understand some basic MEPRS terminology.

### *Terminology*

The following terms and explanations will help you understand the system as it applies to the different services and departments in the hospital.

#### *Activity*

Most of the individuals within the DOD who have the primary responsibility for managing the MEPRS program are work center managers and other personnel that work with finances. These individuals use the word *activity* to describe a work center. MEPRS functional cost codes represent these work centers. In other words: activity = work center = functional cost code.

#### *Work center*

This is a discrete functional or organizational subdivision within a military medical facility. Each work center has provisions to accumulate and measure its expenses and determine its workload performance.

Meeting the following criteria will establish a work center activity:

1. Performance of the function assigned or authorized by higher medical authority.
2. Have identifiable expenses (supplies/equipment/contracts/salaries).
3. Have allocated physical space.
4. Have executive leadership coordination.

Meeting these elements allows a work center to establish and identify, collect, and report expenses; therefore, pharmacy certainly meets the criteria for a work center.

Each work center has an operating expense account. Each of these work center accounts have a three- or four-letter functional cost code, which designates and breaks down the service provided. By breaking down its services, funds properly distribute to cover operating costs. For example, all pharmacy service accounts throughout the Air Force have a work center account code of “DAA.” How does pharmacy end up with as “DAA”? Each of these letters represents a different type of account; let’s first start with functional accounts

#### *Functional categories*

These are the highest levels of accounts in the MEPRS accounts structure. There are seven functional areas in an MTF. They are divided into seven categories designated by a letter, A through G. All MEPRS codes must start with one of these letters—(A) inpatient care, (B) ambulatory care, (C) dental care, (D) ancillary services, (E) support services, (F) special programs, and (G) medical readiness. (NOTE: Ancillary services are those services that assist and augment the attending physician or dentist in diagnosing and treating illnesses or injuries. Pharmacy is an ancillary service, thus, is designated with a functional account code of “D.”)

#### *Summary accounts*

These are the second level accounts within the MEPRS, and you can identify them by the first two letters of their functional cost code. They are subdivisions of the functional accounts and encompass general areas of care or service within each of the seven functional accounts. MEPRS designates pharmacy services (which plans, supervises, and is accountable for all pharmaceuticals and pharmacy activities in the MTF) as a summary account and gives it a functional account code of “DA.”

#### *Sub-accounts—third level*

These are the third level accounts of activity for which costs accumulate. These accounts identify the work centers location. MEPRS identifies pharmacy as a work center, as described above (which procures, preserves, stores, compounds, manufactures, controls, assays, dispenses, and distributes medications for inpatients and outpatients, as well as performs many other tasks for the MTF), and gives it a functional account code of “DAA.”

#### *Sub-accounts—fourth level*

MEPRS identifies a fourth level; these accounts are special identifiers. Pharmacy's fourth level identification is DAAA.

#### *Merging medical expense and performance reporting system data*

MEPRS brings all of the personnel utilization, workload, and expense data into one system. This includes everything from patient visits, to radiology and pharmacy workload, to the amount of time you work at the MTF. MEPRS does this by interfacing with many of the systems within the MTF (such as CHCS, Expense Assignments System Version IV internet (EASIVi), and by manually inputting data.

Actual operating budget data compiles with the information described above. The final product provides an in-depth, in-detail picture of the MTF. A MEPRS report can provide leaders with a gamut of information, such as the cost of a lab test or the cost incurred to operate a specific clinic. Leaders can also determine how much money the unit spent on personnel salaries or the costs associated with outpatient visits. These examples barely scratch the surface. Eventually, all of the information makes its way up to the DOD where they use it in the allocation of resources.

If used properly, MEPRS is an excellent expense accounting system that accurately reports expenses for MTFs. The MEPRS accounting system captures three types of MTF data:

1. Personnel utilization.
2. Workload.
3. Expense.

Leaders at all levels can use the MEPRS information to accurately plan for future medical endeavors. The information in MEPRS provides leaders with the necessary data to consistently project requirements within the medical service. Properly reported MEPRS data enables leaders at all levels within the AFMS to reap the following benefits:

- Have an understanding of the costs associated with running an MTF or *cost awareness*.
- Determine if funds are being spent wisely or determine spending *cost effectiveness*.
- Make *cost comparisons* with other MTFs or civilian facilities.
- Determine aspects of *manpower or personnel utilization*.

MDG commanders can accurately project funds they need for the successful operations of their facilities. They can also focus on workload data to determine trends in specific areas within the MTFs. By analyzing the workload data in conjunction with the personnel utilization data, commanders can hone in on manning issues whether those issues are shortages or overages.

Surgeon generals of MAJCOMs can use the MTF MEPRS information in a similar fashion, yet their focus is on a bigger picture. They can compare an MTF's MEPRS data to other comparable facilities. They can also use the data to determine trends, set goals, and distribute manpower, and budget appropriately. Likewise, other personnel and organizations within the AFMS can use MEPRS data for similar planning.

#### **Responsibilities**

On a monthly basis, MEPRS information the MTF collects makes its way to the highest levels within the DOD. From the MTF all the way to Air Staff and DHA, key personnel at different levels throughout the MEPRS process have different roles and responsibilities within the program. Let's focus on the individual responsibilities at your MTF.

#### *Medical group commander*

Within his or her respective facility, the MDG commander must support the data collection requirements of the MEPRS Program and is responsible for the accuracy of the data reported.

### ***Medical resource management function***

The resource management function is primarily responsible for managing the MEPRS program within the MTF. Personnel within this office are the points of contact for MEPRS.

### ***Work center medical expense and performance reporting system monitor***

Work center's MEPRS monitor compile and review all work center data reported to the MEPRS Program Manager (MPM).

### ***Medical staff members***

Every staff member is responsible to make sure the data he or she reports to his or her work center's MEPRS monitor accurately reflects performance activities.

## **208. The collection and reporting of medical expense and performance reporting system data**

Regardless of where you are stationed, your pharmacy must report workload and personnel utilization data monthly. Not only the pharmacy, but each section within your MTF has MEPRS responsibilities. Understanding the process and collection criteria is critical to the success of each work center.

If you recall, MEPRS is an accumulation of an MTF's expense, workload, and personnel utilization information. Now, we must answer the question: how does this data become a part of the MEPRS report? To understand the answer to this question, we will break it down into the three areas of data that are collected: expense, workload, and personnel utilization.

### **Personnel utilization information**

Did you know that approximately 60–75 percent of an MTF's budget is allocated for personnel in the form of salaries? So you can probably imagine that erroneous personnel utilization data *will* lead to an inaccurate MEPRS report. To correctly distribute the salaries to the personnel assigned to a facility, it is necessary for each work center to account for its employees and how they spent their time. Medical facilities collect personnel utilization data using the Defense Medical Human Resources System-internet (DMHRSi). Your MEPRS work center point of contact (POC) is responsible for ensuring all personnel working in the MTF complete biweekly timesheets in DMHRSi.

You may notice your paycheck amount from month to month is consistent even though you might have been on quarters for a week, outside the MTF on a readiness exercise, or working in a different department within the MTF for a few days. Because you are *assigned* to the MTF, MEPRS tracks your duties on a month-to-month basis. Whether you're an available worker in your work center or non-available because you're sick or on quarters, MEPRS assigns funds for your salary to the proper functional cost code (FCC) in correlation to your performed duties. The available and non-available full-time equivalents by FCC code is the basis for your salary.

### ***Available and non-available full-time equivalent***

Available full-time equivalent (FTE) is the time an individual *is* available in a given work center in support of an established account based on the normal FTE work month (168 hours).

Non-available FTE is the time an individual is *not* available to an MTF work center; however, the salary expense charges back to their assigned work center.

A full-time equivalent is a force equivalent of one individual working full time for a specific period, which may be made up of several different part-time individuals or one full-time individual. Let's simplify that definition. For MEPRS purposes the following equation applies:

$$1 \text{ FTE} = 168 \text{ hours}$$

In other words, an FTE equals 168 hours. For example, SrA Duncan reported in DHMRSi she worked 162 hours in DAA, and SrA Parker reported that he worked 174 hours in DAA for the same time period.

This equates to two FTEs for DAA: 162 hours + 174 hours = 336 hours

$$336 \div 168 = 2 \text{ FTEs}$$

The personnel listed below are responsible for accurately documenting and reporting this information in accordance with established local policy:

- Military personnel.
- Federal civilian employees.
- Foreign national employees.
- Personnel “borrowed” from another facility (i.e., manning assistance).
- Medical program students.
- Contract personnel.
- Volunteers.
- Reservists, Air National Guard, and Individual Mobilization (IMA) personnel.
- Patient squadron personnel.

Some personnel who do not have to document this information in MEPRS personnel utilization data include:

- Foreign Armed Services personnel.
- Direct- and indirect-hire foreign national employees in an unpaid absence status.
- Civilian employees paid from nonappropriated funds.
- Personnel loaned to another facility (on special orders).

### *Guidelines for reporting man-hours*

The MTF reports man-hours or personnel utilization data in three categories: *assigned*, *available*, and *non-available*. A partial list of each category is below. Contact the program manager if your duty time does not fit into the below categories.

Available time includes, but is not limited to the following:

- Mission-related work (health or patient care oriented).
- In-service education.
- TDY for continuing education (such as the annual DOD pharmacy seminar). Meetings that are hospital-related.
- Management of the section (writing Enlisted Performance Reports [EPR] work schedules, and so forth).
- On-call. Time actually spent performing on-call duties. If a person is called to the hospital, reported time starts when the person leaves home and ends when the person returns home.

Non-available time includes, but is not limited to the following:

- Leave.
- TDY (even when medically-related).
- Sick list (on quarters, in hospital, doctor’s appointment).
- Absent without leave (AWOL).
- Leave without pay.
- Military Parades.

Assigned FTEs are based on the actual number of days during each month an individual is assigned to the MTF. Assigned FTEs are not based on hours but the percent of time actually assigned to a work center any given month.



***Personnel utilization information work center medical expense and performance reporting system monitors responsibilities***

As stated earlier, work center MEPRS monitors are responsible for ensuring that each person assigned to a work center completes his or her biweekly timesheet in DMHRSi. They also notify the DMHRSi HR manager and the MPM of all departures, arrivals, transfers, changes in demographic information and other pertinent data.

MEPRS monitors must approve or reject DMHRSi timecards NLT COB the third duty day after timecard period ends (Wednesday). You must correct and resubmit all rejected timecards for approval NLT COB the fifth duty day after the timecard period ends (Friday). Upon rejection of a timecard, timecard approver immediately notifies the individual that his or her timecard was rejected, along with the reason for the rejection. Overall responsibility for reporting MEPRS data (i.e., DMHRSi, expenses, and workload) lies with the squadron commanders or equivalent, as designated by the group/wing Commander.

**NOTE:** Civilian timecard reconciliation happens 7–10 days after submission and approval; any rejected timecards will be corrected within 3 duty days.

***Personnel utilization information individual responsibilities***

Each individual assigned to or working in the MTF during the timecard period will accurately report his or her hours in DMHRSi no later than the first duty day after the timecard period ends (Monday). All individuals need to make sure they enter correct information. Report actual hours for work you did inside and outside the MTF in support of the mission. Accurate accounting of data allows supervisors to keep your pharmacy appropriately staffed.

**The Expense Assignment System**

The Expense Assignment System Version IV internet (EASIVi) is the system responsible for incorporating *all* of the captured expense, workload, and personnel utilization data into a single report. The amount of information this system collects sounds overwhelming; yet, it is able to turn the information into workable, manageable, *meaningful* data! This automated data produces the MEPRS reports.

The primary purpose of EASIVi is to process the MEPRS information and its associated reports. Its capabilities are numerous. It enables the collection of monthly data, fixes errors on-line, provides for an automatic allocation process, and enables separate reporting capabilities for each MTF. Additionally, EASIVi validates all manual and automated inputs prior to their acceptance into the system.

**Collection of workload information**

Through MEPRS, workload information quantifies the amount of work each work center within the MTF completes. Workload data (i.e., outpatient visits, prescriptions, inpatient bed days, and so forth) are one part of the statistical basis for assigning costs within MEPRS. Workload data associates with both patient care and nonpatient care activities. The collected workload data assigns costs of operating expenses to the various MEPRS accounts. The MTF collects workload statistics for each work center and summarizes them for entry into the EASIVi system.

A large portion of workload data is captured using the CHCS; this is how the pharmacy captures their data. The following are some examples of workload data that CHCS reports:

- Outpatient visits.
- Occupied bed days.
- Dispositions.
- Admissions.
- Laboratory workload.



- Radiology workload.
- Pharmacy workload.

CHCS uses the Workload Assignment Module (WAM) to feed the workload data to EASIVi. For lack of a better term, WAM can be described as a “go-between.” Data is transferred from CHCS to the EAS system. Before it reaches EASIVi, WAM seizes the data and places the information into templates. After the information loads onto the WAM templates, it easily transmits into EAS. After the transmission occurs, the Resource Management Office (RMO) can view and report the information. Let’s now look at the pharmacy workload report.

### **Pharmacy services workload report**

As stated above, workload is the amount of work produced in a work center. But all workloads do not measure the same way throughout the MTF. When the pharmacy and the other ancillary service work centers report their total workload, the workload is broken out into two different values: raw and weighted.

Raw values are the number of procedures performed, or in the case of pharmacy, how many prescriptions were filled, sterile products were compounded, or clinic issues were completed. Weighted values are used to try to level the playing field, or in others words, to make workload reporting fair for each work center in the MTF. Why is this important? Remember, the greater your workload, the more resources you earn (that includes people).

If all workload in the MTF measures the same, you could obtain the cost per procedure by simply dividing the total cost of the work center by the number of procedures performed by that work center. For example, if pharmacy’s workload was measured only by raw procedures performed (such as the number of prescriptions filled), the workload report would not reflect output or productivity accurately because it does not consider the consumption of resources, relative complexity, and cost of workload performance. In other words, it helps us to get credit for the true amount of work performed.

The following table lists pharmacy procedures and their weighted values:

<b>Pharmacy Procedures</b>	<b>Weighted Factors</b>
Prescription	1.0
Clinic issue	0.6
Sterile product	2.0
Unit dose	0.15
Bulk issue	2.0

### ***Prescriptions***

Count each written order for a medication or device prescribed for an individual patient. A refill counts the same as a new prescription.

### ***Clinic issues***

Count each handout or prepared issue (medication) to a clinic for later issue to individual patients by nonpharmacy personnel. For each unit count a weighted value of 0.6.

### ***Sterile products***

Count each parenteral bottle, bag, or syringe the pharmacy prepared. That is, any parenteral bottle, bag, or syringe containing additive parenterals that is ready for administration.

### ***Unit dose***

The Print Cart List option in CHCS allows you to print out the Unit Dose Cart List. Each unit dose product needs to be counted and logged in individually to receive proper credit.

### **Bulk issue**

Bulk issue drug items are distributed to a ward or clinic and dispensed from that location. Count each line item issued to clinic and/or wards to be used within the clinic or ward.

You have just received a lot of information about MEPRS because this report identifies the amount of personnel and money we need to operate our pharmacies. It is important that you use this information to accurately report your pharmacy's workload.

### **Prescription usage and cost report**

As we stated earlier, each section or work center in the hospital must keep track of its workload. MEPRS provides this type of information. Each section, in cooperation with the RMO, must classify and record patient and workload data. The data collected assimilates into an MTF-wide Report of Patients. The purpose of the Report of Patients is to provide medical and demographic (size, growth, density of population, and so forth) data in each USAF MTF. It is the mainstay for medical resources planning and allocation at all levels of the USAF medical service. The data you collect in your work section assimilates with other work centers' data by the RMO, transmits monthly to your MAJCOM, and, subsequently, to HQ USAF. Part of the data often transfers to other uniformed services and DOD levels. Each level uses your patient data to assist it in at least one of the following activities:

- Making budget and financial plans.
- Projecting manpower and staffing needs.
- Procuring facilities and equipment.
- Analyzing operational capabilities.
- Managing patients during peacetime and wartime.

The pharmacy Report of Patients compiles using the Prescription Usage and Cost Report function in CHCS (fig. 2-5). This report breaks down information about who is receiving prescriptions, what type of prescriptions they are receiving, and how much those prescriptions cost. The first portion of the report shows the number of prescriptions broken down into schedules (CII-CV, Legend, and OTC) based on how medications are initially loaded into CHCS.

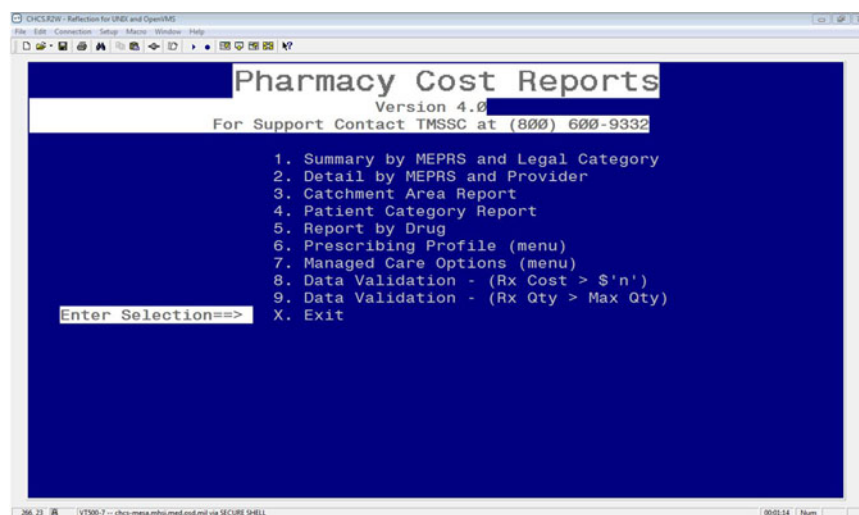


Figure 2-5. Prescription usage and cost report (report of patients).

The next area of the report shows exactly who is getting the medications. Numbers and costs are broken down into active duty (even down to officer and enlisted) for each service, retired for each service, and dependent. This information can be vital to senior management when making decisions for the TRICARE region to include funding for your facility, especially if your region includes other services' MTFs.

The information you collect has far-reaching effects on decision-making at all levels. This is what determines your budget and manning authorizations; therefore, the data must be current, accurate, and verifiable.

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### **Self-Test Questions**

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

#### **207. Medical expense and performance reporting**

1. What is the purpose of MEPRS?
2. What are the criteria for an activity to be considered a work center, and does the pharmacy meet those criteria?
3. What kind of service is the pharmacy designated as in the MEPRS accounts structure, and what is its functional account code?
4. What is the fourth-level account used for in the MEPRS system?
5. What are the benefits to leaders at all levels of properly reported MEPRS data?
6. Who is responsible for supporting the data collection requirements of the MEPRS program?

#### **208. The collection and reporting of medical expense and performance reporting system data**

1. What Air Force system is used to document employee hours to correctly distribute salaries of assigned personnel?
2. What equation is used to determine the appropriate amount of full-time equivalents?
3. Within an MTF, who must report their MEPRS personnel utilization data?
4. What are the three types of personnel utilization data?

5. Who is responsible for ensuring that each person assigned to a work center completes his or her biweekly timesheet?
6. What is the primary purpose of EASIVi?
7. What types of activities is workload data associated with under the MEPRS workload reports?
8. In the Pharmacy Services Workload Report, what are raw values?
9. In the Pharmacy Services Workload Report, how are prescriptions weighted, and how do refills figure into the count?
10. What does the first portion of the Prescription Usage and Cost Report show?

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### Answers to Self-Test Questions

#### 205

1. Federal.
2. Papers that the individual created before entering government service; private materials that the individual brought into, created, or received in the office but are not related to government business, and work-related circumstances, work-related personal papers not used for transacting government business.
3. Non-record copies of documents and copies of materials they drafted, reviewed, or otherwise acted upon.
4. The process of gathering, arranging in proper order, storing, and disposing of paperwork; most staging activities are completed annually.
5. Cutoff date.
6. 14 ¾ inches by 12 inches by 9 ¾ inches.
7. The records packed in staging boxes should be loose enough to allow others to remove files freely or add more files later. Records are placed in boxes in an upright position in the same numerical sequence listed on SF 135, Records Transmittal and Receipt, with the label facing the numbered end of the box.
8. One cubic foot of records.
9. With one-inch filament tape, and on the top of each box, indicate the shippers and addressee's names and addresses.
10. The SF 135 is used to identify records for retirement to a federal records center or staging area (the SF 135A is used when you need a second form); as a packing list for transferred or retired records; as a medium for controlling the location, retrieval, reference, and disposition of records in staging areas and federal records centers; and to identify and account for lost, destroyed, or withheld records that personnel normally would have retired.

#### 206

1. Drugs listed as Schedule II, drugs listed as Schedules III, IV, and V, and drugs listed as non-controlled legend drugs.

2. For each individual batch prepared.
3. Manufacturer's quality control data and amounts for each product used as an ingredient in the preparation.
4. After three years or when it is no longer needed, whichever is sooner.
5. For all medications manufactured in bulk quantities.
6. To record the formula to be followed each time the item is compounded.
7. When it is superseded, becomes obsolete, or is no longer needed.
8. To fulfill information requirements for bulk compounding of pharmaceutical products.
9. After three years or when it is no longer needed, whichever is sooner.
10. AF Form 582.
11. After 3 years.

**207**

1. To report manpower and expense requirements for MTFs; this tri-service resource management reporting system provides a means of comparing MTF costs and productivity.
2. The performance of the function must be assigned or authorized by higher medical authority; a staff must be assigned (manpower); and physical space is allocated/used, a workload is generated, and expenses are identifiable. With these elements satisfied, a work center is established and expenses are identified, collected, and reported. The pharmacy meets the criteria for a work center.
3. Ancillary service and it has a functional account code of D.
4. Special identifiers.
5. (1) They have an understanding of the costs associated with running an MTF or *cost awareness*.  
(2) They determine if funds are being spent wisely or determine spending *cost effectiveness*.  
(3) They make *cost comparisons* with other MTFs or civilian facilities.  
(4) They determine aspects of *manpower or personnel utilization*.
6. The MDG Commander.

**208**

1. Defense Medical Human Resources System-internet (DMHRSi).
2. 1 FTE = 168 hours.
3. Military personnel, federal civilian employee, foreign national employees, personnel "borrowed" from another facility (i.e., manning assistance), medical students, contract personnel, volunteers, and reservists and Air National Guard, patient squadron personnel.
4. Assigned, available, and non-available.
5. Work center MEPRS monitors.
6. To process the MEPRS information and its associated reports. It enables the collection of monthly data, fixes errors on-line, provides for an automatic allocation process, enables separate reporting capabilities for each MTF, and validates all manual and automated inputs prior to their acceptance into the system.
7. Patient care and non-patient care activities.
8. The number of procedures performed, or in the case of pharmacy, how many prescriptions were filled, sterile products were compounded, or clinic issues were completed.
9. Weighted as "1"; a refill is counted the same as a new prescription.
10. The number of prescriptions broken down into schedules (CII-CV, Legend, and OTC) based on how medications are initially loaded into CHCS.

**Complete 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.

10. (205) In accordance with the *United States Code on Records Management* by Federal Agencies, which would be an example of work-related personal papers?
  - a. Appointment schedules that contain work-related information.
  - b. Papers the individual created before entering government service.
  - c. Diaries or journals not used for conducting any government business.
  - d. Private materials the individual created in the office but are not related to government business.
11. (205) The process of gathering, arranging in proper order, storing, and disposing of paperwork, such as, prescriptions and controlled drug documentation is records
  - a. transfer.
  - b. staging.
  - c. purging.
  - d. destruction.
12. (205) Which Standard Form (SF) is used to identify records for retirement to a federal records center or staging area?
  - a. 135.
  - b. 145.
  - c. 155.
  - d. 165.
13. (206) Which type of prescriptions may be filed together?
  - a. Schedules II, III and IV.
  - b. Schedules III, IV and V.
  - c. Non-controlled and Schedule I.
  - d. Non-controlled and Schedule V.
14. (206) For how many years is Air Force Form 781, Multiple Item Prescription retained before it is destroyed?
  - a. One.
  - b. Two.
  - c. Three.
  - d. Four.
15. (206) Which Air Force (AF) form should be destroyed after it has been retained for three years or when it is no longer needed, whichever is sooner?
  - a. 579.
  - b. 582.
  - c. 2380.
  - d. 2381.
16. (206) Air Force (AF) Form 2381, Pharmacy Master Formula is destroyed after it has been
  - a. retained for 1 year or when it is no longer needed, whichever is sooner.
  - b. retained for 3 years or when it is no longer needed, whichever is sooner.
  - c. superseded, is revised, becomes obsolete, or being drafted.
  - d. superseded, becomes obsolete, or is no longer needed.

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17. (206) Bulk order forms, such as Directives Division (DD) Form 1150, Request for Issue or Turn-In, for noncontrolled drugs are destroyed after
    - a. 1 year.
    - b. 2 years.
    - c. 3 years.
    - d. 4 years.
  18. (206) What form is used to track receipt issues and amounts if CHCS is unavailable?
    - a. Directives Division Form 1150 for noncontrolled drugs.
    - b. Air Force Form 2381.
    - c. Air Force Form 579.
    - d. Air Force Form 582.
  19. (206) Which *best* describes the type of inventory that the Air Force Form 582, Pharmacy Stock Record or its automated equivalent maintained on controlled substances?
    - a. Random.
    - b. Selective.
    - c. Frequent.
    - d. Perpetual.
  20. (207) The chain of command for the Medical Expense and Performance Reporting System (MEPRS) is from the military treatment facility (MTF) to which person or agency?
    - a. Commander in Chief.
    - b. Defense Health Agency Secretary.
    - c. Chief of Staff, United States Air Force.
    - d. Deputy Chief of Staff, United States Air Force.
  21. (207) Within the Medical Expense Performance Reporting System (MEPRS) which account does the first letter of every functional cost code represent?
    - a. Functional.
    - b. Summary.
    - c. Tertiary.
    - d. Sub.
  22. (207) Which functional category and cost code is pharmacy assigned to within the Medical Expense Performance Reporting System (MEPRS)?
    - a. Inpatient; A.
    - b. Ancillary Services; D.
    - c. Support Services; E.
    - d. Special Programs; F.
  23. (207) Which Medical Expense Performance Reporting System (MEPRS) account does the first two letters of every functional cost code represent?
    - a. Functional.
    - b. Summary.
    - c. Tertiary.
    - d. Sub.
  24. (207) Which Medical Expense Performance Reporting System (MEPRS) accounts is where work centers are identified?
    - a. Sub-accounts, fourth level.
    - b. Sub-accounts, third level.
    - c. Summary accounts.
    - d. Functional accounts.

25. (207) Within the medical treatment facility, who is responsible for the accuracy of Medical Expense Performance Reporting System (MEPRS) data reported?
- Work center MEPRS monitor.
  - Resource management office.
  - Medical group commander.
  - Medical staff members.
26. (208) The Medical Expense and Performance Reporting System (MEPRS) is an accumulation of military treatment facility (MTF) personnel utilization, workload, and
- expense.
  - formulary list.
  - chain of command.
  - war reserve material.
27. (208) Approximately what percentage of a military treatment facility's budget is allocated for personnel in the form of salaries?
- 30–45.
  - 45–60.
  - 60–75.
  - 75–90.
28. (208) The Defense Medical Human Resources System-internet (DMHRSi) is used to collect information concerning
- costs associated with patients admitted into the hospital.
  - costs associated with personnel assigned to temporary duty.
  - work centers where assigned personnel are spending time and corresponding salaries.
  - work centers where assigned personnel are spending time and corresponding production.
29. (208) A full-time equivalent (FTE) is equal to how many hours?
- 156.
  - 168.
  - 172.
  - 186.
30. (208) Which personnel within a medical facility are required to report their Medical Expense Performance Reporting System (MEPRS) personnel utilization data?
- Students.
  - Inpatients.
  - Foreign armed services personnel.
  - Personnel loaned to another facility.
31. (208) Which personnel within a medical facility are *not* required to report their Medical Expense Performance Reporting System (MEPRS) personnel utilization data?
- Volunteers.
  - Federal civilian employees.
  - US military personnel assigned.
  - Foreign armed services personnel.
32. (208) Which is an example of available time when reporting man-hours for the work center?
- Working on Enlisted Performance Reports (EPR) or work schedules.
  - Absent without leave (AWOL).
  - Temporary Duty (TDY).
  - Leave without pay.



33. (208) What system is responsible for incorporating all of the captured expense, workload, and personnel utilization data into a single report?
- a. Composite Health Care System.
  - b. Expense Assignment System Version IV (EASIVi).
  - c. Defense Eligibility Enrollment Registration System.
  - d. Medical Expense and Performance Reporting System.
34. (208) In the Pharmacy Services Workload Report, what weighted value is given to “clinic issues”?
- a. 0.15.
  - b. 0.6.
  - c. 1.0.
  - d. 2.0.
35. (208) After each section classifies and records patient and workload data, it is assimilated into which military treatment facility (MTF)-wide report?
- a. Expense Report.
  - b. Workload Report.
  - c. Report of Patients.
  - d. Performance Report.
36. (208) The Prescription Usage and Cost Report shows information regarding how much prescriptions cost, what type of prescriptions patients are receiving, and
- a. how many prescriptions the pharmacy is dispensing to the units and clinics per day.
  - b. how many prescriptions the pharmacy is dispensing to outpatients per day.
  - c. who is dispensing the prescriptions.
  - d. who is receiving the prescriptions.

## **Student Notes**

## Unit 3. Medical Readiness Concepts and Controlled Substances

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**P**HARMACY technicians must provide high-quality care to DOD active duty, dependant, and retired members. Most of the time that will occur inside the walls of your assigned pharmacy; however, there are times you will respond to natural disasters or readiness exercises. In a rapidly changing world, you have to be ready to respond to any threat at a moment's notice. This unit will introduce you to vital medical readiness concepts that include force health protection prescription products (FHPPP), home station medical response principles (HSMR), and point of dispensing (POD) procedures. Additionally, you will become familiar with the importance of managing controlled substances. You will look at the multiple forms that you will use for tracking controlled substances and highlight the difference between inpatient and outpatient procedures.

### 3–1. Medical Readiness Concepts

The Air Force Medical Service (AFMS) provides seamless health service support and assists in sustaining the performance, health, and fitness of every Airman, whether at home or deployed in support of global operations. The emphasis is on prevention of illness and injury. When illness or injury does occur, the AFMS provides a rapid medical response. However, if patients require more definitive care, the AFMS has aeromedical evacuation (AE) capabilities to transport patients. To achieve the mission, the AFMS has processes to support operational strategies, emergency management, medical readiness training, manpower and equipment force packaging, medical readiness resourcing, aeromedical evacuation, and global medical operations plans and reporting. As a pharmacy technician, you support this mission by being ready when called upon.

#### 209. Force health protection prescription products dispensing and counseling

AFI 10–403, *Deployment Planning and Execution*, describes force health protection prescription products (FHPPP), which includes certain drugs, vaccines, and other medical products useful for protecting the health of deployed personnel. These drugs are only used under a physician's prescription. Examples include Atropine and Pralidoxime chloride (ATNAA) and Diazepam autoinjectors, Pyridostigmine Bromide (PB) tabs, certain antimicrobials, and antimalarials. In accordance with (IAW) AFI 44–102, *Medical Care Management*, describes appropriate management procedures of FHPPP drugs.

### **Force health protection prescription products dispensing**

Documentation and dispensing of FHPPP is a collaborative effort between medical logistics, pharmacy, and deployment medicine personnel. The military treatment facility (MTF) has local policy defining communication and coordination between departments for this purpose.

When the Air Force Component theater reporting instructions indicate, qualified personnel who know the exclusion criteria (i.e., contraindicators of those who are not required to take the medication for medical reasons) and other medical guidance applicable to the products prescribe or issue the appropriate FHPPP. The provider documents the drug name, strength, quantity, and directions on an SF 600, Chronological Record of Medical Care; and on the deploying members, DD Form 2766, Adult Preventative and Chronic Care Flowsheet, in the medical record and CHCS drug file.

### **Force health protection prescription products for deployment**

Pharmacies dispense prescription medication to deploying personnel in a quantity sufficient to last for the duration of the deployment plus transit time unless federal law, combatant command guidance, or provider judgment prohibits otherwise. When storage or logistical difficulties prevent the deploying member from receiving sufficient quantities of medications to last throughout the deployment, the deployer enrolls in the TRICARE Home Delivery (also known as TRICARE Mail Order Program) or the Deployment Prescription Program to receive medications through the mail.

DODI 6490.03, *Deployment Health*, mandates these products dispense under a physician's prescription. Medical logistics personnel cannot issue FHPPP directly to deploying personnel; however, medical logistics can issue (not dispense) bulk issue FHPPP to a troop commander who acts as a courier until the materiel can be turned into the medical element at the deployed location. Medical logistics has the troop commander sign the issue documentation and acknowledge the requirement to turn in bulk FHPPP to the medical element in theater or deployment location.

### **Post-deployment**

In accordance with 21 Code of Federal Regulations (CFR), Section 1307.21, *Procedures for Disposing of Controlled Substances*, FHPPP cannot return to the pharmacy post-deployment; therefore, medical logistics processes returns of FHPPP. This process applies to the return of FHPPP from returning deployers only. Medical logistics does not accept returns directly from patients under any other circumstances.

Documentation of controlled substances is done using a DD Form 1348-6, *DOD Single Line Item Requisition System Document (Manual Long Form)* or similar locally developed form. Medical logistics ensures the following annotations: the quantity received, unit of issue, item description, and individual's printed name and signature. The logistics vault custodian verifies the information is correct, then prints, signs, and dates the form. Logistics maintains the document in the vault for two years for audit trail purposes.

## **210. Home Station Medical Response Principles**

MTF commanders execute a business plan that maximizes the use of assigned personnel and available resources. Readiness is a critical element of business planning and includes training requirements, exercise opportunities, and deployment and contingency response obligations.

### **Home Station Medical Response**

The AFMS plans for contingencies exceeding normal operating capacity of field units. It provides additional material needed to execute the medical contingency response plan (MCRP) during these situations. This material presents as 886 allowance standards (AS) to standardize training, as well as centralize logistics and maintenance support. The 886 AS provides a capability starting point which the MTF can then tailor to meet its unique needs. The AF/SG programs for these assets are also referred to as home station medical response (HSMR).

The medical logistics flight provides support to include custodian/team-leader training, procurement, receipt, and issue of the supplies and equipment necessary for all HSMR response teams to carry out their missions. However, each team chief tracks and updates his or her inventories monthly using the Defense Medical Logistics Standard Support system (DMLSS).

The HSMR 886 AS managers monitor assets monthly for missing, expired, and/or changed/added items with a full inventory taken annually or 60 days after an incident or exercise.

As outlined in AFI 41-106, *Medical Readiness Program Management*, the following teams are part of the HSMR AS:

- AS 886A—In-Place Patient Decontamination.
- AS 886D—Inpatient Medical Follow-on.
- AS 886E—Pharmacy Response.
- AS 886H—Bioenvironmental Engineering.
- AS 886I—Laboratory Biological Detection.
- AS 886J—Field Treatment.
- AS 886K—Triage.
- AS 886L—Clinical.
- AS 886M—Medical Manpower/Security.
- AS 886P—Public Health.

#### **Pharmacy response team**

The pharmacy team provides medications for patient care. Normally, this occurs directly to the patients or through the clinical services team who treat immediate, minimal, or delayed patients during disasters/contingencies. The pharmacy team also supports all other response teams by supplying and/or resupplying medications. Additionally, the pharmacy team maintains the 886E AS that enhances the pharmacy's response capability for a chemical, biological, radiological, nuclear (CBRN) event.

The pharmacy team usually consists of a pharmacist and pharmacy technicians. The total number of assigned personnel depends on the respective base populous. The team chief is responsible for selection, training, and replacement of assigned personnel. If members of the pharmacy team are not tasked during a disaster/contingency, the team chief may minimally staff the pharmacy and release the rest of the team to support the manpower or security teams as requested by the medical control center (MCC).

### **211. Point of dispensing operations**

Each Air Force installation must have a written disease containment plan (DCP) which meets the requirements set in AFMAN 10-2608, *Disease Containment*. The DCP provides guidelines for mass treatment/prophylaxis for a chemical, biological, radiological and/or nuclear (CBRN) event or naturally occurring pandemic (e.g. pandemic influenza). This capability is crucial to protecting the installation's beneficiary population, preventing or reducing casualties, and effectively maintaining and/or restoring critical or essential operations.

The DCP provides the installation and MTF with resources and checklists customized to the installation's operations. This is a joint effort to include teams from medical command and control, nursing/clinical, security, manpower, patient administration, logistics, systems, and immunizations if needed.

### Pharmacy point of dispensing team

In the event mass prophylaxis/medications need distribution as part of the CBRN response, the pharmacy team is involved in setting up and operating a point of dispensing (POD) site. Below is a list of the medical teams that make up a typical POD operation.

- Public health emergency officer (PHEO).
- Public health team.
- Pharmacy team.
- Manpower/transport team.
- Clinical teams (clinical support team, triage team).
- POD administration team (patient admin team, information services disaster response team [ISDRT]).
- Medical logistics team.
- Medical security team.
- Crisis response team (CRT).
- Facilities team.
- Field response team (FRT).

The POD provides the overall outpatient dispensing procedures for executing mass prophylaxis in response to one of several contingencies where medications or vaccines need to be dispensed to a large number of people in a short time. Most military installations operate as a CLOSED POD, responsible for those individuals affiliated with the base only.

The pharmacy team activates upon notification from the MCC. This occurs by telephone call, overhead page, or runner if during duty hours or by recall if after duty hours. Upon activation, the pharmacy team chief implements the pharmacy team activation checklist. The pharmacy team chief also coordinates with the MCC, PHEO, security forces, logistics, and manpower teams for the acceptance/distribution of mass prophylaxis.

During a disaster or contingency, teams request supplies through the pharmacy runner or MCC who will then relay the resupply request to the pharmacy team. Moreover, a runner can communicate needs between the pharmacy team and the medical logistics team. The table below shows the general POD responsibilities of the pharmacy team members.

Pharmacy Team Chief	POD Pharmacy Technician
Completes the checklist and assigns team members as available.	Is assigned to support the medication supply need of each clinical team.
Provides one technician as runner/liaison between pharmacy and logistics.	Provides medications, including controlled medications, for patient treatment.
Remains in the pharmacy to organize/assign personnel, answer questions, and ensure continued operations.	Relays supply and resupply needs to the pharmacy.
Ensures a team member is manning the phone located in the pharmacy.	Documents inventory management during an event. Inventory will be managed using AF Form 579, Controlled Substance Register, for controlled substances and the Pharmacy 886E package spreadsheet for non-controlled medication to maintain accurate, real-time supply levels.
Coordinates with MCC and medical logistics the transport of emergency pharmaceuticals and/or prophylaxis to the dispensing site.	
Provides one technician to report to Personnel Deployment Function if activated.	

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### 886E AS Package

The pharmacy team has enough supplies on 886E AS to treat up to 300 patients and up to 150 first responders for the first 48 hours following an event and provide up to 5 days of prophylaxis medication for casualties and for 30 days of prophylaxis medication for first responders. Also, the MTF commander can use the 886E package for any real-world response he or she deems necessary. Therefore, maintain these supplies and medications in a climate-controlled, secure environment. The medications are mobile for rapid deployment, if needed.

Rotate the pharmaceuticals in the 886E package if on the formulary and within six months of expiring, with peacetime operation stock (POS). The pharmacy team chief or his or her designee tracks the monthly status (quantity and expiration date) of the medications and supplies in the 886E AS. Make sure to order items nearing expiration through the pharmacy prime vendor. Order items not on the formulary under the HSMR account. Return all expired items that expire to medical logistics for proper crediting.

Perform a full inventory of 886E AS at least annually. Enter all quality control data (lot#, expiration dates, manufacturer, and so forth) into Defense Medical Logistics Standard Support (DMLSS). Within 60 days of an exercise or real-world event, reinventory supplies to identify any consumed items for reorder within 60 days.

### Strategic national stockpile assets

It is also important that you understand the role of the Strategic National Stockpile (SNS) and the protocols for requesting SNS assets. Every Air Force installation should have a memorandum of agreement or understanding (MOA/MOU) with its state or local public health agency that describes the authorization for requesting and receiving SNS assets and identifying the population the base is responsible to serve.

The SNS is a federal asset owned by both the Centers for Disease Control and Prevention (CDC) and the Department of Homeland Security (DHS). The SNS activates in the event of a natural or man-made disaster, epidemic or pandemic outbreak occurs, and if local and state resources are overwhelmed. The governor of the state or his or her designee requests activation. Once the CDC/DHS approves the release of the SNS, a push-pack activates and arrives anywhere in the United States within 12 hours of the federal decision to deploy. These push-packs contain antibiotics, antidotes, antitoxins, and life-support medications that are strategically located throughout the United States at undisclosed locations. Each push-pack can treat 90,000–300,000 people; it weighs about 50 tons and has 135 containers of drugs and equipment. Follow-on shipments of supplies or medications ship to a community, using vendor-managed inventory (VMI), which usually takes 24–48 hours to arrive locally.

Medical logistics provides transportation for the delivery of the SNS. The pharmacy team then takes control of the SNS supplies and repackage for distribution. Strict inventory tracking and accountability measures apply to SNS caches. Manage inventories using the AF Form 579, Controlled Substance Register, for controlled substances and the pharmacy 886E package spreadsheet for non-controlled medication to maintain accurate, real-time supply levels.

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## Self-Test Questions

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

### 209. Force health protection prescription products dispensing and counseling

1. What are some examples of FHPPP?

2. On what two forms must dispensing of FHPPP be annotated?
3. Who can bulk FHPPP be issued to?
4. What section is responsible for processing returns of FHPPP post-deployment?

### **210. Home station medical response principles**

1. What are 886 AS assets referred to as?
2. What AFI list the different HSMR AS teams?
3. What AS is the Pharmacy Response Team under?
4. Who is responsible for selection, training, and replacement of assigned personnel on the pharmacy team?

### **211. Point of dispensing operations**

1. According to AFMAN 10-2608, *Disease Containment*, what is each AF installation required to have?
2. What type of operation is set up in the event mass prophylaxis/medications need to be distributed as part of the CBRN response?
3. What is the purpose of a POD?
4. How many patients and first responders can the Pharmacy Team treat during the first 48 hours following a CBRN event?
5. What is the Strategic National Stockpile (SNS)?



## 3-2. Managing Controlled Substances

The proper management of controlled substances within your facility is crucial. Poor management of this program can quickly turn stellar military careers into complete disasters and call into question the reliability and trustworthiness of your pharmacy services. Your chief of pharmacy services is responsible for the overall management of controlled substances throughout the MTF. This is why the personnel authorized to receive and issue controlled substances are carefully chosen to ensure effective and accurate accountability of controlled substances. In volume one, we initiated our discussion on the Controlled Substance Act (CSA) of 1970. In this section we will expand our knowledge on this act as we learn about managing a controlled substance program.

### 212. Controlled substances principles

In October 1970 the US Congress enacted the CSA which would later become law on 1 May 1971. The CSA required an initial inventory of all controlled substances throughout each MTF on 1 May 1971. Every two years thereafter, on 1 May, the MTF carries out a complete and accurate inventory of all controlled substances within each medical facility (i.e., 1 May of every odd year). (**NOTE:** You may wonder why the compliance requirements are every two years on the odd year when the Controlled Substance Act of 1970 passed in an even year. It is important to realize that even though the CSA passed in 1970, it didn't go into effect until 1971, which would make the compliance requirements every two years on the odd year.

#### What are controlled substances?

Before we get too far into our lesson on managing our controlled substance programs, let's first make sure you have a clear understanding of how controlled substances are defined. Controlled substances are drugs and certain other chemicals, both narcotic and non-narcotic, which come under the jurisdiction of federal and state laws regulating their manufacture, sale, distribution, use, and disposal.

#### *Controlling "Over-the-Counter" products*

Notice the paragraph above says "narcotic and non-narcotic"; remember from volume one when you read about the Combat Methamphetamine Epidemic Act of 2005 and how it affects the way customers purchase Ephedrine, Pseudoephedrine, and Phenylpropanolamine. It is unlikely that at any time in the future you are going to be hand-counting Pseudoephedrine or keeping it in narcotic vaults. However, this is a good example of how non-narcotics are termed "scheduled listed chemical products" by the federal government, and hence, their sale and distribution are controlled.

#### *Controlling "By prescription only" products*

You may also have the unique circumstance of stocking particular noncontrolled medications in your pharmacy that are later deemed "controlled" by your MTF commander due to their high potential for theft. Medications used to treat erectile dysfunction (ED) may fall into this category at your facility.

#### Requisitioning controlled substances

To order a controlled substance, your facility must first obtain a Drug Enforcement Administration (DEA) license. Since all Air Force MTFs have DEA licenses, the vault custodian or alternate can place orders for controlled substances. The vault custodian is also responsible for the daily completion of controlled drug transactions. After submitting a controlled substance order, most pharmacies receive Scheduled III-V medications the following duty day. Orders for Schedule II medications may take longer as a result of the processing time for the DEA Form 222, Controlled Substance Ordering Form (fig. 3-1).

**DEA 222 Form Sample**

See Reverse of PURCHASER'S Copy for Instructions		No order form may be issued for Schedule I and II substances unless a completed application form has been received. (21 CFR 1305.04)		OMB APPROVAL No. 1117-0010	
TO: (Name of Supplier) <b>METC/937 TRG</b>		STREET ADDRESS <b>903 William Hardee</b>			
CITY AND STATE <b>San Antonio, TX 78234</b>		DATE <b>09/05/2015</b>		TO BE FILLED IN BY SUPPLIER SUPPLIER'S DEA REGISTRATION No.	
TO BE FILLED IN BY PURCHASER					
LINE NO.	No. of Packages	Size of Package	Name of Item	National Drug Code	Packages Shipped
1	4	250mL	Fatal Plus Solution		
2	3	5ct	Fentanyl Patch, 25 mcg		
3	2	5ct	Fentanyl Patch, 50 mcg		
4	6	20mL	Morphine Injectable, 15mg/mL		
5	2	20mL	Hydromorphone Injectable, 2mg/mL		
6					
7					
8					
9					
10					
5 LAST LINE COMPLETED (MUST BE 10 OR LESS)			SIGNATURE OF PURCHASER OR ATTORNEY OR AGENT		
Date issued		DEA Registration No.		Name and Address of Registrant	
Schedules		Must include correct schedules for corresponding products ordered.		Dr. Robert George 1234 Mystery Street Anywhere, US 12345-0000-000	
Registered as a		No. of this Order Form			
DEA Form -222 (JANUARY 2010)		U.S. OFFICIAL ORDER FORMS - SCHEDULES I & II DRUG ENFORCEMENT ADMINISTRATION SUPPLIER'S Copy 1		123456789	
Requirements For Properly Completed 222 Forms DEA requires that your 222 form address be the same as the address on your current DEA certificate. DO NOT fill out supplier's DEA Registration No., National Drug Code, Packages Shipped and Date Shipped. This information will be completed by Midwest Veterinary Supply.					

Figure 3-1. Sample DEA Form 222, Controlled Substance Ordering form.

This form is issued by the DEA and is required to purchase Schedule II drugs. This form also allows the exchange of controlled substances from the registrant to another party registered with the DEA (typically used when a controlled substance is sent to a reverse distributor for credit or disposal). The DEA Form 222 is completed by medical logistics. This is important to remember because you must submit your order request in advance for your controlled medications to deliver in a timely manner. If your pharmacy is overseas or anywhere that you may experience delays in receiving your drug orders, be sure you account for these delays to ensure stock replenishment does not cause disruption to pharmacy services.

### Receiving controlled substances

Controlled substances received from medical logistics are documented on a Using Activity Issue List. Each item received is checked against the list to ensure the correct drug and quantity was received. Discrepancies must be resolved prior to pharmacy personnel accepting the drugs from logistics personnel. For example, if the issue list says you are receiving 10 bottles of MS Contin, 100 tablets per bottle, there needs to be 10 bottles of MS Contin, 100 tablets per bottle in front of you—no more, no less. Keep and use a copy of the issue/turn in summary to post the receipt to AF Form 582, Pharmacy Stock Record, or its automated equivalent. After posting, the issue/turn-in summaries are filed by schedule. In other words, Schedule II must be filed separately from Schedules III–V.

### Air Force Form 582, Pharmacy Stock Record

The AF Form 582 is a valid Air Force form and still available; however, you rarely use it due to the continuing advances in our pharmacy computer systems. After CHCS fully implemented in 1995, the Air Force approved this system as a valid and reliable medium for controlled substance management, but AF Form 582 is still relevant for contingency operations or deployed locations where CHCS is not available. The form or its automated equivalent is used to track the perpetual inventory (receipts, issues, and amounts on hand) for all scheduled medication and any other drugs your MTF commander has designated as controlled.

When you receive controlled substances from supply, enter the receipt information into CHCS under the Narcotic System Menu (NSM). Enter the item, quantity, and supply document number, and the

inventory automatically updates. The signed issue list from medical logistics annotates that CHCS updated and then kept on file in accordance with the Air Force Records Information Management System (AFRIMS) Records Disposition Schedule (RDS) or other directives.

If you use the paper-based AF Form 582, prepare a separate form for each item. Since you will not be using the automated CHCS system, you will increment and decrement all amounts manually; the balance column reflects the actual amount on hand. The Air Force mandates AF Form 582s and issue receipts be maintained for three years.

### Correcting errors

If you receive five bottles of Methylphenidate 5mg and accidentally input six bottles into CHCS or other approved automated system such as PYXIS®, you can use the decrement from inventory menu and the supply document to correct the error. If you are in a situation where you use an AF Form 582, you can correct those errors by drawing a single line through the incorrect entry, making a brief note explaining the error (e.g., “posting error,” and so forth), initialing the explanation, and making the correct entry on the next line. The form is retained for three years after the final entry and then destroyed.

## 213. Outpatient-controlled substances management

Those providers authorized to prescribe medications for patients in an Air Force MTF use the AF Form 781, Multiple Item Prescription, civilian prescriptions, or the provider order entry (POE) function of CHCS. POE is a computerized method of prescribing medications and does not require a paper product. All other methods require a paper product that must be filed by pharmacy personnel. This lesson discusses the requirements of the paper prescriptions.

### Proper use of Air Force Form 781, Multiple Item Prescription (Schedules II–V medications)

Prescriptions for drugs in Schedules II–V are required to be written in ink or typed. These prescriptions must only be issued for legitimate medical purposes, and just as importantly, the provider must prescribe these medications within the course of his or her scope of practice or expertise. A sample of an AF Form 781, Multiple Item Prescription, with a requested scheduled medication is displayed below (fig. 3–2). Next, we’ll discuss specific requirements for writing prescriptions for controlled medications.

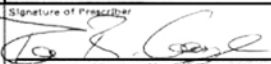
AF FORM 781, JUN 88 Previous Edition will be used		MULTIPLE ITEM PRESCRIPTION		(This form is subject to the Privacy Act of 1974 Use Blanket PAF-DD Form 1015)	
R (Cross out unused blanks below)	Strength	Amount	Directions	Notes	
1. Diazepam	5mg	10 TEN	T po qid prn muscle spasms		
2.					
3.					
a. Full Name of Patient (AGE if under 12) (Use Plastic Card or PRINT)			Signature of Prescriber		PHARMACY USE ONLY
Claudia Esparza			 Dr. Robert George 123 Main St SAN ANTONIO, TX 78234 UCA Code: DCA: RA5492412		
b. SSN of Sponsor: 123-45-6789 FMP:			c. Patient's Address (Mandatory for Controlled Substances)		
			12109 FAIRCREST SAN ANTONIO, TX 78253		
			d. Work/Home Telephone (For emergency only): 808-2062		
			Date: Oct, 06, 2015		

Figure 3–2. Sample AF Form 781, Multiple Item Prescription scheduled medication.

No more than three items may be written on AF Form 781. When fewer than three medications are prescribed, a line must be drawn through the remaining blank spaces. If the prescription is for a

locally compounded item containing more than three ingredients, the prescriber may use the entire left-hand column to list all of the ingredients.

- Separate prescriptions must be written for controlled and non-controlled medications.
- Separate prescriptions must be written for drugs listed as Schedules II from those listed as Schedules III, IV, and V.

**NOTE:** This means you will have three separate outpatient prescription files: Schedule II, Schedules III–V, and non-controlled medications.

- DEA numbers shall be used on any hand-written prescriptions for controlled substances.
- MTF providers may not prescribe themselves medication (i.e., controlled or non-controlled) and may not prescribe medications listed on the controlled substances list for their family members.
- When an MTF provider prescribes a medication, controlled substance, or otherwise for another MTF provider, a decision must be made by the prescriber concerning how that medication may affect the patient's ability to practice medicine.
- The prescribing provider and the pharmacist are equally responsible for correctly prescribing and dispensing controlled substances (Schedules II, III, IV, and V) under Title 21, USC, Sections 829 and 1309, concerning *Prescribing and Dispensing Controlled Substances*.
- Compounded products containing controlled substances require the pharmacist to write a prescription on AF Form 781 indicating the drug and quantity used in formulating the product. The completed product is given a designated control schedule determined by the pharmacist. The prescription number is included on the AF Form 2380 under "Control Action."

Additional requirements for scheduled medications have been broken down in the following table below:

Scheduled Drug Prescription Form	
Entry	Directions
Patient identification	Full name, address, telephone number, age if under 12, and identification number of the patient.
Medication	Name, strength, and quantity of medication (spelled out in addition to the written numeral amount).
Directions	Directions for use.
Date	Date of issuance. The prescribing provider signs prescriptions or documents them via CHCS electronic signature and dates them on the day of issue.
Refills	A prescription for a controlled substance in Schedules III, IV and V may not be filled or refilled after six months from the date of issuance of the prescription or be refilled more than five times; Schedule II prescriptions may not be refilled.
Signature and prescriber's name stamp	Actual signature of the prescriber—a stamp bearing the prescriber's name <u>may not</u> be used in lieu of an actual signature. Prescriptions may be handwritten or typed by an agent of the prescriber, such as a nurse, but the signature must be handwritten by the prescriber as he or she would sign a legal document. The prescriber's name stamp must be used on all hand-written prescriptions. If a prescriber's name stamp is not available, then the prescriber shall write full name, address, telephone, and DEA numbers. If the provider is military, he or she will include rank, corps, Air Force Speciality Code (AFSC), and telephone number.
DEA numbers	The DEA number is the prescriber's registration number with the DEA and allows him or her to write prescriptions for controlled drugs. A hospital's DEA registration number will permit its employed physician interns, physical residents, and foreign physicians to dispense, administer, and prescribe controlled substances for hospital patients.

### Checking the Drug Enforcement Agency number

Check the DEA number; it should have two letters and seven digits. The second, fourth, and sixth digits are added and their sum is multiplied by two. That result is added to the sum of the first, third, and fifth digits. The last digit of the total of the two sums should equal the seventh digit of the DEA number. For example, the DEA number AR5472612 passes the check:

- **Fourteen.** The second, fourth, and sixth digits add up to 7 ( $4 + 2 + 1$ ), and 7 times 2 is 14.
- **Eighteen.** The first, third, and fifth digits add up to 18 ( $5 + 7 + 6$ ).
- **Thirty-two.** The total of the two sums is 32 ( $14 + 18$ ).
- **Two.** The last digit of the total (2) is the seventh digit of the DEA number.
- Finally, the second letter in the DEA number is the same as the first letter of the last name of the provider. For example, the second letter in the DEA number above is an “R”, so your provider’s last name would be something like Roberts, Rodriguez, and so forth.

### Form retention

Retain the AF Form 781 and its civilian equivalent for three years and then destroy. Pharmacies with smaller storage areas will generally store these documents in-house for the first year and then stage them elsewhere for the remainder of the period. Pharmacies possessing the ability to store larger volumes of records can hold their records in-house with the proper coordination with the functional area records manager (FARM) in the facility. The FARM decides how long to hold records in-house, whether to stage them, and when to stage them.

### Label information

Before releasing an outpatient medication from the dispensing area, it must bear a label containing the name and address of the pharmacy, a prescription number, the name of the provider, the name of the patient, directions for taking the medication, and the date of the filling or refilling of the prescription.

You should also check with your supervisor or pharmacist for any additional label requirements directed by state law or institutional policy. Now let’s move from outpatient requirements to inpatient controlled substance management requirements.

## 214. Inpatient-controlled substances management

Documenting the receipt and issue of controlled drugs in the inpatient setting is no less important than the outpatient setting. Just like the other forms and files you’ve learned so far, inpatient management of controlled substances requires attention to detail to make sure nothing just “walks away.” This lesson will explain the concepts of managing these substances in an inpatient setting. We will discuss several forms or the electronic equivalents used to document the dispensing and handling of controlled drugs within your facility’s wards and clinics. Even though pharmacies use computers to do all or part of their controlled drug documentation, the concepts are the same, and it’s important you understand them. Also, you may be deployed to an area where you will not have computer access, and you’ll need to use the paper products.

### Air Force Form 579, Controlled Substances Register and Log

When a ward or clinic within your MTF requests a controlled medication, an AF Form 579 (fig. 3-3) is prepared for each Schedule II–V items stocked by an inpatient unit or clinic and for any other item designated by the MDG commander. Every dose of a controlled substance given to a patient via a doctor’s order is entered on the 579. It becomes the equivalent of a prescription for the patient and is the source document for every dose administered.

[illegible]

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99

Treat the AF Form 579 (when filled in) as controlled as the medication it represents. Correct posting errors in the same manner as AF Form 582. Since the majority of Air Force pharmacies use automated dispensing equipment (PYXIS®, Pickpoint®, or FlexRx®), the AF Form 579 isn't widely used anymore. However, there are two instances where you maintain the 579. As with the AF



Form 582, use the 579 in deployed conditions, and anesthesiologists/anesthetists will use the 579 in surgical suites at facilities that do not use automated surgical carts.

Facilities using automated dispensing equipment use the automated receipt and dispensing record in place of AF Form 579 to audit and replenish drug stocks. Keep automated reports for audit using the same requirements as AF Form 579.

### Numbering log

Each form is numbered serially, and the pharmacy maintains a log showing the number, date issued, inpatient unit or clinic, drug identification, and date the completed form returns. The nurse or designated individual initials the log upon receipt of each form and again when the complete form returns to the pharmacy. Use the automated systems for tracking AF Forms 579s whenever possible.

### Accounting and retention for Air Force Form 579

To help ensure accountability of all AF Forms 579, initiate a new series of forms each calendar year. The incomplete forms from the previous year come back to the pharmacy for filing and disposition. Retain the AF Form 579s for two years after the final entry, and then it is destroyed.

### Maintaining a log

Earlier we made a reference to maintaining a log for all AF Forms 579s that are issued. There is no standard form designated for the purpose of this control log. Some organizations use AF Form 115A, Register of Control Numbers (fig. 3-4), while others use a local form, ledger, or computerized tracking system. Do not destroy this form until all AF Forms 579s entered on it are destroyed.

REGISTER OF CONTROL NUMBERS					
ORGANIZATION OF UNIT				DATE OR FISCAL YEAR	
382 MGD				2015	
CONTROL NUMBER	TYPE OF DOCUMENT	FROM OR TO	PROPERTY CLASS. WORK ORDER. UN ACCOUNT OR AF COST CODE	DATE FILED	ITEM IDENTITY OR OTHER INFORMATION
2015-01	AF Form 579	Ward 3A	Demerol 10/ml 10 ml tubex	31 May 2015	AG/SI
2015-02	AF Form 579	Ward 2C	Percocet tablets	6 Jun 2015	AG/LA
2015-03	AF Form 579	Emergency Room	Tramadol tablets	6 Jun 2015	AG/JP
2015-04	AF Form 579	Labor & Delivery	Morphine 10/ml 10 ml tubex	15 Jul 2015	AG/RG

Figure 3-4. Sample AF Form 115A, Register of Controlled Numbers.

## 215. Filling inpatient-controlled drug orders

The importance of following proper procedures can never be over-stressed; this is especially true when working with controlled substances. This lesson will present procedures for filling and dispensing an inpatient controlled substance order. It is important to note the procedures discussed in this lesson may contain small variations from your MTF/pharmacy operating instructions (OI). It is important you abide by your local OIs so everyone in your facility is working in unison. This lesson

will present as a scenario to enhance your understanding of the procedure, while also providing insight on what procedural steps to follow.

You are a pharmacy technician stationed at Faithcrest Medical Center, Faithcrest AFB, USA. Presently, you have been assigned to the inpatient pharmacy to become proficient in all required upgrade tasks. You have never worked in inpatient before, but you are confident you can handle all tasks correctly and professionally once you understand the “why’s and when’s” of performing your inpatient duties.

You have just received a controlled drug order from one of your nursing units (2–West). You review the order for appropriateness and find Major Robinson, the nursing flight chief, requests 20 Tramadol 100mg tablets to restock the unit supply of this drug (this drug is a Schedule IV controlled substance).

Is Tramadol on 2–West’s authorized drug list?

The pharmacy and therapeutics (P&T) function *evaluates and recommends* drugs on inpatient units and clinics. The drugs the MTF uses are on the authorized drug list (ADL). The P&T function designates a separate list to certain units, clinics, or providers. Tramadol is on the 2–West’s authorized drug list.

Is Major Robinson authorized to order controlled substances for the nursing unit?

Only authorized personnel the MTF command staff designates appropriate can order controlled substances. Check your local OIs or policy letters for personnel authorized to place such orders. Your medical center has designated personnel authorized to order controlled substances by policy letter, and Major Robinson is authorized to place this order.

You recognize Tramadol as a controlled substance and are aware all controlled substances issued to inpatient units and clinics must be done in a certain way for issue/tracking purposes. How will you issue the requested drug to meet this requirement?

Issuing controlled substances to inpatient units and clinics happens using an AF Form 579, Controlled Substances Register, entering the information in an automated dispensing unit such as PYXIS® (use as electronic equivalent). This ensures tracking purposes as required by AFI 44–102, Medical Care Management. The AF Form 579 or the automated dispensing unit becomes the source for every dose of controlled medication administered to a patient. Once AF Forms 579 or electronic equivalents are issued, they themselves become controlled and accountable. Issue a new AF Form 579 or electronic equivalent to the inpatient unit or clinic for each controlled substance request. AF Forms 579s or electronic equivalents are serial numbered by CHCS or bar coded by the PYXIS computer upon issue for tracking purposes.

When receiving controlled substances from supply, you need to enter the receipt information into CHCS under the Narcotic System Menu (NSM); CHCS automatically updates the inventory for each item. But now you must use CHCS to dispense 20 Tramadol 100mg tablets from your vault and show a record of doing so. What steps should you take to dispense the 20 Tramadol tablets requested by Major Robinson on the 2–West nursing ward?

The Air Force-approved CHCS is a valid and reliable medium for controlled substance management. The following CHCS menu path is used to issue a controlled substance:

- “NSM” (Narcotic System Menu).
- “ISM” (Issue Menu).
- “NEW” (New Issue Entry).
- “CONTROLLED ITEM”.

Enter the name of the medication being issued or choose the correct medication from the pick list (in this case, Tramadol 100mg)



**NOTE:** Use the Narcotic System Menu (NSM) and the two following sub-menus, Issue (ISM) and New Issue Entry (NEW), for CHCS to properly record and issue the requested medication. Personnel using these CHCS menus must make sure to enter the correct medication and amounts. If medication receipts (additions) and issues (subtractions) are not in CHCS properly, discrepancies in the controlled drug inventory occur. These discrepancies result in vault custodians spending hours investigating inventory overages or shortages.

“Do you wish to use (P)ackage or (I)nventory units to dispense in:” Enter through “I” default. (CHCS allows the dispensing of medications in packages or units (e.g., a package of Demerol injection [100 mg/1 mL tubex] – 10 tubex’s in a manufacturer’s package). CHCS recognizes the package size of 10 tubex’s or the inventory unit of 1 tubex. Pharmacies can manually adjust these settings within CHCS to suit individual issue practices.) In the case of Tramadol tablets, the manufacturer produces a unit dose package of 10 tablets, so when dispensing this medication, it is critical to understand whether you are dispensing 1 unit dose package of 10 tablets or 1 inventory unit (1 tablet).

1. Enter the requesting nurse’s or physician’s name (in this case Maj. Robinson; remember, tracking controlled drug issues is part of a good controlled substance program and is directed by AFI 44-102).
2. Enter the quantity of units being issued (e.g., 1 vial, 10 tabs, 240 mls)—in this case 20 tablets. Remember, entering incorrect quantities into CHCS can cause a discrepancy in the controlled drug inventory.
3. Enter the unit/clinic requisitioning the item (2–West; again, this is for tracking purposes).
4. Enter the medication’s expiration date (CHCS will track medication expiration dates if they are entered into the CHCS database. An expiration date report can be run from the CHCS report menu).
5. Enter the manufacturer’s name of the medication being issued. (All documentation should match the actual medication being issued. Some medications we use are made by multiple manufacturers under different names. By entering the manufacturer’s medication name into CHCS, any documentation generated by CHCS will match the actual medication being dispensed or issued).
6. Enter the lot number of the medication. (CHCS will track medication lot numbers if they are entered into the CHCS database. If a medication is recalled by the manufacturer, the medication can be easily located by requesting CHCS conduct a search of its database).

You are completing all CHCS requirements to issue the Tramadol to the nursing unit. From the training you have had at tech school and from your CDCs, you know proper tracking and movement of controlled substances is very important. How will you be able to show the issue of the Tramadol 100mg from your pharmacy vault to 2–West?

You must, upon fulfilling the CHCS requirements, print a label showing the issue of the drug to 2–West. This label attaches to your AF Form 579 or the automated dispensing unit issue receipt when the drug is delivered, thus linking your actions from the CHCS to the drug actually dispensing to 2–West. IAW AFI 44-102, facilities using automated dispensing equipment may use the automated receipt and dispensing record in place of an AF Form 579 to audit and replenish drug stocks. Keep automated reports for audit using the same requirements as an AF Form 579. Remember, in the eyes of the Air Force, the AF Form 579 (when filled in) is as controlled as the medication it represents.

You believe you are now ready to issue/deliver the medication, but how will you show you actually issued/delivered the Tramadol to 2–West, and what if Major Robinson is not there to receive the medication he ordered?

When issuing an AF Form 579, you, the pharmacy technician, and the recipient must initial the AF Form 579 in the column on the right-hand side of the form. These initials indicate you issued and he or she accepted the specific quantity of controlled medication the form indicates. Major Robinson, or the person who placed the order, does not need to be the person who receives and initials the AF

Form 579, or in the case of facilities using automated dispensing equipment, who initials the automated receipt.

AFI 44-102 states, “With the exception of authorized pharmacy personnel, only licensed clinical staff may be authorized access to controlled substances storage areas.” It also states, “Schedule II drugs must be stored in a substantial double-locked cabinet in patient areas outside the pharmacy.” Store all other controlled substances in a secure, locked cabinet. Restrict access to those individuals authorized to prepare, administer, or dispense controlled substances. Automated dispensing units meet these storage requirements.

Your local OIs designate who is licensed clinical staff and who may sign for controlled substances. Many times the night shift nursing supervisor orders the controlled substance, and then the pharmacy receives it the next morning. When the pharmacy delivers the medication, another authorized person may sign for the order. Technicians and/or administrative personnel are not licensed clinical staff and cannot sign for or receive pharmaceuticals.

You have delivered the controlled substance and have the proper documentation to demonstrate the proper issuance and receipt of the medication. Now that you delivered the medication, what do you do with the documentation (e.g., AF Form 579, or in the case of facilities using automated dispensing equipment, the automated receipt)?

If delivering to an automation unit, return the issue in CHCS via the following menu path:

- “NSM” (Narcotic System Menu)
- “ISM” (Issue Menu)
- “RAI” (Return an Issue)

**NOTE:** Use the Narcotic System Menu (NSM) and the two following sub-menus, Issue (ISM) and Return an Issue (RAI), for CHCS to account for the serial-numbered AF Form 579. Remember, all AF Forms 579 are controlled and each number issued with these forms by CHCS are accountable. In essence the Narcotic System Menu within CHCS is one big number-crunching calculator. When a controlled substance is issued to a ward, clinic, or unit, this system believes an AF Form 579 was initiated and issues the drug, even though in most cases today, an automated dispensing unit, such as PYXIS®, tracks the administration of controlled substances to inpatients on nursing units. This is why it is important to return the CHCS-issued number so the system does not believe a serial-numbered AF Form 579 is missing. The serial number returns with a product quantity of “0.” If you return it for any other quantity, it adds back into your inventory.

Once delivered, the automation unit tracks the inventory of an item versus an AF Form 579.

Now you need to file your documentation. Keep the initialed AF Form 579/automated receipt on file IAW the Air Force Records Information Management System (AFRIMS) Records Disposition Schedule (RDS) or other directives. Retain the AF Form 579 or automated receipt for two years after the final entry, and then destroy.

You have now gone through the entire process of filling a controlled drug order, the proper steps to follow before issuing the medication, and how to input information into CHCS that will ensure your pharmacy can properly track the medication. You have also learned how to complete and file the proper documentation. Next, we will look at filling outpatient controlled drug orders.

## **216. Filling outpatient-controlled drug orders**

Just like the previous lesson, the importance of following proper procedures when dealing with controlled substances can never be overstressed. This lesson will present procedures for filling and dispensing outpatient-controlled substances orders. As previously stated, it is important to note the procedures discussed in this lesson may contain small variations from your MTF/pharmacy operating instructions (OI). It is important you abide by your local OIs so everyone in your facility is working

in unison. This lesson will also be presented as a scenario to enhance your understanding of the procedure, while also providing insight on why the procedural steps should be followed.

You are a pharmacy technician still stationed at Faithcrest Medical Center, Faithcrest AFB, USA. Recently you have been reassigned to the main outpatient pharmacy to become proficient in all required upgrade tasks. You have never worked outpatient before, but you are confident you can handle all tasks correctly and professionally.

You are the primary prescription filler and an order for 180 Percocet tablets displays for Mr. Antonio Romo. Percocet is a Schedule II narcotic and used to relieve moderate to severe pain. It is a combination drug of Acetaminophen and Oxycodone in different strengths. Before filling the prescription, you must review it for accuracy and identify any errors, if applicable. Specifically, you must ensure:

- Directions are accurate.
- Quantity does not exceed established limits.
- Provider is authorized to prescribe Schedule II medications.
- No refills are on the prescription since it is a Schedule II medication.

So how do you proceed if everything is correct on Mr. Romo's Percocet? More than likely, you will fill the narcotics away from the main filling line where they are secure and have limited access for accountability purposes. Before you can fill the order, you must verify you have enough Percocet on hand. To do this, you will need to use the "INI" (Inventory Record Inquiry). The INI function shows the on-hand quantity for any selected product. After checking INI, you verify there are 240 Percocet tablets available.

So what is your next step since you have enough Percocet to fill Mr. Romo's prescription? Now that you verified the accuracy of the prescription and know you have enough quantity on hand, you can fill and process the prescription. You will have to count out 80 tablets from a full manufacture bottle of 100 and ensure there are 20 tablets left on hand. Another full bottle of 100 is what you'll need to complete the order. Once you have filled the prescription, you will have to complete the transaction in CHCS. You will need to use the "CRT" (Complete RX Transaction) so the prescription quantity subtracts from your inventory. After you complete this step, there should be 60 Percocet tablets left.

Once you have filled the prescription, a second technician or pharmacist must "double count" the Percocet to make sure the count is accurate. If it is not accurate, investigate and correct the error immediately before filling any other Percocet orders. In this case you filled the correct amount so Mr. Romo's prescription is ready for the pharmacist to verify.

The pharmacist makes sure the patient, drug, directions, quantity, day supply, and doctor information is correct. If everything is correct, the pharmacist either initials the prescription label or scans his or her badge to annotate he or she verified the prescription.

Once the pharmacist verifies the prescription, it can be dispensed to the patient. You will either call out Mr. Romo's name or his ticket number, depending on your pharmacy's local procedures. In this case Mr. Romo has left the lobby so the prescription has to be placed on the shelf for later pickup. Since Percocet is a controlled medication, the bag label should clearly identify it as a narcotic. If Mr. Romo does not return before the end of the day, the Percocet along with all other narcotic medications needs to be secured and locked before closing the pharmacy.

Mr. Romo returns to the pharmacy an hour later to pick up his Percocet prescription. You can now dispense it both physically and virtually in CHCS. First, verify Mr. Romo's ID card to make sure you do not dispense the medication to the wrong patient. After validating Mr. Romo's identity, dispense his Percocet using the "DRX" (Dispense a Prescription) in CHCS. This function clears the prescription and annotates the date/time the prescription is dispensed, creating a record trail.

Mr. Romo will also sign for his Percocet. He can sign by signing a prescription slip or an electronic signature pad.

This may seem like a lot of steps to fill one prescription, but accuracy and accountability are critical when working with controlled substances. Also, these steps may vary since some pharmacies have gone away from using CHCS to track controlled medications. Instead, some pharmacies are using automation, such as PYXIS® units, to track, fill, and inventory their narcotic medications.

### **217. The disposal of controlled substances**

Only pharmaceutical products fit for dispensing or medical use should be on the supply shelves of your pharmacy; controlled substances are no exception. Remove or separate from other medications on the shelf as it expires, deteriorates, or is otherwise unfit, so they will not end up accidentally dispensed to our patients. Because of their high abuse factor and the risk of diversion, the proper disposal of controlled substances is always a high visibility item. Presently there are three ways our pharmacies dispose of these substances: a **commercial** credit returns companies, base-wide hazardous materiel removal contract, or in-house destruction. These methods are detailed in AFI 41-209, *Medical Logistics Support*.

#### **Commercial credit returns**

Use commercial credit return companies whenever possible to dispose of pharmaceuticals and other medical materials. Return these materials to the manufacturer directly or through these commercial companies for credit or disposal to streamline disposition of potentially hazardous items and to minimize losses for both MTF operations and the medical-dental division working capital fund. The commercial company must register with the DEA to receive and destroy controlled substances. It is the medical logistics flight commander's responsibility to ensure the vendor registers prior to turning over any controlled material for credit or destruction.

The MTF notifies the contractor in advance of returning Schedule II narcotics. Prior to turnover, complete separate inventories for Schedule II and Schedule III-V controlled substances. The MTF commander appoints a disinterested individual in the rank of MSgt or above or GS-7 or above to supervise the inventories. After fulfilling inventory and other local requirements, the contractor can receive the material for disposal/shipment.

The contractor is responsible for providing shipping labels, filing procedures, completing DEA Form 222, and providing a tamper-evident pouch to ship the material. A copy of the disinterested inventory will also be included with the shipment. A disposal manifest, a proof of destruction document, and a listing of which items will receive credit from the manufacturer also generates and goes to medical logistics. Inventories and destruction documents must be available for two years for inspection and copying by the DEA.

#### **Hazardous materiel removal contractor**

Coordinate destructions done by the base-wide hazardous materiel removal contractor with the BCE Environmental Manager IAW DOD 4160.21-M, *Defense Materiel Disposition Manual*, Chapter 10; AFJI 23-504, *Radioactive Commodities in the DOD Supply System*, Chapter 8; AFJMAN 23-209, *Storage and Handling of Hazardous Materials*, Chapter 11; and AFI 40-201, *Radioactive Materials Management*. Destructions are processed in DMLSS using destruction transactions or credit returns losses. The vendor provides a signed and dated record of receipt, documenting the transfer of materiel from medical logistics.

#### **In-house destruction of controlled substances**

MTFs primarily use commercial companies and contractors when disposing unusable controlled substances, but there are cases where destructions are done in-house. Accountability requirements for in-house destructions require the same level of visibility (e.g., inventories and signed documents) as they do with using a contracted service. The MTF commander appoints a destruction officer who is a

MSgt or higher or GS-7 or above and two witnesses who are not be lower in grade than the destruction officer. They destroy the material in a manner that precludes the use of any portion of the item for any purpose. When the waste disposal plan allows, the material may be dissolved and dissipated through the sewer or, if insoluble, the material may be burned. When these options are not acceptable, obtain the advice of the resident or command bioenvironmental engineer (BEE) for a determination of the appropriate method of destruction to prevent water or air pollution. The destruction officer also annotates the coordination with the BEE on the document.

Prepare a destruction document (AF Form 85, Controlled Substance Inventory Adjustment Voucher may be used); the destruction officer shows and certifies the identity and quantity of items destroyed and the authority, reason, manner, and date of destruction. The following statement must be on the document: "I have witnessed the destruction of the material as indicated," with the signature and date of the two witnesses (see example below).

I have witnessed the destruction of the materiel as indicated.

Witness

Date

Witness

Date

After the destruction, a copy of the certificate is provided for your document files, and a copy is given to the destruction officer, if required. Finally, all appropriate transactions are posted to the vault records (AF Form 582 or electronic equivalent). The decision to destroy and how to destroy controlled items will probably be made by your pharmacy flight commander or other leadership within the medical group. As stated before, controlled substance programs get a lot of visibility, so decisions made about these programs should not be made haphazardly. You can also understand why any person who has the responsibility of oversight of any controlled substance may want to be involved in that decision-making process. If your facility does any destruction of controlled substances, there is most likely an operating instruction (OI) on the subject and that multiple individuals have agreed on the destruction/disposal process.

## **218. Controlled substance management reports**

CHCS keeps track of every "transaction" occurring in the Narcotic System. A transaction may simply be a prescription, or it may be an issue to one of the wards or clinics. Receipts from supply are transactions, as well as when items are moved to the destruction area or to the returned goods contractor. The reports listed below all have various uses. A pharmacy's narcotic custodian will use some on a daily basis and some when troubleshooting overages or shortages.

### **Narcotic System Reports Menu**

The Narcotic System Reports Menu (NRR) is the main function that allows you to produce specific Narcotic System reports. Below are the different menu options available under the NRR.

#### ***Inventory Report***

The Inventory Report (INR) displays or prints reports containing narcotic inventory information. It displays the current quantity on hand as shown in figure 3-5 below. Quantities are affected by prescriptions which have not been completed in the Complete Receipt Transaction (CRT) menu. This report is useful for daily and monthly inventories.

INVENTORY RECORD REPORT (ALPHABETIC)				
PRODUCT	NSN	DEA	UNITS/PKG	QTY ON HAND
VAULT: MAIN				
DIAZEPAM 15MG TAB - 25/PACK	6575-00-948-0039	C-IV	25 TABLETS	1000
DIAZEPAM 5MG TAB - 250/BOTTLE	6506-44-765-9876	C-IV	250 TABLETS	1000
DILAUDID 2MG TAB - 10/PACK	1111-22-333-4444	C-II	10 TABLETS	2000
DILAUDID 2MG TAB - 25/PACK	4444-44-444-3333	C-II	25 TABLETS	1000
DILAUDID 2MG TAB - BOTTLE OF 100	1111-22-333-5555	C-II	100 TABLETS	959
DILAUDID 2MG TUBEX - 10/CARTON	6506-12-345-6791	C-II	10 TUBEXS	1900
FIORINAL TAB - 1000/BOTTLE	6506-88-987-3456	C-II	1000 TABLETS	1000
LIBRIUM 10MG TAB - 25/STRIP PACK	6595-00-777-7736	C-IV	25 CAPSULES	1000
MEPERIDINE 50MG TAB - 100/BOTTLE	6505-00-456-8888	C-II	100 TABLETS	1000
METHADONE 5 MG TAB - 50/BOTTLE	6506-99-994-9227	C-II	10 TABLETS	900
MORPHINE 10MG TUBEX - 25/CARTON	1111-22-333-4444	C-II	25 TUBEXS	975
PHENOBARBITAL 15MG TAB - 100/BOTTLE	6505-87-364-1234	C-IV	100 TABLETS	1000
PHENOBARBITAL 15MG TAB -50/BOTTLE	6505-87-364-1234	C-IV	50 TABLETS	950
RESTORIL 15MG CAP - 25/PACK	6505-01-882-8815	C-IV	25 CAPSULES	975
RESTORIL 30MG CAP - 25/PACK	6505-01-662-7721	C-IV	25 CAPSULES	1000
TYLENOL #3 TAB - 100/BOTTLE	6505-01-883-1192	C-III	100 TABLETS	970
TYLOX TAB - 25/STRIP PACK	6505-96-584-3927	C-II	25 TABLETS	2000
XANAX 5MG TAB - 25/STRIP PACK	0000-22-000-5555	C-IV	25 TABLETS	1000
***** END OF REPORT *****				
The items listed above were inventoried and found correct except for the items listed below which had discrepancies as noted.				
Inventory Officer _____		Date _____		

Figure 3-5. Sample CHCS inventory reports.

### Issue Reports (general)

This option (Issue Reports [general] [GIR]) prints the issue records for all controlled issues. You may obtain a report sorted by location issued to, alphabetical drug name, or DEA schedule. This can help you to track down problems on the clinic or inpatient side of the house.

### Issue Reports (specific)

This option (Issue Reports [specific] [SIR]) prints all issue records in a date range for a particular drug by drug name or location. Unlike the GIR above that gives a wider range of information, this report is more specific and will only report on the drug or location that you specify.

### Narcotic Movement Report

This option (Narcotic Movement Report [NMR]) prints the detailed or total movement of controlled drugs for a narcotic vault in the pharmacy. The report displays the types of transactions that have occurred for each drug alphabetically by date range. This report is a good starting point if you have a discrepancy. It provides an overview of the activity for the medication you need to look at. You can use this information to guide you to which other reports need to be run.

### Outstanding Issue Report

This option (Outstanding Issue Report [OIR]) displays or print a list of all issues that are still at the requested location of the issue. The initial sort is by location. This report can be run for one location or for all locations. The report lists all issues having a status of OUTSTANDING. If you have a missing AF Form 579, this is where you want to start!

### Supply Voucher Reports

This option (Supply Voucher Reports [SVR]) displays or prints a report of all supply vouchers, either issues or turn-ins, by date range. A copy of this report is usually helpful during the monthly disinterested inventory.

### Transaction Reports (general)

This option (Transaction Reports [general]) allows you to display or print a report of every transaction that occurred for each controlled item that caused a change to the quantity on hand for that product. Each transaction includes the date/time, user, type (RX, issue, supply), and quantity of the transaction. This report is very useful, mainly at smaller pharmacies, to conduct the end-of-day count. The running total is shown and should be what is on hand after all prescriptions have been completed in the CRT menu.



### ***Transaction Reports (specific)***

This option (Transaction Reports [specific] [STR]) displays or prints a report of every transaction that occurred for a specific controlled item that caused a change to the quantity on hand for that product. Each transaction includes the date/time, user, type (RX, issue, supply), and quantity of the transaction, as well as, the quantity of the product on hand after the transaction. Again, this is a good troubleshooting tool after you have narrowed down the field to what you want. This report literally dissects all transactions for the specific drug you request.

### **Outpatient pharmacy reports**

The Outpatient Pharmacy Reports menu (OPR) is the main function that allows you to produce various specific outpatient reports.

### ***DEA Report***

This report prints prescription data for all controlled substance prescriptions filled for a specified date range. You may also specify sort criteria for divisions and outpatient sites within divisions to include in the report. We are only going to cover the DEA Report here because it is the only outpatient report that deals strictly with controlled medication.

## **219. Controlled substance inventories**

As stated at the beginning of this section, the proper management of controlled substances is crucial. A big part of that management process is the inventories you and others will conduct on controlled substances. Your controlled substance inventories are one of the most important aspects of your program. Inventories are the key to the loss detection, theft, and the diversion of controlled substances.

### **Biennial inventories**

The CSA requires completing and documenting an inventory every two years (biennially). In accordance with AFI 44-102, inventories must be conducted every two years on 1 May (or before opening on the first duty-day thereafter) of odd-numbered years. Maintain the inventory of Schedule II drugs separately from the inventory of Schedule III, IV, and V drugs. Maintain the document at the location appearing on the registration certificate for at least two years. Each biennial inventory document reflects the following information:

- Lists the name, address, and DEA registration number of the registrant.
- Indicates the date and time the inventory is taken (i.e., open or close of business).
- Be signed by the person or persons responsible for taking the inventory.
- Includes the name of substance: drug name, strength, form (e.g., 20-mg tablets, or for injectables, 10 mg per ml), number of units, unit volume.
- The number of commercial containers of each such finished form (e.g., 10 100-tablet bottles or 20 2-ml ampules).
- An exact count must be made if the container has been opened.
- The inventory document also identifies the location (e.g., labor and delivery, emergency room, pharmacy), time, date, and signature of the person conducting the inventory. Inpatient unit and clinic biennial inventories are filed in the pharmacy.

**NOTE:** Newly stocked controlled substances are inventoried on the date they are received from medical supply. Thereafter, these substances are included in the biennial inventory conducted on 1 May. In accordance with the Air Force Records Disposition Schedule (RDS), destroy inventory documentation after three years. There are both criminal and civil penalties for violating record-keeping requirements, and the Pharmacy Law Digest provides guidance on the subject in the Inventory Records section.

**Disinterested inventory**

The MTF Commander appoints a disinterested officer, noncommissioned officer (NCO) in the grade of E-7 or above or civilian of comparable grade to inventory the MTF's controlled drugs at least monthly. Personnel conduct the inventory in the facility's pharmacy and in all other locations where controlled substances are maintained. "Disinterested" refers to someone who does not order, stock, or administer controlled substances or is not related to an individual who works in a section of the MTF that stocks controlled substances. Appointee must be from a duty section that is not being inventoried.

**Inventory discrepancies**

On rare occasions the pharmacy's physical inventory count will not agree with your controlled substance inventory documentation. Refer discrepancies to the individual managing the particular controlled-substance vault, your pharmacy's narcotics custodian or whomever your pharmacy designates as a point of contact (POC) for these situations.

This individual verifies the recount and looks for discrepancies. If the count is still off, a review of the supporting documents and transactions back to the last inventory will be conducted. If the inspector finds paperwork or posting errors, process a correction transaction to explain any discrepancy. Make all efforts to resolve discrepancies prior to notifying your pharmacy superintendent and flight commander.

If the initial investigation does not identify the cause of the discrepancy, the pharmacy is responsible for documenting the discrepancy for review by the pharmacy flight, squadron, and MTF commanders. These commanders can handle the discrepancy in several different ways, ranging from simply approving an AF Form 85 to initiating an Office of Special Investigation (OSI) investigation. Let's review a few possible ways to resolve a controlled-substance discrepancy within your pharmacy.

***AF Form 85, Controlled Substance Inventory Adjustment Voucher***

Pharmacy-controlled substance monitors initiate this form to adjust shortages and overages of a controlled substance when discovering a discrepancy. The use of this form does not indicate negligence on the part of the pharmacy staff. Some controlled substance bottles sometimes are either short or over one or two tablets; when discovering this, adjust the amount to reflect the actual amount on hand.

The pharmacy flight commander reviews the AF Form 85, Controlled Substance Inventory Adjustment Voucher, and certifies the documents by signing them before submission to the approval authority. The final approval authority for the form is the MTF commander. The MTF commander may delegate this authority by appointing a designee, in writing, for medications in Schedules III-V but must retain authority for all Schedule II medications. The MTF commander may not appoint the pharmacy flight commander as approval authority because of the conflict of interest, and the same officer may not act as both certifying official and approving authority on the same document. If items on the AF Form 85 are not approved, a Report of Survey (ROS) may be required. The AF Form 85 only becomes a valid document once it has been signed by the final approval authority. Once it is signed, the controlled substance monitor corrects the balance on the AF Form 582, Pharmacy Stock Record, or automated product (spreadsheet, database, or work-processing reports) and AF Form 579 if the discrepancy occurred in an inpatient ward or clinic.

***Report of Survey and the Office of Special Investigation***

As mentioned above, if the AF Form 85 is disapproved, the MTF commander may order an ROS or ask for an OSI investigation. Air Force policy is to protect and properly use all US government property. Use a ROS to investigate discrepancies between property records and property available for use. Local commanders have the authority to investigate discrepancies, especially when suspected willful misuse of property, negligence, or other local conditions warrant strict controls. The commander can ask the OSI to investigate if he or she believes the controlled substance discrepancy warrants this type of investigation.



## Self-Test Questions

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

### 212. Controlled substances principles

1. What pharmacy law required an initial inventory of all controlled substances throughout each medical facility on 1 May 1971?
2. Under what federal law is OTC Pseudoephedrine considered a Scheduled Listed Chemical Product?
3. For a facility to order controlled substances, the facility must first obtain what type of license?
4. What form is issued by the DEA and is required to purchase Schedule II drugs?
5. Upon receiving controlled substances from Medical Logistics, what document is used to ensure the correct drug and quantity was received?
6. What form or its automated equivalent is used to track the perpetual inventory (receipts, issues, and amounts on hand) for all scheduled medication and any other drugs your MTF commander has designated as controlled?
7. How long should an AF Form 582 be retained?

### 213. Outpatient-controlled substances management

1. What are the requirements when completing prescription forms for drugs in Schedules II–V?
2. A patient brings three separate AF Forms 781, Multiple Item Prescriptions, to the in-window of your pharmacy. Each of the three prescription forms has one medication written on it; why might the provider use three separate forms to write for three separate prescriptions?
3. A patient comes to the in-window of your pharmacy with an AF Form 781, Multiple Item Prescriptions. The form contains a controlled medication prescription hand-written by the provider. What number must be on the prescription for you to fill it?

4. Who are the two individuals equally responsible for correctly prescribing and dispensing controlled substances in the MTF?
5. Which Scheduled medication prescriptions may not be refilled?
6. What is a DEA number?
7. What does the second letter in the provider's DEA number represent?
8. How long must you retain AF Forms 781, Multiple Item Prescriptions, and what must be done with them after that period of time?
9. Before releasing outpatient medication from the dispensing area, what information must be on the label?

**214. Inpatient-controlled substances management**

1. What is an AF Form 579, Controlled Substances Register and Log?
2. What system for auditing and replenishing drug stocks may be used in place of an AF Form 579?
3. The pharmacy maintains a log of AF Form 579s; what information must be recorded on this log?
4. When is a new series of AF Forms 579 initiated?
5. How long should an AF Form 579 be retained?
6. When can the control log for all AF Forms 579 be destroyed?

**215. Filling inpatient controlled drug orders**

1. The pharmacy just received a controlled drug order for a Schedule IV drug from one of the nursing units in the MTF. What two things must personnel check for before proceeding to fill the medication?
2. IAW AFI 44-102, how does the pharmacy track controlled drugs dispensed to inpatient units and clinics?
3. When controlled substances are received from supply, what menu of CHCS is used, and what type of information is entered so that CHCS can automatically update the controlled drug inventory?
4. If medication receipts (additions) and issues (subtractions) are not entered into CHCS properly, what will happen to the controlled drug inventory?
5. How do pharmacy personnel link the actions of completing CHCS requirements to the drug actually being dispensed to the unit?
6. How do pharmacy personnel prove that the controlled drug was issued to proper nursing unit personnel?
7. What are the final steps that must be performed once the controlled drug has been issued to the nursing unit and the proper documentation (the initialed AF Form 579/automated receipt) has been completed?

**216. Filling outpatient controlled drug orders**

1. What CHCS narcotic function shows the on-hand quantity for any selected product?
2. What does the CRT CHCS function do to your controlled substance inventory?
3. Who needs to double-count a filled narcotic prescription?

4. What CHCS function annotates the date and time the prescription is dispensed creating a record trail?

### **217. The disposal of controlled substances**

1. What is the medical logistics flight commander's responsibility when choosing a commercial company to dispose of pharmaceutical products that are no longer fit for dispensing or medical use?
2. Who appoints destruction officers to be responsible for the destruction of controlled substances?
3. What rank requirements must the destruction officer and two witnesses meet?
4. What statement must be included on destruction documentation?

### **218. Controlled substance management reports**

1. How is the SIR different from the GIR?
2. How does the Supply Voucher Report help with inventories?
3. What can the GTR be useful for in smaller pharmacies?
4. How does the Transaction Reports (specific) help you to troubleshoot narcotics discrepancies?

### **219. Controlled substance inventories**

1. What information is reflected on each biennial inventory document?
2. Where are inpatient unit and clinic biennial inventories filed?
3. What does the term "Disinterested" refer to regarding Schedule II controlled drug inventory?

4. What form must be initiated to adjust shortages and overages in the amount of a controlled substance in which a discrepancy has been discovered, and who has the final approval authority for the form?
5. If the AF Form 85 is disapproved, the MTF Commander is authorized to take what two actions?

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## Answers to Self-Test Questions

### 209

1. ATNAA (Atropine and Pralidoxime chloride) and Diazepam autoinjectors, Pyridostigmine Bromide (PB tabs), certain antimicrobials, and antimalarials.
2. SF600, Chronological Record of Medical Care, and on the deploying members DD Form 2766, Adult Preventative and Chronic Care Flowsheet.
3. Troop commander.
4. Medical Logistics.

### 210

1. HSMR.
2. AFI 41-106, *Medical Readiness Program Management*.
3. 886E.
4. Pharmacy team chief.

### 211

1. A DCP.
2. POD site.
3. To provide the overall outpatient dispensing procedures for executing mass prophylaxis in response to one of several contingencies where medications or vaccines will need to be dispensed to a large number of people in a short period of time.
4. Up to 300 patients and up to 150 first responders.
5. A federal asset owned by both the CDC and DHS. The SNS is activated in the event of a natural or man-made disaster, epidemic or pandemic outbreak occurs, and if local and State resources are overwhelmed.

### 212

1. CSA of 1970.
2. The Combat Methamphetamine Epidemic Act of 2005.
3. DEA license.
4. DEA Form 222, Controlled Substance Ordering Form.
5. Using Activity Issue List.
6. AF Form 582, Pharmacy Stock Record.
7. Three years.

### 213

1. To be written in ink or typed.
2. Separate prescriptions must be written for controlled and non-controlled medications. Separate prescriptions must be written for drugs listed as Schedules II from those listed as Schedules III, IV, and V. The patient at the in-window may have had a prescription written for a non-controlled medication, a medication listed as a Schedule III, IV, or V medication, and a Schedule II medication.

3. The DEA number.
4. The prescribing provider and the pharmacist.
5. Schedule II prescriptions.
6. The prescriber's registration number with the DEA and allows him or her to write prescriptions for controlled drugs.
7. The first letter of the last name of the provider.
8. Three years and then destroyed.
9. The name and address of the pharmacy; a prescription number; the name of the provider; the name of the patient; directions for taking the medication; and the date of the filling or refilling of the prescription.

**214**

1. The equivalent of a prescription for the patient and is the source document for every dose administered.
2. Automated receipt and dispensing record.
3. The serial number, date issued, inpatient unit or clinic, drug identification, and date the completed form is returned.
4. Each calendar year.
5. Two years after the final entry, and then it is destroyed.
6. Once all of the AF Forms 579 recorded on that log are destroyed.

**215**

1. If the controlled medication is on the unit's authorized drug list and that the person ordering the medication is authorized to place the order.
2. With an AF Form 579, Controlled Substance Register, or entering in an automated dispensing unit such as PYXIS® (use as electronic equivalent) for issue/tracking.
3. The Narcotic System Menu; receipt information.
4. A discrepancy in the controlled drug inventory.
5. By printing a label that shows the issue of the drug to the nursing unit; the label gets attached to the AF Form 579 or the automated dispensing unit issue receipt when the drug is delivered.
6. If an AF Form 579 is issued, the pharmacy technician and the recipient must initial the AF Form 579 in the column on the right-hand side of the form. In the case of facilities using automated dispensing equipment, the pharmacy technician and the recipient must initial the automated receipt. Your local OIs will designate who is considered licensed clinical staff who may sign for controlled substances.
7. If delivering to an automation unit, the issue is returned in CHCS; the initialed AF Form 579/ automated receipt are kept on file IAW the AFRIMS RDS or other directives.

**216**

1. INI.
2. Subtracts quantity.
3. Pharmacy technician or pharmacist.
4. DRX.

**217**

1. It must ensure the company is registered prior to turning over any controlled material for credit or destruction.
2. The MTF Commander.
3. The destruction officer must be a MSgt or higher or GS-7 or above and the two witnesses must not be lower in grade than the destruction officer.
4. "I have witnessed the destruction of the material as indicated."

**218**

1. It is more specific and will only report on the drug or location that you specify.
2. It allows you to display or print a report of all supply vouchers, either issues or turn-ins, by date range.

3. To conduct the end-of-day count.
4. This report dissects all transactions for the specific drug you request.

**219**

1. The name, address and DEA registration number of the registrant; the date and time the inventory is taken; the signature of the person(s) responsible for taking the inventory; the name of the substance: drug name, strength, form, number of units, unit volume; the number of commercial containers of each such finished form; an exact count if the container has been opened; and the location (e.g., labor and delivery, etc.), time, date, and signature of the person conducting the inventory.
2. In the pharmacy.
3. Someone who does not order, stock, or administer controlled substances or is not related to an individual who works in a section of the MTF that stocks controlled substances.
4. AF Form 85, Inventory Adjustment Voucher; the MTF Commander.
5. Order an ROS or ask for an investigation to be conducted by the OSI.

**Complete the unit review exercises before going to the next unit.**

## Unit Review Exercises

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

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

37. (209) What Air Force Instruction defines force health protection products (FHPPP)?
  - a. 44-102, *Medical Care Management*.
  - b. 44-250, *Individual Medical Readiness*.
  - c. 10-403, *Deployment Planning and Execution*.
  - d. 10-106, *Medical Readiness Program Management*.
38. (209) Patients issued force health protection products (FHPPP) must have documentation annotated on the following form (s)
  - a. SF 600 only.
  - b. SF 600 and DD Form 2766.
  - c. AF Form 579 only.
  - d. AF Form 579 and DD Form 2766.
39. (209) Who is responsible for force health protection products (FHPPP) returns post-deployment?
  - a. Pharmacy team chief.
  - b. Deployment health.
  - c. Pharmacy supply.
  - d. Medical logistics.
40. (210) According to AFI 41-106, *Medical Readiness Program Management*, what is the allowance standard (AS) designation for the pharmacy response team?
  - a. AS 886A.
  - b. AS 886E.
  - c. AS 886M.
  - d. AS 886P.
41. (210) Who is responsible for selection, training, and replacement of the pharmacy response team personnel?
  - a. Medical Control Center MCC commander.
  - b. Medical group (MDG) commander.
  - c. Pharmacy team chief.
  - d. Pharmacy flight chief.
42. (211) What Air Force publication requires each Air Force installation to have a written disease containment plan?
  - a. AFMAN 10-2608.
  - b. AFI 10-4206.
  - c. AFI 44-102.
  - d. AFI 44-106.
43. (211) *Most* military bases operate what type of Point of Dispensing (POD) site?
  - a. Open.
  - b. Single.
  - c. Double.
  - d. Closed.



44. (211) A full inventory of the Pharmacy Allowance Standard is performed at *least*
- a. monthly.
  - b. quarterly.
  - c. biannually.
  - d. annually.
45. (212) The Controlled Substance Act of 1970 requires biennial inventories of all controlled substances by
- a. 1 March.
  - b. 1 April.
  - c. 1 May.
  - d. 1 June.
46. (212) You can correct posting errors on the Air Force Form 582 by
- a. covering the error with correction tape, then posting the correction.
  - b. writing over the incorrect entry with the proper entry, ensuring that it is legible.
  - c. drawing a single line through the incorrect entry, making a brief explanatory note with your initials, and making the correct entry on the next line.
  - d. completely blacking out the error, making a brief explanatory note with your initials, and making the correct entry on the next line.
47. (213) The two individuals equally responsible for correctly prescribing and dispensing controlled substances in the military treatment facility (MTF) are the
- a. provider and the pharmacist.
  - b. provider and the controlled substance monitor.
  - c. pharmacy flight commander and the MTF chief of medical staff.
  - d. person who fills the prescription, and the person who dispenses the prescription.
48. (213) The second letter in the provider's Drug Enforcement Agency (DEA) number represents the
- a. first letter of the first name of the provider.
  - b. first letter of the last name of the provider.
  - c. state in which the DEA number was issued.
  - d. type of practice specialty.
49. (214) It is necessary to initiate an Air Force Form 579, Controlled Substance Register when you receive a
- a. controlled drug order from one of your nursing units.
  - b. noncontrolled drug order from one of your nursing units.
  - c. controlled drug order for an active duty member who is hospitalized in a local civilian hospital.
  - d. noncontrolled drug order for an active duty member who is hospitalized in a local civilian hospital.
50. (214) Air Force Form 579 is destroyed after being retained for how many years after the final entry?
- a. One.
  - b. Two.
  - c. Three.
  - d. Four.

51. (215) Which Air Force Instruction stipulates all controlled substances issued to inpatient units and clinics must be issued with an AF Form 579?
- 10-201.
  - 10-403.
  - 44-102.
  - 44-209.
52. (215) If a pharmacy technician initiates an Air Force (AF) Form 579 and issues controlled medication to an inpatient unit, to identify that he or she has issued and the unit has accepted the specific quantity of medication indicated on the form, the pharmacy technician and the recipient must
- initial the AF Form 579 in the column on the right-hand side of the form.
  - sign their payroll signatures at the top right-hand side of the AF Form 579.
  - initial the AF Form 579 in the three columns on the left-hand side of the form.
  - sign their payroll signatures at the bottom right-hand side of the AF Form 579.
53. (215) According to Air Force Instruction (AFI) 44-102, Schedule II drugs in patient areas outside the pharmacy must be stored in a
- pharmacy vault.
  - single-locked cabinet.
  - double-locked cabinet.
  - medical logistics vault.
54. (216) Which composite health care system (CHCS) narcotic function shows the on-hand quantity for any selected product?
- Inventory Record Inquiry.
  - Complete RX Transaction.
  - Return a Controlled Prescription.
  - Dispense a Controlled Prescription.
55. (216) Which composite health care system (CHCS) function clears a prescription from a patient's profile?
- Return a Prescription.
  - Dispense a Prescription.
  - Inventory Record Inquiry.
  - Complete RX Transaction.
56. (217) When destroying unserviceable controlled substance medical items, what authority should be contacted to ensure that your destruction methods are environmentally safe?
- Occupational Safety and Health Administration (OSHA).
  - Pharmacy and Therapeutics (P&T) Function.
  - Risk management committee.
  - Bioenvironmental engineers.
57. (217) The military treatment facility commander (MTF/CC) appoints a controlled substance destruction officer, who may be a
- GS-5 who works in the surgical ward.
  - major who works in the inpatient pharmacy.
  - master sergeant who works outside the pharmacy.
  - technical sergeant who works in the TRICARE office.

58. (218) Which Narcotic System Report would you *most* likely run if you had a missing Air Force Form 579?
- a. Issue Report (Specific).
  - b. Supply Voucher Report.
  - c. Outstanding Issue Report.
  - d. Narcotic Movement Report.
59. (219) The individual who appoints destruction officers individuals to be responsible for the destruction of controlled substances is the
- a. Military Treatment Facility (MTF) commander.
  - b. Pharmacy flight commander.
  - c. MTF group superintendent.
  - d. Wing commander.
60. (219) What Air Force (AF) form should the pharmacy controlled substance monitor initiate when a shortage or an overage in the amount of a controlled substance has been discovered and the discrepancy *does not* require a report of survey?
- a. 582, Pharmacy Stock Record.
  - b. 85, Inventory Adjustment Voucher.
  - c. 579, Controlled Substance Register.
  - d. 115A, Register of Controlled Numbers.

## Student Notes

## Glossary of Terms, Abbreviations, and Acronyms

### Abbreviations and Acronyms

<b>AAAHHC</b>	Accreditation Association for Ambulatory Healthcare
<b>ACC</b>	The Accreditation Process
<b>ADL</b>	authorized drug list
<b>AE</b>	aeromedical evacuation
<b>AEF</b>	Air and Space Expeditionary Force
<b>AFI</b>	Air Force Instruction
<b>AFIA</b>	Air Force Inspection Agency
<b>AFIS</b>	Air Force Inspection System
<b>AFISRA</b>	Air Force Intelligence, Surveillance, and Reconnaissance Agency
<b>AFMS</b>	Air Force Medical Service
<b>AFRC</b>	Air Force Reserve Command
<b>AFSC</b>	Air Force Specialty Code
<b>AFRIMS</b>	Air Force Records Information Management System
<b>AF/SG</b>	Air Force surgeon general
<b>APR</b>	Accreditation Participation Requirements
<b>AS</b>	allowance standards
<b>ASHP</b>	American Society of Health-System Pharmacists
<b>ATNAA</b>	Atropine and Pralidoxime-chloride autoinjectors
<b>AWOL</b>	absent without leave
<b>BEE</b>	bioenvironmental engineer
<b>BRM</b>	base records manager
<b>C2</b>	Command and Control
<b>CAM</b>	comprehensive accreditation manual
<b>CAMAC</b>	<i>Comprehensive Accreditation Manual for Ambulatory Care</i>
<b>CAMH</b>	<i>Comprehensive Accreditation Manual for Hospitals</i>
<b>CBRN</b>	chemical, biological, radiological, nuclear
<b>CC</b>	Commander
<b>CCIR</b>	commander's inspection report
<b>CCIP</b>	commander's inspection program
<b>CDC</b>	Centers for Disease Control and Prevention
<b>CDCs</b>	Career Development Courses
<b>CFR</b>	Code of Federal Regulations

<b>CHCS</b>	Composite Healthcare Computer System
<b>CRT</b>	Crisis response team
<b>CRT</b>	Complete RX Transaction
<b>CSA</b>	Controlled Substance Act
<b>CSAF</b>	Chief of Staff of the Air Force
<b>DCP</b>	disease containment plan
<b>DEA</b>	Drug Enforcement Administration
<b>DHA</b>	Defense Health Agency
<b>DHS</b>	Department of Homeland Security
<b>DMLSS</b>	Defense Medical Logistics Standard Support
<b>DD</b>	Department of Defense
<b>DOD</b>	Department of Defense
<b>DODI</b>	Department of Defense Instruction
<b>DMHRSi</b>	Defense Medical Human Resources System-internet
<b>DRX</b>	Dispense a Prescription
<b>EASIVi</b>	Expense Assignments System Version IV internet
<b>EC</b>	Environment of Care
<b>ECD</b>	estimated completion date
<b>ED</b>	erectile dysfunction
<b>EM</b>	Emergency Management
<b>EP</b>	elements of performance
<b>EPR</b>	Enlisted Performance Report
<b>ESC</b>	Evidence of Standards Compliance
<b>ESP</b>	Early Survey Policy Option
<b>FAM</b>	functional area manager
<b>FARM</b>	functional area records manager
<b>FCC</b>	functional cost code
<b>FHPPP</b>	force health protection prescription products
<b>FRT</b>	Field response team
<b>FTE</b>	full-time equivalent
<b>FY</b>	fiscal year
<b>GIR</b>	Issue Reports (general)
<b>GTR</b>	transaction reports (general)
<b>HHQ</b>	higher headquarters
<b>HQ</b>	Headquarters

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<b>HSMR</b>	home station medical response
<b>HR</b>	Human Resources
<b>IAW</b>	in accordance with
<b>IC</b>	Infection Prevention and Control
<b>IG</b>	inspector general
<b>IM</b>	Information Management
<b>IMA</b>	Individual Mobilization Augmentee
<b>INI</b>	Inventory Record Inquiry
<b>INR</b>	Inventory Report
<b>ISDRT</b>	information services disaster response team
<b>ISM</b>	Issue Menu
<b>LD</b>	Leadership
<b>LS</b>	Line Safety
<b>MAJCOM</b>	major command
<b>MAJCOM/CC</b>	major command commander
<b>MAJCOM FAMs</b>	major command functional area managers
<b>MAJCOM/IG</b>	major command inspector general
<b>MCC</b>	medical control center
<b>MCRP</b>	medical contingency response plan
<b>MDG</b>	medical group
<b>MEPRS</b>	Medical Expense Performance Reporting System
<b>MGA</b>	major graded areas
<b>MICT</b>	Management Internal Control Toolset
<b>MM</b>	Medication Management
<b>MOA</b>	memorandum of agreement
<b>MOU</b>	memorandum of understanding
<b>MPM</b>	MEPRS Program Manager
<b>MS</b>	Medical Staff
<b>MTF</b>	military treatment facility
<b>NAF/CC</b>	numbered Air Force commander
<b>NEW</b>	New Issue Entry
<b>NCO</b>	noncommissioned officer
<b>NCOIC</b>	noncommissioned officer in charge

<b>NMR</b>	Narcotic Movement Report
<b>NPSG</b>	National Patient Safety Goals
<b>NR</b>	Nursing
<b>NSM</b>	Narcotic System Menu
<b>OIR</b>	Outstanding Issue Report
<b>OI</b>	operating instructions
<b>OIC</b>	officer in charge
<b>OPR</b>	office of primary responsibility
<b>OPR</b>	Outpatient Pharmacy Reports
<b>OSI</b>	Office of Special Investigation
<b>OTC</b>	over-the-counter
<b>QR</b>	quality report
<b>P&amp;T</b>	pharmacy and therapeutics
<b>PAD</b>	Program Action Directive
<b>PAR</b>	Product Activity Report
<b>PB</b>	Pyridostigmine Bromide
<b>PC</b>	Provision of Care
<b>PCMH</b>	Primary Care Medical Home Certification Option
<b>PHEO</b>	Public health emergency officer
<b>PI</b>	Performance Improvement
<b>PM</b>	Performance Measurement
<b>POC</b>	point of contact
<b>POD</b>	point of dispensing
<b>POE</b>	provider order entry
<b>POS</b>	peacetime operation stock
<b>PSR</b>	Prescription in Suspense Report
<b>QR</b>	Quality Report
<b>RAI</b>	Return an Issue
<b>RC</b>	Record of Care
<b>RDS</b>	Records Disposition Schedule
<b>RI</b>	Rights and Responsibilities of the Individual
<b>RM</b>	records manager
<b>ROS</b>	Report of Survey
<b>RWD</b>	Required Written Documentation
<b>SAF/IG</b>	Secretary of the Air Force Inspector General
<b>SAG</b>	Standards Applicability Grid



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<b>SAV</b>	staff assistance visits
<b>SE</b>	Sentinel Events
<b>SEI</b>	Staffing Effectiveness Indicators
<b>SECAF</b>	Secretary of the Air Force
<b>SF</b>	Standard Form
<b>SII</b>	special interest item
<b>SIR</b>	Issue Reports (specific)
<b>SNS</b>	Strategic National Stockpile
<b>STR</b>	Transaction Reports (specific)
<b>SVR</b>	Supply Voucher Reports
<b>TIG</b>	The Inspector General
<b>TJC</b>	The Joint Commission
<b>TS</b>	Transplant Safety
<b>UEI</b>	unit effectiveness inspection
<b>USAF</b>	United States Air Force
<b>USAF HQ</b>	United States Air Force Headquarters
<b>VMI</b>	vendor-managed inventory
<b>VSR</b>	Volume Summary Report
<b>WAM</b>	Workload Assignment Module
<b>Wing/CC</b>	wing commander
<b>WT</b>	Waived Testing

## Student Notes

## **Student Notes**

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