

CDC A4P051

Pharmacy Journeyman

Volume 1. Introduction to Pharmacy Services



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

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Author: MSgt Alejandro Galvan
MSgt Jessica L. Hughes
382d Training Squadron
Medical Education and Training Campus (AETC)
382 TRS/TRR
2931 Harney Road, Bldg 903
Joint Base San Antonio Fort Sam Houston, Texas 78234-7521
DSN: 420-2060
E-mail address: dha.jbsa.education-trng.mbx.metc-pharmacy-jbsa@mail.mil or jessica.l.hughes44.mil@mail.mil

Instructional Systems

Specialist: Dr. Kenith Isreal

Editor: Evangeline K. Walmsley

Air Force Career Development Academy (AFCDA)
The Air University (AETC)
Maxwell Air Force Base, Gunter Annex, Alabama 36114–3107

Career Development Course A4P051, Pharmacy Journeyman, is designed to satisfy the 5-skill level CDC subject and task knowledge requirements specified in the Specialty Training Standard. This course is four volumes long and set up as follows:

The first volume, *Introduction to Pharmacy Services*, was written to give you an overview of pharmacy services. Unit 1 begins with the mission, function, and organization of the USAF Medical Service, as well as the pharmacy's role within the organization. Unit 2 turns your attention to professional and patient relations, laws of the pharmacy, and regulations that control pharmacy standards. Unit 3 discusses safety requirements and security provision. Keep in mind that, although this career development course (CDC) provides you with valuable information, pharmacy is an ever-changing career field, and it is your responsibility to have a working knowledge of the most current information.

Volume 2, *Pharmacy Administration*, covers medical facility accrediting agencies and methods that military treatment facilities use to achieve quality care and service. After this, you will move on to administrative functions, such as prescription filing, and form, file, and report requirements. You will then move on to publishing the formulary and inspecting drug storage areas. Take your time and try to draw on the knowledge that you gained in technical school, because much of this information was introduced to you when you were there.

Volume 3, *Supply, Inventory Control and Information Systems*, covers just what the title claims. You'll learn how to monitor Department of Defense (DOD) pharmaceutical contract compliance. You will also learn how to maintain equipment and associated records, as well as pharmaceutical supply files and reports. The Composite Health Care System (CHCS) is discussed. Although this topic is rapidly changing, you should find this section fairly easy, because no matter where you are working within the pharmacy, you will use computers on a daily basis.

Volume 4, *Pharmaceutical Calculations, Chemistry, and Compounding*, is the final volume in Set A. This volume provides information on critical pharmacy skills. It provides you with critical performance information vital to the pharmacy career field.

There is a glossary in the back of each volume to give you definitions of acronyms and terms used you might not know.

Once you have finished this course, you'll move on to CDC B4P051, which has five volumes that cover anatomy and physiology, and the medications used to treat ailments within the different systems of the body.

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This volume is valued at 12 hours and 4 points.

NOTE:

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

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Unit 1. United States Air Force Medical Services

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CONGRATULATIONS! You’ve embarked upon an important journey to becoming more capable in your pharmacy duties. This is a big step for you; it signifies you are transitioning from a Pharmacy Apprentice to a Pharmacy Journeyman. Of course, this also means you’ll have to attain the knowledge and skills required to perform those duties. To reach this next step in your career, you must be more competent at your job and learn more about the terms, procedures, and tasks you will face in the pharmacy arena. The purpose of this career development course (CDC) is to provide you with that knowledge, enabling you to become a more proficient pharmacy technician in the United States Air Force.

The key to successfully completing your CDC lies with fully understanding the material and how you perform and apply hands-on training provided by your supervisor. Regardless of how well you progress in upgrade training, feel free to ask your supervisor or trainer any questions you may have.

It’s important you gain a thorough understanding of the material in this course. The successful completion of the course is necessary for your upgrade training. However, you’ll also use the information gained from this course, your supervisors, and fellow co-workers to care for our most valuable resource: the men and women of the United States Air Force (USAF). While completing this course, strive to do your best. The knowledge you gain is not only a skill-level requirement but an opportunity for career growth and development.

Along with growth and development comes change. The pharmacy career field is constantly changing. New medications are continually being added to formularies and less effective therapies are removed from formularies. Pharmacies and their personnel must keep up with these changes in order to provide the best care possible to their beneficiaries.

You are a member of the Air Force Medical Service (AFMS), a service which has undergone changes over the years and will continue to evolve as changes are needed in order to ensure it provides quality care for its beneficiaries. You must be willing to be part of that change and continuously evolve. Being a pharmacy technician takes dedication and you must demonstrate our Air Force (AF) core values on a daily basis. The future of Air Force Pharmacy is literally in your hands.

Without the vision and willingness to implement change when necessary, the AFMS (and the pharmacy) would become less efficient and effective in treating our beneficiaries. What was once innovative or useful may seem outdated in today’s fast-changing world. The following information discusses the history and changes made by the AFMS. It shows the vision of our leadership and their ability to work without blinders to advance what we do best: provide the best healthcare possible!

In this unit, you will learn about the mission and function of the USAF Medical Service, to include the pharmacy’s role in achieving that mission. You will also learn about the organization of the AFMS and the structure of a military treatment facility (MTF).

1–1. Mission and Function of the Air Force Medical Service

Cooperation from each Air Force Medical Service function provides the necessary strength and agility to meet our mission and keep our fighting force at the highest level of performance.

001. Medical Service mission

The AFMS strategy supports the United States Air Force mission to fly, fight and win...in air, space, and cyberspace. The strategy outlines our updated mission, vision, and goals from which all AFMS activities, initiatives, resources and force development must align at every level of the organization.

Mission

The AFMS specific mission is to enable medically fit forces, provide expeditionary medics, and improve the health of all we serve to meet our nation's needs. In order to meet the AFMS mission, senior leaders created strategic goals to help focus our efforts. Those strategic goals are Readiness, Better Care, Better Health, and Best Value (fig. 1-1). Focusing on these goals allows us to deliver "Trusted Care, Anywhere!"



Figure 1-1. AFMS strategic goals.

Readiness

Support optimal medical readiness for all Airmen and ensure Air Force medics are current, trained and equipped to deliver "Trusted Care, Anywhere" in support of the full spectrum of military operations.

Better care

Provide reliable access to safe, quality care for all that we serve, promoting positive patient experiences and outcomes.

Better health

Encourage healthy behaviors through a health-based culture to enhance resilient and human performance, while reducing illness and injury.

Best value

Focus on the appropriate utilization of people and resources applied through effective management of the AFMS Enterprise in order to attain readiness, better care, and better health.

The Air Force Medical Service is part of the Military Health System (MHS) and assists in sustaining the performance, health, and fitness of every Airman, whether in-garrison (at home station) or deployed. The MHS has changed how healthcare is delivered throughout the world. It's a system that combines health care delivery, medical education, public health, private sector partnerships, and

cutting edge medical research. Therefore, the AFMS is capable of responding to a full spectrum of anticipated health requirements, and provides an integrated healthcare system from forward deployed locations through definitive care placing an emphasis on prevention of illness and injury. It arranges for health care capabilities through the TRICARE system when it is unable to provide them on station. Finally, it directly supports USAF operations and theater aeromedical evacuation (AE) of joint and combined forces.

Providing medical care

Our mission is to provide medical services through a combination of the *direct-care* system and the civilian TRICARE participating provider network. The direct-care system provided in the MTF TRICARE system is the Department of Defense's (DOD) healthcare program for uniformed service members to include active duty, Guard/Reserve, retirees, and their family members around the world. TRICARE combines the resources of military hospitals and clinics with civilian healthcare networks. This healthcare is delivered and managed locally within delivery areas by the medical group (MDG) commander, the command staff (within the MTF), and TRICARE regional contractors. Regional contractors are responsible for overseeing and managing the Military Health System's benefit program for patients. Presently, these contractors manage these programs for three regions in the continental United States (CONUS) and three regions outside the continental United States (OCONUS). Their responsibilities will be discussed in the TRICARE section of this unit.

TRICARE-managed care contractors enroll patients directly to the MTF or where services are not available refer them to a network civilian provider. A patient who is enrolled in the MTF but requires additional services not available must obtain a referral from their primary care manager (PCM). This optimizes the use of the military healthcare system direct care resources and minimize out-of-pocket cost for beneficiaries. MTFs and TRICARE-managed care support contractors will implement standardized, strong utilization management programs to reduce unnecessary care and ensure access to the appropriate level of care.

002. Medical Service function

The AFMS is the agency in charge of delivering the Air Force population's healthcare. It works with the Assistant Secretary of Defense for Health Affairs, the major air command surgeons, and the Departments of the Army, Navy, and other government agencies to deliver medical service for approximately 2 million eligible beneficiaries. The AFMS had an annual budget of \$6.02 billion in 2013 and runs 75 military treatment facilities, including 13 hospitals and medical centers.

In the past, the focus of healthcare was on the treatment of the person *after* the onset of illness. Now, the AFMS has moved toward managing the health of the Air Force population. In other words, the emphasis has shifted to *wellness and resiliency*. As a result of this shift, the Air Force Medical Operations Agency (AFMOA), which grew out of the AFMS's old flight medicine program in 1992, now serves as the operational and consultant lead for aerospace medicine, preventive medicine, clinical excellence, optimization of medical resources, bioenvironmental and occupational health, radiation protection, and population health.

It is important we maximize our resources. The bottom line is that we provide our patients with "Trusted Care, Anywhere." The functions of the AFMS and the AFMOA, along with our mission to provide the best healthcare possible, allow us to accomplish those goals.

To reiterate, we have shifted our focus to *wellness and resiliency*, but it is important to remember that we must maximize our resources. One of the main programs the Air Force is utilizing to accomplish this goal is population health.

Population health

Population health is the balancing of awareness, education, prevention, and intervention activities required to improve the health of a specified population. This model of population health unites self-care, MTF, worksite and community-based prevention and wellness activities, and medical

interventions into a comprehensive paradigm centered on primary, secondary, and tertiary prevention to reduce morbidity and premature mortality and improve health.

Population health concepts address three of the AFMS's greatest challenges: (1) providing a healthy, fit, and ready force; (2) improving the health status of our enrolled population; and (3) managing an effective and efficient health delivery system. The objective of population health activities within the AFMS is to achieve measurable gains in the health status of our enrolled population, as well as in the efficiency and effectiveness of the delivery system, and to help build healthy communities in which to live, work, and play. An integrated, collaborative approach incorporating population health concepts into everyday operations forms the basis for implementation and sustainment of the activities required to be successful in our mission.

Roles and responsibilities of Air Force Medical Service agencies

The AFMS coordinates with multiple agencies and personnel in order to deliver quality healthcare to its beneficiaries. Let's look at a few of those roles and responsibilities.

Defense Health Agency

The Secretary of Defense established Defense Health Agency (DHA) on 1 Oct 2013. DHA is a Combat Support Agency that supports the Military Health System, serves as the program manager for the TRICARE health plan, and is responsible for meeting the medical needs of the combatant commanders. This agency is a joint venture that shares Army, Navy, and Air Force resources.

US Air Force Surgeon General

The Air Force Surgeon General (AF/SG) advises both the Secretary of the Air Force (SECAF) and Chief of Staff of the Air Force (CSAF) on medical matters pertaining to Air Force Operations and readiness. A small staff that includes two forward operating agencies, AFMOA, and Air Force Medical Support Agency (AFMSA), support the SG.

Air Force Medical Operations Agency

AFMOA supports all aspects of Air Force and joint missions through the execution of programs to enhance the health and performance of Airmen and other members of DOD. AFMOA is the SG's primary focal point for execution and standardization of plans, practices, procedures, and programs in planning, budget execution, logistics, clinical operations, clinical quality management, and family advocacy and health promotions for the AFMS.

Air Force Medical Support Agency

AFMSA oversees the development of AF/SG policies supporting Air Force expeditionary capabilities and national security strategy. The Agency's mission is to provide synchronous support to the AF Surgeon General and directorates to achieve medical service success.

Air Force major commands

The Air Force major commands (MAJCOM) ensure subordinate organizations implement AF/SG instructions and that these subordinate organizations recommend any additions, deletions, and amendments. Each MAJCOM interacts with assigned MTFs to assist with implementation and command-specific issues affecting population health. The MAJCOM is responsible for allocating the resources necessary to accomplish AFMS population health and healthcare optimization objectives. Another MAJCOM responsibility is to provide input on policy revision and new policy development that affect population health. The MAJCOM also selects a command representative for the AF Population Health Working Group (PHWG) who provides information to the MTFs regarding population health discussions.

Major command surgeon general

The MAJCOM Surgeon General (MAJCOM/SG) controls medical resources, monitors medical functions and coordinates communication between MAJCOM commander, AF/SG, AFMOA and AFMSA.

Air Force Medical Service Population Health Working Group (AFMS PHWG)

The AFMS PHWG is the primary forum for MAJCOMs to provide input on population health policies and activities to AF/SG and AFMSA. It is comprised of representatives from the Chief of the Population Health Support Division (PHSD), AFMSA, and the Office of the AF/SG.

Medical group commanders

MDG commanders (CC) ensure collaboration among subordinate squadrons; population health activities have proper manning, equipment, and training; and the MDGs employ the concepts and principles of population health. The MDG commander also charts an MTF PHWG and evaluates the progress toward population health improvement goals. Another MDG commander responsibility is to report barriers to execution of the Air Force instruction (AFI) on population health and related programs to higher headquarters for resolution.

Fundamental tasks

Within the MTF, the three fundamental responsibilities of population health deal with:

1. Managing costs.
2. Managing diseases.
3. Managing MTF utilization.

Every strategy implemented within the MTF should focus on optimizing healthcare for the MTF's population. All activities such as policies, programs, tools, personnel, and software, should be constantly monitored and evaluated to determine their effectiveness or usefulness. Each should play a role in optimizing healthcare for our customers.

The information received through population health management helps all medical personnel to understand better their roles within the facility. It also provides the leadership with vital information needed to make better, more informed medical decisions that will positively impact all of our MTF's customers.

Two tools the AFMS uses to gather vital information in order to ensure its military population remains a healthy, deployable force are the Air Force web-based health risk assessment and the preventive health assessment. We will look briefly at these two programs.

Air Force Web-based health assessment

The Air Force compiles health information electronically for all active duty, Guard, and Reserve Airmen. One means of accomplishing this is through use of the Web-based health assessment (WEB HA) as required by AFI 44-170, *Preventive Health Assessment*.

The Air Force's WEB HA is an automated questionnaire consisting of general lifestyle and specific health questions that provides a picture about a person's overall health. The HA is an important part of the health improvement process and consists of questions gathered from national sources on behavioral risk factors, personal health, and nutrition, just to name a few.

The HA provides personnel, real-time, wellness-related information and feedback, allowing them to make informed decisions concerning their own health and wellness. As well as providing important health information, data can be collected on participants and reported in aggregate (combined with many others), but data on specific individuals is not used in any way.

Preventive health assessment

The AF annual preventive health assessments (PHA), referred to as the periodic health assessment (PHA) in the Reserves, ensure each Airman receives required clinical preventive services and meets individual medical readiness requirements. Members' records are reviewed annually to ensure all requirements and potential duty-limiting conditions have been addressed. PCMs are responsible for identifying significant items of medical history and any information that may potentially disqualify a

person for deployment or worldwide duty, identifying conditions that require special attention during the PHA, and updating members' physical profile as needed.

These assessments are conducted globally and the data is recorded in the Aeromedical Services Information Management System (ASIMS) on the AF Portal. This allows the health of each Airman, whether active duty, Guard, or Reserve, to be tracked throughout his or her service and in any location. This is an invaluable medical readiness tool for commanders.

TRICARE and the military health system

The mission of the MHS is to ensure the nation has available at all times a healthy fighting force supported by a combat ready healthcare system; and it is to provide a cost-effective, quality health benefit to active duty members, retirees, survivors, and their families. The MHS provides medical care for over 9.6 million beneficiaries through a quality healthcare system that consists of a worldwide network including 56 military hospitals, over 300 military health clinics, and thousands of DOD private sector healthcare partners.

The vision and mission of TRICARE

TRICARE plays a crucial role in the MHS mission. TRICARE is the DOD healthcare program for active duty, National Guard, Reserve, and retired members of the uniformed services, their families, and survivors.

- TRICARE's *vision* is to provide a world-class health system that supports the military mission by fostering, protecting, sustaining, and restoring health.
- TRICARE's *mission* is to enhance the DOD and the nation's security by providing health support for the full range of military operations and sustaining the health of all those entrusted to our care.

The TRICARE program continues to evolve with the ever-changing needs of the AFMS. The more you learn about TRICARE and stay abreast of the TRICARE changes, the more you can assist the MHS beneficiaries.

Need for TRICARE

In response to the challenge of maintaining medical readiness while providing community-based healthcare for all eligible personnel, the DOD introduced TRICARE. It is a regionally managed healthcare program that now serves approximately 9.6 million beneficiaries around the world. TRICARE brings together the healthcare resources of the Air Force, Army, and Navy, and supplements them with networks of civilian healthcare professionals to provide better access and high-quality service while maintaining the capability to support military operations.

The AFMS is part of a managed care system that strives to provide the highest possible quality healthcare at the least resource cost (best value healthcare). It achieves this by maintaining an effective relationship with the DHA managed care support contractors (MCSC), the Services medical departments, and beneficiaries, which emphasizes satisfaction for our beneficiaries.

Throughout the years, the face of military medicine has changed. Many MTFs have either scaled back on services they provide or have closed altogether; therefore, the TRICARE system was developed to meet the challenges of taking care of patients seeking treatment. It was designed to expand access to care, assure high quality care, control healthcare costs for patients and taxpayers alike, and improve medical readiness.

TRICARE has helped to reconcile the growing numbers of beneficiaries who were left without direct healthcare services in MTFs. One of the groundbreaking aspects of this system is the unprecedented relationship that exists between the MTF and a large civilian health delivery system – the health maintenance organization (HMO).

Keep in mind TRICARE came about as a result of a need for the AFMS to effectively and efficiently deliver healthcare to millions of its beneficiaries. TRICARE isn't the same today as it was when it began. TRICARE has evolved to keep pace with the growing demand to care for the beneficiaries.

TRICARE regions

The TRICARE program restructures the geographic MHS into health services regions, each administered by a regional contractor. These regions were established to ensure there were adequate numbers of beneficiaries to support cost-effective volumes of care under TRICARE support contracts and regional access to tertiary care provided primarily by MTFs. TRICARE has been implemented throughout the US, Eurasia-Africa area, Latin America and Canada area, and the Pacific area as a way to improve overall access to healthcare for beneficiaries. Refer to figures 1-2 and 1-3 for a breakdown of the US and overseas TRICARE regions.

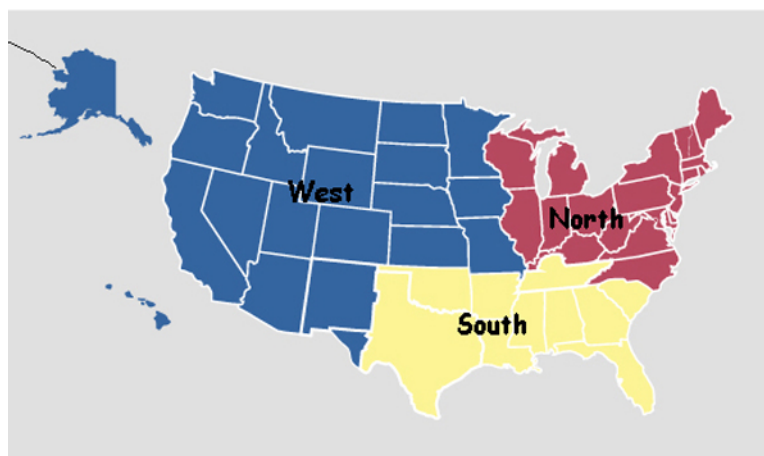


Figure 1-2. TRICARE US regional map.



Figure 1-3. TRICARE overseas regional map.

Healthcare is delivered and managed locally. Within their respective areas, regional contractors and MDG commanders are accountable for healthcare costs, quality, and access. Their responsibilities are interwoven between the civilian networks and the direct-care system.

Now that we have discussed some basics of the how TRICARE came into existence, let's look more in depth at how it is managed.

TRICARE regional office functions

As mentioned earlier, the structure of the TRICARE program has undergone major changes. These changes included reducing the number of stateside healthcare service contracts from seven to three, reducing the number of stateside TRICARE regions from twelve to three, and reducing the number of pharmacy contractors to one in order to make the pharmacy benefit portable to any state. The Office of the Assistant Secretary of Defense (Health Affairs) and the Services Surgeon Generals developed the *TRICARE Governance Plan* that established the overall organizational construct, regional office responsibilities and staffing plan, market manager responsibilities, and the business planning requirements and processes involved with executing the new TRICARE program effectively and efficiently. The plan created a balanced approach to managing the military health benefit with military medical readiness as the first priority, supported by a healthcare delivery system that focuses on joint decision-making and effective resource allocation. It includes TRICARE regional offices (TRO) and managed care support contracts. In the next section, we will discuss the roles of both and their importance in the AFMS healthcare delivery mission.

The TROs represent the new management organization for managing regional contractors and overseeing an integrated healthcare delivery system in the three United States-based TRICARE regions. Shown below are the three regional contractors who were awarded managed care support contracts and the TROs charged with oversight and management of each contract.

TRICARE Regional Offices	Contractors
North	Health Net
South	Humana Military
West	United Healthcare

The TRICARE overseas programs have a TRICARE area office (TAO) that oversees each area. Within each region, the regional director is the health plan manager. They have visibility of both the contract and direct care assets and coordinate with the services to develop and integrated health plan.

TROs manage TRICARE contracts for all eligible MHS beneficiaries in the region. TROs have many responsibilities; they are responsible for contracts between the MTF and the contractor, as well as overseeing customer service issues and satisfaction outcomes.

MTF commanders have the responsibility to make appropriate decisions about delivery of care within their MTFs. This means optimizing healthcare services within the MTF. TROs must support the MTF commander in this goal. TROs also develop business plans for non-MTF areas, remote areas, and those areas in which a service surgeon general requests regional director support. TROs operate under the authority of a regional director, who is responsible for integrating the TRO regional non-MTFs and MTFs business plans. Regional directors have knowledge of all assets, costs, and expenditures, and are able to make recommendations to the Services regarding the flow of dollars and staffing throughout the region. Regional directors monitor MTF's performance in accordance with the business plans and communicates with MTF commanders.

Managed care support contractors

Each of the TRICARE regions has a managed care support contractor that helps coordinate medical services available through the MTFs and a network of civilian hospitals and providers. The contractors are given incentives to provide top performance in quality medical outcomes, telephone access, claims payments, cost control, and satisfaction (beneficiary, MTF commander, and regional director).

Through specific managed care support (MCS) contracts, the regional contractors are responsible for the functions listed in the following table:

Managed Care Support Contractor Responsibility	
Establishing/maintaining the TRICARE Prime provider network	Operating OCONUS services at CONUS MTFs
Establishing and maintaining a retail pharmacy network	Delivering customer service
Providing support, i.e. enrollment, disenrollment, and claims	Operating beneficiary information lines
Providing educational information to beneficiaries and providers	Authorizing healthcare through health care finders
Performing centralized appointments and referral functions	Quality management programs
Managing Nurse Advice Line	Medical review functions

TRICARE plans and eligibility

One of the central features of TRICARE is the choice of healthcare plans it offers. Before discussing those plans and benefits, we need to emphasize that beneficiaries must enroll in the Defense Enrollment Eligibility Reporting System (DEERS).

DEERS is a computerized database of military sponsors, families, and other members worldwide who are entitled under law to TRICARE benefits. All active duty and retired service members are automatically enrolled in DEERS; however, these members must take appropriate steps to ensure their families are registered in the DEERS database. They must also ensure the information is correct and updated (as needed), as incorrect information can cause problems with TRICARE claims. Originally, TRICARE only offered three different plans when it was created in 1993. Today, there are 11 different plans beneficiaries can qualify for. Plan availability depends on the type and location of beneficiary. However, all TRICARE plans meet the requirements for minimum essential coverage under the Affordable Care Act.

TRICARE Prime

TRICARE Prime is the HMO-type option where beneficiaries enroll for a year at a time. They agree to seek healthcare from the network in the region they are assigned. This option offers the lowest out-of-pocket costs for beneficiaries, and is only available in the United States in Prime service areas. Under TRICARE Prime, each enrollee is assigned a PCM, who serves as a gatekeeper for obtaining necessary healthcare. Active duty service members are required to enroll in TRICARE Prime.

Eligible Beneficiaries
Active duty service members and their families
Retired service members and their families *
Activated Guard/Reserve members and their families
Non-activated Guard/Reserve members and their families who qualify for care under the Transitional Assistance Management Program
Retired Guard/Reserve members (age 60 and receiving retired pay) and their families*
Survivors
Medal of Honor recipients and their families
Qualified former spouses
* When retired service members and their families become eligible for TRICARE For Life, they are no longer able to enroll in TRICARE Prime.

Getting care

Beneficiaries have an assigned PCM who provides most of their care. The PCM will refer the beneficiary to a military or network provider for specialty care as required.

Enrollment

Enrollment is required, and there is no fee for active duty families. However, retirees, their families, and all other must pay annual enrollment fees in order to participate.

TRICARE Prime Remote

TRICARE Prime Remote (TPR) is a stateside option that provides healthcare to active duty service members who live and work greater than 50 miles or one hour's drive time from a MTF. Like Prime, it provides healthcare coverage through civilian network or TRICARE-authorized providers, and referrals and authorizations are required for TRICARE-covered specialty care. Most care is received from a PCM, and there are typically no claims to file.

Eligible Beneficiaries
Active duty service members and their families
Active duty family members if they live with the sponsor
Activated Guard/Reserve family members

Getting care

Beneficiaries have an assigned PCM who provides most of their care to include a military or network provider. The PCM refers beneficiaries to specialists as required, works with your regional contractor for referrals/authorization, accepts your copayment, and files claims for you.

Enrollment

Enrollment is required and there is no fee or annual deductible unless using the point-of-service option. With the point-of-service option you can use any eligible TRICARE provider without a referral. However, this option is only available to family members and not the active duty member.

TRICARE Prime Overseas

TRICARE Prime Overseas is an overseas option that provides healthcare to active duty service members who live and work overseas near a military hospital or clinic. Like Prime, it provides healthcare coverage through civilian network or TRICARE-authorized providers. However, referrals and authorizations are required for TRICARE-covered specialty care. Most care is received from a PCM.

Eligible Beneficiaries
Active duty service members and their families
Command sponsored active duty family members

Getting care

Beneficiaries will receive most of their care from the PCM at a MTF. The PCM will refer them to specialist for care as needed.

Enrollment

Enrollment is required, and there is no enrollment fee. Just like the TRICARE Prime Remote plan family members can use the point-of-service option to see any TRICARE provider off base.

TRICARE Prime Remote Overseas

TRICARE Prime Remote Overseas offers TRICARE Prime coverage to active duty service members permanently assigned to designated remote locations overseas and their eligible command-sponsored family members. Only active duty and their beneficiaries who meet the Joint Federal Travel Regulation (JFTR) definition of command sponsored are eligible for TRICARE Prime Remote Overseas enrollment.

Eligible Beneficiaries
Active duty service members and their families
Command sponsored active duty family members

Getting care

Patients get most of their care from the PCM at a military hospital or clinic. The PCM will refer them to specialist for care as required.

Enrollment

Enrollment is required, and there is no enrollment fee. There is annual deductible unless using the point-of-service option explain above.

TRICARE Standard and Extra

TRICARE Standard is a fee-for-service program, meaning each service utilized outside the MTF requires a fee. This option offers the beneficiary the freedom to seek care from any TRICARE-authorized provider. Referrals are not required, but some care may require prior authorization. Beneficiaries may have to pay for services up front and file claims for reimbursement.

Individuals pay current TRICARE deductibles, cost shares, and abide by TRICARE rules. TRICARE Standard is available overseas. TRICARE Extra is a preferred-provider option where a TRICARE Standard beneficiary receives a cost-share discount for using a TRICARE network provider (normally five percent). Enrollment is not required. TRICARE Extra *is not available overseas*.

Eligible Beneficiaries
Active Duty Family Members
Retirees and their family members
National Guard and Reserve families

Getting care

Beneficiaries can get care from any TRICARE authorized provider, network or non-network provider. Referrals are not required; however, some services may require prior authorization.

Enrollment

Enrollment is not required, and there is no enrollment fee. TRICARE Standard is available overseas; however, TRICARE Extra is not. There are annual deductible amounts for this plan and it is based on the rank of the active duty service member.

TRICARE Standard Overseas

TRICARE Standard Overseas is a fee-for-service option, which allows the most flexibility in getting care, but will have more out-of-pocket expenses than one of the overseas Prime options. Beneficiaries may seek care from any TRICARE authorized provider, network or non-network. Referrals are not required but some care may require prior authorizations. Additionally, beneficiaries may have to pay for services when they received and file a claim for reimbursement.

Eligible Beneficiaries
Active Duty Family Members
Retirees and their family members
National Guard and Reserve families

Getting care

Beneficiaries may get care from any qualified host nation provider. Referrals are not required, but some services may require prior authorization. If they live near a military hospital or clinic, the

beneficiary must have a non-availability statement before receiving inpatient care at a host nation facility.

Enrollment

Enrollment is not required, and there is no enrollment fee. This TRICARE plan also has annual deductible amounts based on the service member's rank. However, the annual deductible is waived for family members of National Guard/Reserve members whose sponsor is activated in support of a contingency operation.

TRICARE Reserve Select

TRICARE Reserve Select is a premium-based health plan available for purchase worldwide. Beneficiaries must qualify for and purchase the plan in order to participate. They receive care from any TRICARE authorized provider, network or non-network. Referrals are not required, but prior authorization may be required. Beneficiaries may have to pay for services when received, and submit healthcare claims for reimbursement.

Eligible Beneficiaries
National Guard and Reserve
National Guard and Reserve families

Getting care

Beneficiaries may get care from any TRICARE authorized provider, network or non-network, without a referral; however some services require prior authorization.

Enrollment

Beneficiaries must purchase TRICARE Reserve Select and pay monthly premiums. These costs are also based on the service member rank and the type of doctor seen.

TRICARE Retired Reserve

TRICARE Retired Reserve is a premium-based health plan that qualified retired Reserve members and survivors may purchase. Beneficiaries must qualify for and purchase the plan to participate. They receive care from any TRICARE-authorized provider, network or non-network. Referrals are not required but prior authorization may be required. Costs vary depending on type of provider seen however fewer out-of-pocket costs from TRICARE network providers. Finally, beneficiaries may have to pay for services when they are received, and then submit healthcare claims for reimbursement.

Eligible Beneficiaries
National Guard and Reserve
National Guard and Reserve families

Getting care

Beneficiaries may get care from any TRICARE authorized provider, network or non-network, without a referral; however some services require prior authorization.

Enrollment

Beneficiaries must purchase TRICARE Retired Reserve and pay monthly premiums. Additionally, retirees must pay 25 percent of the TRICARE allowable amount if they see a non-network provider.

TRICARE Young Adult

TRICARE Young Adult is a voluntary, premium-based program that extends TRICARE coverage to certain family members under the age of 26 who have lost or will lose TRICARE eligibility due to age.

Getting care

Most care is received from a primary care manager. The PCM will provide a referral as needed.

Enrollment

Beneficiaries must qualify for, purchase TRICARE Young Adult, and pay monthly premiums in order to participate in TRICARE Young Adult. There is no annual deductible amount for this plan unless using the point-of-service option. Payment amounts depend of whether the sponsor is active duty or retired.

Uniformed Service Family Health Plan

Uniformed Service Family Health Plan (USFHP) is a TRICARE Prime-like option available at community-based, not-for-profit healthcare systems in six areas of the United States. To enroll, eligible beneficiaries must be registered in DEERS and live within one of the designated USFHP service areas. Covered benefits are available only from USFHP-approved providers, except during a medical emergency. Active Duty service members cannot enroll into the USFHP. Some of the main features include enhanced benefits and services including discounts for eyeglasses, hearing aids and dental care in some areas. There are minimal out-of-pocket costs and there are no claims to file.

Getting care

Beneficiaries get all care from their designated US Family Health Plan provider. They will not access care from Medicare providers, military hospitals and clinics, or TRICARE-authorized providers. Beneficiaries receive most care from an assigned primary care physician from their plans network who will provide referrals for specialty care.

Enrollment

Enrollment is required and includes a one-year commitment to receive care from the plan. The only exception is if the beneficiary moves to an area where the plan is not offered. There is not enrollment fee for active duty families however; retirees, their families and all others must pay an annual enrollment fee to participate.

TRICARE for Life

TRICARE for Life (TFL) combines TRICARE Standard coverage with Medicare to provide wrap-around medical coverage to dual-eligible (TRICARE and Medicare) beneficiaries. Before understanding TFL, you need to know what Medicare is and how it works.

Medicare

Medicare is a health insurance program where eligibility is based on age, disability, or disease. This includes individuals age 65 or older, individuals under age 65 with certain disabilities, individuals of any age with end-stage renal disease (ESRD), individuals of any age with amyotrophic lateral sclerosis (ALS), commonly known as Lou Gehrig's disease, and individuals of Lincoln County, Montana who have an asbestos-related disease.

Medicare Part A

Medicare Part A (hospital insurance), funded through payroll taxes, helps cover inpatient care and costs in hospitals, skilled nursing facilities, hospice care, and home healthcare. If a beneficiary paid into Medicare for 40 quarters, he or she is entitled to premium-free Medicare Part A at age 65.

If eligible for premium-free Medicare Part A, a beneficiary receives a Notice of Award, the official letter from the Social Security Administration (SSA) advising the beneficiary of his/her entitlement to premium-free Medicare Part A and enrollment in Medicare Part B (or enrollment in Medicare Part B only). If not eligible for premium-free Medicare Part A based on their own work history, beneficiaries should contact SSA to find out if they may qualify under their spouses or divorced spouse's social security number.

Medicare Part B

Medicare Part B (medical insurance) helps cover medically necessary outpatient services, such as doctor services, outpatient hospital care, home health services, some preventive health services, and other medical services. Medicare Part B premiums are based on an individual's reported income. Beneficiaries should enroll in Medicare Part B when first eligible to avoid paying higher Medicare premium penalties due to delayed enrollment.

The Defense Manpower Data Center (DMDC) automatically notifies TRICARE beneficiaries approximately three months before their 65th birthday of the requirement to enroll in Medicare Part B. There are exceptions to Medicare Part B enrollment requirement. The following beneficiaries do not have to be enrolled in Medicare Part B to remain TRICARE eligible:

- Active duty service members (ADSM) and active duty family members who are entitled to premium-free Medicare Part A do not have to enroll in Medicare Part B while the sponsor is on active duty to maintain TRICARE eligibility.
- Medicare Part B *must be in effect* on or before the sponsor's retirement date, whether medical or regular, to avoid a break in TRICARE coverage.
- If the beneficiary enrolls in Medicare Part B after the sponsor's retirement date, there may be a break in TRICARE coverage until Medicare Part B takes effect.
- TRICARE Reserve Select and TRICARE Retired Reserve enrollees who are entitled to premium-free Medicare Part A are not required to have Medicare Part B to qualify for these programs.

Medicare Part D

Medicare Part D (prescription drug plan) is available to anyone who is eligible for Medicare Part A or Part B living state-side. This part of Medicare is not mandatory; it is a voluntary enrollment program in which beneficiaries must pay monthly premiums, deductibles, and/or co-pays for prescription coverage. There is almost no advantage for TRICARE beneficiaries to enroll in Medicare Part D. However, if beneficiaries decided to enroll in Medicare Part D; they will receive a letter from TRICARE explaining how their prescription coverage works. TRICARE will be the secondary insurance for a beneficiary enrolled in Medicare Part D. That means TRICARE will only pay any portions not covered by Medicare Part D. Medicare Part D is not available for any beneficiaries living overseas.

TRICARE for Life, who is eligible?

Beneficiaries can purchase TRICARE for Life if they are entitled to premium-free Medicare Part A and who purchase Medicare Part B, regardless of their age or place of residence. Under federal law, TRICARE beneficiaries entitled to premium-free Medicare Part A must have Medicare Part B to remain TRICARE eligible. Beneficiaries will lose their TRICARE benefits and their claims will be denied if they do not have Medicare Part B, if they are disenrolled from Medicare Part B, or if they stopped paying their Medicare Part B premiums.

TFL benefits start on the first day Medicare Part A and Part B are in effect. Dual-eligible beneficiaries under age 65 may enroll in TRICARE Prime if available in their local area. Prime enrollment fees are waived for those who have Medicare Part B. TRICARE for Life offers secondary coverage to TRICARE beneficiaries who have both Medicare Part A & B.

Getting care

Beneficiaries can get care from any authorized TRICARE provider.

Enrollment

Enrollment is not required, but beneficiaries must have Medicare Part A and Part B to participate. There is no annual deductible for services covered by both Medicare and TRICARE.

Catastrophic cap

The catastrophic cap varies depending on the sponsor's military status.

- Active duty families: \$1,000 per family per fiscal year.
- National Guard and Reserve families: \$1,000 per family, per fiscal year.
- Retired families (and all others): \$3,000 per family, per fiscal year.

TRICARE Online

Beneficiaries can learn all about their different options using TRICARE Online (TOL). TOL is a tool that provides access to available services and information patients can access to improve their healthcare experience. This allows beneficiaries to access their appointments, prescriptions, and personal health information from a secure website. The Website is available at www.tricareonline.com and beneficiaries have to create an account. They can do this as long as they are 18 or older, and have been treated at a MTF.

TRICARE pharmacy program

Now that you have learned all about TRICARE, you are probably asking how this applies directly to pharmacy. Well, the TRICARE pharmacy program is available to all eligible uniformed service members, retirees, and family members including retired National Guard and Reserve beneficiaries age 60 and above. This TRICARE benefit provides military facility, home delivery, retail, and specialty pharmacy services. The program is designed to provide the medications beneficiaries need, when they need them, and in a safe, convenient, and cost-effective manner.

Pharmacy benefit options

Part of the pharmacy benefit for beneficiaries is that they do have a choice when having prescriptions filled. There is one consideration to keep in mind before having medications filled no matter where you go. TRICARE's mandatory generic drug policy requires that prescriptions be filled with a generic product if one is available unless there is a medical necessity for a brand name drug. As with most prescription drug plans, beneficiaries may enjoy a significant cost savings by asking their doctors to prescribe the generic equivalent of a brand-name drug. In the U.S., all generic drugs must undergo Food and Drug Administration (FDA) testing and approval and are considered safe alternatives to brand-name drugs. Let's explore the different options beneficiaries have to meet their medication needs.

Military treatment facilities

MTF pharmacies fill prescriptions free of charge. However, it is important to note some medications may not be available at MTF pharmacies. If available, MTFs pharmacies can fill prescriptions for a 90-day supply at no cost. Most MTF pharmacies will fill prescriptions for both military and civilian doctors. If a medication is not on formulary, then the patient will have to go to another MTF or take the prescription to a retail pharmacy.

TRICARE pharmacy home delivery

The TRICARE pharmacy home delivery is another option to get prescriptions filled. This program is free for active duty service members. All other beneficiaries can use the program at no cost if they need generic medications. However, there are co-pays associated for brand-name or non-formulary medications as shown below. TRICARE pharmacy home delivery is a great option for patients taking chronic maintenance medications. This option saves patients a trip to the MTF and allows patients to re-order medications online, by phone, or by mail. Patient medication type options are generic, brand name or non-formulary.

Express Scripts, Inc. currently manages the pharmacy home delivery program. As mentioned, most beneficiaries can receive up to a 90-day supply, and prescriptions can be mailed to US postal addresses, including temporary addresses, Army Post Offices (APO), and US Armed Forces Fleet

Post Offices (FPO). Beneficiaries assigned to a US Embassy can also use the program. However, beneficiaries living in Germany cannot use home delivery due to legal restrictions.

Safety of prescriptions is ensured through the program. Registered pharmacists verify orders for accuracy and safety. Prescriptions are checked against the beneficiary medication profile through a direct link to the DOD Pharmacy Data Transaction Service (PDTS), which holds records of all prescriptions processed from MTFs, TRICARE retail network pharmacies, and Express Scripts databases.

Network retail pharmacies

Prescription medications that beneficiaries are required to start taking immediately can be obtained through any of the 57,000 TRICARE retail network pharmacies in the US and US territories. Beneficiaries typically only receive a 30-day supply and will have a co-pay. The cost depends on the type of medication they receive as shown below. If beneficiaries need a 90-day supply then they'll have to pay for each 30-day supply. For example, a 90-day generic supply would cost \$15 and a 90-day supply for a brand-name medication would cost \$132.

Medication Type	Cost
Generic	\$5
Brand name	\$17
Non-formulary	\$44

NOTE: The prices above are current but are subject to change, you can verify currency at <http://www.tricare.mil/CoveredServices/Pharmacy/FillPrescriptions/Network.aspx>.

Non-network retail pharmacies

The final option is for beneficiaries to have their medications filled at a non-network retail pharmacy. Using this option means beneficiaries will have to pay full price and then submit a claim for reimbursement. However, they will not receive 100 percent of the retail price they paid. The reimbursement amount depends on the beneficiary's plan. Additionally, all deductibles, out-of-network costs, and co-pays have to be met before TRICARE will process the reimbursement. This is the most expensive option for the beneficiary.

Now that we have discussed the many aspects of TRICARE and options to beneficiaries, we will next look at the structure of the USAF Medical Service and what role the pharmacy plays within the MTF. Before you move to the next lesson, answer the following questions to test your knowledge.

Self-Test Questions

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

001. Medical Service mission

1. What is the mission of the USAF Medical Service?
2. The AFMS is part of which military system?
3. How do we carry out our mission to provide medical services?

4. Who provides care within the direct-care system?
5. What regionally managed healthcare program did the DOD create?
6. Under MHS, who directly enrolls patients to the MTF, or where care is not available, to civilian providers under a managed care support contract?

002. Medical Service function

1. What agencies do the AFMS work with to provide healthcare for its estimated 2 million beneficiaries?
2. What is the current focus of the healthcare system in caring for its beneficiaries?
3. What is population health?
4. What three greatest AFMS challenges do population health concepts address?
5. What agency was established by the Secretary of Defense on 1 October 2013?
6. What two forward operating agencies support the US AF/SG?
7. What is the mission of the AFMSA?
8. Who is responsible for allocating resources in order to accomplish AFMS population health and optimization objectives?

9. What activities should be monitored in order to ensure their effectiveness and usefulness in optimizing healthcare for beneficiaries?
10. What information can be gained by an individual when completing a WEB HA questionnaire?
11. How is a preventive health assessment used and how often should it be completed?
12. What is TRICARE's vision?
13. Why was TRICARE created?
14. What is the groundbreaking aspect about TRICARE?
15. List the geographic locations where TRICARE has been implemented as a way to improve overall access to care.
16. What was the purpose of reducing the number of pharmacy contractors when TRICARE was restructured?
17. What is the purpose of the TRICARE Governance Plan?
18. Who represents the new management organization for managing regional contractors and overseeing an integrated healthcare delivery system in the three United States-based TRICARE regions?

19. Who has the primary responsibility when making decisions about healthcare delivery within the MTF?
20. Who monitors MTF performance in accordance with the business plans and communicates with the MTF commanders?
21. The contractors are given incentives to provide top performance in what five areas?
22. What is the DEERS database?
23. Who is eligible for TRICARE Prime?
24. Who is eligible for the TRICARE Reserve Select program?
25. What is the cut-off age for family members enrolled in the TRICARE Young Adult program?
26. Which part of Medicare is voluntary and is known as the prescription drug plan?
27. What is TRICARE's mandatory generic drug policy?
28. Which TRICARE program mails medications to beneficiaries and is managed by Express Scripts, Inc.?
29. What type of pharmacy is the most expensive to get prescriptions filled?

1-2. Organization of the Air Force Medical Service

Now that you understand the mission and function of the USAF Medical Service, the next step is to look at how it is organized. This section discusses how our leaders are informed of medical and pharmacy issues and then explains the organizational structure of the medical group. This will help you understand how your chain of command works and the role you play in the success of the mission. Keep in mind this is not a cut and dry science. Organizational structures often differ between medical treatment facilities.

003. Chain of command and key personnel

In September 1947 the combat elements of the Army Air Forces separated from the US Army, forming the USAF; however, a few Air Force support functions, such as medical care, remained US Army responsibilities. In 1948, the Air Force and the Air Surgeon, Maj. Gen. Malcolm C. Grow, began to convince the US Army and President Truman's administration the Air Force needed its own medical service. On the first day of July 1949, Air Force General Order Number 35 established a medical service with the following officer personnel components: Medical Corps, Dental Corps, Veterinary Corps, Medical Service Corps, Air Force Nurse Corps, and Women's Medical Specialist Corps. Thus, the Air Force Medical Service was born.

The United States Air Force Surgeon General

The USAF/SG is the most senior medical service officer in the USAF and establishes all policies concerning Air Force medical operations. In recent times, this position has been a Lieutenant General who serves as head of the United States AFMS. The surgeon general serves as functional manager of the USAF Medical Service. In this capacity, he/she advises the Secretary of the Air Force and Air Force Chief of Staff, as well as the Assistant Secretary of Defense for Health Affairs on matters pertaining to the medical aspects of the air expeditionary force and the health of Air Force personnel. They have authority to commit resources worldwide for the AFMS, to make decisions affecting the delivery of medical services, and to develop plans, programs and procedures to support worldwide medical service missions. The surgeon general is advised by the corps chiefs of the Medical, Dental, Nursing, Medical Service, and Biomedical Science Corps (BSC).

Surgeon general advisors

The USAF/SG has a monumental task and must rely on pertinent information from advisors. Five corps chiefs advise the AF/SG on matters related to their particular corps: medical, dental, nursing, medical services, and biomedical science. Each MAJCOM has its own surgeon general. MAJCOM surgeons general are advisors to their respective MAJCOM commanders on all medical service matters. There is also a senior pharmacist in each MAJCOM stationed at a base under the MAJCOM. These senior pharmacists serve as consultants to their respective MAJCOM surgeons general.

Biomedical Science Corps

The BSC is made up of many different specialties; some of these specialties include medical laboratory, nutritional medicine, physical therapy, optometry, and of course, pharmacy. Each medical specialty within the BSC is headed by an associate chief who advises the chief of the BSC on current data for that particular specialty.

A major focus of the *AFMS Flight Path* is the functional expertise/experience of leadership of the MTFs functional advisors (who are identified below in the key personnel positions) and group superintendent. The MTF is organized around service-lines with squadrons or divisions delivering healthcare and support to beneficiaries. A clear chain of command exists for all personnel, and the role of each squadron/division is clearly defined. Before we cover the structure of the MTF, let's look at a few key personnel positions within the MTF.

Medical group commander

Within the medical facility, the MDG/CC has the overall responsibility for all activities of the medical group and is accountable for accomplishment of all aspects of the medical group mission.

The medical group commander will establish, as a governing body, an executive committee and serve as its chief executive officer; he or she will also serve as the medical advisor to the wing/installation commander. The MDG/CC delegates authority to carry out specific functions within the medical facility. The size and authorized/assigned personnel of the facility dictate if other services or functions are included.

Functional advisors

Functional advisors provide professional and specialized technical perspectives to the commander. They are full participants in executive level decision-making, including strategic and operational planning, design of services, resource allocation, and organizational policies. They actively support a collaborative, multi-disciplinary approach to the delivery of healthcare and organizational management. This includes participating with other leaders in planning, promoting, and conducting performance improvement activities. Functional advisors are members of the medical group's executive committee. As you might have guessed, the functional advisors play an important role in the day-to-day operations of an MTF. Because of their importance, let's take a closer look at a few key duty functions they perform within the MTF.

NOTE: Medical group commanders will not serve as functional advisors.

Administrator

Each medical group will have a senior Medical Service Corps (MSC) officer with a significant level of experience, education, and training in healthcare administration designated as its administrator (SGA). The SGA has the following roles and responsibilities:

- Defines resources and facility requirements; secures and manages medical resources and information; limits institutional risk; and establishes and maintains external organizational relationships essential for healthcare operations.
- Ensures the MDG is resourced for and capable of meeting operational medicine and readiness tasking.
- Guides operations and programs to ensure accreditation and certification standards are met.
- Responsible for the oversight/supervision of medical readiness office.
- Ensures medical elements are organized, trained, and equipped to respond to any operational contingency.
- Has oversight over all matters involving personnel and administration, such as the command support staff (CSS).

Chief Nurse

Each medical group will have a senior Nurse Corps (NC) officer with a significant level of experience, education, and training in nursing administration and healthcare delivery designated as its chief nurse (SGN). The SGN has the following roles and responsibilities:

- Serves on the medical group executive committee.
- Ensures the delivery of nursing services throughout the medical group.
- Collaborates with members at the executive level in planning and designing healthcare services.
- Allocating resources and monitoring resource utilization, and improving organizational performance.
- Maintains functional control of Air Force officers, civilian nurses, and ancillary nursing personnel.
- Accounts for the standards of nursing practice and the nursing standards of care for individuals and populations served by the organization.

- Establishes performance standards for all nursing personnel to ensure compliance with DOD, USAF, professional, and accreditation requirements.
- Ensures enlisted nursing personnel practice within the scope and to the full extent of their respective Career Field Education and Training Plan (CFETP) as appropriate to the work area.
- Ensures appropriate measures are taken for substantiating substandard performance of nursing personnel and subsequent peer review, retraining, and administrative action when necessary.
- Responsible for group education and training programs.

Chief of the medical staff

The chief of the medical staff (SGH) will be a Medical Corps officer who is responsible for the governance of the medical staff with regard to setting facility standards for medical practice and ensuring the quality of professional services provided by individuals with clinical privileges. This individual has the following roles and responsibilities:

- Serves on the medical executive staff
- Chairs the executive committee of the medical staff (ECOMS).
- Directs credentialing and privileging processes in accordance with (IAW) DOD directives, AF instructions and policy, the Joint Commission, and the Accreditation Association for Ambulatory Healthcare (AAAHC).
- Participates in executive level decision-making, including strategic and operational planning, design of services, resource allocation, and decisions regarding utilization and assignment of personnel within the medical group.
- Deploys organization-wide medical care programs, policies, and procedures that describe how patients or patient population's medical care needs are assessed, evaluated, and delivered.
- Coordinates on all actions impacting physicians, including applications for additional training.

Chief of dental services

Each medical group will have a senior Dental Corps officer designated as its chief of dental services (SGD). In groups with squadrons, the squadron commander is the chief of dental services. In groups without squadrons, the dental division chief will hold this position. The chief of dental services advises the medical group commander, medical staff, and MAJCOM/SGD on all professional matters that relate to the base dental service. This individual has the following roles and responsibilities:

- Responsible for implementing and managing dental policies established by higher headquarters and initiating local dental instructions and policies to supplement Air Force and MAJCOM directives and instructions.
- Determines compliance with directives, instructions, and policies, and evaluates the effectiveness of dental standards and the delivery of dental healthcare services.
- Serves on the executive committee, credentialing body, and other advisory bodies required by the Joint Commission and other regulatory agencies.

Biomedical Science Corps executive

Each medical group will have a senior BSC officer designated as its BSC executive (SGB). This individual has the following roles and responsibilities:

- Serves on the executive committee and other advisory bodies as a special staff advisor on BSC issues.

- Participates in executive level decision-making, including strategic and operational planning, design of services, resource allocations, and decisions regarding utilization and assignment of personnel within the medical group.
- Assists the commander in ensuring all BSCs are aware of and contribute to the goals and objectives of the AFMS to the fullest extent.

Chief of aerospace medicine

Each medical group will have a senior officer designated as the chief of aerospace medicine (SGP). This role focuses on functional expertise in aerospace/operational medicine. This individual has the following roles and responsibilities:

- Advises the medical group commander, line commanders, aerospace medicine squadron commander, MAJCOM aerospace medicine staff, and the facility medical staff on all operational medicine matters relating to the wing's missions.
- Directs aircrew support through physical standards, participation in the wing safety program, and optimization of warfighter performance.
- Provides epidemiological expertise for population-based health services.
- Provides guidance on performance aspects of nutrition, food and water sanitation, immunizations, and other community health issues.
- Serves on the executive committee, provides medical oversight of preventive functions, and may be a member of other advisory committees that require an operational medicine perspective.

Medical enlisted representation

The medical group commander selects the best qualified medical (4XXXX) chief master sergeant (CMSgt) regardless of Air Force specialty code (AFSC) as the medical group superintendent to provide expertise on medical enlisted matters. The MDG/CC obtains executive committee and senior enlisted consultation in the selection process. Individuals wishing to volunteer for the medical group superintendent position must apply and compete for this position. Volunteers submit their names to the Air Force Senior Leader Management Office; this office in turn forwards the name(s) to the MDG/CC for selection.

The scope of responsibilities for the medical group superintendent includes, but is not limited to,

- Serving as a member of the group's executive committee and quality council (or equivalent body).
- Interacting with the wing command chief master sergeant and other unit's senior enlisted leadership to support mission requirements.
- Interacting with the medical squadrons/divisions to improve organizational performance.
- Involvement in enlisted specialty training, utilization, career development, and mentoring.

All medical groups have superintendents. Squadron superintendents are authorized based on manpower standards. In many small squadrons and divisions, superintendents are not be earned; the position will be dual-hatted, or an additional duty.

Matrixing

Within the MTF, personnel are sometimes *matrixed*. Matrixing means assigning individuals across functional areas to improve service and support for medical service lines. This may require a permanent change of rater to the receiving area if the individual is performing more than 50 percent of his/her duties in the new functional area. The need to matrix manpower occurs when personnel are permanently assigned to one squadron/flight but perform their regular duties, wholly or substantially, in direct support of another squadron/flight. For example, personnel are assigned to the medical operations division/squadron (pharmacy, clinical laboratory, diagnostic imaging, etc.), but may

perform their duties more effectively where the service is rendered (medical support squadron). This concept allows commanders flexibility in aligning personnel with special skills to those parts of the organization requiring their dedicated support. This promotes an integrated team approach by aligning manpower closer to support functions.

004. The Air Force Medical Service Flight Path structure

The organizational structure of our MTFs follows a master plan or blueprint called the *AFMS Flight Path*. This lesson is a bird's eye look at the *AFMS Flight Path*, but focuses on key points on what is a very detailed and lengthy document.

The flight path has a very important role in the mission, function, and organization of the AFMS. The size and structure of MTFs will vary from facility to facility based on the size and scope of healthcare services offered. With the unique force structure of the AFMS, the ever-changing demands of the healthcare environment and the clear need for expeditionary medical leaders, flight path models focus on patient needs, improve our ability to compete in a business case and managed care environment, and provide a better management framework for our MTFs. There are variations to the flight path structure at a few MTFs, but we will primarily focus our attention on the four standard flight models in use. The Air Force Surgeon General's office is the approval authority for all MTFs requesting exceptions to a flight path models; the MAJCOMs and MTFs will be notified if their organization's exceptions are granted.

Standard military treatment facility levels of organization

Before we jump into the flight path models, let's cover the basic organization structure in medical facilities. The organizational structure varies based on the size of your facility. The following table shows how personnel are aligned under a wing and then a group.

Standard Military Treatment Facility Levels of Organization
Wing
Group
Squadron
Flight
Element

From the group level, most of your pharmacies will align under a squadron and so on. A few objectives of the flight path are as follows:

- Focus on their functional/clinical expertise.
- Train and sustain mission-ready, expeditionary medics.
- Minimize the number of organizational layers within the group and have no more than 5 layers between the frontline Airman and the group commander.
- Reduce the amount of manpower dedicated to administrative duties and retains the product-line delivery to our customers.

The following paragraphs provide a brief description of the smaller facility units.

Medical squadrons

Squadrons are known as the basic "building block" organizations in the Air Force, providing a specific operational or support capability. A squadron has a substantive mission of its own that warrants organization as a separate unit based on factors like unity of command and functional grouping and administrative control, balanced with efficient use of resources. Medical squadrons are established to group functionally similar operations. The primary medical squadrons established by the *AFMS Flight Path* structure is discussed later in this lesson.

Medical flights

A flight is a part of a squadron and may be composed of elements performing specific missions. The mission, size, and complexity of the squadron determines the establishment of flights.

Medical elements

Elements are the smallest, cohesive collection of manpower in the performance of a specific role or mission (e.g., family practice or primary care clinics, optometry, biomedical equipment repair, facility management, etc.). MTFs only have those elements that apply to their MTF operation; not all medical units will have all elements identified in the flight path. Alignment of elements is the prerogative of group commanders.

Air Force medical system flight path models

There are five MTF organizational models in the *AFMS Flight Path*: medical wing (figs. 1-4 and 1-5), medical center/hospital (fig. 1-6), clinic with squadrons (fig. 1-7), limited-scope military treatment facilities (fig. 1-8), and organization threshold review (OTR) medical squadrons (fig. 1-9). These MTFs are then organized as wings, groups, squadrons, and so on, depending on the scope of the medical mission and the size of the organization.

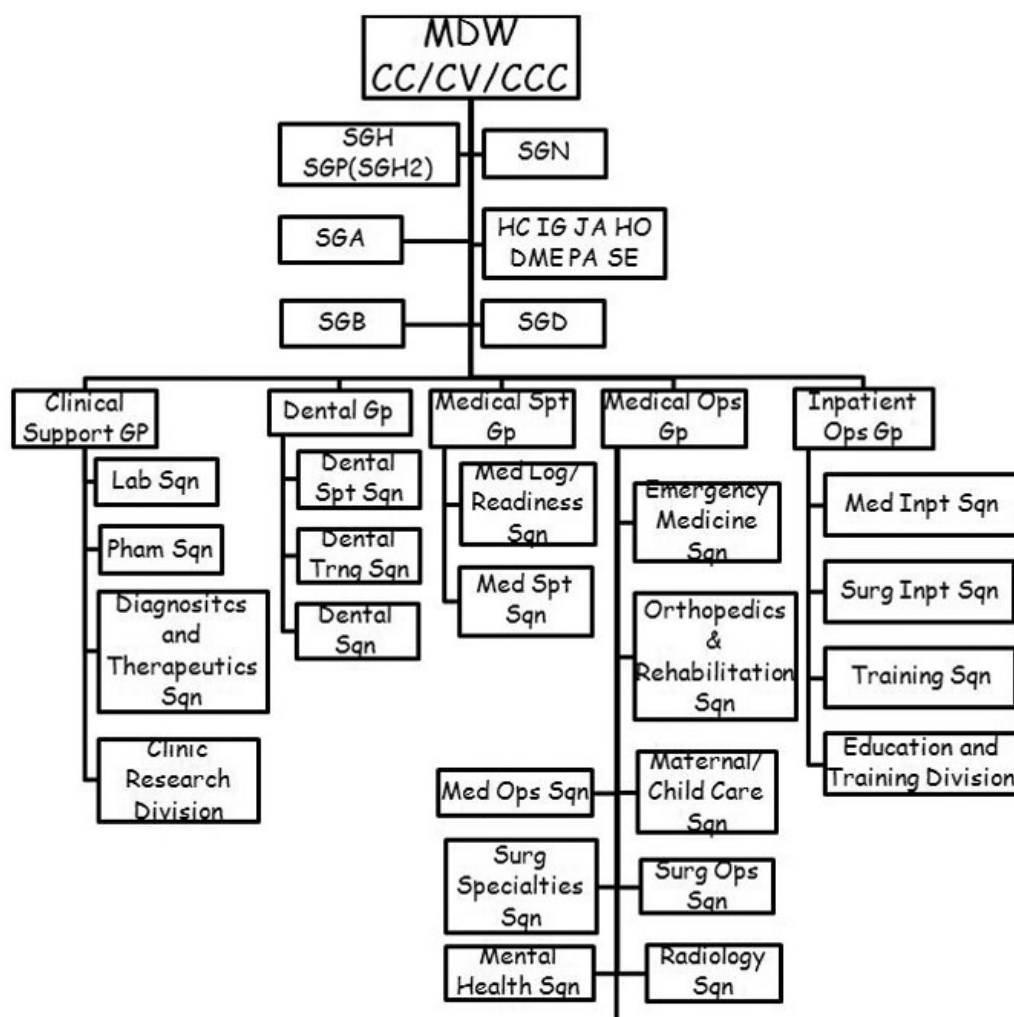


Figure 1-4. Medical wing structure by product line.

Medical wing model

A medical wing (MDW) is the largest of our MTF structures and is unique amongst all the other MTFs, because a medical wing commander reports directly to his/her MAJCOM headquarters. The *AFMS Flight Path* gives two example models of the organization structure of medical wings: structure by product line (fig. 1-4) and structure for geographic mission (fig. 1-5).

The model shown in figure 1-4 is the medical wing organizational structure by product line and presently reflects our only two stateside medical wings at Joint Base Andrews and Joint Base San Antonio Lackland; those product lines are medical operations, inpatient operations, clinical support, medical support, and dental. Due to the size and structure of the wing model, pharmacy is a squadron under the clinical support group. Squadrons approved for this group may include clinical laboratory, diagnostics and therapeutics, clinical research, and pharmacy.

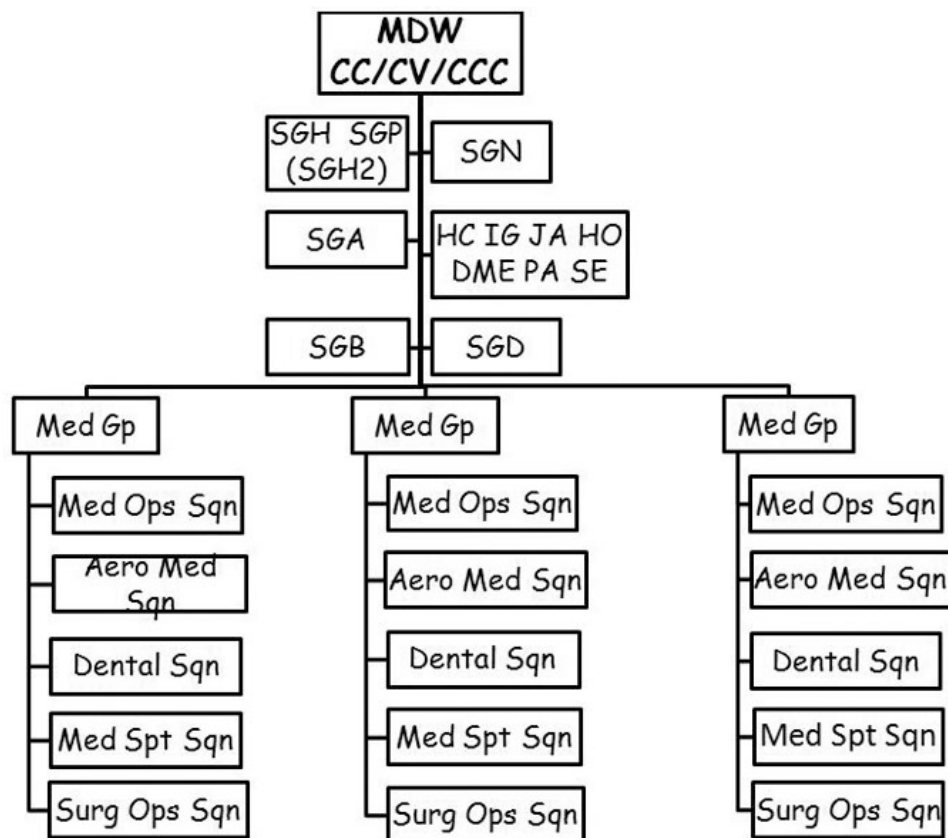


Figure 1-5. Medical wing structure for geographic mission.

Medical center and hospital model

Figure 1-6 is a representation of the medical center/hospital model, but as stated earlier, there are variations to each of the flight path models. In the primary medical center/hospital model, the pharmacy is a flight under the medical support (MDSS) squadron, *except in facilities* with a diagnostics and therapeutics squadron or group.

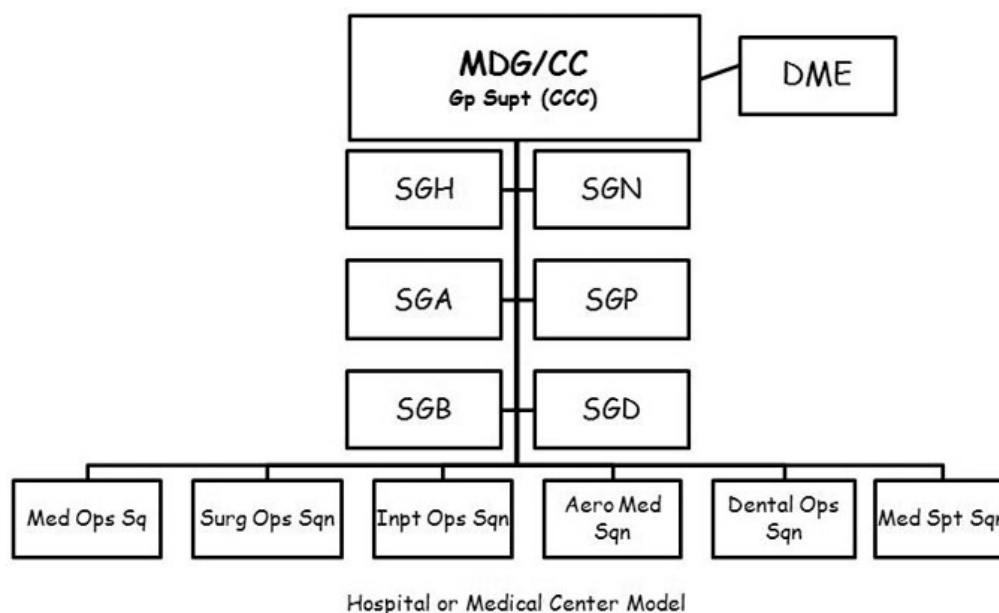


Figure 1-6. Medical center/hospital structure.

Clinic with squadrons model

Most clinics within the AFMS have the four squadron structure depicted below in figure 1-7. However, there are many exceptions where one or more squadrons would not stand up. Furthermore, ambulatory surgery facilities may have additional squadrons based on their mission requirements. All structures must fall within the scope of AFI 38-101, *Air Force Organization*. Each medical group has a minimum of two squadrons.

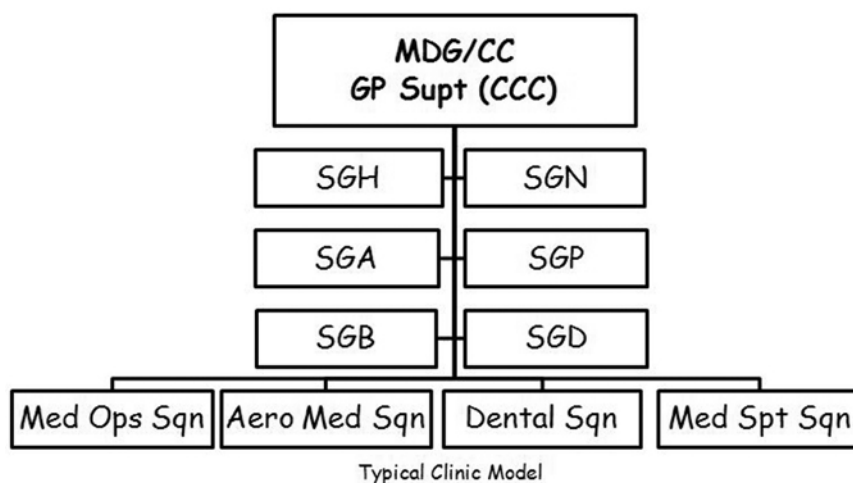


Figure 1-7. Typical clinic model.

Limited scope military treatment facilities model

Limited-scope military treatment facilities (LSMTFs) are medical functional flights and small medical squadrons that do not provide the scope of services found in a medical group. LSMTFs are assigned to non-medical squadrons or groups (e.g. air base squadrons, mission support groups or air base groups). In some cases, the LSMTFs may report directly to the wing.

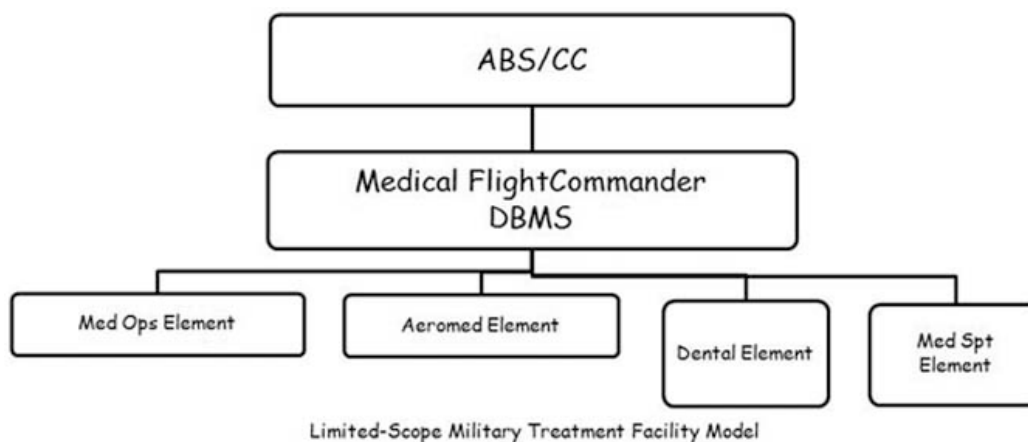


Figure 1-8. Limited-scope military treatment facility.

Organization threshold review medical squadron model

As a result of specific wings not meeting organization threshold minimums, subordinate medical groups (Los Angeles and Hanscom) were directed to redesignate from medical groups to medical squadrons. These squadrons are commanded by medical service officers who have been selected through the AF Departmental Publishing Office game-plan. These are full scope clinics and are peer grouped and inspected utilizing full unit effectiveness inspection (UEI) criteria. Figure 1-9 shows the approved model for these facilities.

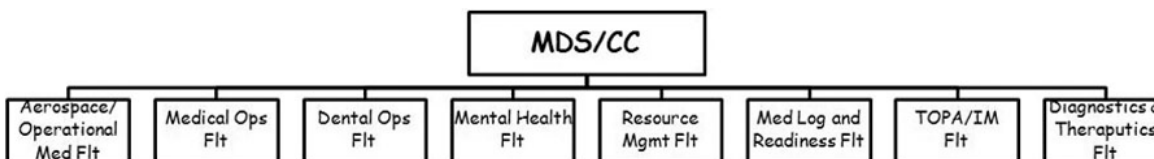


Figure 1-9. OTR squadron model.

Medical support squadron

The medical support squadron provides medical logistics, medical information services, personnel and administration, TRICARE operations and patient administration (TOPA), readiness, pharmacy, clinical laboratory, nutritional medicine, diagnostics and therapeutics, histopathology, and diagnostic imaging in support of the medical group. The MDSS provides or arranges the full scope of preventive and clinical healthcare services for the defined population. The squadron also assesses the healthcare needs and expectations of the population it serves. To do this, the squadron plans, organizes, operates, evaluates, and improves its comprehensive system of healthcare services. In addition, this squadron develops processes to provide seamless, customer-focused access, assessment, diagnostic services, preventive and treatment services, education and continuity in all care settings for health maintenance, as well as acute and chronic management of disease and injury.

Personnel of this medical squadron support information requirements of beneficiaries, staff, and management. They also develop programs to continuously analyze and improve system performance. This includes measures of customer satisfaction, clinical outcomes, costs, and effectiveness of all key processes.

Diagnostic and therapeutics squadron

There are a few MTFs in which this exception has been approved, and they have been granted permission to add a seventh squadron to the medical center/hospital model. This squadron is designated the diagnostic and therapeutics (D&T) squadron, and the pharmacy is a flight aligned

under this squadron. The D&T squadron is optional for medical groups with over one thousand personnel authorizations.

005. Pharmacy functions

As a member of the pharmacy staff, it is your job to provide service consistent with the highest professional standards. This is a big job, and you may be involved in all pharmacy functions or just a few. The pharmacy is expected to provide comprehensive outpatient (and where available, inpatient) pharmaceutical services as well as numerous services involving pharmaceutical products. Some of the services you'll be expected to perform are discussed in this lesson. The information presented is an overview of pharmacy functions. Note that certain items will be discussed in more detail in subsequent CDC volumes.

Inpatient services

The pharmacy is responsible for storage, use, and control of drugs throughout the medical facility. As a member of the pharmacy staff, you may be the one carrying out these duties. When you receive a medication order, review the order for potential drug therapy problems and the patient's profile for potential problems. Automated systems make this a relatively simple task. Contact the pharmacist (and/or prescriber) whenever significant drug mishaps are identified. If you aren't sure if there is a mishap, contact the pharmacist. The results of this intervention must be documented and reviewed as part of the quality improvement process (which we discuss later) and used to demonstrate the positive impact of pharmacy services on patient care.

Discharge counseling

Counseling patients on taking their discharge medications, preparing drug calendars, and providing leaflets explaining each drug are ways to provide this service. Counseling is documented in the patient medical record. Prescription service for patients discharged on weekends and holidays should be available.

The Joint Commission

The Joint Commission standards help health care organizations measure, assess, and improve performance. They promote the use of unit dose and intravenous (IV) admixture programs under pharmacy control. Floor stock medications should be kept to a minimum to prevent waste and pilferage of drug supplies. Unit dose distribution systems promote both patient safety and cost-effective management of very limited resources. All medications stored outside the pharmacy must be inspected and documented monthly by pharmacy personnel. Nursing personnel must be encouraged to check these medications weekly.

Outpatient services

Outpatient prescription services are provided to active duty, Guard, Reserve, retired personnel, and dependent beneficiaries. The demand for prescription services has been growing every year, stretching resources to the limits. Providing top quality service in a timely manner is a never-ending challenge. Many times this is made easier with the automation of many functions.

Managing workload

The increasing demand for outpatient services has resulted in several innovative methods to efficiently manage workload. Call-in refill services, satellite pharmacies, extended hours, and increasing quantities of drugs dispensed for chronic conditions from 30 to 90 days are some examples of these innovations. Efficient design of pharmacies, taking into account workflow patterns, the use of dispensing cells, automation and bar-coding technologies are also being utilized to streamline outpatient operations.

Patient counseling

Patient counseling is an important aspect of both inpatient and outpatient pharmacy services. The high volume of prescriptions filled in most pharmacies requires innovative methods to provide counseling. Targeting specific groups of patients for counseling (e.g., elderly and diabetics) may be necessary.

Patient requests for drug information are another method to selectively deliver counseling service. Whenever possible, space with privacy should be made available for counseling.

Drug specifications and drug evaluation criteria

Although the drug usage evaluation is primarily a medical staff responsibility, this is another critical area requiring pharmacy personnel involvement. Evaluation of products is usually done when products are considered for formulary addition, deletion, and/or monitoring proper use of specific drugs throughout the MTF.

Drug specifications

Drug information services are fundamental to pharmacy practice. Information is provided through regular pharmacy newsletters, formal or informal patient consults, telephone requests, in-service training, and so forth. The goals of these efforts are to keep the medical staff abreast of current pharmacy issues and to provide input into therapeutic decisions. Current literature or information resources are a necessity and should be available in every pharmacy and medical library. The extent of the resources available is determined by each pharmacy's needs. Various tools are available to aid in providing accurate and timely drug information (e.g., Lexicomp® software); selected textbooks and journals should be available as well.

Drug utilization evaluation

The pharmacy, in cooperation with the Pharmacy and Therapeutics (P&T) function, are involved in developing criteria for reviews, collecting and interpreting clinical, economic, and outcome data, and making recommendations based upon findings. Criteria for drug utilization evaluation (DUE) selection include indications, effectiveness, toxicity, and pharmacokinetic properties. DUEs are often based on drugs that are high use, problem-prone, high cost, or have a narrow therapeutic index. Also included are risks, to include adverse drug reactions and potential for errors to include ordering, prescribing, dispensing, and administration. When a DUE is conducted with a finding of poor compliance with the criteria, a repeat DUE should be scheduled in three to six months to document improvement. It is important not to close this item in the P&T function minutes until compliance with established standards is documented.

Policies and procedures

The pharmacy provides oversight for policies and procedures on handling drugs throughout the MTF. The American Society of Health-System Pharmacists (ASHP) and the American Pharmacists Association (APhA) have both established standards on setting goals for Air Force pharmacy practice.

Our own instructions, Health Affairs Policy, DOD Instructions, and federal law govern pharmacy practice in the Air Force. State laws, although not directly applicable to Air Force pharmacies, are important whenever prescriptions from civilian providers are handled and in other unique circumstances. Individual state laws set the standards for practice within a geographic area and are important whenever prescriptions from civilian providers are handled. Conflict may arise when state laws impose a more stringent standard of practice than Air Force requirements. Unless AF instructions are considered necessary to complete the military mission, Federal and state laws set the standard of practice for judicial settings. Pharmacy personnel must use good professional judgment when this occurs, always keeping the welfare of patients in mind.

Maintaining records

Pharmacy also maintains records of all medications prescribed. This procedure must be done in compliance with all legal requirements and quality assurance reviews. We'll discuss this subject a little later.

Drug information

As a member of the pharmacy service, you are expected to provide drug information to patients as well as to the MTF staff.

During a typical workday, pharmacy technicians are confronted with many questions from other technicians, physicians, nurses, other health-care professionals, and patients. Many more questions arise as technicians are performing their duties, and they must find answers before they can continue. As a member of the pharmacy staff, you must recognize your personal limits. Don't be afraid to refer your question to a pharmacist if you have any doubts about your ability or authority to handle the situation. The clinical consequences can be grave if you provide incorrect information or exceed the limits of your position.

Dispensing pharmaceuticals

The pharmacy orders, stores, compounds, and dispenses pharmaceuticals in compliance with regulations and professional standards.

Ordering and storing pharmaceuticals

Responsibility for ordering and storing pharmaceuticals is often assigned to an apprentice, journeyman, or civil service pharmacy technician, yet it is one of the most important responsibilities in the pharmacy operation. In fact, it is one of your most useful experiences as a pharmacy technician and serves at least three purposes:

1. It helps you to become familiar with formulary items.
2. It demonstrates to you the system of controls required for ensuring only those medications ordered can be received from medical supply.
3. It helps you to become familiar with all of the storage locations in the pharmacy.

Dispensing pharmaceuticals

Pharmacy technicians are responsible for many duties related to preparing, delivering, and dispensing medication. Pharmacists and senior pharmacy personnel supervise all work completed and ensure the integrity and safety of each item dispensed. The fact that pharmacy technicians are trained to perform most of the duties within the pharmacy allows the pharmacist to pursue other critical tasks that require his or her attention.

Committee membership and functions

Pharmacists serve on a number of committees and functions, providing an opportunity to share their pharmacy expertise as an integral member of the health-care team. You are a member of the pharmacy team and should be aware of all endeavors we are involved in. There also may come a time when you are asked to assist the pharmacist. The main committee we are involved in is the P&T function.

Pharmacy and therapeutics function

The P&T function is the primary advisory group to the medical staff regarding drug use throughout the MTF. Membership is not limited to, but must include a physician, a nurse, and a pharmacist. Visitors, especially from managed care or resource management are encouraged to participate in this function. The function must meet at least quarterly, but in many facilities the meeting is held more frequently. Specific responsibilities are outlined in AFI 44-102, *Medical Care Management*. The Joint Commission standards state that it is a function of the medical staff. While the Joint Commission no longer specifies a formal P&T function, the function must continue. The responsibilities include at least the following:

- Develop and approve policies and procedures relating to the selection, distribution, handling, use, and administration of drugs and diagnostic testing materials.
- Develop and maintain the drug formulary.
- Evaluate and approve protocols concerned with investigational or experimental drugs if no other mechanism exists.
- Define and review significant adverse drug reactions.

The pharmacist is usually responsible for preparing meeting agendas and acts as or provides the recorder for meetings. The pharmacist plays a key role in coordinating and implementing function decisions. Pharmacists serve on sub-functions or committees that advise the full function on a variety of drug-related issues. We'll discuss some of these sub-functions/committees.

Drug usage evaluation

This sub-function develops protocol and criteria for medication use and monitors selected drugs and prescribing practices within the MTF. Medication use review should include all aspects such as prescribing, distribution, administration, and follow-up. Results may be forwarded to other, functions, committees or departments for action or information (e.g., infection control committee if the study involved antibiotic use).

Nutritional support

This committee monitors appropriate use of enteral and parenteral nutrition. This committee is composed of a pharmacist, nurse, dietitian, and physician. This group recommends policies and procedures for use of nutritional support in the MTF.

Cardiopulmonary resuscitation

This committee recommends drugs for stock on crash carts and emergency kits. It also recommends training requirements, policies on maintenance of equipment and supplies, and other cardiopulmonary resuscitation (CPR) procedures or code blue procedures. In some MTFs the critical care committee has these responsibilities.

New medication request sub-function

This sub-function critically evaluates all new medication requests. It also compares medication(s) requested to like agents in the same therapeutic class and makes recommendations to the function concerning additions, deletions, and formulary status (i.e., open/restricted, tri-service formulary drug, etc.).

Quality or process improvement committee

This committee, which may be called either the quality improvement (QI) or performance improvement (PI) committee, is responsible for maintaining an ongoing quality improvement program to monitor and evaluate the quality and appropriateness of care throughout the MTF by concentrating on patient outcomes. The committee identifies opportunities for improving care, resolves identified problems through coordination, and monitors effectiveness of the MTF QI/PI process. The committee reviews and approves criteria for monitoring and evaluations conducted as well as reviewing conclusions, results, actions, and follow-up of QI/PI activities. Pharmacy quality improvement activities are conducted within the section and reported through the executive committee of the medical staff or ancillary services committee to the QI/PI committee.

The MTF quality improvement coordinator is the point of contact for all QI activities. This individual is responsible for overall management of the program, including training of MTF personnel.

Credentials function

This function is responsible for credentialing healthcare providers, determining the criteria for awarding clinical privileges, monitoring provider performance, and renewing credentials based on provider performance. This function enforces standards of conduct and can take actions to limit, suspend, or revoke privileges for cause. Pharmacists may be required to obtain credentials for clinical practice.

Infection control function

The infection control function assesses the effectiveness of the MTF infection control program. It consists of members of the medical staff, administration, nursing, laboratory, environmental health, surgery, and other departments. Pharmacy contributes to the function by performing antibiotic use review studies and reporting unusual trends in antibiotic use to the function for information and

action. The function also provides training for the MTF staff in infection control procedures and does periodic surveillance to ensure compliance with infection control standards.

Cost center manager

Cost center managers are appointed from each major function in the MTF. They assist the resource manager and commander in acquisition, distribution, and utilization of medical resources. Functions include budgeting, financial management, manpower management, medical expense reporting, and management analysis. Pharmacy is usually the largest single cost center in the MTF, and thus, works closely with the resource management office (RMO) to project budgets, workload, cost analysis, and methods improvement programs. The RMO usually publishes a cost center manager's handbook, detailing responsibilities of the cost center managers.

Equipment review and authorization activity

The equipment review and authorization activity (ERAA) board reviews requests for new equipment and establishes priorities for purchase. Pharmacy personnel often have an interest in the approval and priority process and should attend this meeting whenever an item of equipment for the department is reviewed.

Institutional review committee

The purpose of this committee is to evaluate the scientific merit, ethics, and necessity of all proposed clinical investigations involving human experimentation. Members review protocols to ensure they meet all Air Force and federal regulations governing medical research. Pharmacists with experience in research activities should be a part of this committee. This committee is more common in medical centers and larger regional hospitals than with training programs.

Medical readiness function

This function is responsible for all medical readiness activities and training conducted in the MTF. Pharmacy personnel do not generally attend unless issues relating to pharmacy services are being discussed.

Health promotion function

This function promotes the health and well being of the local community served by the MTF. It is a multidisciplinary group that addresses the physical, mental, and emotional needs of the population and serves as the focal point for preventive medicine activities. Pharmacy personnel are often involved through activities sponsored by the function, such as poison prevention week activities, smoking cessation classes, or teaching nutrition classes for diabetic patients.

Health consumer advisory council

This is the forum for consumers to discuss problems and make recommendations to the commander for improvements and changes to the healthcare delivery system. Membership includes the commander, key administrative personnel, representatives from base organizations, and patients. The council meets quarterly. Pharmacy input is provided on request, and this council is a good opportunity to obtain feedback on how patients perceive our service as well as answer questions on real or perceived problems.

There are some other functions and committees pharmacy personnel could have input to, but they are too numerous to list. We've discussed the functions and committees of primary involvement for you.

Library function

Responsibilities of the library function include ensuring adequate library resources are available to the medical staff. This function also recommends policies and procedures for library operation, maintains books and journals, and makes library resources readily available to staff. Pharmacy personnel should actively review their library needs and submit requests to the function. Since the function often meets only quarterly, timely submissions are critical. Books directly related to pharmacy are often kept in

the pharmacy on a permanent loan status. (**NOTE:** The Air Force is moving away from this function and encouraging MTFs to use on-line resources.)

Self-Test Questions

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

003. Chain of command and key personnel

1. Match the questions in column A with the appropriate response from column B. Each item in column B is used once.

Column A

- ____ (1) Who is the medical staff advisor to the secretary of the Air Force?
- ____ (2) Who advises the Air Force surgeon general on matters relating to their particular specialty?
- ____ (3) Who advises MAJCOM commanders on all medical service matters?
- ____ (4) Who is responsible for all activities and medical resources within a medical facility
- ____ (5) Who serves as consultant to MAJCOM commanders on pharmacy issues?

Column B

- a. Air Force surgeon general.
- b. MAJCOM senior pharmacist.
- c. Corps chiefs.
- d. MAJCOM surgeon general.
- e. Medical group commander.

- 2. Where is the pharmacy element in the MDG core structure?
- 3. What is the acronym for the medical group commander?
- 4. Who ensures the medical group is resourced for and capable of meeting operational medicine and readiness tasking?
- 5. Who has authority, responsibility and accountability for the standards of nursing practice and the nursing standards of care for individuals and populations served by the organization?
- 6. Who has the responsibility for coordinating on all actions impacting physicians, including applications for additional training?
- 7. In groups without squadrons, who will hold the position of chief of dental services?
- 8. Who serves on the executive committee and provides oversight of preventive functions?

9. What is the process one must complete in order to volunteer for the medical group superintendent position?
10. What do we call the process of assigning individuals across functional areas to improve service and support of medical care?

004. The Air Force Medical Service Flight Path structure

1. What is the focus of the flight path models?
2. Who is the approval authority for all MTFs requesting exceptions to a flight path models?
3. List the standard MTF organizational layers?
4. What is the function of the medical squadron?
5. What is the smallest, cohesive collection of personnel who perform a specific role or mission?
6. In the medical center/hospital model, under what squadron is the pharmacy aligned as a flight?
7. In the clinic model, how many squadrons are in most clinics?
8. Which of the MTF organizational models can be assigned to a non-medical squadron or group?
9. What services does the medical support squadron provide in support of the medical group?

005. Pharmacy functions

1. What are you looking for during your review of a medical order?
2. How can you provide discharge counseling to patients?

3. Why should floor stock medications be kept to a minimum?
4. Name four of the innovative methods used to efficiently manage pharmacy workload.
5. What should be made available, whenever possible, to patients being counseled?
6. What should be your goal when you're providing information services to the medical staff?
7. Who is involved in developing criteria for DUE reviews?
8. When do state laws affect pharmacy personnel?
9. To whom are you expected to provide drug information?
10. List three useful purposes for ordering and storing pharmaceuticals provides to pharmacy apprentices.
11. Who has assumed most of the duties related to medication preparation, delivery, and dispensing?
12. Who are the three mandatory members of the P&T function?
13. What are some of the responsibilities of the P&T function?
14. What function or committee critically evaluates all new medication requests?
15. How does the pharmacy contribute to the infection control function?
16. What board reviews requests for new equipment and establishes priorities for purchases?

17. How are pharmacy personnel involved in the Health Promotion function?

18. What is the trend of the Air Force regarding the Library function?

Answers to Self-Test Questions

001

1. To enable medically fit forces, provide expeditionary medics, and improve the health of all we serve to meet our nation's needs.
2. Military Health System.
3. Through a combination of the direct-care system and the civilian TRICARE participating provider network.
4. Military treatment facilities.
5. TRICARE system is the DOD managed healthcare program.
6. TRICARE-managed care contractors direct enrolled patients to the MTF or to civilian providers in order to ensure beneficiaries obtain appropriate healthcare.

002

1. It works with the Assistant Secretary of Defense for Health Affairs, the major air command surgeons, and the Departments of the Army, Navy, and other government agencies.
2. It has moved toward wellness and resiliency.
3. It is the balancing of awareness, education, prevention, and intervention activities required to improve the health of a specified population.
4. Providing a healthy, fit, and ready force; improving the health status of our enrolled population; and managing an effective and efficient health delivery system.
5. The DHA.
6. AFMOA and AFMSA.
7. To provide synchronous support to the AF surgeon general and directorates to achieve medical service success.
8. The MAJCOM.
9. Policies, programs, tools, personnel, and software.
10. It provides a picture about a person's overall health.
11. It ensures each Airman receives required clinical preventive services and meets individual medical readiness requirements; annually.
12. To provide a world-class health system that supports the military mission by fostering, protecting, sustaining, and restoring health.
13. In response to the challenge of maintaining medical readiness while providing community-based healthcare for all eligible personnel.
14. The relationship that exists between the MTF and a large civilian HMO.
15. The US, Eurasia-Africa area, Latin America and Canada area, and the Pacific area
16. To make the pharmacy benefit portable to any state.
17. The plan created a balanced approach to managing the military health benefit with military medical readiness as the first priority, supported by a healthcare delivery system that focuses on joint decision-making and effective resource allocation.
18. TRICARE regional offices.
19. MTF commanders.
20. The regional director.
21. Quality medical outcomes, telephone access, claims payments, cost control, and satisfaction.

22. It is a computerized database of military sponsors, families, and other members worldwide who are entitled under the law to TRICARE benefits.
23. Active duty service members and their families, retired service members and their families, activated Guard/Reserve members and their families, non-activated Guard/Reserve members and their families who qualify for care under the Transitional Assistance Management Program, retired Guard/Reserve members (age 60 and receiving retired pay) and their families, survivors, Medal of Honor recipients and their families, and qualified former spouses.
24. National Guard/Reserve members and their families.
25. 26.
26. Part D.
27. Prescriptions must be filled with a generic product if one is available unless there is a medical necessity for a brand name drug.
28. TRICARE pharmacy home delivery.
29. Non-network retail pharmacy.

003

1. (1) a.
(2) c.
(3) d.
(4) e.
(5) b.
2. BSC.
3. MDG/CC.
4. The administrator (SGA).
5. The chief nurse (SGN).
6. The chief of the medical staff (SGH).
7. The dental division chief (SGD).
8. The chief of aerospace medicine (SGP).
9. Individuals wishing to volunteer for the position must apply and compete; they must submit their names to the Air Force Senior Leader Management Office, which in turn forwards the name(s) to the MDG/CC for selection.
10. Matrixing.

004

1. They are designed to focus on patient needs, improve our ability to compete in a business case/managed care environment, and provide a better management framework for our MTFs.
2. The Air Force Surgeon General's office.
3. Wing, group, squadron, flight, element.
4. They are known as the basic "building block" organizations in the Air Force, providing a specific operational or support capability.
5. Elements.
6. The medical support squadron. There are also a few MTFs in which the diagnostic and therapeutics squadron is being added. The pharmacy will be a flight aligned under this squadron.
7. Four.
8. Limited scope military treatment facilities.
9. Medical logistics, medical information, personnel and administration, TOPA, readiness, pharmacy, clinical laboratory, nutritional medicine, diagnostics and therapeutics, histopathology, and diagnostics imaging.

005

1. Potential drug therapy problems and the patient's profile for potential problems.

2. By counseling patients on taking their discharge medication, preparing drug calendars, and providing leaflets explaining each drug.
3. To prevent waste and pilferage of drug supplies.
4. Call-in refill services, satellite pharmacies, extended hours, and increasing quantities of drugs dispensed for chronic conditions from 30 to 90 days.
5. Whenever possible, space with privacy should be made available for counseling.
6. To keep the medical staff abreast of current pharmacy issues and to provide input into therapeutic decisions.
7. The pharmacy, in cooperation with the P&T function.
8. Whenever prescriptions from civilian providers are handled and in other unique circumstances.
9. To patients and the MTF staff.
10. It helps you to become familiar with formulary items; it demonstrates to you the system of controls required for ensuring only those medications ordered can be received from medical supply; and it helps you to become familiar with all of the storage locations in the pharmacy.
11. Pharmacy technicians.
12. One physician, one nurse, and one pharmacist.
13. Develop and approve policies and procedures relating to the selection, distribution, handling, use and administration of drugs and diagnostic testing materials; develop and maintain a drug formulary; evaluate and approve protocols concerned with investigational or experimental drugs if no other mechanism exists; and define and review significant adverse drug reactions.
14. New Medication Request Sub-function.
15. It contributes by performing antibiotic use review studies and reporting unusual trends in antibiotic use to the function for information and action.
16. ERAA.
17. Through activities such as poison prevention week, smoking cessation classes, etc.
18. It is moving away from this function, encouraging MTFs to utilize on-line resources.

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

Unit Review Exercises

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

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

1. (001) The Air Force Medical Service (AFMS) specific mission enables medically fit forces, provides expeditionary medics, and
 - a. ensures we fly, fight, and win.
 - b. focuses on maximizing readiness and least value.
 - c. sustains the health of all we serve to meet our nation's needs.
 - d. improves the health of all we serve to meet our nation's needs.
2. (001) The Air Force Medical Service (AFMS) provides medical care in support of its mission through
 - a. a combination of the direct-care and TRICARE systems.
 - b. a Health Maintenance Organization.
 - c. the TRICARE system.
 - d. the direct-care system.
3. (001) Primary care managers and health care finders play an important role in getting patients the health care they need by
 - a. directly enrolling patients to the military treatment facility (MTF) or civilian providers under managed care support contracts, if necessary.
 - b. directly enrolling patients to receive their care strictly from civilian health care providers.
 - c. directly enrolling patients to receive their care strictly from the MTF.
 - d. allowing patients to direct their own health care affairs.
4. (001) Which military healthcare system resource is used to minimize out-of-pocket cost for beneficiaries?
 - a. Routine.
 - b. Referral.
 - c. Direct care.
 - d. Sub-contracted.
5. (002) Which of the following is an automated Web-based questionnaire consisting of general lifestyle and specific health questions that provides a picture about a person's overall health?
 - a. Optimization health evaluation review.
 - b. Health evaluation assessment review.
 - c. Primary care health assessment.
 - d. Preventive health assessment.
6. (002) Which commanders' readiness tool does a military treatment facility (MTF) use to ensure that each Airman receives required preventive services and meets individual medical readiness requirements?
 - a. Health enrollment/evaluation assessment review.
 - b. Primary care management team.
 - c. ASIMS.
 - d. TRICARE.

7. (002) How is TRICARE managed so that it can provide community-based health care while also maintaining medical readiness?
 - a. Locally.
 - b. Regionally.
 - c. State-wide.
 - d. Nationally.
8. (002) You recently got married; what do you need to do in order to ensure that your spouse will be eligible for her/his TRICARE benefits?
 - a. You must ensure your spouse is enrolled in the Defense Enrollment Eligibility Reporting System (DEERS).
 - b. You must wait for TRICARE and DEERS to contact your spouse.
 - c. Nothing; your spouse is automatically enrolled in the system.
 - d. Your spouse must enroll in the system.
9. (002) All TRICARE plans meet the requirements for minimum essential coverage of what legislative act?
 - a. Inexpensive Act.
 - b. Affordable Care Act.
 - c. Military Health Care Act.
 - d. Fair Pricing Medical Act.
10. (002) Which part of Medicare is voluntary and is known as the prescription drug plan?
 - a. D.
 - b. C.
 - c. B.
 - d. A.
11. (002) Which is the TRICARE tool that allows beneficiaries access to their appointments, prescriptions, and personal health information from a secure Website?
 - a. TRICARE Online (TOL).
 - b. TRICARE for Life (TFL).
 - c. TRICARE Health Info (THI).
 - d. TRICARE Prime Remote (TPR).
12. (002) If a medication is required to be taken immediately, what is the typical day supply of medication that a beneficiary can have filled in a TRICARE retail network pharmacy?
 - a. 30 days.
 - b. 60 days.
 - c. 90 days.
 - d. 120 days.
13. (003) Within the medical facility, who has the overall responsibility for all activities of the medical group and is accountable for accomplishing all aspects of the medical group mission?
 - a. Senior pharmacist.
 - b. Medical Logistics Chief.
 - c. Biomedical Science Corps Chief.
 - d. Medical Group Commander.
14. (003) Reassignment of individuals across functional areas in order to improve service and support for medical service lines refers to
 - a. staffing.
 - b. matrixing.
 - c. medical manpower rightsizing.
 - d. organizational flux management.

15. (004) The approving authority for medical treatment facilities requesting exceptions to the Air Force Medical Service's flight path models is the Office of the
 - a. Air Force Chief of Staff.
 - b. Secretary of the Air Force.
 - c. Air Force Surgeon General.
 - d. Medical Group Commander.
16. (004) The military treatment facility (MTF) flight path is designed to have no more than how many organizational layers between the group commander and the frontline Airman?
 - a. Three.
 - b. Four.
 - c. Five.
 - d. Six.
17. (004) Which unit does the Air Force consider the basic building block of an organization because of its specific operational and support capability?
 - a. Group.
 - b. Element.
 - c. Division.
 - d. Squadron.
18. (004) In a military treatment facility (MTF) designated as a Medical Wing, the Pharmacy is aligned as a squadron under which group?
 - a. Dental.
 - b. Clinical Support.
 - c. Medical Operations.
 - d. Inpatient Operations.
19. (004) In a military treatment facility (MTF) designated as a Medical Center and authorized a seventh squadron, the pharmacy is aligned as what unit under the Diagnostic and Therapeutics (D&T) Squadron?
 - a. Flight.
 - b. Branch.
 - c. Division.
 - d. Element.
20. (005) Who is responsible for storage, use, and control of drugs throughout a medical facility?
 - a. Chief of Aerospace Medicine.
 - b. Resource management.
 - c. Chief nurse.
 - d. Pharmacy.
21. (005) Which pharmacy function would you most likely be assigned to in order to become more familiar with formulary items?
 - a. Patient counseling.
 - b. Records maintenance.
 - c. Compounding pharmaceuticals.
 - d. Ordering and storing pharmaceuticals.
22. (005) Which personnel is usually responsible for preparing meeting agendas for the Pharmacy and Therapeutics (P&T) function meetings?
 - a. Appointed pharmacist.
 - b. Medical logistics director.
 - c. Chief of medical services.
 - d. Chief of surgical services.

23. (005) You would like to suggest a process that could decrease the amount of time that patients have to wait for their prescriptions to be filled. Who in the military treatment facility (MTF) do you need to speak with?
- a. MTF patient advocate.
 - b. Quality improvement coordinator.
 - c. Pharmacy and Therapeutics function.
 - d. Institutional Board Review Committee.
24. (005) In what way does the pharmacy contribute to the Infection Control function?
- a. Counseling patients.
 - b. Reviewing antibiotic use.
 - c. Developing drug use protocols.
 - d. Providing new drug request information.
25. (005) A meeting is being held regarding the purchase of new pharmacy equipment; which of the following should you meet with in order to have some input regarding this acquisition?
- a. The Equipment Review and Authorization Activity.
 - b. The New Medication Request Sub-function.
 - c. Institutional Board Review Committee.
 - d. The Consumer Advisory Council.
26. (005) To whom would you submit your request to obtain the most current volume of *Pharmacy Law Digest*?
- a. New Medication Request Sub-function.
 - b. Institutional Review Committee.
 - c. Health Promotion function.
 - d. Library function.

Please read the unit menu for unit 2 and continue ➔

Student Notes

Unit 2. Pharmacy Standards

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YOU ARE JUST BEGINNING your pharmacy career, and as you have now discovered, training did not end with completion of technical school. Your supervisor enrolled you in this career development course shortly after you arrived on station. Training is a very important aspect of your job, and so is conducting yourself professionally. Your continuous improvement is what distinguishes you as one of the nation’s top pharmacy technicians. Your knowledge of pharmacy is essential to the performance of your duties, but so is treating others with respect. You are viewed as a reliable source of information on pharmacy matters. Patients and staff alike must trust you to provide information correctly and in a professional manner. That’s why it’s also important you conduct yourself professionally and demonstrate positive relations in your dealings with patients and staff.

2–1. Professional and Patient Relations

Occasionally, the pharmacy workweek may seem very hectic. There will be times when fellow technicians are out for training, on quarters, or out performing details. Additionally, computer systems will malfunction from time to time. So how can you do your job properly when multiple challenges like these occur? In this section, you’ll learn ways to keep a professional attitude, perform your duties with a high standard of conduct, and keep your pharmacy functioning at an optimal level, no matter what.

006. Professional ethics

Ethics are theories or standards governing the conduct of the members of a profession. You’re in the medical profession, helping fulfill people’s pharmaceutical needs. You must follow the principles of right or good conduct.

The concept of ethics dates back to primitive times when man adopted certain behaviors that would allow him to live in harmony with others—moral behavior. Thus, a system of moral values had to be developed. Medical ethics enjoyed the same development process. Practices, beliefs, and theories that were adopted by members of the medical profession became standards for ethics in the practice of medicine. These are still changing through research, development, and societal norms, and as a result of this evolutionary process, some beliefs, theories, and practices that were acceptable 10 or 20 years ago are probably questionable today.

We frequently use the Golden Rule (treating others as you wish to be treated) as a basic ethical standard. However, in the medical profession, ethics are a little more complex than the Golden Rule.

Therefore, each medical profession has developed a code of ethics to guide the behavior of its members.

Medical ethics are the moral laws adopted by the medical profession and accepted by the society it serves. In this regard, there are certain ethical concepts that have endured the test of time. For example, the Hippocratic Oath, the Oath of Maimonides, and Florence Nightingale's pledge all stipulate health care providers must have certain character traits and perform their duties in a moral way. They include such traits as service above self, doing no harm, keeping patient confidences, and treating all patients with compassion.

Along with the changes in medical ethics came a change in the language used to describe ethical behavior. As ethics continue to change and develop, the language used to define them grows more complex. Before you can understand the codes of conduct, you must understand the many terms used within the codes.

Prior to moving on to these terms, however, let's take the concept of ethics one step further. It is important to remember the overarching ethics in the Air Force are our core values: *Integrity first, Service before self, and Excellence in all we do.*

If you apply the Air Force core values to your conduct, you can safely say that your ethics will be above reproach.

Moral character

What is moral character? What attributes or virtues make up a moral health care provider? The ancient Grecian traits of temperance, wisdom, courage, and fortitude were all facets of moral character. These are still valid today. Spiritual attitudes of faith, hope, and charity are also still valid, as is the Puritan ethic of industriousness. Add to this list confidentiality, honesty, and compassion. Now ask yourself, "Do I possess these traits?" If you can answer yes, then your moral character is most certainly above reproach. So always strive to be the exemplar of these qualities.

Moral obligations

What is an obligation? Many philosophers agree that an obligation is more than just a feeling we have. It's more about a pull to do something based on certain character traits. If you feel compelled to act a certain way, it's because your moral character pulls you or tells you to act that way. Take the following example: It's Friday afternoon at 1600, and you are trying to get ready for a weekend of leave. An elderly patient brings in a prescription for a medication your pharmacy doesn't stock. How will you handle this situation? Your pharmacy will probably have an operating instruction on this situation, but we're talking about moral obligation here, and you can't govern someone's morals with an operating instruction. The key here is what are you allowed to do or what can you do? Does your pharmacy have a medication in the same class you can substitute with the doctor's permission? Are you willing to take the extra time to do the right thing to get the prescription filled and take care of the patient? The scenario ends here, but the key to this scenario is to think about how your moral character reflects the Air Force core values. If you apply the Air Force core values to the way you conduct business, your ethical troubles should be nonexistent. By applying these principles consistently, you establish a pattern of excellence. If your moral character is sound, then the moral obligations and resultant behavior will be sound, and you'll perform your duties with a high standard of conduct. The following paragraphs describe the obligations or duties inherent to ethical conduct.

Fidelity

Fidelity means you are faithful to your patients and your duty. This faithfulness may be clearly defined or implied. Regardless of its nature, it should be upheld. Patient confidentiality and interstaff confidentiality are part of fidelity. Remember, what a patient tells you about his or her condition is for the purpose of *treating* his or her condition, *not for open discussion* with your friends.

Nonmaleficence

This duty or obligation means you'll refrain from harming yourself or others. It means you'll treat patients with procedures and medications that aren't harmful. Ensuring a medication is not expired prior to dispensing it is one way you fulfill this obligation. It's your duty to avoid harming yourself, patients, or staff members by inappropriate treatment or conduct.

Beneficence

Beneficence is nearly the opposite of maleficence. It means you have a duty to bring about good or render a treatment in the best interest of the patient. Don't take short cuts; give each patient the best treatment possible.

Reparations

Reparation is the act of making repairs or the process of making amends. This occurs after someone has wronged someone else. Reparation implies giving compensation to someone who has suffered an injustice, loss, or injury at the hand of someone else. It can range from a simple apology to legal restitution.

Justice

The duty of justice occurs when you're in a position to distribute either benefits or burdens among persons or groups. Clinically, justice implies you should do everything possible for each patient. Unfortunately, because you often work with limited resources, you can't. This often creates a conflict with your feelings of duty and obligation. The concept of ethical behavior requires a delicate balance of judgment, maturity, and acceptance of your moral obligations. Frustrations will arise, but when you behave and perform your duties with high standards of conduct, you'll be fulfilling your moral and ethical obligations to the best of your ability.

Justice can usually be broken down into these three types:

1. Distributive.
2. Compensatory.
3. Procedural.

Distributive justice

Distributive justice concerns the treatment of individuals with a set amount of resources. Each patient who comes to the pharmacy window has an equal right to the best possible treatment. But with limited resources (equipment, personnel, time) it's impossible to provide all that is medically possible for each patient. The decision-making regarding which patient receives what treatment and how often, and how many patients can be treated, is the challenge of distributive justice. An example of this is when certain medications are limited to prescriptions by particular specialties, such as internal medicine.

Compensatory justice

Compensatory justice, on the other hand, implies some patients should receive better treatment because they've been wronged. Often, this feeling of justice comes from the patient. For example, the patient who has been injured in the hospital expects to receive special treatment even though it may be at the expense of other patients' convenience. The injured patient feels he or she should be compensated for his or her pain or inconvenience. Good judgment is the key here.

Likewise, people who have been wronged by society because of race, color, sex, or creed often feel they should receive preferential treatment. The MHS possesses its own unique conflicts because of its rank structure. Should the quality of treatment rendered be based on the member's rank? No. You treat patients to the best of your ability, with the resources available to you, no matter what rank they are or what they look like.

Procedural justice

The last element of justice is procedural. In this type of justice, impartiality is the key concept. Fairness is entertained on a first-come, first-served basis. For example, is it fair to fill a prescription for your best friend ahead of someone who turned his or her prescription in 20 minutes earlier? You shouldn't harm or inconvenience the many for the benefit of one. However, many Air Force pharmacies do give priority to active duty members in support of the mission and emergency situations, thus overriding the first-come, first-served method of procedural justice.

Moral responsibility

When someone is held morally responsible, you can infer the person was free to perform the duty and voluntarily chose to do it. Within this explanation is the implication the person had the necessary knowledge, skills, and authority to perform the task. Within an ethical context, the discussion of moral responsibility rests heavily on the premise that a person can be held responsible if there's no doubt the person was free to choose to act as he or she did.

In the pharmacy, you're morally responsible for filling prescriptions in a particular manner. Thus, much of the decision-making is already done for you. If you choose to alter a prescription without the proper authority, you could be held responsible for any complications that may arise. You may have had the authority by job description or regulation to perform the task, but you didn't have the authority to alter the prescription.

In contrast, you also have the moral responsibility to question a prescription you think may harm a patient. In this case, you're not obligated to fill it until you get clarification. If you have any questions concerning the appropriateness of a prescription, consult with your supervisor, a pharmacist, or the prescribing practitioner. Additionally, you have a moral responsibility not to perform a duty you're not qualified and competent to perform.

007. Professional relationships with patients

Patients are thinking, feeling human beings with diverse physical conditions, personal beliefs, and methods of coping with illness and medical treatment. For patients, there are many threats associated with the physical, psychological, and social consequences of illness or disability, as well as threats associated with the treatment environment and staff-patient relationships. You are normally the last person the patients come in contact with before they leave the hospital. Because of that, you can have a great impact on them. Your attitude toward the patients can be extremely important in developing and maintaining good relationships. One thing to keep in mind is that patients have certain rights, and you must honor those rights. However, patient relationships are not one-sided. In addition to rights, Department of Defense Instruction (DODI) 6000.14, *Patients Bill of Rights*, outlines responsibilities the patient must uphold. Your facility may have its own variation of the patient's rights and responsibilities but the following is a standard patient bill of rights.

DOD Patient's Bill of Rights and Responsibilities

1. Patient's Rights. Health care personnel must support the patient's rights and ensure these rights become an integral part of the healing process. Specific patient's rights exist in a number of areas.
 - a. **Medical Care and Dental Care**. Patients have the right to quality care and treatment consistent with available resources and generally accepted standards. The patient has the right also to refuse treatment to the extent permitted by law and government regulations, and to be informed of the consequences of his or her refusal.
 - b. **Respectful Treatment**. Patients have the right to considerate and respectful care, with recognition of his or her personal dignity.
 - c. **Privacy and Confidentiality**. Patients have the right, within law and Air Force regulations, to privacy and confidentiality concerning health care.

DOD Patient's Bill of Rights and Responsibilities

- d. **Identity.** Patients have the right to know, at all times, the identity, professional status, and professional credentials of health care personnel, as well as the name of the health care practitioner primarily responsible for his or her care.
 - e. **Explanation of Care.** Patients have the right to have their diagnosis, treatment, procedures, and prognosis of illness explained in terms they can be expected to understand. When it is not medically feasible to give such information to the patient, it will be provided to appropriate family members or surrogates.
 - f. **Informed Consent.** Patients have the right to be given, in nonclinical terms, information needed to make knowledgeable decisions on treatment options. Such information should include anticipated complications, risks, benefits, and alternative treatments available.
 - g. **Research Projects.** Patients have the right to be advised if the medical facility proposes to engage in research associated with their care or treatment. The patient has the right to refuse to participate in any research projects.
 - h. **Safe Environment.** Patients have the right to care and treatment in a safe environment which meets appropriate safety codes and is prudently and reasonably managed.
 - i. **Medical Facility Rules and Regulations.** Patients have the right to be informed of the medical facility's rules and regulations that relate to patient or visitor conduct. The patient has the right to expect that explicit rules (e.g., smoking) will be impartially enforced for all.
 - j. **Patient Complaints.** Patients are entitled to information about the medical facility's mechanism for the initiation, review, and resolution of patient complaints.
 - k. **Timelines of Care.** Patients have the right to the most timely access and treatment which medical facility resources and medical circumstances allow.
2. **Patient's Responsibilities.** Providing quality health care is a complex task that requires close cooperation between patients and medical facility personnel. Patients can take responsibility for their care by helping health-care personnel give the best possible care. Toward that end, patient responsibilities exist in a number of areas:
- a. **Providing Information.** Patients must provide, to the best of their knowledge, accurate and complete information about symptoms, past illness, hospitalization, medication, and other matters relating to their health. A patient must let his or her primary health care practitioner know whether he or she understands the treatment and what is expected of him or her.
 - b. **Respect and Consideration.** Patients must consider the rights of other patients and health care personnel. This includes assuring that they and their visitors comply with noise, smoking, and visitor congestion policy. Patients must respect the property of other persons and the medical facility.
 - c. **Compliance with Health Care.** Patients must comply with the medical, dental, and nursing treatment plan, including follow-up care recommended by health care personnel. This includes keeping appointments.
 - d. **Medical and Dental Records.** Patients must ensure they promptly return records to the medical facility for proper filing and maintenance if they hand-carry the record for purposes of consultation. All records documenting care provided in a federal government facility are the property of the US Government.
 - e. **Medical Facility Rules and Regulations.** Patients must follow general medical facility rules and regulations affecting patient and visitor conduct.
 - f. **Reporting of Complaints.** Patients should help the medical facility commander provide the best possible care to all beneficiaries. The medical facility commander should promptly report recommendations, questions, or complaints to the service or the patient advocate.

Patients are, and probably have good cause to be, apprehensive. Most people have a definite fear of the unknown, and the hospital can be an intimidating place. You can help calm these anxieties. Every time you speak with patients, convey a genuine interest in meeting their needs. This interest, or the lack of it, is reflected in your attitude, manner, and speech. Always conduct patient care activities in a

pleasant, positive, and reassuring manner. Never treat a patient rudely or abruptly; instead, be courteous and tactful. There are times when this can be easier said than done.

When patients come to the pharmacy, they are most likely injured or ill. It is usually easy to spot an injured patient, but illnesses are not always visible. It is not your responsibility to determine what is wrong with the patient; that is the responsibility of the practitioner. Your job is to dispense the medication prescribed and answer any questions about that medication the patient may have. Be careful to not discuss a patient's condition where other patients may overhear you. It is important to remember you are a professional. Your attitude and behavior are just as important to the patient's well-being as the medication you dispense. Let's cover some more basic attitudes and behaviors you must portray to your patients, and then we will move on to professional relationships.

Appearance

As a professional, always present a proper military appearance. Avoid fads as well as wearing excessive amounts of jewelry or cosmetics. Patients and supervisors usually form a first impression of you based on the way you look. If your hair, clothes, and fingernails are dirty and you have an offensive body odor, what kind of impression do you think you will make? If you look sharp, it generally helps you to act sharp; this leaves a favorable impression of you with others. Just make sure your performance equates to the same standards as your appearance!

Be courteous

Whether spoken or unspoken, always communicate in a friendly, respectful manner. If you are overly familiar with your patients, they may think you have a casual attitude about their care. Address *military members*, both active and retired, *by their titles*. That is a right they have worked hard to earn. Failure to show proper respect for military members, particularly those who outrank you, is a breach of military courtesy and discipline. Adolescent patients may be more cooperative if you address them in the same way you address adults. Children usually respond better if you address them by their first name or nickname. When dealing with children and infants, get the parents involved whenever possible. A high percentage of a patient's perception of quality health care comes from personal contact with members of the health care team. Remember, good communication is the key to improving this perception.

We should all show good manners and politeness toward patients. There will be times when you have problems in your own life. These problems could affect your attitude at work. You need to be aware patients also have problems, some of which could be the same or even greater than yours. This stress on a patient can affect his or her attitude, also. You are the professional in this situation, and you must act like one. When you speak to patients or other members of the medical staff, be courteous and show them respect. Put a smile on your face and ask, "May I help you?" Most importantly, don't forget that your job is to provide a service for these patients and medical staff members. You are expected to provide it courteously, even if the patient is not showing you the same respect.

There will be times when a patient may be argumentative with you. Remember, people usually go to the hospital because they are sick. The patient you are dealing with may be feeling poorly or may have just been given a bad prognosis. If the patient gets rude or abusive, stay calm and professional. The minute you are unprofessional, you have failed and will ultimately be held accountable for the incident. This does not mean patients can cross the line and mistreat you. Remember, patients also have an obligation to be respectful and considerate. However, if you are not able to diffuse a heated situation or feel you are losing your temper; ask a supervisor or pharmacist to assist the patient.

Attentive

Pay attention to patients; no one likes to be ignored. Do not ignore them at the window of the pharmacy. Stop what you're doing and help them. After all, without them you would not have a job. Time after time, we go to an office for assistance, and the people in that office are overloaded with work, just like you. How do you feel if a worker continues on with his or her business and does not even acknowledge your presence? It makes you angry, doesn't it? Well, our patients feel the same

way when they come to the pharmacy window and no one seems to notice. Make a point to treat patients the same way you wish to be treated: politely, in a timely manner, and respectfully.

There never seems to be an end to the tasks that must be done in the pharmacy. Although you have had a busy day and need a break, do not neglect to wait on patients. If you need to take a break, don't congregate around the window; catch your breath in the back, away from public view. Patients waiting in the pharmacy lobby watch your work habits closely and may complain to the commander about how long they had to wait while the staff took breaks. Of course, some patients will complain regardless, so make sure the complaint is unjustified.

Telephone etiquette

A lesson about professional relationships needs to include a discussion regarding telephone etiquette, because you will spend a great deal of time on the telephone. It is important you use proper telephone etiquette when talking to both patients and medical staff. When you answer a military telephone, identify yourself and your location (e.g., "Good morning, Main Pharmacy, Airman Armstrong, how may I help you?"). Make sure you're courteous and cordial. Speak with a clear, pleasant voice. There is nothing that irritates the person on the other end more than not being able to understand you.

If you have to place a person on hold, ask his or her permission before you do so. Don't just push the hold button without warning. Then, make sure you *push* that button. Conversations are easily overheard if the telephone is just laid down on the counter or desk. Do not leave the person on hold indefinitely. You should check back with the person on hold approximately every 30 seconds. Keep your patients updated. They will feel more appreciative if you interact with them.

When you receive a telephone call that cannot be taken care of right away, make sure you take a message. If the caller does not offer to leave a message, you should ask if he or she would like to leave a message. At the very least, get the caller's name and telephone number. Write the message down as it is given to you, and deliver the message immediately if possible. Avoid putting the message in your pocket as you may possibly forget about it.

Medical information communication

Keep medical information confidential. Do not discuss it with people who do not have a need to know. This is not the same as classified security information, which affects national security and is classified confidential, secret, or top secret. Medical information is considered "confidential" in the context that it is revealed, sometimes without the patient's specific consent, to certain people only. This information should only be discussed when it is necessary for the treatment of the patient. Hold all discussions out of earshot of other patients. One sure way to lose patient confidence is to let a patient overhear you discussing his or her illness or medications openly. If you treat people with dignity and honor their privacy, then you will earn their respect.

So who does have the right to medical information? Obviously, if you learn something concerning the health of your patient, such as a drug allergy, the provider should know. You should also notify the provider if the patient is already taking a medication that will interact with the one just prescribed. These are common situations that call for medical information being given on a "need to know" or confidential basis.

Communication between a patient and a doctor is not always privileged communication. When it is privileged, the doctor has the right and duty to keep silent about the things learned from the patient. The doctor doesn't have to tell about it in a court of law but may testify about it if the patient asks. When the communication isn't privileged, a doctor can be legally ordered by a court to testify about information learned from a patient. Some states have laws that make certain communications between a patient and doctor privileged.

In the armed forces, a communication between an active duty patient and an armed forces doctor is not considered "privileged" under the *United States Manual for Courts-Martial, Rule 501 General rule*. This means a doctor can be ordered to testify about information learned from a patient. The

results of an evaluation can be used to discharge a person from the Air Force. Technically, any information an armed forces doctor learns from a patient can be used by the armed forces either in a court martial or in other administrative actions taken against the patient. However, you should keep in mind that even though information learned by an Air Force doctor from an Air Force patient is not privileged, it's not public information. A patient can sue a doctor who uses medical information in an unprofessional way. The same applies to you as a pharmacy technician. You hear a lot of medical information in your MTF and see a lot of prescriptions for particular diseases. Use it in your official job only. Don't tell other people about it unless they need the information to help treat the patient.

Patient advocacy

By now you may have visited several different patient treatment areas within your MTF. Did you notice each patient treatment area has a photograph, displayed where patients can see it, with the words "PATIENT ADVOCATE" on it? The word *advocate* is defined as, "A person who pleads for or in behalf of another; an intercessor." A *patient advocate* is an intercessor for the patient. When a patient has a problem or question pertaining to the pharmacy, he or she can ask to speak to the patient advocate for the pharmacy.

Most MTFs have a section called "Patient Advocacy." This section is designated to handle unresolved patient issues with the area of the hospital that was providing care for the patient. When the patient advocate responds to a patient problem or concern, the advocate must strive to achieve balance and also to fulfill his or her professional duty. The advocate cannot be so passive toward a patient's interest that patient care is compromised, nor can he or she be so actively involved that no regard is shown for the roles of other health care providers. Ideally, the patient advocate needs to find a happy medium. Teamwork is a treasured commodity worth seeking whenever patient care is at stake.

Pharmacy personnel are able to serve as patient advocates by communicating with patients and learning about their pharmacy-related problems and concerns. Because each patient interaction is different, the patient advocate will usually determine a plan of action based on an assessment of the situation. This assessment should include consideration of the severity of the problem, the patient's ability to understand the problem, and consideration of available options. For instance, there may be a situation in which the patient advocate identifies a potential problem while conducting a patient medication history interview. The patient advocate could point out this problem to the patient and expect the patient to resolve the problem alone or with the help of the prescriber. In a more serious situation, or when the patient cannot be expected to perform the necessary follow-up, the patient advocate may contact the prescriber about potential problems or concerns on behalf of the patient.

All members of the pharmacy are patient advocates to a certain degree. The patient is the focus for the practice of pharmacy and for all of the activities related to it. The patient is our ultimate customer, and we should do everything possible to resolve any problems he or she has. Knowledge about therapeutics, no matter what great depth and quantity, is useless unless it can be translated into specific health-seeking services for the patient. Another thing to remember is illness is a frightening and undesirable state for most patients, and their behaviors and attitudes are very much modified by their state of illness or wellbeing.

008. Professional relationships with medical personnel

If you exhibit in your daily activities the desirable and ethical characteristics we have just discussed, patients and staff members will respect your efforts. That respect can make your job much easier. In order for a patient to receive complete health care, the combined efforts of the entire health care team are required. You are an important member of that team and play a vital part in the overall treatment of the patient. Your job influences the big picture and how well that job is done depends on you. You must be able to provide accurate information on pharmaceuticals to both staff and patients.

Professional courtesy

Almost every day you'll come in contact with other members of the medical staff. Since they are also part of the Air Force medical team, show them the courtesy and professional acknowledgment they

deserve. Some of them may be doctors who want to get drug information or request a pharmacy favor. You should try to help them out as best you can, even if it's an inconvenience. This is called professional recognition or courtesy, and you shouldn't take offense. It is needed in a hospital environment to maintain good patient care and foster communication and teamwork. Professional courtesy creates esprit de corps, or a sense of pride that you belong to a great team of medical professionals who only have the benefit of the patient in mind. Not only does it enhance the image of the pharmacy, but it also demonstrates your professionalism as a pharmacy technician. The rewards will follow if you have this kind of attitude. Remember, pharmacy is your profession and should receive your highest commitment.

Interactions with staff

There will be times when you'll have to discuss the patient's illness and medications with the professional staff. Practitioners need to be notified of items such as patient allergies, drug interactions, incompatibilities, and medication order inaccuracies. Be respectful, and do not tell the practitioner he or she has made a mistake. Be tactful by informing the prescriber that you consulted a reference and it indicates there is a problem with the prescription. There are times when prescribers intend to prescribe out of the normal dosage range. You are not aware of everything that is wrong with the patient; therefore, just inform the practitioner of the discrepancy. It is the practitioner's responsibility to determine if an error has been made. If after discussing the problem with the prescriber you still feel there is a problem, notify your supervisor or pharmacist.

You also may have to notify practitioners of a drug's status (e.g., backordered or expired). When you notify the practitioner a drug is not available, be sure you know of an alternative medication (e.g., medication in the same drug class) that could be prescribed for that patient until the medication originally ordered is available. There are many medical references that can assist you with this, so you will have to familiarize yourself with references specific to your pharmacy setting. Let's look at some more attitudes that promote professional interactions with other medical staff and patients.

Caring

Courtesy and kindness, both to those you serve and to those you work with, help to ensure individuals are not treated solely as a means to an end. Caring for others is the counterbalance against the temptation to pursue the mission at any cost.

Confident

You, as a pharmacy technician, are providing a public service to both patients and fellow medical professionals. You are expected to set an example of superior diligence and commitment. Along with being attentive and courteous to patients and staff members, you also need to be confident in your job. You have received, and are receiving, some excellent training. Don't be afraid to use your knowledge. Also, increase your competence in order to maintain your self-confidence. Competence in any profession is gained through routinely completing specialized training. Participation in pharmacy related education, either through formal or in-service methods and advancement to the various skill levels within the career field, are ways to achieve and maintain competence. In doing so, you'll enhance your knowledge and skills, and you'll provide better service to patients and staff.

Be sure

Accuracy is essential when providing drug information. The pharmacy section is the center for drug information within the hospital. Physicians, nurses, and other health care professionals will contact the pharmacy (you) requesting information on medications, dosages, side effects, etc. Before you pass on information affecting the health or safety of a patient, *be sure it is correct*. If there is even the slightest doubt about any part of your response, play it safe; look it up or ask for assistance from your supervisor.

Initiative

You have received quite a bit of training up to this point in your career. Now that you're working in the pharmacy, you're probably not using all of the skills and knowledge you've obtained. To maintain

or increase your proficiency, it's up to you to take the initiative. Ask questions about medications you are unfamiliar with. Volunteer for additional pharmacy duties, such as supply or equipment custodian, vault custodian, or clinic drug inspector. If you sit quietly and never seek out new skills, you may only be qualified to fill prescriptions on the line. This limits your ability to truly assist your co-workers in a productive manner. A strong knowledge foundation and variety of skills mean greater flexibility in being able to aid in mission accomplishment. Also, you will feel like a more productive member of the pharmacy, which will increase your job satisfaction. However, stay within your capabilities. It is important to reiterate you should only perform tasks for which you have been properly trained; otherwise, your actions could inadvertently harm a patient. Let your supervisor know if you cannot perform a task; he or she will be able to provide the training you need.

Integrity

Being faithful to your convictions is part of integrity. Following principles, acting with honor, maintaining independent judgment, and performing duties with impartiality help to maintain integrity and avoid conflicts of interest and hypocrisy.

Accountability

Department of Defense employees are required to accept responsibility for their decisions and resultant consequences. Accountability promotes careful, well-thought-out decision making and limits thoughtless action. Part of the commitment to professional excellence is understanding you are not a walking pharmacy reference book. You will not always have the answer to patients or other medical professional's medication questions. However; you do have references available and a lot of knowledge around you in a pharmacy. So don't be afraid to ask for help when needed but always try to look up information before asking. This will make you more self-reliable and increase your pharmaceutical knowledge.

Self-Test Questions

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

006. Professional ethics

1. What are medical ethics?
2. What is fidelity?
3. What does nonmaleficence mean?
4. What term is used to refer to your duty to bring about good or render a treatment in the best interest of a patient?
5. What does compensatory justice imply?
6. What is the key concept of procedural justice?

7. What situations may override the first-come, first-served method of procedural justice?
8. What action should you take if you feel a prescription will harm a patient?

007. Professional relationship with patients

1. List the eleven patient rights areas.
2. List the six patient responsibility areas.
3. How can you assist in calming a patient's anxieties?
4. In what context is medical information considered "confidential"?
5. What is one sure way to lose a patient's confidence?
6. What is privileged information?
7. Communication between an active duty patient and an armed forces doctor is not considered "privileged" under what rule of the *United States Manual for Courts-Martial*.
8. What is a patient advocate?
9. What section in the MTF is designated to handle all unresolved patient issues?

008. Professional relationships with medical personnel

1. What is needed in a hospital environment to maintain good patient care and foster communication and teamwork?
2. Whose responsibility is it to determine if an error has been made on a prescription?

3. What additional information should you give the practitioner when notifying him or her of the unavailability of a medication?
4. What should you do prior to passing on information that affects the health and safety of a patient?
5. What actions can you take to increase your job proficiency?

2-2. Laws of Pharmacy

In this section, we will discuss some of the laws that govern pharmacy practice and the AFls which supplement those laws. We will address the historical significance and substance of the original laws and then explain how subsequent changes to the law apply to you as pharmacy technicians.

The Federal Food, Drug, and Cosmetic Act (FDCA) and the Controlled Substances Act (CSA) are the most important federal laws affecting the practice of pharmacy.

009. Food, Drug, and Cosmetic Act

Although this law encompasses many aspects of consumer protection, we will discuss only those areas that pertain to pharmacy. The FDCA of 1938 stems from the Federal Pure Food and Drug Act of 1906. It is one of the most important laws ever passed because it created the Food and Drug Administration. The 1906 Act was a good first step but mainly dealt with prohibiting adulteration and misbranding of drugs. The definitions of adulteration and misbranding have been altered over the years, but they are generally defined as follows.

Adulteration

Adulteration occurs if a product contains any filthy, putrid, or decomposed substance. A drug is adulterated when it is packed or held under unsanitary conditions or when its strength, purity, or quality does not comply with its label.

Misbranding

Misbranding results if the label is false or misleading or if it does not contain directions for use, precautions, and in some cases, the statement “Warning: May Be Habit Forming.” It also applies to pharmacists who supply or refill prescription drugs without prescriber authorization. We’ll discuss this more in-depth when we cover the Durham-Humphrey Amendment.

One of the most significant changes brought about by the enactment of the FDCA was the requirement for product marketers to prove their products were safe for use under conditions set forth on the label. This change was brought on by deaths associated with the product Sulfanilamide Elixir. The vehicle used for the elixir was Diethylene Glycol, which is now recognized as a toxic substance. At that time, however, there were no toxicity tests done on product ingredients. More than 100 people reportedly died from taking the elixir before the FDA took the product off the market. The FDCA is enforced and regulated by the FDA, an agency of the Federal Department of Health and Human Services. The FDA governs the quality, strength, purity, and labeling of drugs as defined by the FDCA.

As with many other laws, however, the FDCA was far from perfect when it was initially enacted. The Durham-Humphrey and Kefauver-Harris Amendments were added in subsequent years.

Durham-Humphrey Amendment

In 1951, the Durham-Humphrey Amendment, also known as the prescription drug amendment, was enacted. The amendment requires drugs that are not considered safe for use without medical supervision will be dispensed only under the following circumstances:

- On the written prescription of a practitioner licensed by law to administer such drugs.
- On a practitioner's oral prescription that is promptly reduced to writing and filed by the pharmacist.
- By refilling any written or oral prescription if refilling is authorized by the prescriber. This is done either on the original prescription or in the oral order that is reduced to writing and filed by the pharmacist.

If these conditions are not met and a prescription drug is dispensed without a valid prescription or authorization for refills, the drug may be deemed misbranded.

Pharmacists and pharmacy interns under the direct supervision of a pharmacist are the only persons permitted to transcribe an original prescription or refill an order. The information must be immediately written down. This has a two-fold purpose: it reinforces what was heard, and it establishes a record of the prescription. Generally, a note is made on the prescription to annotate the prescription was taken as an oral or telephone prescription.

Kefauver-Harris Amendment

The FDCA required that a product's safety must be proven. The FDCA did not, however, require proof of efficacy, or effectiveness, of drugs before the FDA approved them. Therefore, drugs were not subject to rigorous testing before approval.

Proof of efficacy

The Kefauver-Harris Amendment (KHA) of 1962 is best noted for requiring proof of efficacy of drugs before the FDA approved them. The KHA applies to all drugs introduced after 1962 and drugs that had new applications approved from 1938 to 1962. The federal government was already considering stricter regulations over the drug industry when another drug tragedy unfolded. In this instance, it was the drug Thalidomide, an anti-nausea drug being given to pregnant women in West Germany.

Thalidomide

Sometime around 1961, thalidomide was discovered to cause a severe birth defect known as phocomelia. Infants born with phocomelia have severe limb deformities. These infants were born without one or both arms or legs, or with extremities partially formed, looking like flippers. Phocomelia is thought to have affected thousands of infants in West Germany. There were also a few cases reported in other European countries.

In May 2006, the FDA approved the use of thalidomide in treating new cases of multiple myeloma (a blood and bone marrow cancer). Research is continuing on thalidomide for the use in other disease states such as inflammatory diseases, human immunodeficiency virus (HIV)-related mouth and throat ulcers, and several types of cancer; however, more studies are needed to fully assess the risks and benefits to patients before thalidomide is approved as a treatment for these diseases.

Approval withheld

Thalidomide was on the market in West Germany. It had been tested by drug manufacturers for various uses for several years prior to the discovery of its teratogenic (causing fetal malformations) effects. As a matter of fact, Thalidomide was being tested experimentally in the United States in 1960, and the FDA withheld final approval of the drug until further safety tests were conducted.

Better control

The KHA strengthened the FDA's authority over human drug testing. This led to drug companies conducting better controlled and more adequate clinical studies. They were more likely to detect any problems with safety and efficacy before a drug was approved.

The FDA Modernization Act

The FDA Modernization Act of 2004 was passed to update labeling requirements on prescription medications. Medications previously labeled with "Caution: Federal Law Prohibits Dispensing without a Prescription" were changed to read "Rx Only."

Classification of drugs

Before we move on, now is a great time to discuss how drugs are classified. We will also discuss some of the specifics of prescription refills and prescribing authority.

Prescription or legend drugs

Prescription drugs, or legend drugs, require a prescription before they can be dispensed to a patient. These drugs are *not* considered safe for use without medical supervision. In this case, "medical supervision" means a practitioner is following the patient. Legend drugs are *not* meant to be taken by anyone other than the person for whom they are prescribed. Manufacturers of legend drugs are required to label them with the federal legend (consequently, the name "legend drugs"): "Prescription Only" or "Rx Only."

Scheduled listed chemical products

There is a new classification of medication brought on by the Combat Methamphetamine Epidemic Act of 2005 that covers over-the-counter (OTC) Pseudoephedrine. It is now in a class called "Scheduled Listed Chemical Products" and went into effect March 2006. The term "*Scheduled Listed Chemical Product*" means: a product that contains Ephedrine, Pseudoephedrine, or Phenylpropanolamine; and may be marketed or distributed lawfully in the United States under the Federal Food, Drug, and Cosmetic Act (FDCA) as a nonprescription drug.

Specifically, the Combat Methamphetamine Epidemic Act of 2005:

- Limits daily retail sales to 3.6 grams per person.
- Limits 30-day retail purchases to 9 grams per person.
- Requires nonliquid forms to be sold in blister packs (with some exceptions).
- Requires sellers to place the product behind-the-counter.

It also requires sellers to maintain a written or electronic list "logbook" and purchasers must present a photo identification before signing the logbook. The log of each sale must identify:

- The product name.
- Quantity sold.
- Names and addresses of purchasers.
- Dates and times of sales.

Mobile sellers (such as kiosks in airports) must place the product in a locked cabinet and are subject to a 7.5 gram sales limit per customer during a 30-day period. Similarly, mail-order sellers must, prior to shipping the product, confirm the identity of the purchaser and may not sell more than 7.5 grams of products per customer during a 30-day period.

The US Attorney General is directed to establish criteria for the logbook and training programs that all sellers must take and to promulgate regulations to address the privacy issues that could arise with the logbook.

The new standards do not preempt state laws; they will be considered a minimum standard. Tougher state laws, such as the Oregon law that requires a prescription to obtain Pseudoephedrine-containing

products, will continue to remain in force. The federal law also established tougher penalties for individuals who make Methamphetamine illegally and committed additional federal resources to finding and shutting down so-called "super labs" in Mexico which supply most of the Methamphetamine for US users.

Nonprescription or over-the-counter drugs

Nonprescription drugs, or over-the-counter (OTC) drugs, are recognized as safe and effective for use without a prescription and may be bought over the counter. Manufacturers of nonprescription drugs are required to label their products with directions for safe and effective consumer use.

Federal and some state laws may give certain controlled substances exempt status and permit pharmacists to dispense them without a prescription. An example of this is cough medicine with Codeine.

Prescribing authority

Each state may stipulate who is authorized to prescribe drugs and the scope of their prescribing authority. For example, medical doctors may have wide latitude for prescribing; while dentists could be restricted to treating conditions related to the mouth and be allowed to prescribe only medications such as antibiotics for a tooth infection or painkillers for a painful procedure. Some states give other healthcare professionals, such as nurses and pharmacists, limited prescribing authority.

Refilling prescription medication

A prescription can be refilled as many times as the prescriber indicates on the prescription within a specified time limit determined by the state; this is generally one year from the time the prescription is written. If the prescriber does not annotate refill information on the prescription, it is considered to have no refills.

As needed

Refill authorizations should be displayed as a number. Some prescribers use *PRN* (as needed) as a refill indication. The FDA does not acknowledge PRN as a valid designation. Therefore, pharmacists may use their professional discretion in deciding whether to refill the prescription. Prescriptions with PRN refills should be consistent with the directions for use. For example, antibiotics are usually taken for a short period of time; therefore, they should not have PRN refills. On the other hand, Digoxin, which is used for congestive heart failure, would be appropriate for PRN refills because it is for an ongoing condition. You may need to contact the provider after a reasonable time to be sure the refills are reflecting what the prescriber intended.

Information

When refilling a prescription, state laws usually require the prescription be annotated as to the quantity dispensed, date dispensed, and pharmacist's initials. Many states allow refill information to be kept electronically in a computer database rather than by notation on the prescription.

Authorization

When a patient's prescription does not have any refill authorizations or the patient uses all of the refills allowed, the patient can ask the pharmacist to contact the prescriber to authorize refills. The pharmacist may regard the authorization either as a refill and annotate the information as described previously or as a new prescription. If a different prescriber gives the authorization for the refill, state law may mandate the refill be treated as a new prescription.

Emergency dispensing

In cases where the pharmacist is not able to obtain refill authorization, he or she may dispense a limited amount of the drug to the patient to supply the patient until the prescriber can be contacted. When this type of situation exists, it is usually referred to as *emergency dispensing*. State law typically limits the quantity dispensed to a 72-hour supply. Pharmacists must use their

professional judgment to assess each situation and decide whether it warrants giving the patient an emergency supply.

Refilling prescriptions in accordance with AFI 44-102, Medical Care Management

A provider authorizes a pharmacy to refill certain prescriptions by giving refill information to the original prescription, but pharmacies *may not* refill prescriptions for drugs listed in the Schedule II category. Also, pharmacies may not refill prescriptions for drugs listed in Scheduled III, IV, and V more than six months after the date of issue or more than five times total.

Pharmacies normally honor prescription refills only if they have the original prescription on file. Pharmacists may request a transfer of an original prescription provided the validity of the prescription (e.g., that refills are available and the prescription is still active, etc.) is verified with the pharmacist at the transferring facility before filling the prescription. The transferring facility will discontinue the original prescription and note in the comment field of Composite Health Care System (CHCS) the name of the pharmacist, the facility, and the date transferred. The receiving facility must ensure its database reflects the original fill date, prescription number, provider name and Drug Enforcement Agency (DEA) number, and the adjusted number of refills remaining. Prescriptions for controlled medications may be transferred once, while prescriptions for noncontrolled prescriptions may be transferred more than once as necessary for patient needs. Transferring prescriptions shall follow federal law and where possible, local and state pharmacy regulations.

Prescriptions may be refilled when 75 percent of the quantity dispensed has been used by the patient; based on the directions for use and the quantity prescribed, or at the discretion of the pharmacist.

Mailing medications in accordance with AFI 44-102, Medical Care Management

Under usual circumstances, routine mailing of prescriptions to eligible beneficiaries by MTF pharmacies *is not* authorized. Prescriptions may be mailed to patients enrolled at, or routinely receiving care at an MTF in an emergency or when personal hardship/disability keeps them from leaving their homes. In a situation where medications are mailed, postal service regulations for mailing controlled substances must be followed. Encourage patients requesting mail order pharmacy services to enroll in the TRICARE Pharmacy Home Delivery program.

010. Controlled Substance Act

Like the FDCA, the CSA grew from and improved on other laws. The CSA is the primary federal law that regulates the manufacture, distribution, and dispensing of controlled substances. Throughout this lesson and in the remainder of your CDCs we will refer to controlled substances by a few different names such as controlled drugs, controlled medications, scheduled drugs, and scheduled medications. All of these different terms are not meant to confuse you but are to expose you to the various terms used within our career field. Items that are referred to as “controlled” 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. The Air Force can also classify items as controlled due to their high diversion potential. Items that are referred to as “scheduled” are listed in groups or classes of controlled substances, divided as such by their relative potential for abuse, status of accepted medical use, and the degree of physical or psychological dependence that may be caused by abuse of the drugs.

Enforcing and regulating

The DEA, an agency of the Department of Justice, enforces and regulates the CSA. However; the FDA retains the authority to regulate some habit-forming drugs. These drugs may be subject to regulation by both the FDA and the DEA. Laws that deal with controlled drugs are often more stringent than FDCA governance of noncontrolled drugs.

The American Society of Health-System Pharmacists

In spite of the comprehensiveness of the CSA, ASHP founded in 1949, provides safe and effective drug therapy information through a variety of publications. ASHP interacts with the Joint

Commission, Congress, and other healthcare organizations to support pharmacy practice in hospitals, clinics, and other professional settings. ASHP also provides education and resources to aid pharmacists and technicians maximize pharmacy services.

Schedules

The CSA divides controlled substances into five schedules: Schedule I through Schedule V. These schedules, referred to as classes, are sometimes called C-I through C-V. The meaning of each schedule is as follows.

Schedule I

Drugs placed in Schedule I (C-I) have no accepted medical use in the United States. They also have a high potential for abuse and lack accepted safety for use under medical supervision. Examples of drugs that fall into this schedule are heroin and lysergic acid diethylamide (LSD).

Drugs in Schedules II through V have an accepted medical use in the United States and are defined as follows.

Schedule II

Drugs in Schedule II (C-II) have a high potential for abuse. This includes severe psychological or physical dependence. Examples of drugs that fall into this schedule are amphetamines, cocaine, codeine, hydromorphone, meperidine, methadone, morphine, and opium.

Schedule III

Drugs placed in Schedule III (C-III) have less potential for abuse than drugs in Schedules I and II. They have high psychological and low-to-moderate physical dependence. An example of a drug in this category is testosterone. Some Schedule II drugs are also in Schedule III when they are found in limited quantities (e.g., acetaminophen with codeine).

Schedule IV

Schedule IV (C-IV) contains drugs that have less potential for abuse than drugs in Schedule III. These drugs have limited psychological and physical dependence. Examples of drugs that fall into this schedule are chloral hydrate, phenobarbital, and benzodiazepines.

Schedule V

Drugs placed in Schedule V (C-V) have less potential for abuse than drugs in Schedule IV. These drugs have limited psychological and physical dependence. Some examples of drugs in this schedule are drugs listed in other schedules that are combined in limited quantities with other drugs. An example would be cough medicines with codeine such as Robitussin A-C.

Handling requirements

The chances of you ever dealing with a Schedule I drug while working in an Air Force pharmacy are slim to none. The most stringent requirements are placed on Schedule II drugs. Drugs in Schedule II are often handled specially as a group. Schedules III and IV drugs have numerous requirements that are similar, and they are often grouped together. Drugs in Schedule V have the least stringent requirements and may not require the same strict handling as other schedules, or they may be grouped with Schedule III and IV drugs.

Labeling

Commercial containers are generally required to bear labels designating the schedule with the appropriate C symbol in the upper right corner, twice the size of the largest type or overprinted over at least half the label (fig. 2-2).



Figure 2-1. Schedule drug label.

Dispensing

Some state laws permit certain controlled drugs to be dispensed without a prescription. These are usually limited to Schedule V drugs, such as cough medicines with codeine. A pharmacist must make the sale of these drugs. No more than 240 milliliters (mL) or 48 dosage units of opium-containing substances, or 120 ml or 24 dosage units of other controlled substances, may be sold in a period of 48 hours. The purchaser must be 18 years or older, and the sale must be recorded in a bound book, include the name of the drug and quantity sold, name and address of the purchaser, date of purchase, and the pharmacist's initials.

011. Prescription/Label requirements

Certain requirements exist for outpatient prescriptions and prescription labels for controlled and noncontrolled substances. These requirements differ slightly in some instances. The focus of this lesson is on the proper use of writing prescriptions. The reference for this information is AFI 44-102, *Medical Care Management*, chapter 9 which focuses its attention on doctor order entry and AF Form 781, *Multiple Item Prescription*, used within your facility.

Keep in mind not all requirements on the proper use of AF Form 781 apply to civilian prescriptions. For example, no more than three prescriptions should be written on AF Form 781 because the form has only three prescription blocks in which to write patient prescriptions. As you will quickly learn in your facility, most civilian prescriptions are not set up in this format; therefore, this requirement would not apply. Air Force pharmacies honor prescriptions from the following:

- Privileged providers of the Uniformed Services and their civilian counterparts.
- Veterinarians of the Uniformed Services.
- Privileged providers of consulting referral military facilities.

Providers who are not employees of the United States government must be duly licensed by the jurisdiction in which the MTF is located. (**NOTE:** This line refers to the contracted providers in your MTF and *should not* be misinterpreted as to believe the pharmacy turns away prescriptions that are not written in your local area.)

Writing prescriptions

Individuals who are authorized to prescribe medication for patients (authorized providers) in treatment facilities must adhere to guidance directed by AFI 44-102 to include the way they write or input prescriptions. As you will learn, writing or inputting a prescription may not be as easy as you

thought. First, each provider must review the patient's identification data for accuracy. This is to ensure the prescription is provided to the right person; just think about how many Thomas Smiths or Mary Jones exist in your database.

In the MTF, authorized providers are directed to use electronic order entry for prescriptions whenever available. If electronic order entry is not available, an AF Form 781 is used. The prescribing provider signs prescriptions or documents them via the Composite Health Care System /Armed Forces Health Longitudinal Technology Application (CHCS/AHLTA), using an electronic signature and dates them on the day of issue. Now, look at some key information that must be included on AF Form 781.

Proper use of AF Form 781, Multiple Item Prescription and civilian prescriptions (noncontrolled and scheduled medication)

There are requirements placed on written prescriptions for both noncontrolled and scheduled medications. There are additional specific requirements placed on writing for controlled medications, but we will cover that information later when we discuss managing controlled substance programs.

- Write no more than three prescriptions on AF Form 781.
- Draw a line through unused blocks on AF Form 781.
- Noncontrolled medication may not be prescribed on the same form as controlled medication.
- Separate prescriptions for drugs listed in schedules II, from those in schedules III, IV, and V by writing them on separate AF Forms 781.
- Write in complete patient identification data on AF Form 781 (full name, address, and patient identification number). Generally, the provider will write the patient's name on the prescription, and the patient will complete the required information prior to turning the prescription into the pharmacy for dispensing.

The prescriber's name stamp must be used on all hand-written prescriptions (both for AF Form 781 and civilian prescriptions). If a prescriber name stamp is not available, then the prescriber writes his/her full name and telephone number. If the provider is military, he/she will include rank, corps, and AFSC. The pharmacy may decline to fill such a prescription if there is any uncertainty as to the identity of the prescriber.

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, U.S.C., Section 829, Prescriptions, concerning prescribing and dispensing controlled substances. The prescribed amounts of controlled substances must be spelled out in addition to the written numeral amount. Additionally, DEA numbers must be included on any hand-written prescriptions for controlled substances.

Prescriptions for chronic maintenance medications may be written for up to a 90-day supply. Nonchronic medications are written for an adequate quantity to treat the acute problem, as deemed by the provider. In most instances, this will not exceed a 30-day supply.

Pharmacies may accept FAX prescriptions for noncontrolled substances and controlled substances in Schedules III-V from provider's offices, hospitals, or nursing homes in keeping with applicable state and federal laws.

Where feasible, the pharmacist contacts the prescriber to resolve problems of legibility, compatibility, dosage, or quantity prescribed. The pharmacist verifies authenticity of prescriptions and may refuse to fill prescriptions that contain errors, omissions, irregularities, ambiguities, alterations, or are contrary to the pharmacist's clinical judgment.

Label information

Make sure the prescription label contains the following information:

- Pharmacy name and address.
- Prescription or serial number.

- Name of patient.
- Name of the prescriber.
- Directions for use including precautions, if any, as indicated on the prescription.
- The date prescription is filled or refilled.

Packaging and labeling requirements in accordance with AFI 44-102, Medical Care Management

First and foremost, the packaging of prescriptions must adhere to the Poison Prevention Packaging Act (PPPA) guidance, and the label must conform to the requirements stated in the FDCA. If the pharmacy issues prepackaged medications to clinics for outpatient dispensing by providers, the medication must include a label for the patient's name, patient education material, and directions for use with every container. Only pharmacy personnel are authorized to label and transfer medications to different containers. Pharmacy personnel will prepare a label for each prescription and fasten it securely to the container before issuing medication to the clinics.

Prepackaged medications dispensed by the authorized health care provider directly to the patient do not require prescriptions, but the provider must record the prescribed treatment on the patient's Standard Form (SF) 600, Health Record-Chronological Record of Medical Care or SF 603, Health Record-Dental. Dispensing outside the pharmacy is limited to providers whose license allows dispensing directly to patients (generally dentists and physicians). It is important to remember that if a provider dispenses medication directly to a patient, he/she (the provider) must adhere to the same procedures and standards of practice that apply to dispensing from the pharmacy in order to ensure a single standard of care.

012. Medication dispensing requirements

Dispensing is defined as the provision of medication(s) to a patient, for self-administration, during the course of a patient's visit. In accordance with (IAW) AFI 44-102, the pharmacy is the primary area within the MTF for dispensing medications during normal operating hours. Exceptions and after hours dispensing must comply with all applicable pharmacy practice standards.

Pharmacies procure, dispense, recommend, or use only drugs approved by the FDA. The exception to this rule is in the use of investigational drugs. We'll discuss the dispensing of investigational drugs when we review AFI 40-402, *Protection of Human Subjects and Adherence to Ethical Standards in Air Force Supported Research* in the next section of this unit.

Key provisions and restrictions for providers on medication prescribing/dispensing

A provider may not prescribe themselves medication (controlled or noncontrolled) and may not prescribe medications on the controlled substances list for their family members. Providers who prescribe noncontrolled medication for their family members must ensure an evaluation and documentation of that evaluation is placed in the family member's health record.

When a provider prescribes a medication, controlled substance or otherwise, for another provider, a decision must be made by the prescriber concerning how that medication may affect the patient's ability to practice medicine.

Medication samples obtained from pharmaceutical representatives are not to be dispensed by providers; furthermore, manufacturer samples may not be kept in the MTF or dispensed to patients.

Providers dispensing medications outside of the pharmacy (i.e., after-hours clinics) annotate the medication dispensed on the patient's SF 600, Chronological Record of Medical Care; SF 603, Health Record-Dental; SF 858, Emergency Care and Treatment; or in the electronic medical record.

Key provisions for pharmacy personnel on medication dispensing

Pharmacists review all pharmaceutical orders occurring after normal duty hours and ensure the dispensed medications are annotated in the automated patient profile.

Pharmacies may not curtail or withdraw civilian prescription service nor restrict formulary drugs to any beneficiary class, regardless of the source of the prescription. Limiting drug availability to specific patients is acceptable when the limitations are based on clinical considerations, such as efficacy and/or potential toxicity. Such limitations shall be accomplished using published disease management guidelines or those developed cooperatively between members of the medical staff and the pharmacy.

Dispensing to inpatient/institutional care facilities outside the MTF is not authorized. Inpatient and institutional care facilities must have pharmacy services available. The MTF is not able to meet labeling and packaging requirements for other facilities. This does not apply to mutual aid situations at the discretion of the Pharmacy officer and MDG/CC.

OTC medication programs are permitted as long as the following conditions are met:

- Medications are included on the MTF formulary.
- The OTC medication program functions under the supervision of providers.
- Medications are entered into CHCS/AHLTA.
- Medications are dispensed through the MTF pharmacy.

The only exception to the rules above regarding OTC medications is the dispensing of emergency contraceptive products. However, the following dispensing criteria must apply:

- Patients 17 years of age or older may obtain emergency contraceptives directly from a pharmacist who will also enter the medication in CHCS/AHLTA to screen for overlaps, contraindications, and frequency of use before dispensing.
- Upon dispensing, every patient will receive the FDA-approved drug information handout provided by the manufacturer or downloaded from the FDA Website.
- Males requesting emergency contraceptives from the pharmacist must present their military identification card along with the military identification card of the female beneficiary who will consume the medication.
- Pharmacists who dispense emergency contraceptive medications and note that a patient has requested the medication more than twice within a six-month period shall refer the patient to a provider for family planning counseling to discuss the use of other contraceptive methods or medications.
- Medical personnel who object to dispensing emergency contraceptive medications or engaging in family planning services for moral, ethical, religious, personal, or professional reasons will not be required to engage or assist in such procedures unless the refusal poses a life-threatening risk to the patient. However, the MTF/CC must ensure alternate arrangements are available for the patient to obtain the medication with no delay in care.

Medication dispensing with automation equipment

Pharmacy automation equipment will be used to the maximum extent possible in the dispensing of outpatient prescriptions. In the event of a power outage or equipment malfunction, pharmacies must have appropriate downtime procedures to maintain accuracy in the dispensing process. Pharmacists will ensure safety features designed into automation equipment are used and access to safety overrides is limited.

Every manufacturer package intended for stock in automated dispensing equipment will be barcode scanned and logged in at the time it is placed into the equipment. Unclaimed prescriptions that are returned to stock must also be barcode scanned prior to being loaded into equipment.

The dispensing of force health protection prescription products

Military personnel may be deployed to high-risk areas of the globe in which there is an increased chance of contracting malaria or there is a chance that chemical agents may be used by the enemy

against them. To guard against these dangers and to support the mission, the military dispenses items deemed “Force Health protection prescription products” (FHPPP); these include items such as atropine/2-PAM (pyridine aldoxime methychloride) chloride/CANA (convulsant antidote for nerve agent) auto-injectors, certain antimicrobials including antimalarials, and pyridostigmine bromide.

The medical record and CHCS drug file of all patients issued FHPPPs will be documented with the drug name, strength, quantity, directions, and name of ordering provider on an SF 600, Health Record – Chronological Record of Medical Care, and on the deploying member’s DD Form 2766, Adult Preventive and Chronic Care Flowsheet.

Documentation and dispensing of FHPPPs is a collaborative effort between Medical Logistics, Pharmacy, and Deployment Medicine personnel. The MTF will develop a local policy to establish communication and coordination between departments for this purpose.

Patient’s representative or third parties

Patients may authorize adult third parties to pick up their prescriptions. An individual acting as the patient’s representative can pick up a prescription for the patient under the following circumstances:

- The patient has identified, either verbally or in writing, that a family member, other relative, personal friend, or other person is authorized to pick up prescriptions.
- The patient is not present to give consent; the health care provider may use professional judgment to determine if it is in that patient’s best interest to provide the prescription to the patient’s representative.

The Health Insurance Portability and Accountability Act (HIPAA) regulations also permit the conveyance of limited protected health information to the patient’s representative. For instance, the pharmacist may explain to the representative that a medication shall be taken on an empty stomach but shall not disclose that a medication is for the treatment of a particular condition.

013. Handling poisonous and hazardous substances

This lesson discusses the Poison Prevention Packaging Act (PPPA) and the Hazardous Substance Act (HSA). Both of these legislations play a prominent role in the dispensing of pharmaceuticals.

Poison Prevention Packaging Act

The PPPA of 1970 regulates household substances and requires they be packaged *for consumer use* in child-resistant packaging.

Child-resistant packaging

Child-resistant packaging is defined as special packaging that is significantly difficult for children under the age of five to open. The standards imposed by the PPPA do not mandate all children be prevented from gaining access to a container packaged as child-resistant. To meet PPPA standards for child-resistant packaging requirements, not more than 20 percent of a test group of children *should be able* to open the container after a visual demonstration. On the opposite end of the scale, the standards imposed by the PPPA *do not require* that adults be able to gain access into the container. However, not more than 10 percent of adults *should be unable* to open the container.

Outpatients

One of the main purposes of the PPPA is to yield the special requirements to nonprescription drugs, as well as prescription drugs. The PPPA is particularly relevant to outpatient pharmacies.

Discharged patients

The PPPA also applies to clinic and emergency room dispensing, physician dispensing, and medications dispensed to patients being discharged from the hospital.

Inpatients

Normally, medications prepared for immediate administration to an inpatient are exempt from the PPPA requirements. However, if a patient is allowed to keep bedside medications; the standards of PPPA must be followed.

Medication packaging

There are some instances when both prescription and nonprescription drugs may be exempt from the PPPA's child-resistant container specifications. We will list only a few of those here.

Patient requests noncompliant packaging

The exemption applies when the prescriber or the consumer requests that noncompliant packaging be used. Federal law permits consumers to make a blanket request for all of their medications to be supplied in noncompliant packaging. This request should be made in writing (this could possibly be an annotation on the back of a prescription or a permanent record to be filed). There are a limited number of prescription drugs that are exempt for varying reasons. One example is sublingual nitroglycerin because quick access to the drug may be needed. There are other drugs that are packaged in such small amounts they would not harm a child under the age of five. Still others may be packaged to help the consumer comply with directions (e.g., oral contraceptives).

Elderly and handicapped

Nonprescription drugs may be made exempt to aid an elderly and/or handicapped individual. Manufacturers are permitted to market one size of a product in noncompliant packaging. The package must contain the printed statement, "This package is for households without young children."

On the opposite end of the spectrum, there are situations in which drugs are rarely, if ever, exempt from being dispensed in child-resistant containers. Examples of these drugs are products containing aspirin, acetaminophen, elemental iron, and controlled substances.

When the manufacturer supplies prescription drug containers (such as prepackaged bottles of 30, 60, or 100 tablets) intended for consumer use, they should also be supplied in child-resistant packaging.

Refill/reuse

There are times when customers bring their prescription bottles to supply refill information. Other times, they bring in their plastic bottles to literally be refilled (reused). The concept of refilling a prescription by reusing a customer's old bottle and applying a new label is tempting, but the bottom line is: Don't do it! The PPPA prohibits the reuse of plastic child-resistant containers because the wear and tear of normal use may decrease their effectiveness. Some pharmacies do, however, save plastic prescription bottles (as well as plastic bulk containers from manufacturers) for recycling.

Poisons

Today, poisons are not routinely sold in retail pharmacies; nevertheless, we will discuss this topic here since you will be working with them in Air Force pharmacies. There was a time when pharmacies commonly sold poisonous substances for killing vermin, especially rats.

Labeling

The definition of poisons, and the laws regarding their sale, may differ from state to state. Their labeling however must follow the Federal Hazardous Substances Act (FHSA) of 1966 unless state law mandates identical or more stringent labeling.

Recording

Some states require that the sale of OTC poisons be recorded. The following information is normally required:

- Purchaser information: name, address, and age.
- Poison information: type (name), amount purchased, intended use, name and initials of person dispensing the poison.

- Require purchasers be of a certain age (such as 18 years of age) or that the pharmacist ensures that the purchaser is aware of the hazardous nature of the poison. Poisons dispensed by prescription may be exempt from some or all of these requirements.

Enforcing

The power to enforce the FHSA and the PPPA rests with the Consumer Product Safety Commission (CPSC) as a result of the Consumer Product Safety Act (CPSA). This Act transferred certain functions, including the power to impose criminal sanctions, to the CPSC. This power was once held by the FDA.

Federal Hazardous Substance Act

The significance of the FHSA to pharmacy is in respect to the sale of items, such as household bleach, antifreeze, drain cleaners, and other cleaning fluids that are often stocked in retail settings and sold in manufacturer containers that bear proper labeling.

Defining

A substance is defined as hazardous if it can cause injury through handling and cause potential danger, especially to children, if misused. Hazardous substances can include toxicants, corrosives or irritants, flammables, and substances that can generate pressure through heat or decomposition.

Regulating

The FHSA requires that all hazardous substances be regulated. It also requires all dangerous substances in household containers be labeled with the following information:

- Precautions.
- Directions for safe use and storage.
- Appropriate first aid directions.
- Instructions to get medical treatment from a physician in case of accidental injury.

014. Generic and therapeutic drug product substitution

The ASHP Statement on the Formulary System describes *generic equivalence* as existing when drug products are considered identical with respect to their active components. An example of this would be two brands of tetracycline. It also describes *therapeutic equivalence* as existing when drug products differing in composition or in their basic drug entity are considered to have very similar pharmacological and therapeutic activities. For example, two different antacid products.

The Pharmacy and Therapeutics function

The Pharmacy and Therapeutics (P&T) function usually makes decisions on generic and therapeutic equivalence in MTFs. For instance, the function may decide the MTF will not carry any brand-name products if there is a generic brand available. Another option might be to carry only one drug of several in the same class or type of drug. The function may also establish conditions and procedures for dispensing a therapeutic alternative to the prescribed drug. In accordance with AFI 44-102, Air Force pharmacies may fill prescriptions written by DOD providers for brand-name drugs with an FDA-approved generic equivalent when available.

Pharmacies

Pharmacies must fill prescriptions for formulary drugs written by civilian providers for eligible beneficiaries. Substitution of generic for brand-name products on prescriptions from non-MTF providers follows applicable state pharmacy practice guidelines. Pharmacies will not special purchase brand-name drugs to fill civilian prescriptions.

Dispense as written

In the retail setting, physicians desiring a particular brand name product be dispensed to a patient may so indicate on the prescription. The physician would either write in or check the appropriate

block/box with the instruction “dispense as written,” or “DAW.” Some prescription forms have two different signature lines to indicate whether a substitution is allowed.

Let’s look at one more act that affects how we practice in our pharmacies.

015. Omnibus Budget Reconciliation Act

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) encompasses a number of laws relating to pharmacy practice.

Intention

OBRA 90 is intended to save taxpayers money, as the full name indicates. Congress decided to reduce the government’s cost for pharmaceuticals in the Medicaid program. In addition, Congress made a positive statement about the pharmacist as a healthcare professional who can improve the quality of a patient’s drug regimen. Congress obviously believes higher quality patient care is more cost-effective patient care, and the pharmacist has been chosen as the key player in the latest congressional effort to improve quality of care.

Medicaid prescription drug program

The section of OBRA 90 that relates to the Medicaid prescription drug program is lengthy and touches upon almost every aspect of pharmacy practice. There are three main sections:

1. Manufacturer rebates to individual state Medicaid programs.
2. Mandatory drug utilization review (DUR), which includes patient counseling. A DUR (also known as a drug usage evaluation or DUE) is an ongoing, systematic (carried out in a methodical and organized manner), criteria-based (an accepted standard used in making decisions or judgments about something) program of drug evaluations that will help ensure that appropriate drug use is provided. (**NOTE:** If therapy is determined to be inappropriate, interventions with providers or patients will be necessary to optimize drug therapy. We will discuss DURs/DUEs in greater detail later on in this CDC.)
3. Government-sponsored demonstration projects relating to the provision of pharmaceutical services.

Pharmacists as professionals

The section of OBRA 90 that recognized pharmacists as professionals whose expertise could detect potential problems with drug therapy and promote rational outcomes is the next topic.

Review of drug therapy

Each state establishes regulations that encompass a review of drug therapy before each prescription is filled or delivered to an individual, typically at the point-of-sale (or in our case, dispensing). The review includes screening for potential drug therapy problems due to therapeutic duplication, drug disease contraindications, drug-drug interactions (including serious interactions with nonprescription or OTC drugs), incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse or misuse.

Standards for counseling

As part of a state’s prospective drug use review program, applicable state laws establish standards for pharmacist counseling of individuals receiving prescriptions. The pharmacist must offer patient counseling to every individual, or caregiver of such individual (in person whenever practicable or by telephone), matters which, in the pharmacist’s professional judgment, he or she deems significant, including the following:

- The name and description of the medication.
- The dosage form, dosage, routes of administration, and duration of drug therapy.
- Special directions and precautions for preparation, administration, and use by the patient.

- Common severe side effects or adverse effects or interactions and therapeutic contraindications that may be encountered, including avoiding them and the action required if they occur.
- Techniques for self-monitoring drug therapy.
- Proper storage.
- Prescription refill information.
- Action to be taken in the event of a missed dose.

Obtain, record, and maintain information

A reasonable effort must be made by the pharmacist to obtain, record, and maintain at least the following information regarding individuals receiving prescriptions:

- Name, address, telephone number, date of birth or age, and gender.
- Individual history where significant, including disease state or states, known allergies and drug reactions, and a comprehensive list of medications and relevant devices.
- Pharmacist's comments relevant to the individual's drug therapy. If the patient refuses counseling, the pharmacist should document the patient's refusal.

This concludes our discussion of OBRA 90 and the entire section on laws of pharmacy. This section dealt with the laws and information that have the most impact on the duties of a pharmacy technician. The laws discussed are not the only relevant ones, and remember, state laws may differ.

Self-Test Questions

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

009. Food, Drug, and Cosmetic Act

1. From what law does the FDCA of 1938 stem?
2. What is the definition of adulteration, as it applies to drugs?
3. What is the definition of misbranding, as it applies to drugs?
4. What was one of the most significant changes brought about by the enactment of the FDCA?
5. What agency enforces and regulates the FDCA?
6. What amendment to the FDCA was known as the prescription drug amendment?
7. What members of the pharmacy staff are permitted to transcribe an original prescription or refill an order orally?

8. What is the purpose for promptly writing down the information received from an oral prescription or refill?
9. What is another name given to prescription drugs?
10. What types of drugs are required to be labeled “Prescription Only” or “Rx Only?”
11. What new classification of drugs was created by the Combat Methamphetamine Epidemic Act of 2005?
12. What is another name for nonprescription drugs?
13. When the prescriber does not annotate refill information on the prescription, how many refills is the prescription considered to have?
14. What is emergency dispensing?
15. According to AFI 44–102, when can prescriptions be refilled?
16. Under what circumstances do we mail prescriptions to patients?

010. Controlled Substance Act

1. What does the CSA regulate?
2. What agency enforces and regulates the CSA?
3. What type of drugs are designated as Schedule I?
4. What are the requirements for commercial containers for controlled substances?

011. Prescription/Label requirements

1. From what sources do USAF pharmacies honor prescriptions?
2. What is the maximum number of prescriptions that may be written of an AF Form 781?
3. What should be done when a provider does not use all the prescription blocks on the AF Form 781?
4. What information should a prescription label contain?
5. The packaging of prescriptions must adhere with what legislative act?

012. Medication dispensing requirements

1. Pharmacies procure, dispense, recommend, or use only drugs approved by what agency?
2. What restrictions are placed on providers who wish to prescribe medication to their family members?
3. Who must review all pharmaceutical orders occurring after normal hours to ensure dispensed medications are annotated in the automated patient profile?
4. What conditions must be met for over-the-counter medication programs?
5. Pharmacies that wish to dispense medication with automation equipment must accomplish what task prior to placing the medication into the automated dispensing equipment?
6. By prescription, the dispensing/issuance of FHPPPs may be accomplished through what three entities in the MTF?
7. Under what circumstances may a patient authorize adult third parties to pick up their prescriptions?

013. Handling poisonous and hazardous substances

1. What does child-resistant packaging mean?
2. What drugs are exempt from the PPPA?
3. What information do some states require when selling OTC poisons?
4. Define the term hazardous substance.
5. List the required FHSA label information for all household containers with dangerous substances.

014. Generic and therapeutic drug product substitution

1. What is generic equivalence?
2. What is therapeutic equivalence?
3. What committee usually makes decisions on generic and therapeutic equivalence in MTFs?

015. Omnibus Budget Reconciliation Act

1. What is the intention of the OBRA 90?
2. In general, what does OBRA mandate in regard to state regulations?

2-3. Air Force Instructions and Other Directives

Now that you are familiar with some of the important federal laws that govern the pharmacy, the next step is to recognize we also have AFIs that provide additional guidance in operating Air Force military treatment facilities and pharmacies. Pharmacy operations are governed by Air Force instructions, which are written to comply with federal laws and are often supplemented with additional MAJCOM guidance. The AFI with which pharmacy personnel must be most familiar is AFI 44-102. MTF instructions specify how AFIs and MAJCOM supplements are implemented in the facility. OIs are the department-level implementation of AFIs. Pharmacy OIs specify in detail how all key departmental functions are accomplished. Some pharmacy OIs may affect other departments and therefore must be coordinated with other sections.

As pharmacy professionals, we are obligated to comply with these instructions and laws. In some cases you may have an AFI that conflicts with federal, state, or local law. While each set of circumstances is unique, the general rule is to follow the law or AFI that is the most stringent of the group.

016. Air Force Instruction 44-102, *Medical Care Management*

This AFI provides guidance for the organization and delivery of medical care. It implements various publications of DOD recognized professional organizations such as: the Joint Commission, the AAAHC and appropriate health and safety agencies. This instruction applies to all personnel assigned to or working in Air Force MTFs, Air Reserve Component (ARC) medical units, and Aeromedical Evacuation units including Guard and Reserve personnel during their active duty periods, civilian personnel, contractors, trainees, and volunteers.

Chapter 1 – Roles, Responsibilities and Organization

This chapter of AFI 44-102 provides guidance for the general delivery of patient care and management of clinical services throughout the AFMS. It describes areas of responsibilities, the MTF organization, limited-scope medical treatment facilities (LSMTF), personnel management, and functions of the various sections throughout the MTF. Particularly important to pharmacy is *Chapter 8 – Pharmacy Services*.

Chapter 8 – Pharmacy Services

This chapter of AFI 44-102 provides guidance for the delivery of pharmacy services. Each chapter within AFI 44-102, including *Chapter 8 – Pharmacy Services*, is broken into sections (e.g., Section 8A—Pharmacy Services and Section 8B—Policies and Procedures). To give you a better understanding of the AFI, we will review Sections 8A and 8B; other guidance provided by this chapter has been incorporated into individual lessons throughout your CDCs, such as compounding and sterile product preparation in volume four.

For clarification or further guidance on items not discussed in this section, refer to local policies and procedures. Also, don't forget to ask your supervisor or pharmacist, because he or she may know where to locate information and guidance on any topic not covered in AFI 44-102.

Section 8A—Pharmacy Services, Organization

This section states the MTF/CC ensures the pharmacy operates under the supervision of a pharmacist IAW federal laws, DOD and Air Force policy, and accepted standards of practice as defined by the following healthcare organizations:

- The Joint Commission.
- ASHP.
- APhA.
- AAAHC.
- The United States Pharmacopeia.

Exception: A designated medical corps officer may supervise a pharmacy as a “pharmacy officer” when a pharmacist is not available. The designated officer must follow the same standards as would a pharmacist in carrying out the duties of pharmacy officer, including review of inpatient orders and prescriptions for accuracy and completeness.

Pharmacists or designated pharmacy officers provide direct supervision of pharmacy technicians.

Section 8B—Policies and Procedures

Pharmacies must develop policies and procedures, which provide:

- Pharmaceutical care consistent with the facility's scope of care and patient needs.

- Security measures to prevent the loss of pharmacy stock and unauthorized entry into the pharmacy.
- A perpetual inventory of schedule II, III, IV and V drugs.

The Pharmacy Flight commander, pharmacy officer, or element chief supervises drug storage and preparation areas throughout the MTF and satellite pharmacy operations.

Pharmacists and trained pharmacy technicians shall offer to counsel patients regarding drug therapy in general and their newly prescribed medications in particular.

Presently, AFI 44-102, *Chapter 8 – Pharmacy Services* has a total of nine sections (Sections 8A through Section 8I). Other sections include 8C (Medication Dispensing), 8D (Formulary Management), 8E (Pharmacy and Therapeutics function) 8F (Drug Inventory), 8G (Writing Prescriptions), 8H (Packaging Prescriptions), and 8I (Inpatient Pharmacy Services).

017. Other Air Force directives

Before we complete this unit, we will discuss a few more AF directives with which you should be familiar.

Air Force Instruction 33-364, Records Disposition—Procedures and Responsibilities

This AFI guides personnel in disposing special types of records, retiring or transferring records using staging areas, and retrieving information from inactive records. It applies to all Air Force military, civilian, and contractor personnel under contract by the DOD who maintain records in their area of responsibility, including the Air National Guard (ANG), Air Force Reserve Command (AFRC), and unified commands for which the Air Force is the executive agent. This instruction refers to, and works in correlation with, the Air Force Records Information Management System (AFRIMS) and the Records Disposition Schedule (RDS) Website.

Air Force Instruction 40-402, Protection of Human Subjects and Adherence to Ethical Standards in Air Force Supported Research

AFI 40-402 (formerly titled, *Protection of Human Subjects in Biomedical and Behavioral Research*), is a mandatory instruction that reissues DOD Directive (DODD) 3216.02 to establish policy and assign responsibilities for the protection of human subjects in DOD supported research programs. It provides guidance and procedures for conducting research investigations at MTFs, clinical investigation facilities (CIF), and other medical support centers. Additionally, it also provides guidance for using human subjects in research, development, testing, and evaluation (RDT&E) conducted or funded by the Air Force.

Earlier we mentioned pharmacies normally procure, dispense, recommend, or use only drugs that have been approved by the FDA, but we also noted that an exception to this rule exists. AFI 44-102, *Medical Care Management*, states pharmacies may dispense approved investigational drugs for clinical projects using guidelines in AFI 40-402, *Protection of Human Subjects and Adherence to Ethical Standards in Air Force Supported Research*, and when US Presidential Waiver Authority precludes the need to obtain individual service member consent to receive investigational drug(s). (**NOTE:** In order for investigational drugs to be procured for the purposes of clinical investigations, they must be dispensed according to an Institutional Review Board (IRB) approved protocol. We won't go into detail in this CDC; however, the process for participation in clinical investigations is outlined in AFI 40-402.)

It is important to note the Surgeon General (SG) is the single point of authority for the Air Force Human Research Protection Program (HRPP) and ensures human subjects are protected during research activities. The SG appoints a Surgeon General's Human and Animal Research Panel (SGHARP) to provide advice regarding ethically and scientifically challenging research involving human subjects.

Air Force Instruction 41-106, *Medical Readiness Program Management*

This AFI sets procedures for medical readiness planning, training, exercising and reporting in support of the full spectrum of medical operations, including expeditionary, humanitarian assistance, all hazards response, global health engagement and stability operations.

Air Force Policy Directive 41-2, *Medical Support*

Air Force Policy Directive (AFPD) 41-2, *Medical Support*, states medical support is necessary to sustain Air Force medical care around the world. This directive establishes policies for the main functions of medical support: patient administration, medical resources and manpower, information systems, medical readiness, medical logistics and medical facility management. By efficiently applying medical support, the Air Force can offer medical care at a reasonable cost while improving quality and access.

Air Force Instruction 41-209, *Medical Logistics Support*

This AFI implements AFPD 41-2, *Medical Support*, and provides guidance for establishing and operating medical logistics support for AF MTFs. This instruction provides logistics policy, procedures, and guidance for Air Force Medical Logistics (AFML) activities.

Air Force Instruction 41-201, *Managing Clinical Engineering Programs*

This instruction provides guidance on establishing and managing a clinical engineering program for MTFs. The clinical engineering program covers medical equipment maintenance, facility management, and medical equipment management, but this instruction specifically addresses facility management and medical equipment maintenance.

In accordance with this AFI, personnel are directed to investigate and report to the Biomedical Equipment Technician (BMET) section any equipment anomalies such as erratic responses, electrical flashing, or unusual sounds that may indicate malfunction. The facility management program ensures the Air Force acquires, operates, repairs, maintains, alters, and cleans its medical buildings and associated utility, transport, and communications systems in a manner that provides the suitable and productive environment for normal and anticipated contingency operations.

Air Force Instruction 44-119, *Medical Quality Operations*

This instruction outlines MTF roles and responsibilities in the area of clinical performance improvement (PI), explains patient safety and risk management (RM) programs, PI/accreditation/self-inspection requirements, credentials and privileging processes, and scope of practice in order to provide optimal healthcare delivery. This instruction applies to all AFMS personnel and where specifically identified within this instruction for units of the ARC and Aeromedical Evacuation Squadron (AES). This instruction also directs collecting and maintaining information protected by the Privacy Act of 1974.

Self-Test Questions

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

016. Air Force Instruction 44-102, *Medical Care Management*

1. What chapter of AFI 44-102, *Medical Care Management* provides guidance for pharmacies?
2. Under what circumstances may a designated medical corps officer supervise a pharmacy as a “pharmacy officer?”

3. What three individuals are designated by AFI 44-102 to supervise drug storage and preparation areas throughout the MTF and satellite pharmacy operations?
4. According to AFI 44-102, who shall offer to counsel patients regarding drug therapy in general and their newly prescribed medications?

017. Other Air Force directives

1. Which AFI guides personnel in disposing special types of records, retiring or transferring records using staging areas, and retrieving information from inactive records?
2. Which AFI contains guidance for using human subjects in RDT&E conducted or funded by the Air Force?
3. Which AFI provides logistics policy, procedures, and guidance for AFML activities?
4. In accordance with AFI 41-201, *Managing Clinical Engineering Programs*, to whom should equipment anomalies be reported?
5. Which AF directive explains PI and RM programs for optimal health care?

Answers to Self-Test Questions

006

1. The moral laws adopted by the medical profession and accepted by the society it serves.
2. That you are faithful to your patients and your duty.
3. That you'll refrain from harming yourself or others.
4. Beneficence.
5. That some patients should receive better treatment because they've been wronged.
6. Impartiality.
7. Priority to active duty members in support of the mission and emergency situations.
8. Consult with your supervisor, a pharmacist, or the prescribing practitioner.

007

1. (1) Medical and dental care.
(2) Respectful treatment.

- (3) Privacy and confidentiality.
- (4) Identity.
- (5) Explanation of care.
- (6) Informed consent.
- (7) Research projects.
- (8) Safe environment.
- (9) Medical facility rules and regulations.
- (10) Patient complaints.
- (11) Timelines of care.
- 2.
 - (1) Providing information.
 - (2) Respect and consideration.
 - (3) Compliance with health care.
 - (4) Medical and dental records.
 - (5) Medical facility rules and regulations.
 - (6) Reporting of complaints.
- 3. By conveying a genuine interest in meeting their needs.
- 4. In the context that it is revealed, sometimes without the patient's specific consent, to certain people only.
- 5. By discussing his or her illness or medications openly.
- 6. When the doctor has the right and duty to keep silent about the things learned from the patient.
- 7. 501.
- 8. An intercessor for the patient.
- 9. Patient advocacy.

008

- 1. Professional courtesy.
- 2. Practitioner.
- 3. Alternative medication.
- 4. Be sure it is correct.
- 5. Volunteer for additional pharmacy duties, such as supply/equipment custodian, vault custodian, or clinic drug inspector.

009

- 1. Federal Pure Food and Drug Act of 1906.
- 2. Occurs if a product contains any filthy, putrid, or decomposed substance.
- 3. The label is false or misleading, or if it does not contain directions for use, precautions, and in some cases, the statement "Warning—May Be Habit Forming."
- 4. The requirement for product marketers to prove their products were safe for use under conditions set forth on the label.
- 5. FDA.
- 6. Durham-Humphrey Amendment.
- 7. Pharmacists and pharmacy interns under the direct supervision of a pharmacist.
- 8. To reinforce what was heard, and to establish a record of the prescription.
- 9. Legend.
- 10. Legend.
- 11. Scheduled Listed Chemical Products.
- 12. OTC.
- 13. No refills
- 14. A limited amount of the drug to the patient to supply the patient until the prescriber can be contacted.

15. When 75 percent of the quantity dispensed has been used by the patient, based on the directions for use and the quantity prescribed; or at the discretion of the pharmacist.
16. In an emergency or when personal hardship/disability keeps patients from leaving their homes.

010

1. The manufacture, distribution, and dispensing of controlled substances.
2. DEA.
3. Drugs that have a high potential for abuse, no accepted medical use in the United States, and lack accepted safety for use under medical supervision.
4. Commercial containers are generally required to bear labels designating the schedule with the appropriate *C* symbol in the upper right corner, twice the size of the largest type or overprinted over at least half the label.

011

1. From privileged providers of the Uniformed Services and their civilian counterparts, veterinarians of the Uniformed Services, and privileged providers of consulting referral military facilities.
 - (1) Privileged providers of the Uniformed Services and their civilian counterparts.
 - (2) Veterinarians of the Uniformed Services.
 - (3) Privileged providers of consulting referral military facilities.
 - (4) Providers who are not employees of the United States government must be duly licensed by the jurisdiction in which the MTF is located. (NOTE: This line refers to the contracted providers in your MTF and *should not* be misinterpreted as to believe the pharmacy turns away prescriptions that are not written in your local area.)
2. Three.
3. Line should be drawn through unused blocks on AF Form 781.
4. Pharmacy name and address, prescription or serial number, name of patient, name of the prescriber, direction for use including precautions, and the date the prescription is filled or refilled.
 - (1) Pharmacy name and address.
 - (2) Prescription or serial number.
 - (3) Name of patient.
 - (4) Name of the prescriber.
 - (5) Direction for use including precautions.
 - (6) Date the prescription is filled or refilled.
5. PPPA.

012

1. FDA.
2. They may not prescribe medications on the controlled substances list.
3. Pharmacists.
4. Medications must be on the MTF formulary, the program must function under the supervision of providers, medications must be entered into CHCS/AHLTA, and medications must be dispensed through the MTF pharmacy.
5. Scan and log the medication.
6. Medical logistics, pharmacy, and deployment medicine.
7. The patient has identified, either verbally or in writing, that a family member, other relative, personal friend, or other person is authorized to pick up prescriptions, or the patient is not present to give consent, the health care provider may use professional judgment to determine if it is in that patient's best interest to provide the prescription to the patient's representative.

013

1. Special packaging that is significantly difficult for children under the age of five to open.
2. Medication prepared for immediate administration to an inpatient.

3. Purchaser name, address, and age; poison type, amount purchased, intended use, name and initials of person dispensing the poison; some states also require that purchasers be of a certain age (such as 18 years of age) or that the pharmacist ensures that the purchaser is aware of the hazardous nature of the poison.
4. A substance is defined as hazardous if it can cause injury through handling and cause potential danger, especially to children, if misused.
5. Precautions, directions for safe use and storage, appropriate first aid directions, the instruction to get medical treatment from a physician in case of accidental injury.

014

1. When drug products are considered identical with respect to their active components.
2. When drug products differing in composition or in their basic drug entity are considered to have very similar pharmacological and therapeutic activities.
3. The Pharmacy and Therapeutics (P&T) committee.

015

1. To save taxpayers money.
2. Each state establishes regulations that encompass a review of drug therapy before each prescription is filled or delivered to an individual, typically at the point-of-sale (or in our case, dispensing). The review includes screening for potential drug therapy problems due to therapeutic duplication, drug disease contraindications, drug-drug interactions (including serious interactions with nonprescription or over-the-counter drugs), incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse, misuse.

016

1. Chapter 9.
2. When a pharmacist is not available.
3. Pharmacy flight commander, pharmacy officer, or element chief.
4. Pharmacists and trained pharmacy technicians.

017

1. AFI 33-364, Records Disposition—Procedures and Responsibilities.
2. AFI 40-402, Protection of Human Subjects and Adherence to Ethical Standards in Air Force Supported Research.
3. AFI 41-209, Medical Logistics Support.
4. BMET section.
5. AFI 44-119, Clinical Performance Improvement.

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

Unit Review Exercises

Note to Student: Consider all choices carefully, select the *best* answer to each question, and *circle* the corresponding letter.

Do not return your answer sheet to AFCDA.

27. (006) Moral laws adopted by the medical profession and accepted by the society they serve are known as
- moral responsibility.
 - medical ethics.
 - beneficence.
 - justice.
28. (006) Which term is used to describe your duty to bring about good or render a treatment in the best interest of the patient?
- Nonmaleficence.
 - Beneficence.
 - Reparations.
 - Fidelity.
29. (006) What action should you take if you think a prescription will harm a patient?
- Tell the patient that the practitioner made an error in the prescription.
 - Fill the prescription; it is not your place to question a prescription.
 - Refuse to fill the prescription and send the patient away.
 - Consult with the practitioner about the prescription.
30. (007) What should you do if a patient becomes rude or abusive?
- Call the medical group (MDG) commander.
 - Remain calm and professional.
 - Return the favor.
 - Walk away.
31. (007) What action should you take before placing a person on telephone hold?
- Ask for his or her permission.
 - Push the hold button.
 - Ask you supervisor.
 - Take a message.
32. (007) You have just been made aware of the medical history of a retiring master sergeant; this information is considered to be
- secret.
 - top secret.
 - confidential.
 - unclassified.
33. (007) Under the *Manual for Courts Martial*, communication between an active duty patient and an armed forces doctor is considered to be
- not privileged.
 - restricted.
 - privileged.
 - secret.

34. (007) What section in the hospital is designated to handle all unresolved patient issues?
- The medical group (MDG) commander's office.
 - Resource management.
 - Patient advocacy.
 - Patient affairs.
35. (008) The most appropriate action that you should take when a practitioner has prescribed a medication that is unavailable is to
- fill the prescription with an alternative medication.
 - notify the practitioner and suggest an alternative medication.
 - tell the patient that the pharmacy does not carry that medication.
 - notify the practitioner and suggest that he or she submit a new drug request.
36. (008) Which of the following factors is essential when you are providing drug information?
- Speed.
 - Accuracy.
 - Sensitivity.
 - Confidentiality.
37. (008) What is your part in maintaining accountability to your profession?
- Understanding that you have limitations and may need help finding the answers.
 - Believing that you know everything there is to know about pharmacy.
 - Leaving younger Airmen to learn procedures on their own.
 - Not attempting to help a member of the medical staff.
38. (009) If a product contains any filthy, putrid, or decomposed substance; if drugs are packed or held under unsanitary conditions; or a drug's strength, purity, or quality does not comply with its label, what has occurred?
- Fraud.
 - Negligence.
 - Misbranding.
 - Adulteration.
39. (009) A drug that has false or misleading information on its label is an example of
- fraud.
 - negligence.
 - misbranding.
 - adulteration.
40. (009) Which personnel are permitted to transcribe an original prescription or refill an order orally?
- Pharmacists only.
 - Pharmacy interns only.
 - Pharmacy technicians only.
 - Pharmacists or pharmacy interns under the direct supervision of a pharmacist.
41. (009) Manufacturers of legend drugs are required to label them with the federal legend of
- "Caution, legend drug product" or "Prescription Only."
 - "Caution, legend drug product."
 - "Prescription Only" or "Rx Only."
 - "Dispense as written, Rx Only."

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42. (009) In cases where a pharmacist cannot obtain refill authorization from a prescriber, he or she may *emergency dispense* a limited amount of the drug to the patient; state law typically limits the quantity dispensed to a
- 96-hour supply.
 - 72-hour supply.
 - 48-hour supply.
 - 24-hour supply.
43. (009) According to Air Force Instruction 44-102, when may Air Force pharmacies mail medications?
- When there is an emergency.
 - When requested by the patient.
 - When the patient lives out of state.
 - Medications may never be mailed.
44. (010) Which act is the primary law that regulates the manufacturing, distribution and dispensing of narcotic medications?
- Omnibus Budget Reconciliation Act.
 - Poison Prevention Packaging Act.
 - Food Drug and Cosmetic Act.
 - Controlled Substance Act.
45. (010) A drug that has no acceptable medical use in the United States, but has a high potential for abuse and is not safe even under medical supervision, is classified in Schedule
- I.
 - II.
 - III.
 - IV.
46. (010) Drugs that have limited psychological and physical dependence potential and are considered the lowest risk for abuse are classified in Schedule
- I.
 - II.
 - IV.
 - V.
47. (010) Which requirements apply when state law allows certain controlled drugs to be dispensed without a prescription?
- Drug Enforcement Administration (DEA) number must appear on prescription label.
 - Sale must be reported to the DEA within 24 hrs.
 - Must be packaged in unit dose containers.
 - Purchaser must be 18 years or older.
48. (011) Air Force pharmacies will honor prescriptions from which of the following types of veterinary service?
- Veterinarians in the Air Force only.
 - Veterinarians from the local community.
 - Veterinarians of the Uniformed Services.
 - Veterinarians of the Uniformed Services and the Drug Enforcement Administration (DEA).
49. (011) The labeling of prescriptions must adhere to what legislative act?
- Poison Prevention Packaging Act (PPPA).
 - Food, Drug, and Cosmetic Act (FDCA).
 - Controlled Substance Act (CSA)
 - Hazardous Substance Act.

50. (012) According to Air Force Instruction 44-102, *Medical Care Management* what section within the Medical Treatment Facility (MTF) is the primary area for dispensing medication during normal operating hours?
- Pharmacy.
 - Emergency room.
 - Family practice clinic.
 - Aerospace medicine clinic.
51. (012) Providers who wish to prescribe medications for family members have restrictions placed on them so they may
- not prescribe any medication.
 - not prescribe medications listed on the controlled substances list.
 - prescribe ONLY drugs considered “maintenance medication” by their P&T function.
 - prescribe ONLY over the counter medication that the MTF has of formulary.
52. (013) The Poison Prevention Packaging Act (PPPA) of 1970 regulates household substances and requires that they
- be packaged *for industrial use* in child-resistant packaging.
 - be packaged *for consumer use* in child-resistant packaging.
 - are labeled with the legend statement.
 - are packaged in metal containers.
53. (013) Which of the following does the Poison Prevention Packaging Act mandate?
- All adults be able to gain access into the container.
 - Child-resistant containers must be on all medications.
 - The request for noncompliant packaging should be made in writing.
 - All children be prevented from gaining access into a child-resistant container.
54. (013) Which drug is exempt from compliance with the Poison Prevention Packaging Act?
- Aspirin.
 - Elemental iron.
 - Acetaminophen.
 - Sublingual nitroglycerin.
55. (013) Which agency can impose criminal sanctions for noncompliance with the Hazardous Substance Act?
- Drug Enforcement Agency.
 - Consumer Product Safety Commission.
 - American Society of Health-System Pharmacists.
 - Occupational Safety and Health Administration.
56. (013) Which Federal law requires that all dangerous substances in household containers be labeled with precautions, directions for safe use and storage, appropriate first aid directions, and instructions to get medical treatment from a physician in case of accidental injury?
- Controlled Substance Act.
 - Food, Drug and Cosmetic Act.
 - Federal Hazardous Substance Act.
 - Poison Prevention Packaging Act.

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57. (014) Which statement *best* describes drug product *generic equivalence* according to the American Society of Health-System Pharmacists (ASHP)?
- Differ with respect to their active components.
 - Are identical with respect to their active components.
 - Are identical and considered to have very similar pharmacological and therapeutic activities.
 - Differ in composition and considered to have very similar pharmacological and therapeutic activities.
58. (014) Which statement *best* describes drug product *therapeutic equivalence* according to the American Society of Health-System Pharmacists (ASHP)?
- Differ with respect to their active components.
 - Are identical with respect to their active components.
 - Are identical and considered to have very similar pharmacological and therapeutic activities.
 - Differ in composition and considered to have very similar pharmacological and therapeutic activities.
59. (014) Which description is an example of therapeutic equivalence?
- Two different antacid products.
 - An antacid product and an anti-ulcer product.
 - An antacid product and an anti-inflammatory product.
 - The same antacid product made by two different companies.
60. (014) Which authority usually makes decisions on whether to carry generic or brand name products in the Medical Treatment Facilities (MTFs)?
- Drug Enforcement Agency.
 - Food and Drug Administration.
 - Medical group (MDG) commander.
 - Pharmacy and Therapeutics committee.
61. (015) The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) mandates that each state will establish regulations that include screening for
- drug-drug interactions.
 - generic equivalent substitutions.
 - therapeutic equivalent substitutions.
 - alternate health care insurance coverage.
62. (015) The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) requires the pharmacist to offer counseling to each individual patient or caregiver on information such as
- the price of the medication.
 - possible substitutions for their medication.
 - techniques for self-monitoring drug therapy.
 - the condition the patient has that required the prescribing of the medication.
63. (015) To comply with the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), the pharmacist must make a reasonable effort to obtain, record and maintain a patient's name,
- address, telephone number, date of birth or age, and gender.
 - Social Security Number, and place of employment.
 - age and driver's license number.
 - and nothing more.

64. (016) Which Air Force Instruction (AFI) provides guidance for the organization and delivery of medical care?
- a. AFI 44-135, *Clinical Dietetics*.
 - b. AFI 44-102, *Medical Care Management*.
 - c. AFI 41-201, *Managing Clinical Engineering Programs*.
 - d. AFI 41-115, *Authorized Health Care and Health Care Benefits in the Military Health System*.
65. (016) Who is directed to ensure that pharmacies operate under the supervision of a pharmacist in accordance with federal laws, Department of Defense and Air Force policy, and accepted standards of practice?
- a. The Air Force Surgeon General.
 - b. The USAF Bio-Medical Corps Chief.
 - c. The Pharmacy Associate Corps Chief.
 - d. The Medical Treatment Facility Commander.
66. (016) According to Air Force Instruction (AFI) 44-102, *Medical Care Management*, when a pharmacist is not available, who may be designated as a “pharmacy officer”?
- a. Nurse corps officer.
 - b. Dental corps officer.
 - c. Medical corps officer.
 - d. Local civilian pharmacist.
67. (017) In order for investigational drugs to be procured for the purposes of clinical investigations, the drugs must be dispensed according to whose approved protocol?
- a. The Food and Drug Administration (FDA).
 - b. The Drug Enforcement Agency (DEA).
 - c. An Institutional Review Board (IRB).
 - d. A Health Consumer advisory council.
68. (017) According to Air Force Instruction (AFI) 41-201, *Managing Clinical Engineering Programs*, any unusual sounds that may indicate equipment malfunction should be reported to
- a. Medical Logistics.
 - b. the Medical Group commander.
 - c. the Resource Management Office.
 - d. The Biomedical Equipment Technician.
69. (017) Which Air Force Instruction (AFI) directs collecting and maintaining information protected by the Privacy Act of 1974?
- a. AFI 37-138, *Records Disposition*.
 - b. AFI 44-102, *Community Health Management*.
 - c. AFI 44-119, *Medical Quality Operations*.
 - d. AFI 41-115, *Authorized Health Care and Health Care Benefits in the Military Health System*.

Please read the unit menu for unit 3 and continue ➔

Unit 3. Pharmacy Environmental and Security Requirements

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IT WOULD SEEM that medical care facilities, dedicated to the care and healing of the sick and injured, would be very safe places. Unfortunately, accidents and injuries occur even in MTF. This unit is designed to make you aware of safety and health standards in place to prevent the possibility of an accident or injury occurring in your workplace. Also in this unit, you will learn about the many different security provisions in the pharmacy. As you will learn, many of our security requirements restricting drug access to “authorized personnel only” are often the result of legal requirements, hospital policy, and established standards of practice.

3–1. Pharmacy Safety Requirements

Safety, safety, safety—it seems to be all you hear. The Air Force loses thousands of dollars a year to safety-related incidents, but most significant is the loss of life. By actively promoting safety, the Air Force hopes to save lives and money. Safety is so important to the Air Force that there are hundreds of MAJCOM and Wing publications on this topic. Just as we must follow Air Force instructions regarding safety, we also have civilian accreditation and safety standards we are obligated to comply with. For instance, you don’t just follow the speed limit on your base; it’s also a requirement in the town or city you live. The same is true of safety requirements. Safety is not just an Air Force issue but is found at all levels of government through policy documents and accreditation agency requirements.

The nature of your work demands an awareness of safety. Often that awareness involves prescription accuracy and activities concerning patient safety. In addition, it includes recognizing hazards in the work environment that could affect your safety.

This section explains the significance of the Occupational Safety and Health Administration (OSHA) program. You’ll learn about some of the general standards to follow when working with dangerous substances and operating equipment. You will also be able to identify the OSHA standards that apply specifically to the pharmacy.

018. Occupational Safety and Health Administration

OSHA is a federal agency established in 1970 with a mission to ensure safe and healthful workplaces in the United States. Since the agency’s creation, workplace fatalities have been cut by more than 65 percent and occupational injury and illness rates have declined by 67 percent. OSHA’s mission is to assure the safety and health of America’s workers by setting and enforcing standards, and by providing training, outreach, education and assistance. One of the ways that OSHA accomplishes this mission is to assist employers in reducing or eliminating workplace hazards; in turn, employers, including the DOD and the Air Force, protect their employees (you and other Air Force personnel) by using or adopting hazard communication standards (HCS).

Hazard communication standard

One potential hazard to pharmacy technicians is exposure to hazardous chemicals and drugs brought about by a lack of proper training or awareness. The HCS provides personnel exposed to chemicals with the right to know about the chemical hazards and the associated protective measures. This

happens through implementation of the hazard communication program in each workplace where personnel are exposed to hazardous chemicals. Employers are required to:

- Provide training for personnel to understand the chemicals hazards and be able to use the information on the labels and safety data sheets (SDSs) (formerly MSDSs or material safety data sheets) to know how to protect themselves.
- Ensure that hazardous chemicals are labeled with chemical identity.
- Provide appropriate hazard warnings.
- Maintain current SDSs for hazardous chemicals in the workplace and make them readily accessible to exposed personnel with the name and address of the manufacturer, importer, or responsible party.

The hazard communication standard applies only to pharmaceuticals that the drug manufacturers have determined to be hazardous and that are present in the workplace (pharmacy) in such a form that employees can be exposed under normal conditions of use or in a foreseeable emergency. The pharmaceutical manufacturer and the importer have the primary duty for the evaluation of chemical hazards, and the employer may rely upon the hazard determination performed by the pharmaceutical manufacturer or importer. Please note that the Air Force also gives us guidelines for hazardous communication in AFI 90-821, *Hazard Communication (HAZCOM) Program*. Since we are discussing the hazard communication standard, let's define "workplace hazards."

Workplace hazards

OSHA requires employers to protect employees from workplace hazards that can cause injury. Hazards can be, but are not limited to, any of the following:

- Chemical.
- Explosion and fire.
- Biological hazards.
- Safety hazards.
- Electrical hazards.
- Noise.

It is imperative to identify and evaluate all potential workplace hazards in order to protect personnel from those hazards. Apply the following concepts when evaluating any work exposure:

- Recognition – Recognize the hazard.
- Evaluation – Measure the hazard.
- Control – Control the hazard.

Controlling a hazard at its source is the best way to protect employees. Depending on the hazard or workplace conditions, OSHA recommends the use of engineering or work practice controls to manage or eliminate hazards to the greatest extent possible. For example, building a barrier between the hazard and the employee is an engineering control; changing the way in which employees perform their job is a work practice control (e.g., length of time the employee works with the hazard).

When engineering, work practice, and administrative controls are not feasible or do not provide sufficient protection, employers must provide personal protective equipment (PPE) to their employees and ensure its use.

Personal protective equipment

Personal protective equipment is worn to minimize exposure to a variety of hazards. Examples of PPE you may see in your pharmacy include such items as latex gloves, eye protection, rubber aprons, and chemotherapy gowns. Some of your friends who work other jobs around the base may wear different PPE in performing their daily tasks such as steel-toed boots, protective hearing devices

(earplugs, muffs), and hard hats. Your MTF commanders and pharmacy leaders do everything that they can to help keep you from getting injured, but that does not negate your responsibility to assist them in this effort. Not wearing the required PPE is like driving your car without your seatbelt on. Like the seatbelt, PPE can't help protect you if you don't use it properly. To ensure the greatest possible protection for you in your workplace, a cooperative effort between you, the MTF commanders, and pharmacy leadership will help in establishing and maintaining a safe and healthful work environment. In general, your MTF commanders and pharmacy leaders are responsible for the following:

- Performing a “hazard assessment” of the workplace to identify and control physical and health hazards.
- Identifying and providing appropriate PPE for employees.
- Training employees in the use and care of PPE.
- Maintaining PPE, including replacing worn or damaged PPE.
- Periodically reviewing, updating, and evaluating the effectiveness of the PPE program.

You and other pharmacy personnel should, properly wear PPE (notice that *properly wear* is mentioned a few times). Wearing your PPE and wearing it properly are two different things. Perhaps the best example of this is safety glasses. You may occasionally notice people wearing their safety glasses but not wearing them properly. Wearing your safety glasses on top of your head does make a fashion statement but does very little to protect your eyes. So, to reiterate, use your PPE and make sure you use it properly!). In addition you must also do the following:

- Attend training sessions on PPE.
- Care for, clean, and maintain PPE.
- Inform supervisors of the need to repair or replace PPE.

Hand-washing

Hopefully by now when you read PPE, you're going to think of things to “put on” to protect yourself. Another element in protecting yourself is the removal of contaminants that can harm you, your coworkers, or your patients. In addition to the use of PPE, OSHA directs personnel to thoroughly wash their hands. You should wash your hands immediately or as soon as possible after you remove gloves or other PPE. Hand-washing is the single most important procedure for preventing nosocomial (originating in the hospital) infections. In addition, pharmacy personnel who contact infected or potentially infected patients, body fluids, or contaminated or potentially contaminated inanimate objects must wash their hands promptly after such contact. If you are not sure whether you have come into contact with these contaminants, the best practice to follow is to *always wash your hands*.

Your MTF has infection control policies and procedures that address hand-washing, including both a hand-washing technique and cleaning agent. These policies and procedures are the responsibility of the infection control function. This function assesses the effectiveness of the MTF infection control program and consists of members of the medical staff. The function also provides training for MTF staff in infection control procedures and does periodic surveillance to ensure compliance with infection control standards.

Perform routine hand-washing at the beginning of your shift, after visiting the rest room, before and after eating, and when your hands are obviously soiled. Pay close attention to the areas under the fingernails; keep these areas very clean. The following technique is an example of routine hand-washing:

Using bar or liquid soap and lukewarm water do the following:

1. Wet hands with water.
2. Rub all surfaces of hands with soap for at least 10 seconds.
3. Rinse hands thoroughly under a stream of water.

4. Dry the hands with a paper towel.
5. Use a paper towel to grasp the faucet to turn off the water (although not essential for routine hand-washing) is also a good habit.

Safety data sheets

Have you ever wondered why the pharmacy was required to have safety data sheets (SDS) for some medications and preparations and not for others? Chemical manufacturers and importers are required to obtain or develop a SDS, for each hazardous chemical they produce or import. Distributors are responsible for ensuring that their customers are provided a copy of these SDSs. The pharmacy must have a SDS for each hazardous chemical which they use and may rely on the information received from suppliers. Think about the chemicals in your pharmacy. Some are pharmaceutical products; others may be compounding ingredients, both medicinal and nonmedicinal, as well as cleaning products.

The pharmacy is required to have SDSs on file for chemicals containing hazardous ingredients. It's more obvious when dealing with hazardous compounding ingredients and cleaning supplies. If they are deemed hazardous, you must have an SDS; but what about medication? Surely what we call medication wouldn't be considered hazardous, would it? There are HCS exceptions but generally it comes down to the phrase, "solid, final form." When you have hazardous chemicals in bulk form or that you must reduce (crush or dissolve) in order to compound other products, these chemicals are not in their solid, final forms; you must have SDSs for these medications. However, when you have tablets and capsules that are in their solid, final forms that can be immediately dispensed to patients you don't have to have SDSs, even if the medications contain hazardous ingredients.

The SDSs provide detailed information on each hazardous chemical, including its potential hazardous effects, its physical and chemical characteristics, and recommendations for appropriate protective measures. This information is very useful in designing protective programs as well as determining what PPE is required when working with a particular substance.

The SDSs in your pharmacy must be readily accessible; this can be accomplished in many different ways. For instance, many military and civilian pharmacies keep their SDSs in a binder and in a central location. Others organizations, particularly in workplaces with large numbers of chemicals, computerize the information and provide access through terminals. As long as personnel can get the information when they need it, any approach is appropriate. As new chemicals come into your duty section, make sure to update the list of your SDSs. For more details regarding OSHA and the HCS, you can log on to <http://www.osha.gov/>.

Ergonomics

Pharmacies can be very busy places. You have to fill prescriptions, answer the phones, call practitioners, deliver the unit dose carts, as well as perform other assorted tasks during your shift. Many of the tasks that you carry out could expose you to musculoskeletal disorders, such as carpal tunnel syndrome, tendonitis, and lower back injuries since they generally result from activities that involve repetitive tasks, forceful exertions, awkward postures, or contact stress. For example, how many times during the day do you open or close a prescription bottle? How comfortable is the prescription typing station? OSHA recommends addressing ergonomic problems that are common to pharmacy personnel with the following solutions:

- Use devices to eliminate the need to do the tasks, such as using devices designed to remove bottle lids.
- Modify tasks to decrease the incidence of work-related musculoskeletal disorders. Redesign the processes to incorporate variation into the tasks, or alternate repetitive tasks with those that do not require high repetition.
- Use ergonomically comfortable workstations, including wrist pads, adjustable padded chairs, and keyboard trays. Also, place monitors at a comfortable height.

Workplace violence

Pharmacy personnel may be exposed to workplace violence. The availability of drugs in the pharmacy area makes the pharmacy and its staff potential targets. You may think that just because you are on a military installation that you do not have to worry about this type of risk. Don't fool yourself; robberies *do* occur on military installations!

OSHA recommends employers establish and maintain a violence prevention program as part of their facility's safety and health program. Measures such as security devices, panic buttons, alarm systems, and good lighting are a few of the precautions suggested. Your pharmacy will have specific guidance in place; make sure that you are familiar with it. Your safety is important!

OSHA also recommends employers provide training for staff in recognizing and managing hostile and assaultive behavior. Most bases do include suicide and violence prevention training as part of their mandatory training sessions. You may not have had this training yet, but you will eventually be scheduled for it.

019. Facility requirements

To keep medical treatment facilities safe, they first have to be built to accepted standards and then maintained to specific standards. The Air Force built your MTF in accordance with *Unified Facilities Criteria* (UFC) 4-510-01. This handbook provides mandatory policies and procedures for programming, planning, design, and construction criteria for DOD military medical facilities. In addition to this handbook, AFI 91-203, *Air Force Consolidated Occupational Safety Instruction* consolidated all Air Force Occupational Safety and Health (AFOSH) standards into a single document. This AFI applies to all Air Force military and civilian personnel working in medical facilities. Two purposes of this instruction are to assist the managers of USAF medical organizations in maintaining a safe environment and administering a safety program compatible with Air Force directives, National Fire Protection Association (NFPA) codes, standards of the Joint Commission or the AAAHC, and other pertinent federal regulations.

Information provided in AFI 91-203 highlights hazards that are common throughout the Air Force, but it also includes guidelines that are specific to each major sections of a medical facility. In the next several paragraphs, we'll look at the specific guidelines pertaining to facility layout and requirements.

Space and layout requirements

Depending on where you are stationed, your pharmacy may be slightly larger than most people's living rooms or it may be so large that only one physical facility won't meet the needs of your mission. Whether you are working at a large facility or a small one, your pharmacy's space and layout will be based on the size of your patient load and mission. When we are arranging our pharmacies, it is important to have a well-thought-out plan. Some of the aspects that go into planning our layouts include the following:

- Flow of prescriptions and information.
- Access to fixed or shared equipment (e.g., the PharmASSIST® dispensing system).
- Need for visual supervision.
- Desire to minimize travel, movements, and delay time between work areas.
- Privacy for counseling patients.
- Safety considerations such as restricted preparation areas; OSHA and the ASHP recommend that hazardous drug preparation be performed in a restricted area, with signs restricting the access of unauthorized personnel prominently displayed. In addition, drinking, eating and applying cosmetics where hazardous drugs are prepared, stored, or used increases the chance of exposure and should be prohibited.

Remember, arranging how you provide your pharmacy services requires that you not only think about your working environment but the patient environment as well. Our facilities must also comply with

accreditation organization requirements such as the Joint Commission. Listed are some of the requirements:

- The MTF will have adequate space, equipment, and other resources; the arrangement and allocation of this space should facilitate efficient, effective delivery of care, treatment, or services.
- The MTF will have appropriate interior and exterior space for the care, treatment, and services offered and for the ages and other characteristics of its patients. Additionally, the MTF will ensure the safe use of, maintenance of, accessibility to, and supervision of grounds, equipment, and special activity areas.
- The MTF will have adequate and appropriate space and equipment for safely handling and storing hazardous materials and waste.

Lighting

In accordance with AFI 91-03, each drug preparation area will be well lit. An illumination level of at least 100 foot-candles will be maintained on working surfaces.

Ventilation

In accordance with UFC 4-510-01, the primary requirement of the heating, ventilation, and air conditioning (HVAC) system in a medical facility is to support medical functions and the assurance of occupant health, comfort, and safety. The HVAC system functions not only to maintain minimum requirements of comfort and ventilation, but it is an essential tool for the control of infection, removal of noxious odors, dilution and expelling of contaminants, and establishment of special environmental conditions conducive to medical procedures and patient healing. Also, HVAC design is based upon the environmental requirements of the stored supplies and equipment.

Supplies and equipment

The Pharmacy Flight commander, pharmacy officer, or element chief supervises drug storage and preparation areas throughout the MTF and satellite pharmacy operations. All drugs must be labeled, including the addition of appropriate accessory or cautionary statements, as indicated. It is also important to store all supplies properly, especially hazardous agents, so that accidental exposure is avoided. Unidentified or outdated substances are *not* permitted in the pharmacy.

Hazardous drug storage

Improperly stored hazardous drugs may put personnel at risk of exposure; therefore, there are several precautions taken to protect the pharmacy staff. Limit access to authorized personnel where you prepare and store hazardous drugs, hang signs to restrict entry. The bins or shelves design for these drugs must prevent breakage and to limit contamination in the event of a leak. Storage bins must have barrier fronts or other design features that reduce the chance of drug containers falling to the floor, and place warning labels on all hazardous drug containers, shelves, and bins where these containers are stored.

In addition to the OSHA guidance, the ASHP recommends that hazardous drugs requiring refrigeration be stored separately from nonhazardous drugs, and in individual bins, to prevent breakage and to contain leaks.

Chemotherapeutic and antineoplastic agents

Any medical facility using chemotherapeutic and antineoplastic agents must have a response plan for dealing with spills or mishaps involving these agents. Disinfectants and drugs for external use must be stored separately from internal and injectable medications, and poisons must be separated from therapeutic agents.

Intravenous solutions for cancer treatment, such as Vincristine, Fluorouracil, and Dacarbazine are examples of chemotherapeutic and antineoplastic injections with which you may come in contact. Prior to preparing these drugs, you must receive proper training. OSHA requires the medical facility

to assess potential hazards and then select and ensure the use of appropriate PPE whenever you handle hazardous chemicals including chemicals that are carcinogenic, corrosive, toxic or highly toxic, irritating, sensitizing, or target organ-affecting (these are all considered to be hazardous).

Flammable liquids and compressed gases

Supplies of flammable liquids must be kept as small as possible. If more than 10 gallons total must be kept in the pharmacy; AFI 91–203 and the National Fire Protection Association’s publication NFPA 30, *Flammable and Combustible Liquids Code*, stipulate that a fire safety cabinet must be used for storage. The standard allows for either metal or wooden cabinets but must display “FLAMMABLE-KEEP FIRE AWAY.” The maximum storage amount allowed is 60 gallons of Class I or Class II liquids and 120 gallons of Class III flammables.

Acetone, oxygen, butane, carbon dioxide, alcohol, and various gases, such as nitrous oxide and anesthesia gases, are examples of flammable substances and compressed gases. These gases are absorbed into the bloodstream through the respiratory tract and are usually maintained in respiratory therapy and anesthesia departments. Acetone is used as a solvent. You can use alcohol as a solvent or a disinfectant.

Remember that these substances are potentially dangerous because of their explosive or flammable natures. You might also keep in mind that many of these substances are colorless and odorless, making the detection of their presence difficult.

Safety and hazardous substances

You know that all pharmacies contain certain hazards. As a pharmacy technician, you should be very concerned about your personal safety as well as those around you. You must be aware of the substances you are working with and exposing yourself to; you gain this knowledge by reviewing SDSs. Only by having a clear understanding of the substances you are working with do you keep yourself and your workmates safe. Before you read any farther, let’s define a few terms that will be used in the rest of this lesson.

Health and physical hazard

A *health hazard* is any condition for which there is statistical, significant evidence that acute or chronic health effects may occur in exposed employees. Health hazards include chemicals such as carcinogens, antineoplastics, toxic substances, caustic substances, and poisons.

A *physical hazard* is any condition that may involve a combustible liquid, a compressed gas, an explosive, or a flammable or reactive (unstable) chemical. All of these agents, by their very nature, need to be handled with extreme caution.

Hazardous chemicals

A *hazardous chemical* is any chemical that is either a health or physical hazard. If pharmacies handle “hazardous chemicals,” they are responsible for providing certain information and training to their personnel. The proper handling and disposal procedures for hazardous chemicals should also be explained to personnel.

Toxic and caustic substances

Toxic (poisonous) substances are agents that are considered to be harmful to the human body. All drugs can be considered toxic because improper use may cause harm to the person using them.

Caustic substances are substances that will cause destruction or burning of tissue on contact. Caustic substances are often used to soften or destroy tissue (e.g., warts), cauterize wounds, disinfect, or anesthetize an area. Some specific examples of caustic substances are acids, sodium hydroxide, potassium hydroxide, ammonia, podophyllin resin, and silver nitrate.

You usually store toxic and caustic substances in clear or amber glass, depending on the light sensitivity of the substance. Always open and close containers of these substances with care. Never store these substances in anything but their original containers unless they are being dispensed.

All toxic and caustic substances must contain a label with a warning in bold print, indicating that care should be used when handling the substance. Sometimes a skull and crossbones are also used to warn the user of the dangerous nature of the product.

Always handle toxic and caustic substances with care. Avoid direct contact with these substances and their vapors. If you are working with these substances, wear protective gloves, and work in a well-ventilated, isolated area. Before working with these substances, familiarize yourself with appropriate antidotes, how to use them, and where they are kept.

If a toxic or caustic material should happen to come in contact with your skin or eyes, flush the affected area with large amounts of cold water. Then immediately notify your supervisor, or other pharmacy personnel, of the incident. You need to receive medical attention immediately, even if you do not feel anything is wrong. It is better to be safe than sorry!

Heavy and/or bulky items

Store heavy and/or bulky items on lower shelves and lighter ones on top. If storage space is above 6 feet, use suitable stepladders to retrieve items. Do not use a chair, table, or stand on top of boxes! Always think safety first (fig. 3-1)! Items should also not project from shelves into aisles causing a tripping hazard. Additionally, do not store items within 18 inches of ceiling fire sprinkler heads.

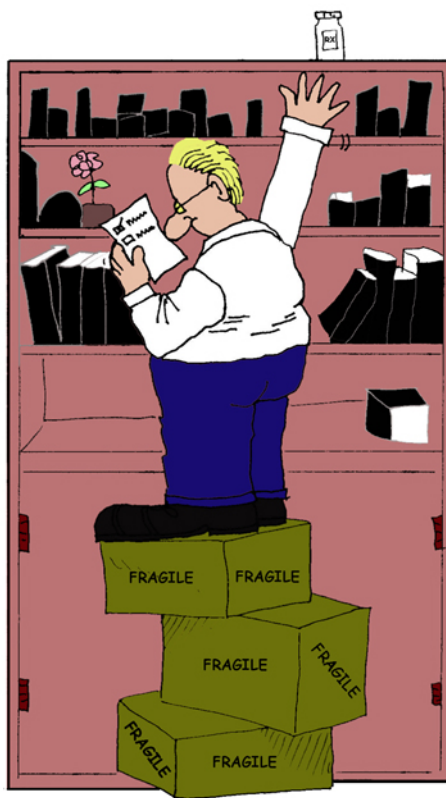


Figure 3-1. Unsafe practices.

Self-Test Questions

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

018. Occupational Safety and Health Administration

1. What is the mission of the OSHA?

2. What AFI gives us guidelines for hazardous communication?
3. List the six OSHA workplace hazards.
4. What concepts should be applied when evaluating work exposure?
5. What is the purpose of PPE?
6. List your responsibilities regarding PPE.
7. What is the single most important procedure you can perform to prevent nosocomial infections?
8. What is the proper routine hand-washing procedures?
9. What are SDSs?
10. Explain the “solid, final form” of medications as it relate to the HCS and SDSs.
11. List three OSHA recommendations to solve ergonomic problems common to pharmacy personnel.
12. What recommendation does OSHA give to employers concerning workplace violence?

019. Facility requirements

1. What are two purposes of AFI 91–203?
2. What is your pharmacy’s layout and space based on?

3. What activities should be prohibited in the hazardous drug preparation area because they increase the chance of exposure?
4. What illumination level is required in each drug preparation area?
5. In accordance with UFC 4-510-01, what is the primary requirement of the HVAC system in a medical facility?
6. How should storage bins be designed for hazardous drugs?
7. What quantity of flammable liquids can you have in the pharmacy before you are required to store them in a flammables cabinet?
8. Where should heavy and/or bulky items be stored?

3-2. Security Provisions

Security in the pharmacy is paramount. It is important not only because of the large dollar value of drugs stored in the pharmacy but also because of the types of drugs we stock. Pharmacies and controlled substance storage areas are designated as controlled areas because they are lucrative areas for pilferage, burglary and robbery. They must be protected in accordance with AFI 31-101, *Integrated Defense (for official use only (FOUO))* and the UFC 4-510-01. Additionally, they must meet the specifications as outlined by the Code of Federal Regulations (CFR) in 21 CFR 1301.72 and 1301.75 pertaining to physical security. MAJCOMS and base level leadership usually publish specific guidance, or supplements, for the pharmacy. All pharmacy personnel who handle, control, or maintain controlled substances are required to follow all guidelines that pertain to security. Keep in mind that this lesson is not-all inclusive regarding guidelines and procedures. Refer to AFI 31-101 and other security regulations for more detailed security provisions.

020. Pharmacy access and entry control

Only personnel with proper authority and qualifications may enter controlled areas such as your pharmacy. Installation commanders grant authority and determine qualifications for personnel who enter controlled areas to include escort procedures. This responsibility may be delegated to the owning unit commander. In most instances, the chief of pharmacy services has primary responsibility for ensuring that entry into the pharmacy is controlled. An entry authorization list (EAL) is developed

and maintained for this purpose; this list is generally posted in each pharmacy, and a copy of it is sent to base security forces.

You will have individuals who request entry into the pharmacy but are not listed on the authorized access list. Your pharmacy will have an OI for the procedure you should follow. Generally, the procedure will entail challenging the individual to provide information concerning his/her need to enter the controlled area. You need to verify his/her identification by military ID card or civilian identification, if appropriate. Once you are satisfied with their verification, have the person requesting entry to sign in on AF Form 1109, Visitor Register Log, and escort him or her the entire period he/she is in the controlled area.

Some pharmacies have a policy that does not allow medical staff, visitors, or off-duty pharmacy personnel entry unless their entry is necessary to conduct official business. The pharmacy vault is normally further restricted to a certain number of pharmacy personnel. The SF 700, Security Container Information form (we will cover the SF 700 in a later CDC) lists the personnel. This form is affixed onto the inside of the safe or vault and lists the individuals who are authorized can access the container access. The form also lists the home addresses and telephone numbers of these individuals.

Another form used in maintaining security of controlled substances is the SF 702, Security Container Check Sheet. Most pharmacies affix this form to the controlled substance safe or vault. Record all openings and closings of the safe or vault on this form. Some pharmacies have guidance requiring that someone other than the person closing the safe or vault, when possible, initial this form after ensuring that the safe or vault is properly secured.

Many pharmacies restrict access after daily opening by use of cipher-locks on doors. Change the combination any time there is proof, or suspicion that there is a compromise to the combination, or when personnel leave or are no longer assigned to the pharmacy. Also, careful control of the master keys to the pharmacy is essential, only issue keys to a minimum number of personnel.

Finally, proper entry and access control to the vault/safe is crucial. Provide combinations only to those with a need to know. Air Force pharmacies generally have one or two technicians that need to have free access, along with certain pharmacists or other personnel who may have to access the vault after duty hours. Vault combinations should be changed when they are suspected to be compromised, when personnel no longer have a need to know, or periodically throughout the year as deemed necessary by the Chief of Pharmacy Services.

Before closing pharmacy access and entry control, remember you work in a controlled area. When you open your door, you provide easy access for someone to enter your pharmacy. So before you open that door, know who is on the other side, and know the proper procedures before allowing that person to enter.

021. Security requirements

As with most other areas of business in the pharmacy, security has its own requirements. The following security requirements are directed under AFI 31-101, the Uniformed Controlled Substances Act, or 21 CFR 1301.72, and 1301.75. This list may not be all-inclusive due to additional MAJCOM or base requirements.

The main pharmacy dispensing area must meet the following protection requirements to provide a maximum level of resistance against burglary:

1. Walls, floors, ceilings, doors, and windows must provide resistance to forced entry.
2. Doors and windows should be kept to a minimum and equipped with intrusion detection systems (IDS) to meet security requirements.
3. Double-locked doors, one of which must be a deadbolt lock with at least a one-inch throw. The main staff entrance should have a cipher lock or card access system for entry.

4. Exterior and dispensing windows, during non-duty hours, must be secured from the inside (locks or deadbolts not accessible from the outside) with provisions, such as roll-up shutters.
5. Along with these reinforcements, all pharmacies with controlled areas where controlled medications are stored are required to post Air Force Visual Aid (AFVA) 31-250, Controlled Area Sign.
6. Satellite pharmacies must maintain controlled substances in a secured room or in a General Services Administration (GSA)-approved container inside a secured room if bars or equivalent do not protect windows and glass doors.

When the pharmacy closes, it must provide for after-hours physical security. At least two levels of security are necessary; for example, an IDS and duress alarms. Doors must be double locked and exterior windows barred, padlocked, or heavily screened. Ceilings, walls and floors must be adequately reinforced to prevent unauthorized entry.

Not all security requirements have to do with steel bars or reinforced walls; another aspect of security involves simply inspecting the pharmacy. Pharmacy personnel may be assigned working as building/property custodians and must provide support to the USAF Resource Protection Program (RPP).

Inspections

Resource monitors/custodians are responsible for performing the following inspections:

- Daily — security and safety inspections are conducted each duty day.
- Monthly — all work areas are inspected each month to determine if doors, windows, locks, and security lighting are adequate. Deficiencies are reported, and work requests are submitted through Security Forces to Civil Engineering to correct deficiencies found.
- Facility — before a facility is vacated for an extended period of time (e.g., closing for the day), the pharmacy area is inspected to ensure the security and safety of the area. This inspection is documented on SF 701, Activity Security Checklist.

The inspections are conducted using the appropriate items listed on checklists. You can personalize the checklists by adding appropriate security or safety required to be checked before closing. An inspection criterion is as follows:

1. Secure controlled drugs in appropriate locked storage areas.
2. Ensure all areas where typewriters, computers, and other office equipment are secure.
3. Check counter tops for controlled substances and “Official Use Only” documents.
4. Complete facility inspection actions listed on SF 701.
5. Check all windows, doors, and other points of entry to ensure that they are properly secured. Ensure that all lights (except fire and security lights) are turned off. Items such as coffee pots, adding machines, and other electrical equipment, with the exception of computer equipment, refrigerators, and time clocks, also must be turned off.
6. Record any unusual findings and report them. If you find any significant discrepancies, report them immediately.

Robbery and bomb threat procedures

What good does a secure facility do you if you aren’t properly trained to handle security issues such as robbery or bomb threat procedures?

Pharmacies are robbery targets, and the pharmacy resource protection checklist normally contains specific guidance related to robberies or robbery attempts (actual or simulated). A visual aid to assist you with information is normally posted near each window and telephone.

Each MTF has briefings or training to ensure proficiency of all personnel in anti-robbery and antiterrorism procedures. Make sure to document the training. Additionally, newly assigned personnel

usually do not complete duties in the pharmacy until they demonstrate proficiency in this area. You also want to include volunteers when scheduling briefings or training. Volunteers also must know on their responsibilities concerning actual or simulated anti-robbery or antiterrorism procedures, and they must know how their actions can affect the outcome of an actual robbery or exercise. Security forces at most installations will provide assistance and guidance upon request. Some pharmacies conduct their own in-house anti-robbery exercises.

If your particular area of the pharmacy is selected as the target for a robbery exercise, you need to give your total support to this program. Ensure that each procedure applying to your operation is accomplished as required. In the event of an exercise or actual robbery, you will need to fill out the AF Form 439, Robbery Checklist.

Bomb threat telephone calls

All personnel need to be familiar with the procedures in the event of a bomb threat telephone call. If you receive a bomb threat, *do not hang up*. Try to keep the caller on the line. Obtain as much information as possible about the call and caller, and contact Security Forces immediately. Every phone will have an AF Form 440, Bomb Threat Aid, near it. Use this form as an aid in the event of a bomb threat telephone call. It provides you with specific questions to ask the caller and a checklist for you to describe the individual's voice, background sounds, and language.

022. Alarm system requirements

Pharmacies must be equipped with a minimum of two levels of intrusion detection equipment (alarm systems such as motion detectors and contact sensors) and must be equipped with a duress alarm. Some bases utilize a key pad with a controlled entry code for every staff member. They enter the pharmacy and have 20 to 30 seconds to depress the code onto the keypad and press enter. Older systems may require personnel to call Security Forces to open, close, test, or reset the alarm. Civil engineering is normally responsible for the repair and maintenance of government-owned alarm systems. However, there may be other base organizations or contractors that are responsible for the repair of communication cabling that supports alarm systems. In your pharmacy someone is appointed as an alarm custodian. This person coordinates alarm systems tests with security forces on a monthly basis. Document the alarm system tests on AF Form 2530, Alarm System Test Record, or other form directed by your command or local policy. Some newer security systems are also capable of consolidating a report that shows the status of each security device in the pharmacy, and then e-mailing or faxing the report.

If you have any questions on security in the pharmacy, ask your supervisor or the resource protection section of your MTF.

Self-Test Questions

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

020. Pharmacy access and entry control

1. In most instances, who has the primary responsibility for ensuring entry into the pharmacy is controlled?
2. What is the procedure for visitors to the pharmacy that are signed in on AF Form 1109, Visitor Register Log?
3. Which form is used to list the names of all personnel authorized to have access to the safe/vault or other security containers?

4. When must the combinations to all safes and vaults or other security containers be changed?

021. Security requirements

1. What is one security provision regarding double-locked doors in preventing theft and burglary?
2. What facility sign is required to be posted in all controlled areas where controlled medications are stored?
3. What items are inspected in the monthly building/property custodian inspection of the pharmacy?
4. Which form is used to document facility inspections?
5. During your inspection of the pharmacy, what is the procedure to follow if you find something unusual or if you have any significant discrepancies?
6. What is required to ensure proficiency of all personnel in anti-robbery and antiterrorism procedures?
7. Which form must be filled out in the event of an exercise or actual robbery?
8. Why is AF Form 440 used?

022. Alarm system requirements

1. What is the minimum number of levels of intrusion detection equipment pharmacies must have in place?
2. Who is normally in charge of repairing and maintaining government-owned alarm systems?
3. Which form is used to document monthly alarm system tests?

Answers to Self-Test Questions

018

1. To ensure safe and healthful workplaces in the United States.
2. AFI 90-821, HAZCOM Program.
3. Chemical, explosion/fire, biological, safety, electrical, noise.
4. Recognition – recognize the hazard; evaluation – measure the hazard; and control – control the hazard.
5. It is worn to minimize exposure to a variety of hazards.
6. Properly wear PPE; attend training sessions on PPE; care for, clean, and maintain PPE; and inform supervisors of the need to replace PPE.
7. Hand washing.
8. Use bar or liquid soap and lukewarm water; rub all surfaces of lathered hands together vigorously for 10 seconds; rinse hands thoroughly under a stream of water; and dry the hands with a paper towel.
9. Safety Data Sheets; manufacturers are required to develop one for each hazardous chemical that they produce; they are required to provide their customers a copy of these forms.
10. Tablets or capsules in their solid, final forms that do not require changes to compound other product and are ready to be dispensed to patients; don't require SDSs, even if they contain hazardous chemicals.
11. Use devices to eliminate the need to do the task; modify tasks to decrease the incidence of work-related musculoskeletal disorders; use ergonomically comfortable workstations.
12. Establish and maintain a violence prevention program as part of a facility's safety and health program.

019

1. To assist the managers of USAF medical organizations in maintaining a safe environment; to administer a safety program compatible with AF directives, NFPA Codes, Standards of The Joint Commission or the AAAHC, and other pertinent federal regulations.
2. Size of your patient load and mission.
3. Drinking, eating, and applying cosmetics.
4. At least 100 foot-candles.
5. To support medical functions and to assure occupant health, safety, and comfort.
6. Designed to prevent breakage and to limit contamination in the event of a leak. They should also have barrier fronts or other design features that reduce the chance of drug containers falling to the floor.
7. More than 10 gallons.
8. On lower shelves.

020

1. Chief of Pharmacy Services.
2. They must be escorted the entire period they are in the controlled area.
3. SF 700.
4. Each time an employee having access is released, departs, or no longer requires access, or when the combination is suspected to be, or has been, compromised.

021

1. Double-locked doors, one of which must be a deadbolt lock with at least a one-inch throw.
2. AFVA 31-250, Controlled Area Sign.
3. All doors, windows, locks, and security lighting.
4. SF 701.
5. Record any unusual findings and report them; if you find any significant discrepancies, report them immediately.
6. Briefings or training are required to ensure proficiency of all personnel in anti-robbery and antiterrorism procedures.
7. AF Form 439, Robbery Checklist.

8. It is used to aid you in the event of a bomb threat telephone call. It provides you with specific questions to ask the caller and a checklist for you to describe the individual's voice, background sounds, and language.

022

1. Two.
2. Civil Engineering.
3. AF Form 2530, Alarm System Test Record.

Unit Review Exercises

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

Do not return your answer sheet to AFCDA.

70. (018) Which federal agency was established in 1971 to ensure safe and healthful workplaces in the United States?
 - a. Occupational Safety and Health Administration (OSHA).
 - b. Air Force Occupational Safety and Health (AFOSH).
 - c. National Fire Protection Association (NFPA).
 - d. The Joint Commission.
71. (018) Changing the way an employee performs his/her work in order to minimize exposure to a work hazard is which type of control?
 - a. Engineering.
 - b. Work hazard.
 - c. Work practice.
 - d. Hazard engineering.
72. (018) What is the most important factor in preventing nosocomial infections?
 - a. Hand-washing.
 - b. Wearing a gown.
 - c. Personal hygiene.
 - d. Wearing a mask.
73. (018) Whose responsibility is it to provide the customers with safety data sheets (SDS)?
 - a. Distributors.
 - b. Security forces.
 - c. Medical group (MDG) commander.
 - d. Occupational Safety and Health Administration (OSHA).
74. (018) The drugs that are exempt from the Occupational Safety and Health Administration (OSHA) Hazard Communication Standard concerning pharmaceuticals include drugs that
 - a. are in solid, final form for direct administration to patients.
 - b. must be reconstituted for intravenous preparation.
 - c. are prepared in a biological safety cabinet.
 - d. are maintained in a restricted area.
75. (018) What must be done when hazardous chemicals/materials are introduced into your pharmacy?
 - a. Obtain the package inserts.
 - b. Obtain Safety Data Sheets for the hazardous materials.
 - c. Nothing; hazardous materials aren't allowed in the pharmacy.
 - d. Nothing; medical logistics is responsible for the storage of all hazardous materials in the military treatment facility.
76. (018) Which solution should be used to solve ergonomic problems common to pharmacy personnel?
 - a. Use a device designed to remove bottle lids.
 - b. Use a counting tray to count tablets and capsules.
 - c. Redesign tasks to promote the need for repetitive tasks.
 - d. Limit access to pharmacy information systems' clinical screening.

77. (019) Within the medical treatment facility (MTF), the Air Force Occupational Safety and Health (AFOSH) Program applies to
- only military personnel.
 - only civilian personnel.
 - only union members.
 - all personnel.
78. (019) In drug preparation areas, what illumination level *must* be maintained on working surfaces?
- 50 foot-candles.
 - 75 foot-candles.
 - 100 foot-candles.
 - 125 foot-candles.
79. (019) According to Occupational Safety and Health Administration (OSHA) guidance, access to areas where hazardous drugs are prepared should be
- limited to personnel wearing personal protective equipment.
 - limited to the pharmacy personnel only.
 - limited to authorized personnel only.
 - open to all personnel.
80. (019) Which amount of flammable liquid *must* be stored in an approved flammables storage cabinet?
- 3 gallons.
 - 6 gallons.
 - 9 gallons.
 - 12 gallons.
81. (019) All toxic and caustic substances in the pharmacy *must* have labels that indicate in bold print that
- care should be taken when ingesting the substance.
 - care should be taken when handling the substance.
 - the substance should be taken on an empty stomach.
 - the substance should be taken with either food or milk.
82. (020) In most instances, who has primary responsibility for ensuring controlled entry into the pharmacy?
- US Air Force Surgeon General.
 - Security Forces Commander.
 - Medical Group Commander.
 - Chief of Pharmacy Services.
83. (020) If an individual is not listed on the authorized access list, which form is used to document entry into a controlled area?
- SF 700.
 - SF 702.
 - AF Form 457.
 - AF Form 1109.
84. (020) Which form is used to document names of personnel who are authorized access to the vault or other security containers within the pharmacy?
- Air Force (AF) Form 475.
 - Standard Form (SF) 700.
 - AF Form 765.
 - SF 702.

85. (021) How often are security and safety inspections conducted in the pharmacy?
- a. Each duty day.
 - b. Once a week.
 - c. Twice a week.
 - d. Once a month.
86. (021) Fill out a Standard Form (SF) 701, Activity Security Checklist after
- a. a telephoned-in bomb threat.
 - b. a duress alarm has been activated.
 - c. an incident has occurred in which a patient has become violent.
 - d. you inspect the pharmacy before it is vacated at the end of the duty day.
87. (021) If you receive a bomb threat on the telephone, you should
- a. obtain as much information from the call as possible, then contact security forces.
 - b. refer the caller to the commander's direct line, then contact security forces.
 - c. refer the caller to your supervisor and let he or she contact security forces
 - d. hang up immediately and contact security forces.
88. (022) Who is normally responsible for repairing and maintaining government-owned alarm systems?
- a. The Pharmacy.
 - b. Security Forces.
 - c. Civil Engineering.
 - d. The Fire Department.
89. (022) If you are appointed as the alarm custodian, who will you coordinate with regarding alarm systems tests?
- a. The Medical Group (MDG) Commander.
 - b. Your immediate supervisor.
 - c. The base general.
 - d. Security Forces.
90. (022) Which Air Force (AF) form is used to record alarm system tests?
- a. AF Form 457.
 - b. AF Form 1109.
 - c. AF Form 2530.
 - d. AF Form 3078A.

Student Notes

Glossary

Abbreviations and Acronyms

AAAHC	Accreditation Association for Ambulatory Healthcare
ADSM	active duty service member
AE	aeromedical evacuation
AES	Aeromedical Evacuation Squadron
AF	Air Force
AFI	Air Force Instruction
AFML	Air Force Medical Logistics
AFMOA	Air Force Medical Operations Agency
AFMS	Air Force Medical Service
AFMSA	Air Force Medical Support Agency
AFOSH	Air Force Occupational Safety and Health
AFPD	Air Force Policy Directive
AFRC	Air Force Reserve Command
AFRIMS	Air Force Records Information Management System
AFSC	Air Force specialty code
AFVA	Air Force visual aid
AHLTA	Armed Forces Health Longitudinal Technology Application
ALS	amyotrophic lateral sclerosis
ANG	Air National Guard
APhA	American Pharmaceutical Association
APO	Army Post Office
ARC	Air Reserve Component
ASHP	American Society of Health-System Pharmacists
ASIMS	Aeromedical Services Information Management System
BMET	Biomedical Equipment Technician
BSC	Biomedical Science Corps
CC	commander
CDC	career development course
CFETP	career field education and training plan
CFR	Code of Federal Regulations
CHCS	Composite Health Care System
CIF	clinical investigation facilities

CONUS	Continental United States
CPR	cardiopulmonary resuscitation
CPSA	Consumer Product Safety Act
CPSC	Consumer Product Safety Commission
CSA	Controlled Substances Act
CSAF	Chief of Staff of the Air Force
CSS	command support staff
D&T	diagnostic and therapeutics
DAW	dispense as written
DEA	Drug Enforcement Administration
DEERS	Defense Enrollment Eligibility Reporting System
DHA	Defense Health Agency
DMDC	Defense Manpower Data Center
DOD	Department of Defense
DODD	Department of Defense Directive
DODI	Department of Defense Instruction
DUE	drug utilization evaluation
DUR	drug utilization review
EAL	entry authorization list
ECOMS	executive committee of the medical staff
ERAA	equipment review and authorization activity
ESRD	end-stage renal disease
FDA	Food and Drug Administration
FDCA	Food Drug and Cosmetic Act
FHSA	Federal Hazardous Substances Act
FHPPP	health protection prescription products
FOUO	For Official Use Only
FPO	United States Armed Forces Fleet Post Office
GSA	General Services Administration
HA	health assessment
HAZCOM	Hazard Communication Program
HCS	hazard communication standards
HIPPA	Health Insurance Portability and Accountability Act
HIV	human immunodeficiency virus
HMO	health maintenance organization
HRPP	Human Research Protection Program

HSA	Hazardous Substance Act
HVAC	heating, ventilation, and air conditioning
IAW	in accordance with
IDS	intrusion detection systems
IRB	Institutional Review Board
IV	intravenous
JFTR	Joint Federal Travel Regulation
KHA	Kefauver-Harris Amendment
LSD	lysergic acid diethylamide
LSMTF	limited-scope military treatment facilities
MAJCOM	major command
MCS	managed care support
MCSC	managed care support contract
MDG	medical group
MDSS	medical support squadron
MDW	medical wing
MHS	Military Health System
mL	milliliter
MSC	Medical Service Corps
MTF	military or medical treatment facility
NFPA	National Fire Protection Association
OBRA 90	Omnibus Budget Reconciliation Act of 1990
OCONUS	Outside the Continental United States
OI	operating instruction
OTC	over-the-counter
OTR	organization threshold review
OSHA	Occupational Safety and Health Administration
P&T	pharmacy and therapeutics
PCM	primary care manager
PDTS	Pharmacy Data Transaction Service
PHA	preventive health assessment or periodic health assessment
PHSD	population health support division
PHWG	population health working group
PI	performance improvement or package insert
PPE	personal protective equipment
PPPA	Poison Prevention Packaging Act

PRN	as needed
QI	quality improvement
PI	performance improvement
RDS	records disposition schedule
RDT&E	research development testing and evaluation
RM	risk management
RMO	resource management office
RPP	Resource Protection Program
SDS	safety data sheet
SECAF	Secretary of the Air Force
SF	Standard Form
SG	Surgeon General
SGA	administrator
SGB	Biomedical Science Corps executive
SGD	Chief of Dental Services
SGH	Chief of the Medical Staff
SGHARP	Surgeon General's Human and Animal Research Panel
SGN	Chief nurse
SGP	Chief of Aerospace Medicine
SSA	Social Security Administration
TAO	TRICARE area office
TFL	TRICARE for Life
TPR	TRICARE Prime Remote
TOL	TRICARE Online
TOPA	TRICARE Operations and Patient Administration
TRO	TRICARE regional office
UEI	unit effectiveness inspection
UFC	<i>United Facilities Criteria</i>
USAF	United States Air Force
USFHP	Uniformed Service Family Health Plan
WEB HA	Web-based health assessment

Student Notes

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