

CDC Z4Y071

Dental Assistant Craftsman

Volume 1. Dental Assistant Craftsman



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

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Material in this volume is reviewed annually for technical accuracy, adequacy, and currency. For SKT purposes the examinee should check the *Weighted Airman Promotion System Catalog* to determine the correct references to study.

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CONGRATULATIONS! You are now one step closer to becoming a dental assistant craftsman. Hopefully, you will find this course enjoyable, interesting and a useful tool in your Air Force career advancement. While some of this material may seem to be repetitive if you have been working at a small clinic, remember that not all dental assistant journeymen are working in that environment. Some technicians have not had the trial-by-fire experience in clinic management that plays a large part in the 7-level training of this career field.

This course, Z4Y071, *Dental Assistant Craftsman*, is a single volume that fulfills one of the requirements for your upgrade to 7-level. The volume contains three units that discuss a variety of areas relevant to your responsibilities as a craftsman.

Unit 1, Dental Management, concentrates on the USAF Dental Service's mission, function, and organization. Staffing, professional relations, career progression, training programs, workload management and standards, as well as dental service inspections are also covered.

Unit 2, Dental Clinic Administration concentrates on the administrative side of clinic management; topics include Air Force dental readiness, disposition of dental records, the automated Dental Service requirements, and the Preventive Dentistry Program.

Unit 3, Dental Clinic Logistics is an in depth coverage of materiel basics, research, procurement, and issue/turn-in of supplies and equipment. Customer support listings and information to assist you in understanding the budget process and the different types of budgets used in the Air Force will also be thoroughly explained.

A glossary of terms, abbreviations, and acronyms is included for your use.

Code numbers on figures are for preparing agency identification only.

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

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

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This volume is valued at 15 hours and 5 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. Dental Clinic Management

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CONGRATULATIONS! You are enrolled in the Dental Assistant Craftsman course and that means you are well on your way to earning your 7-skill level. This course is your next step toward achieving your 7-skill level. The career knowledge you obtain from this course and the hands-on training provided by your supervisor will greatly enhance your abilities and skills to help you serve as a team member in our diversified and ever-changing career field. You will soon see that the only constant in our career field is change! New people bring new ideas, and many improve the present way of doing things.

This course is intended to provide training to develop your administrative and management skills. As you read and study this material, keep in mind this course is only as current as the information available at the time of writing. We recommend you periodically review the directives that govern your assigned duties.

1-1. USAF Dental Service Mission, Function, and Organization

Oral health and hygiene are important components of physical fitness and combat readiness. The USAF Dental Service establishes and maintains comprehensive programs for the prevention and treatment of dental disease to ensure maximum personnel readiness.

001. Mission

The USAF Dental Service mission is to achieve oral health to ensure readiness, best value, and excellence in all we do. We can only accomplish this mission by functioning efficiently from the very

top of the Dental Service organization down to the flights and elements that get the job done. Now, let's take a moment to decipher just what this mission statement means to Air Force personnel.

Readiness

The Chief of Dental Services (CDS) makes sure that all local dental programs and activities supporting the dental readiness of military forces are incorporated into the Air Force Dental Readiness Assurance Program (AFDRAP). Periodic evaluations are provided for all Air Force personnel to establish their dental health classification, and provide and document treatment. An appointment prioritizing system is used to ensure maximum readiness.

Best value (quality-cost-access)

The overarching philosophy of "best value" health care in the Air Force Medical Service (AFMS) is implemented using a systematic review for over- and under-utilization of services linked with quality management and risk management. Best value balances quality, cost, and access to services.

Quality

The delivery of dentistry is a series of processes that can be defined, evaluated, and improved to provide better care for our customers. When we consider quality as a means of providing best value for our members, we use the Clinical Performance Assessment and Improvement (CPA&I) program. The CPA&I program is based largely on philosophies currently employed by the Air Force, and the Joint Commission (TJC). The program includes clinical indicators based on practice parameters or clinical guidelines and also introduces a cycle for improving performance that is very similar to several quality improvement tools used by TJC, the Air Force, and other civilian organizations. The CPA&I program is a tool used to evaluate clinical performance and identify improvement when necessary. Envision the dental service as a large group practice that operates in many different settings and shares patients worldwide. The CPA&I program gives us a means to propose improvements that can be applied throughout the USAF Dental Service to ensure quality care.

Cost

How do we determine cost? We use workload data to assign costs of operating expenses to the Medical Expense and Performance Reporting System (MEPRS) using the Defense Medical Human Resources System-internet (DMHRSi). The medical treatment facility (MTF) collects workload statistics for each work center and summarizes them for entry into the Expense Assignment System (EAS). DMHRSi is used to import the personnel expenses into EAS. EAS is a management support tool that provides standardized reporting of expense, manpower, and workload data by the Department of Defense (DOD) medical and dental facilities. It was designed to record, accumulate, and report information regarding the expense and workload of specific and aggregate functions performed in MTFs.

Data is reported in various data sets on a monthly basis. EAS personnel use the Base Dental Service Report to ensure workload reported is transferred accurately to EAS from the Corporate Dental Application (CDA) system. Workload is validated after input and data is processed before transmitting. One part of the statistical basis for assigning cost within the EAS is generated from workload data. Workload data is the performance factor used to quantify the amount of work accomplished by a work center. Workload data is associated with patient care and non-patient care activities.

Access

The CDS establishes local procedures to ensure that active duty (AD) personnel maintain optimal dental health. The number one concern is that the active duty members receive needed treatment. Dental treatment facilities (DTF) alleviate patient care issues by maximizing clinic efficiency, coordinating staffing requirements through the respective major commands (MAJCOM), and ensuring all locally available care (other Uniformed Service DTFs, Veteran's Administration (VA),

local purchase agreements, etc.) are used. It is reasonable to consider a 21-day access standard for dental care. When other options have been exhausted, supplemental funding for civilian private-sector treatment may be appropriate.

Excellence (customer satisfaction)

Retired, Air Force Chief of Staff, Ronald Fogelman made it clear why customer satisfaction is high on our list of priorities as a service organization. “The people who make up our Air Force team are the most important thing for our service to focus on. They are the foundation of our strength. We must recruit, train, and retain the highest quality force possible. If we are to be successful, then we must take care of our people and their families.” The USAF Dental Service offers this level of excellence via commitment to service leadership, professional growth, and mentorship.

Commitment to service leadership

A customer-focused culture centers on force health protection (FHP) and prevention-oriented health programs and processes. Customer satisfaction, from the theater commander to the family member or beneficiary, is a result of effective communication, leadership, education, and training. Applying the best clinical practices contributes to customer satisfaction and is a result of constant performance measurement and performance management as well as user evaluation of product delivery, services, and support systems. Commitment to answering the needs of the individual ensures stability and continuity of world-class health care.

Professional growth

Dental personnel have numerous opportunities to excel professionally. Continuing education is available for the professional (dentist) and the enlisted staff. Specific educational opportunities will be covered later.

Mentorship

Over the past several years, the Air Force has taken great strides to ensure that all personnel understand the concept of mentorship. Air Force Manual, (AFMAN) 36-2643, *Air Force Mentoring Program*, was recently revised to include all Air Force personnel. Mentoring is an essential ingredient in developing well-rounded, professional, and competent future leaders. Mentoring helps prepare people for increased responsibility and helps them reach their maximum potential. As a service-based organization, it is imperative that our personnel strive to be the pinnacle of excellence.

002. Organizational and administrative responsibilities

One of the most important strategic elements of an organization is its structure; how the people are arranged in order to get the mission accomplished. The organizational structure and the administrative responsibilities are mechanisms of coordination and control, formalization, and centralization of power from the highest to the lowest level.

Becoming familiar with the USAF Dental Service chain of command allows us to better understand the important role each plays in accomplishing the mission. The following explains the Dental Service organizational levels with the positions and responsibilities at each level.

Assistant Surgeon General for Dental Services

The Assistant Surgeon General has the following responsibilities:

- Advises the Air Force Surgeon General concerning dental operations and force development.
- Provides strategic vision and oversight for development of dental policies.
- Serves as Chair of the AF Dental Service Executive Board and presides over Dental Executive Board meetings.
- Recommends active duty dental consultants to the Air Force Surgeon General to draft standards of care unique to the specialties.

- Serves as Chair of the Dental Development Team (DT).
- Coordinates AF dental activities with other federal and national dental activities.
- Recommends AF Dental Service Liaisons to federal and national dental activities.

Dental career field manager

The following is a list of responsibilities of the Dental career field manager (CFM):

- Advises Assistant Surgeon General for Dental Services, Director, Dental Corps, and Air Force Medical Operating Agency/Dental Directorate (AFMOA/SGD) staff on matters related to the morale, welfare, utilization, and training of dental ancillary personnel.
- Advises Director, Dental Programs and Resources staff in the formulation of dental policies, standards, and requirements ensuring base level execution through AFMOA/SGD.
- Serves as the AFCFM for the 4Y0X1/H and 4Y0X2 specialties.
- Conducts utilization and training workshops (U&TW).
- Serves as a member of the AF Dental Service Executive Board and Dental Operations Panel.
- Mentors ancillary personnel on career progression and developmental opportunities and identifies/develops future Air Force Leaders.
- Schedules/develops the agenda for the enlisted Deliberate Development Board (DDB); serves as Chair for the enlisted DDB.

Director, Dental Corps

The director of the Dental Corps does the following:

- Advises the Assistant Surgeon General for Dental Services on recruiting, retention, promotion, and educational issues.
- Serves as CFM for all dental officers in the force development program.
- Schedules/develops agendas for the Dental DT meeting.
- Provides guidance to Air Force Personnel Center (AFPC) and the Deputy Chief of Staff, Manpower and Personnel regarding assignments, career development, and personnel issues.
- Serves as the primary representative to the Office of the Assistant Secretary of Defense (Health Affairs)/TRICARE Management Activity for dental personnel and special pay issues.

Director, Dental Programs and Resources

The director of Dental Programs and Resources is responsible for the following:

- Advises Assistant Surgeon General for Dental Services; Director, Dental Operations; and Director, Dental Corps on all AFMS dental planning and programming matters.
- Develops AFMS Medical Annual Planning and Programming Guidance as it relates to dental operations.
- Serves as the Dental Operations panel chair.
- Validates, adjusts (if required), and recommends program adjustments (disconnects, initiative, offsets) to and from AFMOA/SGD.
- Works with the Dental Panel Program element manager to coordinate on all dental issues, plans, programs, and proposals that require resources.

- Formulates and directs dental policies, standards, and requirements ensuring their execution through the AF Medical Operation Agency, Dental Directorate.

Director, Dental Operations

The director of dental operations has the following responsibilities:

- Advises the Assistant Surgeon General, Health Care Operations, and Assistant Surgeon General for Dental Services concerning dental operations.
- Serves as chair of the AF Dental Service Executive Board in the absence of the Assistant Surgeon General for Dental Services.
- Interprets and oversees execution of dental policies, standards, and requirements.
- Ensures pertinent dental data is collected, analyzed, and used to improve dental care delivery.
- Oversees comprehensive programs to continuously improve prevention and treatment of dental disease to ensure deployment readiness of AF members.

AFMOA/SGD division chiefs, Air Force Reserve Component (AFRC)/SGD, and Air National Guard Assistant to Air Force Surgeon General, Dental Services

These people are responsible for the following:

- Ensure implementation/execution of AF dental programs and policies across all AF dental treatment facilities.
- Advise AFMOA/SGD on the management of dental programs and policy compliance as appropriate.
- Provide career guidance to identify, develop and recognize future Air Force leaders.
- Serve as members of the Dental DT, Dental Executive Board, and Dental Operations Panel, and/or Air Reserve Component Dental DT.

Military dental consultants to the Air Force Surgeon General

These consultants are recommended by the Assistant Surgeon General for Dental Services and appointed by Air Force Surgeon General. Their responsibilities include the following:

- Provide advice to the Director, Dental Corps and AFPC regarding assignment of officers in their specialty.
- Serve as liaison between the AF Dental Service and their respective specialty academies and professional associations.
- Provide professional, technical, and resource advice in their respective specialty.

AFMOA/SGD MAJCOM functional managers

These functional managers have the following responsibilities:

- Advise AFMOA/SGD, division chiefs, AFCFM, Dental Services, and AFPC on the management of dental enlisted programs, policy compliance, and manpower, as appropriate.
- Ensure implementation/execution of AF dental programs and policies at AF DTFs.
- Advise the CDS/superintendent/NCOIC at AF DTFs on matters related to the development and execution of dental operations and enlisted training programs. Conduct clinic staff assistance visits and site visits at the request of the base CDS as appropriate and available.
- Mentor enlisted personnel on career progression and developmental opportunities and identify/develop future Air Force leaders.

Chief of Dental Services

The CDS has the following responsibilities:

- Manages base dental services.
- Advises the MTF commander and AFMOA/SGD on all matters related to all dental activities.
- Compiles and sends reports/data to AFMOA/SGD.
- Provides for the management, career progression, and mentoring of assigned dental officers in accordance with (IAW) Air Force, MAJCOM, and local policies.
- Appoints a noncommissioned officer (NCO) to manage enlisted and other ancillary personnel.
- Coordinates dental activities with other local governmental and civilian dental activities, as appropriate.
- Provides base dental support to ARC dental activities (AD only).

Superintendent/NCOIC

The superintendent/NCOIC has the following responsibilities:

- Assists the CDS in the management of base dental services and recommends process improvements, as necessary.
- Oversees and manages the utilization and training of dental enlisted and civilian ancillary personnel.
- Coordinates dental activities with AFMOA/SGD and other base and civilian agencies, as appropriate.
- Mentors ancillary personnel on career progression and developmental opportunities and identifies/develops future Air Force leaders.
- Compiles and forward required reports to AFMOA/SGD.

Once at the base level, the actual clinic is organized into squadrons and even further broken down into flights. The size of the base population determines which squadrons and which flights will be formed.

Squadron

The dental squadron is the basic functional unit in the MTF. Squadrons will vary in size according to responsibility.

Dental squadron

Dental squadrons are formed when the MTF is small and has a unique dental mission. The clinic may have a significantly high percent of dental personnel due to dental requirements.

Aeromedical-dental squadron or medical operations squadron

The aeromedical-dental squadron or medical operations squadron is also formed when the MTF is small, but there is a large aeromedical capability. The dental flights and the aeromedical flights are combined into one squadron. The commander of the squadron may be a dental officer or the ranking aeromedical officer.

Flights

Dental flights are an internal subdivision composed of elements performing specific missions. There are five approved flights for a Dental Squadron: clinical dentistry, dental support, dental laboratory, and as applicable, dental residency, and/or area dental laboratory.

Flight chiefs/commanders

Officers or NCOs may hold the position of flight chief/commander. This individual reports directly to the squadron commander or squadron superintendent. This person is typically a member of the squadron management team and/or the operational flight management team.

Clinical dentistry flight

Personnel assigned to the clinical dentistry flight are responsible for the actual delivery of treatment to the patient. They provide diagnostic and preventive services, comprehensive dental treatment, and professional oversight in support of worldwide missions. The facemask and gloves they wear make these individuals easy to recognize. Protective barriers are the trademarks of the clinical dentistry flight's workplace.

Dental support flight

The dental support flight is comprised of individuals who offer direct support to the dental team. Primary duties include personnel management, records, reports, publications, correspondence, training, resource management, logistics, and general management of patient data. These individuals may be found scheduling staff members for ancillary training, or scheduling patients for follow-up appointments. Whatever the task; individuals assigned to the dental support flight usually are found at the end of a paperwork trail.

Dental laboratory flight

The dental laboratory flight is responsible for fabricating dental restorations and prostheses to support local treatment needs. Workloads are referred to the area dental laboratory (ADL) or other activity as required.

Area dental laboratory

There are three ADLs in the Air Force. Their primary mission is to support the Air Force and other federal dental and medical services. Duties include fabricating restorations and prostheses, removable partial denture frameworks, maxillofacial, and implant supported prostheses.

Dental residency flight

The USAF Dental Service offers numerous opportunities for dental officers to expand and improve dental skills, as well as readiness capabilities through residency programs. Personnel assigned to the dental residency flight provide a wide variety of support to include education, training, and administrative. Dental residencies are official formal dental education residencies approved by the Assistant Surgeon General for Dental Services.

Executive teams

Executive teams exist to provide management throughout the dental clinic. They are responsible for the organization, performance of duty, operational readiness, provision of dental care services, training plans, and good order and discipline within the dental clinic.

Squadron management team

Each dental organization forms a team of individuals within the dental clinic to manage the overall dental operations among the flights. This team is equivalent to and functions as the dental executive committee. Its mission is twofold: they plan, organize, operate, evaluate, and improve all aspects of system performance for the squadron. It also provides oversight for education, training, and career management of squadron personnel.

Flight management team

A large-scale dental squadron may form an operational flight management team. A flight management team consists of a representative from each flight meeting to discuss day-to-day operations of the flights. Flight management teams are normally found in larger clinics when there is an increase in personnel assigned. Meeting at this level helps to assure tasks are handled at the lowest level to ensure a smooth flowing organization.

Civilian personnel administration

The Air Force depends upon a large civilian work force to accomplish its various missions. As a NCO, you may be tasked to supervise civilian personnel. In doing so, you need to have a working knowledge of the following:

- Civilian employee leave.
- On-the-job injury/illness.
- Disciplinary action.
- Labor relations.
- Civilian Performance Program.
- Awards.
- Employee work folders.

For local policies and current information on the areas listed above, contact your base Civilian Personnel Office.

Dental Evaluation & Consultation Service

The USAF Dental Evaluation & Consultation Service (DECS) was established on 1 October 1976 to provide investigative guidance and assistance for all USAF dental personnel. DECS consists of clinical, laboratory, and consultative capabilities maintained as a detachment of the USAF School of Aerospace Medicine at Brooks Air Force Base in San Antonio, Texas. DECS is located at Fort Sam Houston, Texas. This nine-member organization has been set up specifically to solve operational problems and to evaluate methods, techniques, procedures, equipment, and materials as identified by military dental activities and by the office of the Air Force Surgeon General. In addition, DECS supports military medical centers and dental training programs by providing continuing education lectures and technical assistance for investigations that contribute to the training programs.

Self-Test Questions

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

001. Mission

1. What are the three parts to the USAF Dental Service mission?

2. Who makes sure that all local dental programs and activities supporting the dental readiness of military forces are incorporated into the AFDRAP?

3. What program do we use to ensure our patients receive quality treatment?

002. Organizational and administrative responsibilities

1. Who conducts the U&TW?
2. Who is responsible for formulating and directing dental policies, standards, and requirements?
3. What are the primary responsibilities of the clinical dentistry flight?
4. You may supervise civilian personnel during your career: therefore, you need a working knowledge of what areas?

1-2. Staffing and Professional Relations

The success of your dental squadron's mission depends, to a great extent, on the people assigned to it. Supervisors ensure the highest quality health care with the personnel assigned. If the number of people assigned cannot satisfy patient needs, or professional relations are not maintained among staff and patients, supervisors must take decisive action. In this section, you will learn about the Air Force system for allocating personnel resources and look at some of the behaviors that affect our professional relations with patients and medical personnel.

003. Interpreting manning, staffing, and utilization requirements

The Air Force considers manpower a resource that supports approved programs. Manpower is not a program by itself that can be manipulated separately from the programs it supports. It is a limited resource that is sized to reflect the minimum essential level to accomplish the required work.

To accomplish the objectives of manpower personnel requirements, HQ USAF functional managers and HQ USAF/Programs and Evaluation (HQ USAF/PE) are responsible for ensuring that the minimum essential level of manpower required to support specific functions is met. First, they establish the minimum manpower needed to do the work from manpower standards and guides. Then, they determine the mix of military, civilian, or contract personnel required. The final step is to determine the required category and grade of military, officer, or enlisted.

Manpower/staffing

Have you ever wondered what is used to create manpower/personnel statistics; how and why the manning numbers add up the way they do? CDSs and superintendents/NCOICs use Air Force manpower documents and personnel rosters that reflect manpower authorizations and allocations, within each dental clinic, to analyze this information.

Unit manpower document

The unit manpower document (UMD) is the primary manpower planning tool, it reflects quarterly manpower authorizations by fiscal year for each functional account code (FAC) in the organization, and it does *not* identify individuals by name (fig. 1-1). All Air Force units are made up of skills that are grouped according to function. That is, personnel who use similar machines and methods of operations are grouped together and assigned a FAC. These individuals perform work that contributes to the same end product and their duties are similar or closely related. The FAC code is a four-digit code, the first digit represents the major type of work performed; for example, 5000 is the major area

Figure 1–1. Sample, unit manpower document.

In planning for a proper mix and number of technical staff, start with your UMD. It details the rank/grade structure that should be assigned to your clinic. However, if the UMD shows you have an A1C, SSgt, and TSgt, but you physically have assigned an Amn, SrA, and TSgt, you won't necessarily get more technicians; most of the time, UMD positions can be filled with one grade up or down. Periodically review your portion of the UMD. There have been instances of clinics being authorized additional technical help without their knowledge. Contact the Resource Management Office (RMO) and request your UMD if you are not familiar with this document.

Manpower authorizations

The Air Force manpower requirements determination process uses a bottom-up approach. This process determines organization and manpower requirements for effective and economical accomplishment of approved missions and functions. The Air Force uses specific tools and techniques to determine and validate manpower requests and authorizations to accomplish the dental mission. This data is finalized in the form of requirements, priorities, and equations for estimating

program or mission requirements. The Air Force uses this information to request manpower authorizations from DOD and Congress.

After the DOD establishes the limit on manpower authorizations, it allocates them to the Air Force, which, in turn, allocates them to the medical corps. The authorizations are given on a priority basis because total requirements often exceed the number of authorizations the Air Force receives. Normally, each base identifies manpower requirements through its MAJCOM to the Air Force level.

For USAF medical manpower, the DOD imposes a ceiling on total dollar (production) and a ceiling on total officer, enlisted and civilian manpower authorizations. Based on a predetermined formula for calculating authorizations and priorities, the Air Force distributes total numbers of officer, enlisted, and civilian authorizations to the medical corps. In addition to the overall ceiling on numbers generated from the manpower formula, authorizations are also controlled by grade and skill. The process of allocating manpower authorizations is an extremely complex process. For this reason, your local RMO will assist you by working with AFMOA to ensure your manning authorizations are handled properly.

Dental functional accounting codes

There are three main FAC for the dental service: FAC 5421, *Dental Clinic*; FAC 5422, *Base Dental Laboratory*; and FAC 5423, *Area Dental Laboratory*. We will describe the more commonly used FACs: the Dental Clinic and Base Dental Laboratory.

FAC 5421, Dental Clinic

The Dental Clinic contains a workload factor linked to the active duty population assigned according to Military Personnel Flight, Employment Section, using the Military Personnel Data System (MILPDS) of total assigned including tenant units. The workload factor (active duty population) is used in the standard man-hour equation to determine the number of dental officers earned. FAC 5421 includes the Clinical Dentistry Flight as well as the Dental Support Flight. Normally, only 4Y0X1, Dental Assistants are assigned to this FAC; however, a few dental clinics have a 4A0X1, Health Services Management technician authorization.

The *Clinical Dentistry Flight* provides diagnostic and preventive services, delivers comprehensive dental treatment, and assures professional oversight of the delivery of patient care. This flight maintains oral health of active duty personnel in support of worldwide missions. Key functions may include emergency services, orthodontics, preventive dentistry, oral pathology, endodontics, dentistry related to rated personnel, general dentistry, examination services, consultant services, periodontics, pediatric dentistry, prosthodontics, radiology, oral and maxillofacial surgery, and forensic dentistry.

The *Dental Support Flight* supports the dental squadron in matters relating to personnel management, records, publications, correspondence, training, resource management, logistics, and general management of patient data. Activities support both patient care and dental squadron personnel. Key functions include administrative services, dental data systems, Air Force Dental Readiness Assurance Program, dental facility management, dental instrument processing, logistics, dental occupational safety and health, CPA&I and peer review, dental infection control, patient administration, dental records, and dental appointments.

FAC 5422, Dental Laboratory Flight

The Dental Laboratory Flight fabricates dental prostheses and other appliances to support local needs and refers workload to the Area Dental Laboratory (ADL) as needed. The key functions of the dental laboratory include laboratory logistics, precious metals, shipping and receiving, orthodontics, fixed prosthodontics, ceramics, maxillofacial prosthodontics, quality control, removable prosthodontics, training and administration. Only 4Y0X2, Dental Laboratory Technicians, are authorized in this FAC.

Unit personnel management roster

The unit personnel management roster (UPMR) is a monthly computer product that lists authorized and assigned military manpower allocations by fiscal year, quarter, and name and grade of personnel assigned (fig. 1–2). Incoming personnel and those outbound are also reflected. The manpower authorizations must correspond to and be verified with the current UMD calendar period. As a supervisor, it may be your responsibility to review the UPMR to ensure that those listed are reflected against the correct position number and are a “match” for the grade and AFSC requirements for that position.

PERSONAL DATA - PRIVACY ACT

As of: 11 JAN 2013

PASCODE	ORGN_STRUCT_ID	AFSC_AUTH	GRD_AUTH	POS_NR	FAC	PEC	DAFSC	GR_ASGN	NAME	PAFSC
RJ03F1Y5	SGDD	4Y031	A1C	02238340J	542100	0087715C	4Y031	SRA	TAYLOR JOHN D	4Y051
RJ03F1Y5	SGDD	4Y031	A1C	02853270J	542100	0087715C	4Y031	SRA	LOUIS DAVID P	4Y051
RJ03F1Y5	SGDD	4Y031	A1C	02853290J	542100	0087715C	4Y031	SRA	STEVENS ROGER L	4Y051
RJ03F1Y5	SGDD	4Y051	SRA	02258980J	542100	0087715C	4Y051	SRA	GAINS DENISE O	4Y051
RJ03F1Y5	SGDD	4Y051	SRA	03446400J	542100	0087715C	4Y051	SSG	JEFFERSON ALICE T	4Y071
RJ03F1Y5	SGDD	4Y051	SRA	02258980J	542100	0087715C	4Y051	SSG	KEY MARCUS A	4Y071
RJ03F1Y5	SGDD	4Y051	SRA	03446400J	542100	0087715C	4Y051	SSG	BURKHART TERRY B	4Y071
RJ03F1Y5	SGDD	4Y071	TSG	02258990J	542100	0087715C	4Y071	TSG	ARNETT KEVIN W	4Y071
RJ03F1Y5	SGDL	4Y052	SSG	02324740J	542200	0087715C	4Y052	SSG	MATTHEWS JOSEPH J	4Y072
RJ03F1Y5	SGDS	4Y051	SSG	02853210J	542100	0087715C	4Y051	SSG	FREDRICKS HOLLY R	4Y071
RJ03F1Y5	SGDS	4Y071	MSG	02238290J	542100	0087715C	4Y071	MSG	DAVIS LYNN E	4Y071
RJ03F1Y5	SGDS	4Y071	MSG	02238290J	542100	0087715C	4Y071	MSG	HILL GARY S	4Y071
RJ03F1Y5	SGDS	4Y071	MSG	02238290J	542100	0087715C	4Y051	TSG	BRIDGES LARRY C	4Y071
RJ03F1Y5	SGDS	4Y090	SMS	02258970J	542100	0087715C	4Y090	SMS	JONES DANIELLE M	4Y090

Figure 1–2. Sample, Unit Personnel Management Roster.

004. Patient relations

Every member of the dental clinic is a patient relations representative, but the individuals who come into contact with the patient first have the greatest opportunity to leave a positive impression. Greet patients with a smile, whether it's face-to-face when checking in at the front desk or by a telephone call to confirm an appointment. Patients will often experience anxiety when visiting the clinic, what we do as health providers can help to diffuse this anxiety.

Partner-in-care-concept

Treat each patient with respect; always call the patient from the waiting room by using the individuals rank and last name or the proper Ms. or Mr. for civilians. Establish a rapport with the patient by talking about noncontroversial subjects. Speak with the patient about the visit today; find out what the patient's wants, needs, and expectations are. Patients will be more committed to the goal if they share in its development and it meets their needs. Be sure to demonstrate sincerity when communicating with the patient, remove as many communication barriers as you can. Patients are able to detect whether they are an object or partner through the tone of your message (verbal or nonverbal).

Patient complaints

When a patient is unhappy with a visit to the dental clinic, he or she will typically respond in one of three ways. Some patients will avoid returning for treatment until it becomes urgent, others may voice their concern using patient surveys or speaking with the patient advocate, and others choose to ignore the problem. Watch patients for changes in attitudes and nonverbal cues. Sometimes the issue may be something to improve customer service, or could simply be a misunderstanding.

When a patient complains, put the complaint into perspective. Avoid viewing it as a negative and try to see the positive. If the complaint proves to be genuine, it gives us the opportunity to improve a process.

Six steps in handling the irate patient

Some patients bring outside issues with them when they visit the dental clinic. These issues can lead them to be easily angered. The patient may express anger toward you, but if you observe the patient closely and listen to the complaint, you may find that the cause of the anger is from other circumstances. The following are easy tactics you can use to calm an irate patient:

1. Listen carefully to the patient.
2. Ask questions to help find the root problem; demonstrate concern.
3. Listen actively to the patient's answers to your questions.
4. Ask questions that require some thought from the patient; suggest alternatives to answer their concerns.
5. Use genuine empathetic statements, if there was a mistake; apologize even if you are not to blame.
6. Solve the problem or find someone who can. Explain to the patient what the other person can do to help.

Dealing with the upset patient requires a special talent to separate the problem and the patient. The dental assistant/laboratory technician's behavior must remain above reproach at all times. The following are some tactics that you will want to keep in mind:

- Do not directly challenge the patient.
- Do not let the conversation wander off the specific problem.
- Do not participate in fault-finding; it does not help to shift the blame.
- Do not let your personal feelings get in the way.

Refusal of treatment

Occasionally a patient will refuse to have a recommended treatment. Patients who refuse dental treatment, or are unwilling to keep their dental appointments but require dental treatment must be identified. These individuals will be counseled by the CDS concerning the need to maintain proper oral health. If the patient continues to refuse dental treatment, the individual's commander must be notified in writing of the consequences of refusing dental treatment on the patient's readiness capability.

Complete an AF Form 469, Duty Limiting Condition Report immediately for patients who refuse treatment and are in Dental Readiness Class 3 or 4. An entry should be made on the AF Form 603, Health Record-Dental/603A, Health Record-Dental-Continuation, noting the refusal and the reason they refused treatment.

005. Understanding medical/clinic relationships

This lesson describes clinic relationships. In all dental clinics, relationships will form. Relationships will range from friendships to professional relationships. It is important to always have an understanding of how to handle these relationships in a clinic setting.

Dynamics

Dynamics is the processes, changes, and any structure that influences the group personality. Each person in the group influences and is influenced by each other person; as people come into and leave the unit, the dynamics of the group can change. Cohesive groups will share unit successes and failures, and will adapt to meet new values and objectives. Members who do not conform to group norms are usually isolated. In summary, the dynamic of a group is constantly changing due to forces from within the group (i.e., promotions) and pressure exerted from external sources (i.e., deployments).

Superintendent's role

The superintendent has a key role in the dynamics of the dental staff. The ability to deal effectively with conflict is the essence of leadership and vital to managerial success. The relationship between the superintendent and the staff impacts the entire workplace down to the most junior airman. This individual must be able to resolve issues concerning the enlisted staff and choose solutions that bring about the greatest number of positives. Empowering those in subordinate positions to share in the decision-making process can enhance this relationship.

Uniting the dental team

The superintendent is responsible for guiding the enlisted staff to accomplishing the Air Force dental mission while instilling in them the pride and professionalism that comes with the Air Force uniform. As health care providers, it is essential that we are an effective team. We will discuss what makes an effective team, and how to maintain unity.

Effective teams

Teams are defined as highly communicative collections of individuals, guided by a common purpose and striving for the same results. The superintendent oversees the interactions of the dental team to achieve the desired results (mission accomplishment).

These teams are not just created; it takes hard work and a high level of communication among its members. Replace words like “I, me, and mine” with “we, us, and ours.” Team members express a high level of trust among each other. Helping others who have worked through their lunch hour clean up their area is conducive to effective team-building. Effective team members share common goals, and team members are involved in accomplishing those goals. Leadership is shared as needs emerge. Flexibility, creativity, and growth of teams simply increase job satisfaction and productivity.

Common psychological needs

Drawing people into the team concept takes a certain level of leadership ability. The leader's job will be easier if he or she realizes that team members exhibit some common psychological needs. You should first let people know *how they contribute to the end product*, communicate that everyone has a specific and clearly defined role, and show them how their position relates to the overall objective. Be careful to avoid letting members determine their own level of participation.

The second common need by individuals is to *feel competent*. Making people feel incompetent only frustrates staff and makes them feel powerless and dissatisfied. Incompetence can be conveyed in varying ways. The words you choose can have a dramatic effect in expressing your lack of confidence in the member's ability to accomplish the task. If you assign people to complete certain tasks, let them do it without your intervention or doing it yourself.

The third need is for team members to *achieve results*. Set goals so that everyone knows what outcomes he or she is working toward. Superintendents track various trends and analyses that can be passed to the members.

The final psychological need that is common to team members is to have their *efforts recognized and rewarded*. Be sure to recognize the team as an entity and talk about success where others can hear you. Frequent public recognition of accomplishment can help ensure that the team will continue to produce a quality product.

Set limits and ground rules

Team building is a skill; all team members must have limits and ground rules to ensure that each member is able to meet his or her psychological needs, and the team can accomplish its goals. Ground rules can minimize the negative impact of highly aggressive or passive team members. Rules and limits also help the superintendent oversee the dental staff by using impartial standards when making unpopular decisions.

Building cohesiveness among the team

We have discussed how to unite the dental team into an entity, but how do we build them into a cohesive team? Creating a shared goal by getting the team invested in the goal and making it their own (i.e., time off awards) builds team cohesiveness. Always project the positive attitude you want your team members to have. Be assertive, honest and open. Your team should feel respected by what you say and the actions you choose. Communication is essential, make giving and receiving messages as clear as possible, act in a timely, consistent manner, and above all, do what you say you're going to do.

Group dynamics

Gathering a group of people together and getting it to perform at the highest levels is a complex process. Each person joins the military to meet individual needs; some of these individuals are assigned to the dental service to meet the Air Force's organizational needs. It is imperative that superintendents and supervisors have a basic understanding of group dynamics in order to manage various kinds of conflict that arise.

Professional relationships

Professional relationships contribute to the effective operation of the Air Force. An assistant has a close working relationship with the dentist they assist; however, the relationship should always stay professional. The Air Force encourages personnel to communicate freely with their superiors regarding their careers and performance, duties, and missions. This type of communication enhances morale and discipline and improves the operational environment while at the same time preserving proper respect for authority and focus on the mission. Participation by members of all grades in organizational activities, such as base intramural, inter-service, and intra-service athletic competitions, unit-sponsored events, religious activities, community welfare projects, and youth programs, enhances morale and contributes to unit cohesion.

Unprofessional relationships

On or off duty, unprofessional relationships may detract from the authority of superiors or result in, or reasonably create the appearance of, favoritism, misuse of office or position, or the abandonment of organizational goals for personal interests. This can lead to poor morale throughout your dental facility and cannot be tolerated. Unprofessional relationships can exist between officers, between enlisted members, between officers and enlisted members, and between military personnel and civilian employees or contractor personnel.

Communication

Communication is critical to good relations. It is a two-way process that allows individuals or groups to transfer information between sender and receiver. From the monthly staff meeting or eating at the dining hall with a group, virtually everything we do is a form of communicating. Every day we communicate to perceptive observers through a system of symbols (written and spoken), behaviors (tone of voice), and actions (nonverbal gestures). Effective communication occurs when an individual sends a message and the receiver understands the message. The sender can verify that messages are interpreted correctly through feedback received. The receiver becomes the sender when he or she reacts to the message. Ineffective communication occurs when the sender's message and the receiver's message are not congruent. According to psychologist, Albert Mehrabein, the total impact of the message is 7 percent verbal (words), 38 percent vocal (tone), and 55 percent facial expression.

Communication is extremely important within the dental clinic. Always make sure your patient has received your information correctly when scheduling the next appointment through both written (appointment slip) and verbal communication. Now that you are a supervisor, communicate with your subordinates properly. Always give specific expectations through clear messages to ensure the dental assistant you are molding has the proper tools to support the mission.

We must do all we can to make sure our ideas and interests are properly communicated to the receiver. The way we communicate, what we say and do, is what people form their impressions by; the message we send influences the message we get back.

Verbal communication

Verbal communication is the words we use, either written or spoken, to communicate a message. The words are verbal symbols used to represent an object or a meaning. Miscommunication occurs because these symbols are not repeatedly checked against the things they represent which results in confusion. Good verbal communication depends upon the foundation of a common language, in which the sender and receiver are using words that have the same meaning. Depending on whom you're talking to, the acronym CDC could mean the Center for Disease Control and Prevention, career development course, or even Child Development Center. One way to make sure that your message is being understood is to ask questions. Questions are used to gather information, but if used incorrectly, can be misleading. Try to use *open-ended questions* that permit the responder to elaborate. Close-ended questions are those that the respondent can answer with a simple one-word reply. Verify that your communication is understood to prevent it from being ineffective.

Nonverbal communication

Nonverbal communication categories encompass all other forms of communication. Body language is the messages we send by the way we carry ourselves and move about, gestures, and facial expressions. The quality of our voice is also a nonverbal and impacts one third of the message. Voice quality can convey emotions like joy, anger, and anxiety, as well as fatigue. Learning to read "nonverbals" aids in the interpretation of messages. Patients may demonstrate tension, anger, or embarrassment when visiting the clinic; we must be cognizant of these gestures to enable the patient to have a positive dental visit.

Listening

Just as the sender must verify the message is understood, the receiver has the responsibility to be attentive to the message being sent. This sounds like an easy task, but listening is known as the most neglected communication skill; approximately 90 percent of all spoken words are never heard. There are several things that we can do to improve our listening skills:

- Put aside personal concerns while the person is talking.
- Concentrate on what the person is really saying.
- Cue in on nonverbals.
- Be sensitive to what the person is expressing in terms of feelings and needs.
- Allow the person to take the conversational lead; be sensitive to the signals that are being sent.
- Not be busy formulating a reply.
- Avoid responses that may hurt the individual:
 - Critical – a put-down that does not help anyone.
 - Irrelevant – has nothing to do with the feelings behind what the person has just said.
 - Hitchhiking – use any opening to start their favorite topic; diverts from the issue at hand.

Conflict

Even when managers practice assertive behaviors, they will inevitably be confronted with conflicts within the workplace. The choices they make to resolve the conflicts will determine if it will be disruptive or destructive in nature.

Definition of conflict

Conflict arises within, between, and among people out of differences in facts, definitions, views, authority, goals, values, and controls. It is a clash that occurs when one's balance among feelings, thoughts, desires, and behavior is threatened. Many people believe that more than one person must be involved for conflict to exist, but that is a myth, only one person needs to perceive conflict for it to be a reality.

Benefits of conflict

Humans have a long history of conflict. It is a normal part of human relations and inherent in the dental environment because dentistry is a people-focused business. Many consider conflict harmful, and therefore, avoid it. A positive view of conflict will see that it is inevitable and we should search for ways in which it can result in constructive outcomes. Conflict has the ability to bring hidden problems to the surface where they may be confronted and resolved. Conflict can also make necessary change more acceptable because personnel recognize that there is a need and may have more of a buy-in. Confronting conflict paves the way to innovation and improvement.

Levels of conflict

Conflict can occur within an individual, between individuals or groups, and across organizations. Many different situations create perceived conflict. Conflict exists when people have differing motives, misunderstandings, conflicting priorities, and unrealistic goals. The primary types of conflict you need to be concerned with follow:

Levels of Conflict	
Primary Types	Description
Intrapersonal conflict (within oneself)	Occurs when a person is expected to perform a task that does not meet his or her personal goals, values, beliefs, or expertise. For example, the dental laboratory technician that cross-trained from dental assisting is required to periodically work in the dental exam section.
Interpersonal conflict	Occurs between two or more staff members when they disagree on an issue.
Intragroup conflict (within the group)	Occurs between members at the same level (assistant to assistant, dentist to dentist). Usually this conflict is caused by differing goals, tasks, and procedures.
Intergroup conflict	Occurs between two or more groups with conflicting goals. For example, the preventive dentistry technicians may disagree with helping to pull the next day's dental records at the front desk.

Sources of conflict

Supervisors most often deal with interpersonal conflict. Interpersonal conflict may arise from role ambiguity, role overload, specialization, role interdependence, task blurring, change, and communication.

Role ambiguity

Role ambiguity occurs when a person is not aware of the expectations others have for a particular role. For example, a supervisor assigns a task to an individual, but does not allow the person the freedom to make decisions regarding the task. The subordinate is unsure of his or her limits.

Role overload

Role overload happens when a person cannot meet the expectations of others for a role. Expecting a new airman to understand and flawlessly perform dental prophylaxis procedures before becoming fully proficient as a chair-side assistant is a prime example of a source for conflict.

Specialization

Specialization occurs when a person or group assumes responsibility for a particular set of tasks or area of service and sets itself apart from other groups. Clinics experience this when they fail to train more than one person on a clinic program. What typically happens is that the one person responsible for the program is not available and no one else can help because they've never been trained to do the job.

Role interdependence

Role interdependence occurs when individual domains of responsibility have to be discussed with others who may compete for certain areas of control. It seems that we can witness this quite frequently when ordering supplies from Dental Logistics. The logistics noncommissioned officer-in-charge (NCOIC) is showing good stewardship of our resources by reviewing our orders. Conflict occurs when the logistics noncommissioned officer (NCO) tells us we cannot order everything that we want.

Task blurring

Role ambiguity and failure to designate responsibility and accountability for a task to one individual or group can result in task blurring. Those involved may be confused about who is supposed to actually perform the task.

Change

As change becomes more apparent and or threatening, the probability and depth of conflict increases proportionately. For example, a new NCOIC takes over management of the dental residency section and implements a different leadership style than the employees are accustomed to. The employees may reject the new style.

Communication

Communication problems can emerge when communication channels are used incorrectly. You may have experienced the conflict that can result when an individual skips over the supervisor in their chain of command.

Conflict process

You can now see that there are many different types and sources of conflict. Conflict is a constant in any organization; it does not usually appear suddenly. Each conflict generally passes through stages. See the following table for stages and characteristics:

Stages of Conflict	
Stage	Characteristic
Antecedent condition	Basic condition for conflict exists but hasn't been recognized by the individual(s).
Perceived conflict	Recognition of conditions that exist between parties or within self then can cause conflict.
Felt conflict	Strong feelings associated with conflict, fear, anger, tension, threat, hostility, etc.
Manifest conflict	The conflict is out in the open, and the existence of the conflict becomes obvious to parties that are not involved.
Conflict aftermath	Conflict is resolved. Learning takes place within an individual and can become the antecedent condition for conflict in another time and place.

Managing conflict

Managing conflict is simply an attempt to contain or reduce the negative consequences. There are various methods to resolving conflict but here we examine five specific approaches: (1) avoiding, (2) forcing, (3) accommodating, (4) compromising, and (5) confronting/problem solving.

Avoiding

Avoiding is the physical or mental withdrawal from a conflict. This form of resolution does not address the underlying cause of the conflict. When a manager has two individuals in a conflict, one of them may be moved to another area. Subordinates may perceive the avoiding method as being indecisive, and often results in a lose/lose situation where neither party reaches its goal. It is effective when time is important, but may provide the foundation for future conflicts.

Forcing

Managers utilizing the forcing method rely on aggressive dominance to achieve resolution. Sometimes this is necessary if a conflict has become physical in nature. The supervisor can step in to demand separation. It may also be effective if there is a lack of knowledge or expertise. The forcing method has been found to be *the least effective approach*, and may harm the relationship beyond repair. It reflects a win-lose approach, so that only one will come out ahead.

Accommodating

This approach is also known as *smoothing*, and the focus is placed on accommodating the other person's interests. Normally, the accommodating individual places a great emphasis on others, but a low value on self. It is useful for long-term action planning to encourage cooperation and in instances where the manager passively accepts the power of others, to buy time for assessing the situation and surveying alternatives. The person who is accommodating loses in this method and the other wins.

Compromising

The compromising approach *seeks the middle ground*, it is effective with interpersonal conflict when all can benefit. The conflict can be resolved when each side makes concessions. It is a give and take process; all parties give up something to attain resolution. Compromising is a good method when the issue is not important or there is a need to expedite a solution, but can stifle creativity. It can be a win-win situation, but may leave the root cause of the conflict buried, thus leading to future conflict.

Confronting/problem solving

Confrontation is by far *the most effective and lasting method* for resolving conflict. It requires the involved parties to face the conflict directly and work through it until there is mutual agreement. It is better known as problem solving. The goal is for all to achieve their goals, which results in a win-win outcome. For the confronting approach to work—there must be some basic guidelines. If the intent is to attain a long-term solution, we must treat the problem and not the symptoms. To do this, we must first analyze the problem and then work the problem.

The first step in analyzing a problem is to correctly identify the problem. What is conflict doing to the individuals involved as well as the rest of the dental team? Take into consideration the personnel involved and their levels of responsibility. How large or small is the problem; has it spread from a localized event into a broader issue encompassing more staff members? Once you have correctly identified the cause of the conflict, then you will be able to get the involved parties together.

Next, bring all parties together to work the problem. Encourage them to communicate freely; there should be no blame placed since they are there to move past the issue into new territory. Investigate all areas of consideration; avoid permitting attacks on sensitive areas. Identify common goals and areas of agreement. This will allow a more thorough pool of possible solutions. Be careful not to jump into a solution too quickly, consider all advantages and disadvantages. When both sides have reached an agreement, apply the solution/decision.

Now that you have a good understanding of conflict, let's address one of your most important supervisory tools—counseling.

006. Counseling

The responsibilities of a supervisor are certainly broad. You as the supervisor must demonstrate certain qualities to be an effective counselor. These qualities include respect for subordinates, self-awareness, cultural awareness, empathy, and credibility. The inherent nature of the job is to work with people. You won't be able to effectively supervise everyone in the same manner. Some subordinates are easy to supervise and others will present more of a challenge. Employees have varying needs. Some will come to you as a confidant, wanting only your opinion in a matter. Others will require more direct guidance and leadership. As you progress in the hierarchy of the organization, you will find that from time to time you will need to counsel individuals. Supervisors must communicate that they are there to help the member and that they have a genuine concern for them. Counseling is a learned skill and this section will provide you the information and guidance to use when counseling your subordinates.

Reasons to counsel

The general objective of counseling is to help our subordinates grow in self-confidence, understanding, self-control, and perform the job effectively. These objectives are consistent with Maslow's hierarchy of needs; individuals will be able to gain self-esteem and potentially self-actualization.

People generally think of counseling as a negative experience, probably because we have each been on the receiving end of an uncomfortable counseling session at one time or another in our careers. Counseling does not have to be negative and our use of counseling is not restricted to correcting substandard behavior. Effective counseling can prevent substandard behavior from occurring as well as reinforce positive behavior. Whether preventive or corrective in nature, counseling identifies a necessary, optional, or potential behavior change.

Supervisors coach subordinates the same way athletic coaches improve their teams: by identifying strengths and weaknesses, setting goals, developing and implementing plans of action, and providing oversight and motivation throughout the process. To be effective coaches, supervisors must thoroughly understand the strengths, weakness, and goals of their subordinates. You conduct counseling to help your subordinates become better members of the team, maintain or improve performance, and prepare for the future. To conduct effective counseling, you should develop a counseling style with the following characteristics:

Effective Counseling Style	
Characteristic	Description
Purpose	Clearly define the purpose of the counseling.
Flexibility	Fit the counseling style to the character of each subordinate and to the relationship desired.
Respect	View each subordinate as unique, complex individual. Each with a distinct set of values, beliefs, and attitudes.
Communication	Establish open, two-way communication with subordinates using spoken language, nonverbal actions, gestures, and body language. Effective counselors listen more than they speak.
Support	Encourage subordinates through actions while guiding them through their problems.

Counseling skills

All supervisors should seek to develop and improve their own counseling abilities. The techniques needed to provide effective counseling will vary from person to person and session to session. However, general skills needed in almost every situation include active listening, responding, and questioning.

Active listening

During counseling, you must actively listen to your subordinate. When you are actively listening you communicate verbally and nonverbally that you have received the subordinate's message. The following table shows the different reasons to listen:

Types of Active Listening	
Types	Description
Informative	<ul style="list-style-type: none"> Your primary concern is to understand the information exactly as transmitted. Keep an open mind, set aside your preconceptions and just listen. Respond and ask appropriate questions. This will help you clarify and confirm that you understand the message.
Critical	<ul style="list-style-type: none"> This is thought of as the sum of informative listening and critical thinking. You are actively analyzing and evaluating the message your subordinate is sending. You need to try to understand the message first and then evaluate it second. Do not mentally argue with the speaker until the message is finished.
Empathic	<ul style="list-style-type: none"> This is useful when communication is emotional. Often used as the first step in the listening process, a prerequisite to informational or critical listening. Appropriate during mentoring and nonpunitive counseling sessions.

Responding

A supervisor responds to communicate understanding towards the subordinate, clarifies and confirms what has been said, and responds to subordinates both verbally and nonverbally. Verbal responses consist of summarizing, interpreting, and clarifying the subordinate's message. Nonverbal responses include eye contact and occasional gestures such as a head nod.

Questioning

Although questioning is a necessary skill, you must use it with caution. Too many questions can aggravate the power differential between a supervisor and a subordinate and place the subordinate in a passive mode. The subordinate may also react to excessive questioning as an intrusion of privacy and become defensive. Ask questions to obtain information or to get the subordinate to think about a particular situation. Generally, questions should be open-ended to evoke more than a "yes" or "no" answer. Well posed questions may help to verify understanding, encourage further explanation, or to help the subordinate move through the stages of the counseling session.

Types of counseling

Often, you can categorize counseling based on the topic of the session. The two major categories of counseling are (1) event-oriented and (2) performance and professional growth.

Event-oriented counseling

Event-oriented counseling involves a specific event or situation. It may precede events, such as going to a promotion board or attending a school; or it may follow events, such as a noteworthy duty performance, a problem with performance or mission accomplishment, or a personal problem. Event-oriented counseling includes, but is not limited to counseling for specific instance, crisis counseling, and referral counseling.

Counseling for specific instances

Sometimes counseling is tied to specific instances of superior or substandard duty performance. The key to successful counseling for specific performance is to conduct the counseling as close to the event as possible. Many supervisors focus counseling for specific instances on poor performance and

miss, or at least fail to acknowledge, excellent performance. You should counsel subordinates for specific examples of superior as well as substandard duty performance.

Crisis counseling

You may conduct crisis counseling to get a subordinate through the initial shock after receiving negative news, such as notification of the death of a loved one. You may assist the subordinate by listening and, as appropriate, providing assistance.

Referral counseling

Referral counseling helps subordinates work through a personal situation and may or may not follow crisis counseling. Referral counseling may also act as preventive counseling before the situation becomes a problem. Usually, the supervisor assists the subordinate in identifying the problem and refers the subordinate to the appropriate resource, such as legal services, a chaplain, or an alcohol and drug counselor.

Performance and professional growth counseling

During performance and professional growth counseling, you conduct a review of a subordinate's duty performance during a certain period and set standards for the next period. Rather than dwelling on the past, focus the session on the subordinate's strengths, areas needing improvement, and potential.

Counseling techniques

At this point, you are becoming more aware that you have some very distinct responsibilities in the counseling process. Before we go deeper into the counseling session, you will need to determine which technique will have the greater benefit for the given situation. We will discuss three techniques: the nondirective, the directive, and the combined. Supervisors must be familiar with these various approaches and understand their strengths and limitations.

Deciding what approach to use is based on the mix of the counselor's personality and style, the demands of the situation, specific problem, and makeup of the counselee. Different people and different situations require different counseling techniques. The counselor must be aware of the alternative approaches and be sufficiently prepared to use any of them when applicable.

Nondirective

The nondirective technique is the preferred for most counseling sessions. It emphasizes the importance of the subordinate taking responsibility for and solving the problem. Your role is to listen rather than make decisions or give advice. Clarify what is said. The use of questioning helps the counselee solve the problem, and the supervisor gains a greater degree of understanding about the problem and manner in which the counselee approaches issues. When appropriate, summarize the discussion. The advantage of this approach is that the "ownership" of the solution lies with the "owner" of the problem. The counselee is allowed to choose his or her own goals, make decisions, and take responsibility for his or her choices. Avoid providing solutions or rendering opinions; instead, maintain the focus on the goals and objectives. Ensure the subordinate's plan of action supports those goals and objectives. This approach is limited to the ability of the counselee by his or her desire to change and is not effective for individuals who do not care about the consequences of their behavior.

Directive

In contrast to the non-directive technique, the supervisor directs the course of action for the subordinate. Choose this technique when time is short, when you alone know what to do, or if a subordinate has limited problem-solving skills. The directive approach is also appropriate when the subordinate needs guidance, is immature, or is insecure. The direct technique works best to correct simple problems, make on-the-spot corrections, and correct aspects of duty performance. This is a

counselor-centered approach in which you as the counselor maintain a firm stand and decide the best course of action and direct the session towards a selected end or solution. Using the directive technique, you do most of the talking and you tell the subordinate what to do and when to do it. You will have already decided upon the goal of the session so inputs from the counselee are incidental based upon the assumption that you already know the situation and have arrived at the best solution.

There are three forms of directive counseling: informational, disciplinary, and support giving.

Informational counseling

Information counseling can be considered *advice giving*. The key is to provide specific information to the counselee. This form of counseling is very useful when the situation is due to ignorance, inexperience or a lack of training. The disadvantage of this approach is its potential to reduce the counselee's initiative and to make the counselee dependent upon the counselor.

Disciplinary counseling

The disciplinary approach is a *rule setting* style. This form is generally punitive or restrictive and is designed to promote rule compliance and reduce unacceptable behavior. It is recommended when there are obvious transgressions and a high probability of recurrence by the same individual.

Support giving counseling

The support giving approach is the last form of directive counseling. This form works best if applied sincerely.

Combined technique

In the combined technique, the supervisor uses techniques from both the non-directive and directive techniques, adjusting them to articulate what is best for the subordinate. The combined technique emphasizes the subordinate's planning and decision making responsibilities. With your assistance, the subordinate develops a plan of action. It stresses the joint responsibility and cooperation between the counselor and counselee. It tends to move the focus of the issue away from the counselor and counselee, while involving both in the solution. Listen, suggest possible courses, and help analyze each possible solution to determine its good and bad points, and then help the subordinate fully understand all aspects of the situation and encourage them to decide which solution is best.

Counseling process

The four stages of the counseling process are: identifying the need for counseling, preparing for counseling, conducting the counseling session, and following up.

Identify the need for counseling

Conduct counseling whenever the need arises for focused, two-way communication aimed at subordinate development. Developing subordinates consist of observing the subordinate's performance, comparing it to the standard, and then providing the feedback to them in the form of counseling.

Prepare for counseling

Depending on the issue, preparing to counsel can either be quick or time consuming. Select a suitable place. Schedule the counseling in an environment that minimizes interruptions and is free from distractions. Schedule the time. The length of time required depends on the complexity of the issue. Generally, a session should last less than 1 hour. If you need more time, schedule a second session. When scheduling the session, avoid holding it late in the day because the individual may take anger and tension home where it will build up. Notify the subordinate well in advance. They should know why, where, and when the session will take place.

Solid preparation is essential to effective counseling. Review all pertinent information including the purpose of the counseling, facts, and observations, identification of possible problems, main points of

discussion, and the development of a plan of action. Make certain that you, as the counselor, are not emotionally upset while counseling, as this can cause irreparable damage to the interpersonal relationship. Plan your counseling approach.

Establish the right atmosphere. The right atmosphere promotes two-way communication between you and your subordinate. To establish the right atmosphere, offer the subordinate a seat or a cup of coffee. Sit in a chair facing them since a desk can act as a barrier. Some situations make an informal atmosphere inappropriate. A more formal atmosphere is normally used to give specific guidance, and reinforces the supervisor's rank, position, and authority.

Conduct the counseling session

Be flexible when conducting a counseling session. Often, counseling for a specific incident occurs spontaneously as supervisors encounter subordinates in their daily activities. Good supervisors take advantage of naturally occurring events to provide subordinates with feedback. Even when you have not prepared for a formal counseling, you should address the four basic components of a counseling session:

Open the counseling session

One of the most important elements of the session is to establish rapport with the individual. This can set the stage for a productive meeting. A small discussion about common interest topics is acceptable. The best way to open a counseling session is to clearly state its purpose. Establish the preferred setting early in the session by inviting the subordinate to speak. If you let the counselee know your opinion of the situation first, then the member may not open up if his opinion does not mesh with yours.

Discuss the issues

You and the subordinate should attempt to develop a mutual understanding of the issues. You can best develop this by letting the subordinate do most of the talking. Use active listening; respond and question without dominating the conversation. Ask as many open-ended questions as you can; many times the object is to get the person to share. Help the subordinate better understand the subject of the counseling; for example, duty performance, a problem situation and its impact, or potential areas for growth. Avoid taking notes; it gives the appearance that you may not be listening attentively. Sometimes a pause can be used to your benefit, interrupting the counselee may inhibit his ability to be open and honest. Both you and the subordinate should provide examples or cite specific observations to reduce the perception that is unnecessarily biased or judgmental. However, when the issue is substandard performance, you should make it clear how the performance did not meet the standard and then develop a plan of action.

Develop a plan of action

A plan of action identifies a method for achieving a desired result. It specifies what the subordinate must do to reach the goals set during the counseling session. The plan of action must be specific; it should show the subordinate how to modify or maintain his or her behavior.

Close and record the session

To close the session, summarize key points and ask if the subordinate understands the plan of action; give the person opportunity to summarize in his or her own words what you have discussed. Invite the subordinate to review the plan of action and what is expected. You may be surprised that what he or she heard is not what you think you covered; some have a tendency to recall only the negative points. With the subordinate, establish any follow-up measures necessary to support the successful implementation of the plan of action. These may include providing the subordinate with resources and time, and following through on referrals. Schedule any future meetings, at least tentatively, before dismissing the person.

Documentation serves as a reference to the agreed upon plan of action and the subordinate's accomplishments, improvements, personal preferences, or problems. It is best to record the counseling *after* the session, and do not try to keep up with notes during it. Your record of the session needs to include: the immediate cause of the counseling, your appraisal of the subordinate (i.e., demeanor), what plan of action was chosen, and counselee comments and signatures of both parties.

Follow-up

The counseling process does not end with the counseling session; avoid the misconception that all problems are resolved. You must support the subordinate as he or she implements his or her plans of action. You must observe and assess this process and possibly modify the plan to meet goals. Measures taken after counseling include follow-up counseling, making referrals, informing the chain of command, and taking corrective measures.

Self-Test Questions

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

003. Understanding manning, staffing, and utilization requirements

1. What is the manpower document?
2. What does the FAC code represent?
3. Where can you request a current UMD?
4. What personnel are reflected on the UPMR?

004. Patient relations

1. How can we get the patient to be more committed to the goal?
2. What are the six tactics that can be used to calm the irate patient?

005. Understanding medical/clinic relationships

1. Define dynamics.

2. What are some characteristics of an effective team?
3. What effect does the establishment of ground rules have on team members?
4. What percentage of the message is verbal? Vocal (tone)? Facial expression?
5. What type of question is best to ensure that your message was understood?
6. List five things that we can do to improve our listening skills.
7. What are three advantages to conflict?
8. Name the four primary types of conflict and give a brief description of each.
9. List the five ways of approaching conflict management.

006. Counseling

1. What is the general objective of counseling?
2. What are the five characteristics you should use to develop an effective counseling style?
3. What are the two major categories of counseling?
4. What are the three general approaches to counseling?

5. What are the four stages of the counseling process?

1-3. Career Progression

Timely training and progression from the apprentice to the superintendent skill level play an important role in the Air Force's ability to accomplish its mission. It is essential that you understand career progression and the required duties and responsibilities for each specialty.

007. Duties of Air Force Specialty 4Y0XX

Individuals in the dental assistant specialty assist dental officers in treating patients, performing preventive dentistry procedures, exposure and processing of dental radiographs, performing general dental duties, performing dental administrative and materiel duties, and inspect and evaluate dental activities.

Duties and career progression in the 4Y0X1 AFS

Training and timely progression from the apprentice to the superintendent level plays an important role in the Air Force's ability to accomplish its mission. Now let's take a look at skill-level progression (figs. 1-3, 1-4, and 1-5).

Apprentice (3-skill level)

After completing initial skills training (tech school), an apprentice works with qualified assistants and dentists to enhance his or her knowledge and skills. The apprentice enters upgrade training (UGT) using the career development course (CDC) and qualification training (QT) to progress in the career field. Minimum training times are a total of nine months for re-trainees and 12 months for normal UGT. Primary emphasis in training should be on chair-side assisting, dental radiology, and patient records and reception. Tasks taught during initial-skills training and performed on-the-job are evaluated at the member's first duty station. Individuals participate in ongoing dental continuing education programs to expand their knowledge and skills. Apprentices need to devote their full time to learning the specialty.

Journeyman (5-skill level)

Once upgraded to the 5-skill level, journeymen enter into continuation training. Journeymen may be assigned duties in various functional areas such as general dentistry, dental specialty areas, dental radiology, preventive dentistry, and patient records and reception. Duty position rotations are necessary to adequately train and certify journeymen. Journeymen should consider becoming nationally certified by the Dental Assistant National Board (DANB), and continue their education towards a Community College of the Air Force (CCAF) degree. Journeymen are eligible for special duty assignments such as technical training instructor. Completing computer training offered through the American Dental Assistant Association (ADAA) is also beneficial. Individuals attend the Airman Leadership School (ALS) after 48-months time-in-service (TIS) or prior to sew-on of SSgt.

Craftsman (7-skill level)

A craftsman is expected to be knowledgeable and highly skilled in a wide variety of patient treatment procedures and patient administration duties. The craftsman is the primary trainer of those trainees working toward advancement to the 5- and 7-skill levels. Craftsman can also expect to fill various supervisory and management positions. Craftsmen are eligible for special duty assignments such as technical training instructor or the DECS. Craftsmen must become knowledgeable on management of resources. Continued education through CCAF and higher degree programs is encouraged.


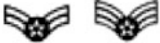







Education and Training Requirements	Grade Requirements	
	Rank	Broadening Experience (Examples)
Basic Military Training		
Apprentice Technical School		<ul style="list-style-type: none"> Complete Infection Control and Radiation Health and Safety National Certification exams
Upgrade to Journeyman (5-Skill Level) Complete 4Y051 CDCs Certified in all STS Core Tasks Minimum 12 months UGT (9 months for retrainees) Complete all duty position training requirements		
Airman Leadership School (ALS) Must be a SrA with 48 months time in service or SSgt selectee Resident graduation is a prerequisite for SSgt sew-on (AD only)		<ul style="list-style-type: none"> Earn National Certification Attend Oral Hygiene Course Apply for Dental Hygiene Training Scholarship Program
Upgrade to Craftsman (7-Skill Level) Complete 4Y071 CDCs Minimum 12 month UGT (6 months for retrainees) Minimum rank of SSgt Complete all core tasks Id'd at the 7-skill level		<ul style="list-style-type: none"> Military Training Instructor (MTI) Professional Military Education Instructor (ALS) Recruiter Duty Schoolhouse Instructor FTAC NCOIC
Noncommissioned Officer Academy (NCOA) Must be a TSgt or TSgt select Resident graduation is a prerequisite for MSgt sew-on (AD only)		<ul style="list-style-type: none"> Professional Military Education Instructor (NCOA) Element NCOIC
Senior NCO Academy (SNCOA) Correspondence Must be a TSgt with at least 2 years TIG Must complete NCOA in residence (AD Only)		<ul style="list-style-type: none"> Professional Military Education Instructor (NCOA) Flight NCOIC
Senior NCO Academy (SNCOA) Must be a MSgt or SMSgt Resident graduation is a prerequisite for SMSgt sew-on (AD Only)		<ul style="list-style-type: none"> First Sgt Duty AFMOA Special Duty Assignment Course Supervisor, Schoolhouse Flight NCOIC/Squadron Superintendent
Upgrade to Superintendent (9-Skill Level) Minimum rank of SMSgt 4Y0XX Career Fields Merge		<ul style="list-style-type: none"> Professional Military Education Instructor (SNCOA) Squadron Superintendent
Chief Enlisted Manager (CEM) (4Y000) Selected for promotion to the rank of CMSgt MAJCOM CMSgt Orientation		<ul style="list-style-type: none"> MDG Superintendent AFMOA/MAJCOM Functional Air Force Career Field Manager Command Chief Master Sergeant (CCM) Chief, Medical Enlisted Force (CMEF)

Figure 1-3. Dental enlisted education and training path.

Duties and career progression in the 4Y0X2 AFS

Individuals in the dental laboratory specialty fabricate and repair dental and maxillofacial prostheses and appliances, inspect dental laboratory equipment, and manage laboratory activities.

Apprentice (3-skill level)

After completing initial skills training (tech school), an apprentice works with qualified dental laboratory technicians and dentists to enhance his or her knowledge and skills. The apprentice enters upgrade training using the CDC and QT to progress in the career field. Minimum training times are a total of nine months for re-trainees and 12 months for normal UGT. Tasks taught during initial-skills training and performed on-the-job are certified at the member's first duty station. Once certified on a task, a trainee may perform the task unsupervised. Individuals participate in ongoing dental continuing education programs to expand their knowledge and skills. Apprentices should devote their full time to learning the specialty.

Journeyman (5-skill level)

Once upgraded to the 5-skill level, journeymen enter into continuation training to broaden their experience base. Journeymen may be required to perform a variety of diverse laboratory tasks, or specialize in specific areas such as removable or fixed prosthodontics. Journeymen need to concentrate on honing their technical skills. When resources are available, individuals are encouraged to periodically attend ADL workshops. Individuals will attend the ALS after 48 months TIS or prior to sew-on of SSgt. They should also continue their education toward a CCAF degree. Individuals are eligible for special duty assignments such as technical training instructor.

Craftsman (7-skill level)

A craftsman can expect to fill various supervisory and management positions such as NCOIC of the dental laboratory or NCOIC of a section or department in an ADL. Craftsmen are the primary trainers of technicians working toward advancement to the 5- and 7-skill levels. STQ2 Continued academic education through CCAF and higher degree programs is encouraged. Craftsmen should consider becoming a certified dental technician (CDT) through the National Board for Certification (NBC) and applying for technical training instructor duty. When promoted to TSgt, individuals will attend the Noncommissioned Officer Academy.

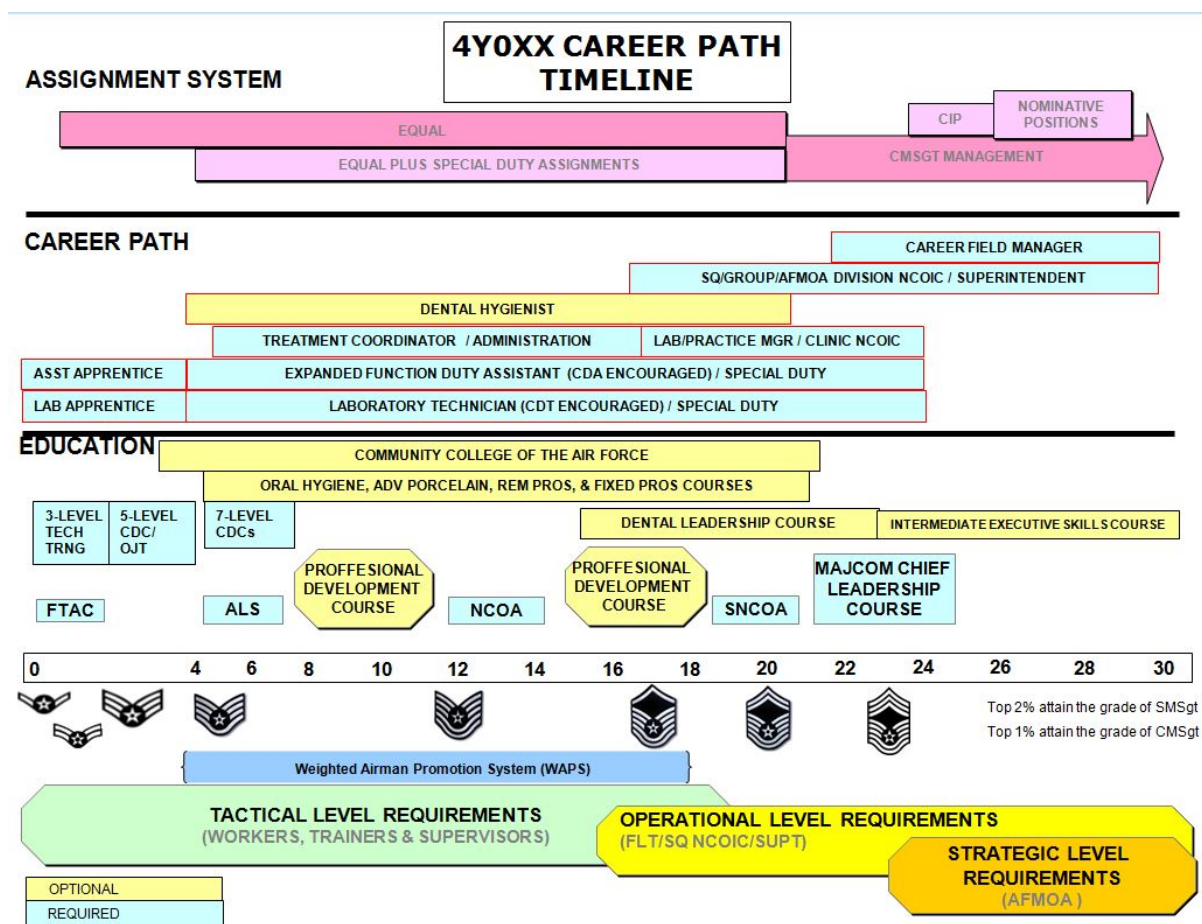


Figure 1-4. Enlisted career path.

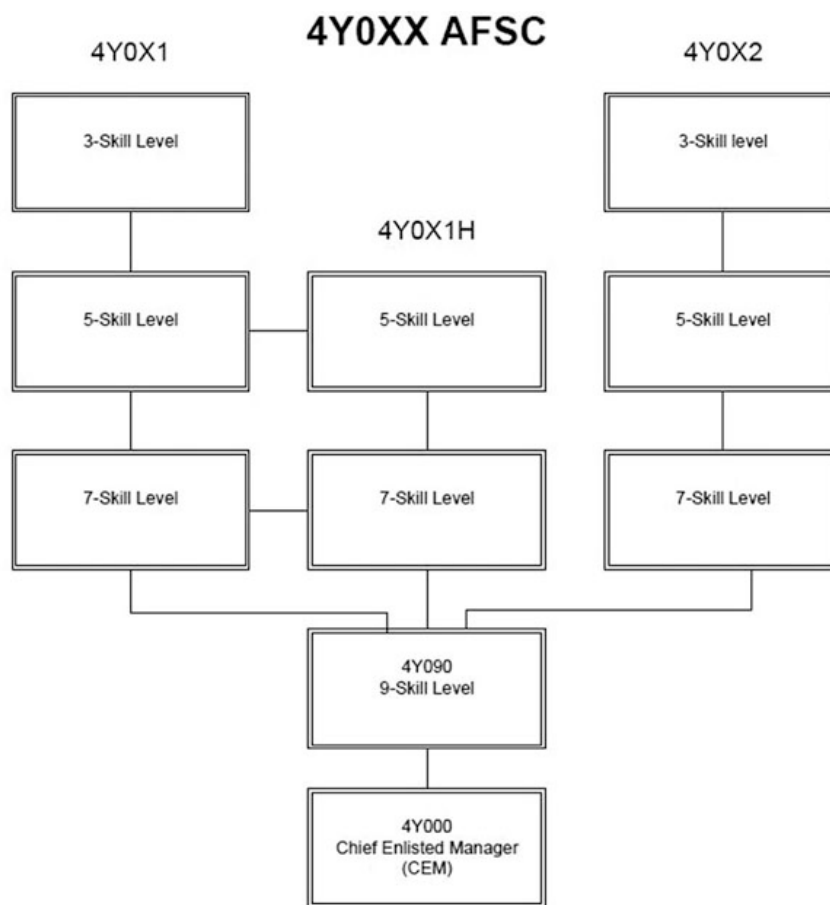


Figure 1-5. Dental enlisted dental career path.

Superintendent (9-skill level) and chief enlisted manager

The superintendent and chief enlisted manager (CEM) perform a myriad of dental administrative duties. The 4Y0X1 and the 4Y0X2 career paths merge at the 9-skill level, 4Y090. Before attaining the 9-skill level, individuals must be a SMSgt. A 9-skill level is expected to fill superintendent positions. Before attaining CEM, individuals must be a CMSgt.

The superintendent and CEM manage dental functions and assist the CDS in managing and operating the dental activity. Typically they review correspondence, reports, and records for accuracy. They also develop, manage, and conduct self-assessments, hazard communication, and dental training programs. They are responsible for manpower and staffing issues. The superintendent and CEM inspect and evaluate dental activities and administrative and paraprofessional practices used in the dental service.

Career progression and training for Air Reserve Component personnel

The Air Reserve Component (ARC) is made up of the Air National Guard (ANG) and the Air Force Reserve. Individuals in the dental assistant specialty that are members of Air Reserve components progress through their career much the same as active duty members, except for the manner that they are promoted. Whereas, active duty personnel are promoted through time-in-grade (TIG), TIS, and the Weighted Airman Promotion System (WAPS), these folks are promoted as a position becomes available in their unit. ARC personnel must also complete professional military education (PME) requirements like their active counterparts. They have the option to either complete these courses in-residence or via correspondence.

Mirror Force

Training is the same for both active duty and ARC personnel. It is more difficult for the ARC units because they are required to complete all training but time is a limited commodity. The requirement to have everyone trained the same is commonly known as Mirror Force.

Mirror Force is the intent to maximize the mission readiness capability of the Air Force Medical Service through a combined effort of AD, Reserve, and National Guard by sharing values and principles, optimizing a total force strategy, using technology effectively and efficiently, training for joint tasking, and creating a dynamic environment which maximizes everyone's potential. Mirror Force is important to the dental service to ensure that both active duty and reserve components receive the same training. This training gives the supervisor confidence that when deployed and working beside a member from a reserve component, he or she will have the skill to perform the duties (fig. 1-6).

Enlisted and Training Requirements	GRADE REQUIREMENTS			
	Rank	Average Sew-on	Earliest Sew-on	High Year of Tenure
Basic Military Training School				
Apprentice Technical School (3-skill level)	Amn A1C	6 months 16 months		
Upgrade to Journeyman (5-skill level) -Minimum 15 months on-the-job training -Complete appropriate CDC if/when available	A1C SrA	16 months 3 years	28 months	
Airman Leadership School (ALS) -Must be a SrA with 48 months time in service or SSgt select -ALS/Correspondence Course required to sew-on SSgt (N/A for ANG)	Trainer -Must attend the formal AF Training course and be appointed by Commander -Trainers must be qualified and certified on tasks to be trained			
Upgrade to Craftsman (7-skill level) -Minimum rank of SSgt -Minimum 12 months OJT -Complete appropriate CDC if/when available -Advanced technical school	SSgt	4.5 years	3 years	33 years
Retrainees -Minimum 9 months for 5 level -Minimum 12 months for 7-level upgrade training	Certifier -SSgt with a 5-skill level or civilian equivalent -Attend formal AF training course and be appointed by Commander -Be a person other than the trainer (Core and Critical tasks only)			
Noncommissioned Officer Academy (NCOA) -Must be a SSgt or TSgt select -Resident/correspondence is a prerequisite to sew-on MSgt (N/A for ANG)	TSgt MSgt	8.2 years 13.1 years	5 years 8 years	33 years 33 years
USAF Senior NCO Academy (SNCOA) -Must be a SMSgt or a selected MSgt	SMSgt	18 years	11 years	33 years
Upgrade to Superintendent (9-skill level) -Minimum rank of SMSgt	CMSgt	21.4 years	14 years	33 years

Figure 1-6. Air Reserve component enlisted education and training path.

008. Educational opportunities in the 4Y0X1/2 Air Force specialties

A good understanding of the educational opportunities in our career field will benefit you and the Airmen that you supervise. The CCAF provides the opportunity for every enlisted member of the Air Force to obtain an Associate in Applied Science Degree. CCAF also offers other educational opportunities in addition to the associate degree program.

CCAF is one of several federally chartered degree-granting institutions; however, it is the only 2-year institution exclusively serving military enlisted personnel. The college is regionally accredited through Air University by the Commission on Colleges of the Southern Association of Colleges and Schools (SACS) to award Associate in Applied Science (AAS) degrees designed for specific Air Force occupational specialties and is the largest multi-campus community college in the world. Upon completion of basic military training and assignment to an AF career field, all enlisted personnel are registered in a CCAF degree program and are afforded the opportunity to obtain an Associate in Applied Science degree. In order to be awarded, degree requirements must be successfully completed before the student separates from the Air Force, retires, or is commissioned as an officer. See the CCAF website for details regarding the AAS degree programs at <http://www.au.af.mil/au/barnes/ccaf/>

CCAF Associate Degree requirements

Upon completion of basic military training and assignment, all active duty, ANG, and AFRC enlisted members are *automatically enrolled* into the CCAF program. Prior to completing an Associate degree, the 5-skill level must be awarded and the following requirements must be met as of this writing:

- Technical education (24 semester hours).
- Leadership, management, and, military studies (6 semester hours).
- Physical education (4 semester hours).
- General education (15 semester hours).
- Program elective (15 semester hours).

You may refer to the 4Y0X1 Career Education and Training Plan (CFETP) for specific course requirements in each subject or contact your base education office for degree counseling since these requirements change periodically.

Professional certifications

Certifications assist the professional development of our Airmen by broadening their knowledge and skills. Additionally, specific certifications may be awarded collegiate credit by CCAF and civilian colleges. To learn more about professional certifications and certification programs offered by CCAF, visit <http://www.au.af.mil/au/barnes/ccaf/certifications.asp>. In addition to its associate degree program, CCAF offers the following certification programs and resources:

CCAF Instructor Certification Program

CCAF offers the three-tiered CCAF Instructor Certification (CIC) Program for qualified instructors teaching at CCAF affiliated schools who have demonstrated a high level of professional accomplishment. The CIC is a professional credential that recognizes the instructor's extensive faculty development training, education and qualification required to teach a CCAF course, and formally acknowledges the instructor's practical teaching experience.

CCAF Instructional Systems Development (ISD) Certification Program

CCAF offers the Instructional Systems Development (ISD) Certification Program for qualified curriculum developers and managers who are formally assigned at CCAF affiliated schools to develop and manage CCAF collegiate courses. The ISD certification is a professional credential that recognizes the curriculum developer's or manager's extensive training, education, qualifications and experience required to develop and manage CCAF courses. The certification also recognizes the individual's ISD qualifications and experience in planning, developing, implementing and managing instructional systems.

CCAF Professional Manager Certification Program

CCAF offers the Professional Manager Certification (PMC) Program for qualified Air Force NCO's. The PMC is a professional credential awarded by CCAF that formally recognizes an individual's

advanced level of education and experience in leadership and management, as well as professional accomplishments. The program provides a structured professional development track that *supplements* Enlisted Professional Military Education (EPME) and CFETP

Air Force Credentialing Opportunities On-Line

Air Force Credentialing Opportunities On-Line (AF COOL) replaced the CCAF Credentialing and Education Research Tool (CERT). The AF COOL Program provides a research tool designed to increase an Airman's awareness of national professional credentialing and CCAF education opportunities available for all Air Force occupational specialties. AF COOL also provides information on specific occupational specialties, civilian occupational equivalencies, CCAF degree programs, AFSC-related national professional credentials, credentialing agencies, and professional organizations. AF COOL contains a variety of information about credentialing and licensing and can be used to:

- Get background information about civilian licensure and certification in general and specific information on individual credentials including eligibility requirements and resources to prepare for an exam.
- Identify licenses and certifications relevant to an AFSC.
- Learn how to fill gaps between Air Force training and experience and civilian credentialing requirements.
- Get information on funding opportunities to pay for credentialing exams and associated fees.
- Learn about resources available to Airmen that can help them gain civilian job credentials.

Trade skill certification

When a CCAF student separates or retires, a trade skill certification is awarded for the primary occupational specialty. The college uses a competency based assessment process for trade skill certification at one of four proficiency levels: Apprentice, Journeyman, Craftsman/Supervisor, or Master Craftsman/Manager. All are transcribed on the CCAF transcript.

Course examinations

Examinations are available free to Air Force personnel through the Base Education Center. CCAF will apply up to 30 semester hours of examination credit toward degree requirements. You should take advantage of these credit awarding exams whenever possible. This includes the College-Level Examination Program (CLEP) and Defense Activity for Non Traditional Support (DANTES). CLEP general and subject exams give students the opportunity to demonstrate college-level knowledge they've gained through prior study, independent study, professional experience, and/or cultural pursuits, and to receive in return course credit, course exemption, and/or advanced placement toward a degree. Likewise, DANTES is an extensive series of examinations in college and technical subjects that are comparable to the final or end-of-course examinations in undergraduate courses.

Tuition assistance

Tuition assistance is a tremendous benefit that you and your coworkers can utilize. At the time of publication, the Air Force will pay 100 percent of the tuition costs of college courses within certain parameters and up to a pre-set limit each fiscal year. Make an appointment with your base education office or visit the Air Force Virtual Education Center (AFVEC) on the AF Portal for up-to-date tuition assistance information.

Self-Test Questions

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

007. Duties of Air Force specialty 4Y0XX

1. Where should the primary emphasis of training be for the dental assistant apprentice?
2. Who are the primary trainers of those trainees working toward advancement to the 5- and 7-skill levels?
3. What duties are the superintendent and CEM expected to perform?
4. What is the purpose of Mirror Force?

008. Educational opportunities in the 4Y0X1/2 Air Force specialties

1. When may members enroll into the CCAF?
2. What must occur before a member can be awarded an Associate degree from CCAF?
3. What is the maximum amount of semester hours that CCAF will apply toward degree requirements from credit awarding exams (DANTES, CLEP)?

1-4. Training

Properly trained personnel are essential to the Air Force Dental Service. The objective of our training programs is to provide realistic job-oriented training so the mission can be met. You may have personally experienced some frustration when you were asked to complete a task before being trained properly. If you have experienced this, you understand the importance of timely, effective training. As a 7-level supervisor you may have the responsibility to evaluate the quality of training given your assigned personnel. In addition, you may be responsible for developing and supervising a training program within your clinic. This section explains your responsibilities in these areas and presents a variety of topics on training.

009. Evaluating training needs

This lesson explains the different ways to determine training needs. Topics include how to evaluate personnel to determine who needs training and what type would be appropriate.

Utilization and training workshop

Through the use of career field surveys and questionnaires, the career field determines the areas of training for each career field. Once this information has been processed, the career field manager (CFM) usually convenes a utilization and training workshop (U&TW) to review the data and address training requirements. The U&TW is normally held at the base where the technical training is administered for the career field and is closely coordinated with the training manager and resident instructional staff. In addition to the schoolhouse staff, subject matter experts (SME) representing MAJCOMs from across the career field also participate. U&TW participants meet for a 1-week period and use the gathered data to revise training requirements, establish skill levels and proficiency codes to achieve training objectives, and update the specialty training standard (STS). The revised STS is combined with other stated training requirements, including resident and non-resident courses, to produce a CFETP document, which establishes training requirements for the entire career field. The U&TW participants also make an evaluation of the quality of the training provided and recommend changes. One of the most important factors in this process and needs assessment is your evaluation, as the supervisor, of a formal course graduate.

Career Field Education and Training Plan

The CFETP is a comprehensive core-training document that identifies life-cycle training and education requirements, training support resources, and minimum core task requirements. The CFETP contains the STS, a document that identifies the duties, tasks, and technical references to support training.

Specialty training standard

The STS identifies training required for the most common tasks at the 3-, 5-, and 7-skill levels of an enlisted specialty. It is developed using information from job inventories, Occupational Survey Reports, and the job description in AFI 36-2101, *Classifying Military Personnel (Officer and Enlisted)*. The STS is an extensive document that provides the specifications of what will be taught at the formal 3-level course and is the basis to the CDCs, which in turn dictate the majority of the field's skill knowledge test (SKT) for promotion. Qualification Training Package (QTP) requirements, core tasks, and wartime course requirements are all identified in the STS document.

Evaluating personnel to determine need for training

Take a look around your clinic and you will likely find that personnel changes happen on a frequent basis. Enlisted members may come to you from a number of sources; you may have the pipeline member straight from tech school, or maybe the NCO PCSing (permanent change-of-station) from another assignment, and sometimes even an Air Force reservist that is performing her or his two-week duty. Regardless of how they get to your clinic, you will need to get them up to speed on your clinic's practices.

Just as each clinic performs independently of one another, every member comes to you with varying levels of experience. Your job as the supervisor is to determine what level the member is at and what training needs to be accomplished. To get the ball rolling, you are required to conduct an initial evaluation within 60 days of assignment. Per AFI 36-2201, *Air Force Training Program Training Management*, ARC personnel are evaluated within 120 days. Let's first evaluate the person that has just graduated from the 3-level, Dental Assistant Apprentice Course at Medical Education & Training Campus (METC).

Evaluating formal training course graduates

As a supervisor, you will be called upon to provide an evaluation of formal course graduates. This is necessary to determine that USAF training programs are teaching what they are supposed to teach. The primary means of meeting this challenge is through questionnaires that evaluate the graduates of these programs. As a supervisor, your timely and accurate response to questionnaires contributes

greatly to the evaluation effort. Through evaluation and analysis, training evaluators are able to detect deficiencies and excesses in training and make adjustments to their programs.

Supervisor feedback

Now that you are more familiar with the process of training development, you know that the formal school training is directly related to tasks performed in your clinic. What you are evaluating is how well those graduates are able to perform entry-level jobs when they reach your dental clinic. There is an established system for evaluating graduates of formal courses. This system is called the Field Evaluation Questionnaire (FEQ). It is an opportunity for the supervisor to provide subjective feedback regarding a recent technical school graduate to the CFM and the schoolhouse. This feedback identifies specific problems or deficiencies in training. This questionnaire arrives approximately six months after the graduate's arrival. The FEQ, governed by AFI 36-2201, is used in conjunction with the Occupational Survey Data to drive the career field training needs and is monitored by the Standards Evaluation Office at METC. A 3-level comment sheet is attached to questionnaire. This allows the supervisor to provide a summary of problems.

The importance of this program cannot be emphasized enough. Have you ever said, "If I ever get the chance to change things ...?" Well, you have just been handed your invitation to do so. Timely, honest, and specific comments and recommendations are encouraged as part of the continuing effort to ensure that training is adequate for and relevant to the clinic's needs.

As you are well aware, the need for training does not stop upon formal school completion. It is really the beginning of a long-term commitment to training. Our career field is one where we must keep up with new developments and master new or changed procedures while maintaining our certification. This means that we must also rely on on-the-job-training (OJT) programs or continuing education training to maintain proficiency. In later lessons we discuss your role in developing and delivering training for your section.

Evaluating newly assigned personnel for training

When people are assigned to our organization, we cannot just arbitrarily place them into any job position. We must first determine exactly what level they have been trained to previously. Evaluate individuals, even when they change duty positions within the clinic. Do not assume that a demonstrated proficiency in one set of duties means that a technician is also proficient in a newly assigned position. The best source that we have at our fingertips is the Job Qualification Standard (JQS) maintained in the electronic training record, Air Force Training Record (AFTR). It indicates all tasks performed in a specialty. You will use this to document evaluation of your personnel to determine their qualifications. You may recognize the JQS as being the same document as the STS, but there is a definite difference between the two.

When an individual is newly assigned to your work area, unless he or she is a non-prior service member, you will be able to reference the JQS to see in which tasks the individual has been previously qualified. Evaluate the knowledge and skills of each member. Use the individual's JQS to certify or decertify the tasks the individual performed. You compare these qualifications to the tasks required in the duty section. Now you have the information to determine short falls in the trainee's qualifications and to effectively determine the training needs.

Job qualification standard

The main difference between the STS and the JQS is that the JQS is maintained in AFTR and is documented with the training an individual is receiving or has received. When the trainee enters training for the specified task, place a start date in the appropriate column. Once training is complete, enter completion date in the appropriate column. Also get the trainer's, trainee's, and certifier's initials (when required) entered in the appropriate columns.

On-the-job training programs

In our career field, like others, much of the 5- and 7-skill level training is accomplished through a combination of CDC and OJT. The CDC provides background and in-depth knowledge from an Air Force-wide career field perspective. This complements the OJT that is aimed at making recently assigned airmen productive in your work area. Both of these training methods also fulfill part of the career advancement requirements.

OJT responsibilities

The OJT program must support the organization's mission; the focus should be on what personnel need to know to do their jobs. The idea is to build on previous training to avoid duplication, and to use simple, easy-to-understand policies and procedures.

OJT development

The ideal work center training program would permit everyone to be 100 percent qualified on all tasks, but we know that is not always practical. Each clinic should have a Master Task List (MTL). The MTL is a complete list of all tasks performed in the work area. It helps to identify training needed to qualify the trainees to perform all duties and responsibilities assigned to the work center.

Information can be gathered from the JQS, AF Form 797, Job Qualification Standard Continuation/Command JQS, interviews and questionnaires. Not every task on the MTL may require training because of its simplicity or because adequate training has been provided; the task should remain on the MTL but you need only question the trainee to verify he or she can perform the task, depending on the proficiency code.

Now you're ready to build some OJT. Where to begin? The best starting point is the CFETP, especially the STS section. Why? This tells you exactly what your newly assigned personnel have been trained to do and at what level of proficiency. In addition, this indicates what training they are to receive at the 5- and 7-skill level, both CDC and OJT.

Remember that you are responsible for the OJT and it should be tailored to your clinic's needs. Most of the knowledge for upgrade to the 5- and 7-skill level will be provided in the CDC. Focus your OJT effort to provide the practical task knowledge and experience to supplement the CDC information and perform day-to-day job functions. Before you begin, you need to understand the proficiency codes used in the STS.

Proficiency codes

The proficiency codes are used to indicate levels of training and the expected performance level of the member who completes the training. In relation to your OJT program, the proficiency code provides two important facts: the level of proficiency achieved in the 3-level residence course and the level of proficiency expected of your 5- and 7-level OJT (for those items designated for OJT). The proficiency codes are used to separate levels of training into three categories—task performance, task knowledge, and subject knowledge. The specific codes assigned to certain knowledge and subject areas can assist you in determining where to start your OJT. So how does this work? To help illustrate, look at the abbreviated proficiency code key in the following table:

Proficiency Code Key		
	Scale Value	Definition
Task Performance Levels	1	Can do simple parts of the task. Needs to be told or shown how to do most of the task.
	2	Can do most parts of the task. Needs only help on hardest parts.
	3	Can do all parts of the task. Needs only a spot check of completed work.

	4	Can do the complete task quickly and accurately. Can tell or show others how to do the task.
Task Knowledge Levels	a	Can name parts, tools, and simple facts about the task.
	b	Can determine step-by-step procedures for doing the task.
	c	Can identify why and when the task must be done and why each step is needed.
	d	Can predict, isolate, and resolve problems about the task.
Subject Knowledge Levels	A	Can identify basic facts and terms about the subject.
	B	Can identify relationship of basic facts and state general principles about the subject.
	C	Can analyze facts and principles and draw conclusions about the subject.
	D	Can evaluate conditions and make proper decisions about the subject.

Using the key, you can designate training by a number, a small letter, a capital letter, or a combination of these. For example, an STS item could be coded at any level of training: 2, 2a, b, 2b, B, A, etc. This coding then specifically identifies the level of training that is provided by the 3-, 5-, or 7-level courses. A complete explanation of this coding is provided at the front of the STS that is found in the CFETP.

NOTE: Task knowledge and task performance levels can be combined to indicate a specific level such as 2a (the student must demonstrate both knowledge and ability to perform the task to a specific level).

However, subject knowledge levels *do not* use task performance level numbers. So how does this work in reality? Let's use the STS element "*Prepare written job descriptions*" for our working example. *Preparing written job descriptions* is trained to the "b" (task knowledge) level in the 7-level CDCs. This is not to be confused with the "B" (subject knowledge) level. A big "B" and a little "b" both mean something entirely different. The "b" means that the craftsman has been provided task knowledge training to a level just higher than the lowest measurable level. That is "Can determine step-by-step procedures for doing the task." In short, the trainee can identify the procedures needed to write a job description. This person hasn't performed the actual task, but can tell you each of the elements needed to accomplish it. This is the objective of your OJT program for this particular STS element.

Customizing training

The manner in which you achieve the desired proficiency level is your choice. Here is where your experience, ingenuity, and resourcefulness come into play; use the CFETP/STS as a guide. You can recycle training that you have had, develop new training, ask other training managers for ideas that have worked, or use any combination of these methods. Some trainers supplement the 5-level CDC using reading assignments from pamphlets, texts, or other materials. Others may use the entire task knowledge portion of the 5-level CDC along with the demonstration/performance method. Remember, OJT can be as simple as the "tell, show, do method" of training: tell them what you want them to know; show them how to do it; then have them do the task. Bear in mind that you, the supervisor, makes the final determination of the level of training given.

Types of OJT

OJT ensures each individual is qualified to perform the specific duties of his or her job. This in turn supports the organization's mission. We can further subdivide OJT into two types: UGT and QT. Upgrade training trains tasks required for advancement to the next higher skill level. Qualification Training trains tasks required in a specific duty position. Qualification Training requirements may

vary from clinic to clinic or even in positions within a clinic. You must provide both types of training to your personnel to fully develop their knowledge and skills.

Job proficiency upgrade training

Remember that UGT trains tasks required for advancement to the next higher skill level. These tasks are identified as *core tasks* in the STS. Those identified as 5-skill-level core tasks are required for the award of the 5-skill level. Those identified as 7-skill level core tasks are required for the award of the 7-skill level. You must be confident of a trainees' proficiency in these tasks prior to certification. The career field has determined that these tasks are essential to the performance of the 4Y051 duties. You will be responsible for monitoring the effectiveness of your subordinate's upgrade training. You must evaluate the training honestly and implement changes to the training process whenever training objectives are not being met.

Qualification training

Each duty section has a MTL. The MTL identifies tasks required for each duty position in the dental clinic. It may include tasks not listed in the 4Y0X1 STS. Also, note that all tasks in the STS are *not* designated as core tasks; these are identified as non-core tasks. These non-core tasks may still be required in a duty position and are referred to as qualification training tasks (opposed to upgrade training). Monitor the effectiveness qualification training just as you do upgrade training since these tasks will be required for 100 percent task coverage in your section.

Career knowledge upgrade training

At some point, you will administer a CDC to a trainee. The CDC satisfies career knowledge requirements for upgrade training.. It provides basic principles, techniques, and procedures that are common to an Air Force specialty code (AFSC). In the event that a CDC is not available to fulfill the career knowledge requirements, you must instead identify and use the STS training references. These training references are listed below each STS item.

010. Conducting training

Effective training is not something that magically happens when a trainer spends several hours or days with the trainee. Effective training requires many elements of instruction, engaging each trainee in a way that promotes learning, and facilitating sharing of ideas. Conducting training will be one of your most challenging duties. As with any program, planning is crucial for success. The ultimate goal is for trainees to become fully qualified as quickly as possible. Though challenging, it deserves your best effort. If you cut corners here, you will undermine the foundation of the clinic's most important resource – the people. This lesson discusses various ways you can increase the effectiveness of training through good preparation.

Initial evaluations

Any newcomer to the organization arrives with a certain set of skills and knowledge. You must conduct initial evaluations within 60 days of assignment. The purpose of the initial evaluation is to determine specifically, the qualifications the technician possesses. You should also do an evaluation when individuals change duty positions. You should not assume that a demonstrated proficiency in one set of duties means that a technician is also proficient in a newly assigned position. When you conduct an initial evaluation, sit down with the member and review their AFTR. Compare the technician's qualification to the duty position tasks, noting all additional training needs. To handle the needs of trainee, you must first have an understanding of who they are. Who is the person attending your session? Where are their skills and knowledge lacking? What is their attitude about training? To keep a training session interesting and relevant, it is important to understand and respect the individual being trained, and to relate the information conveyed to the specific jobs of the trainee.

It is also important to spend time (but not too much) getting to know the trainee during the session. You may be very well prepared, but it is important to also get to know them personally as much as

possible. People often learn better when they sense that the trainer knows them personally and cares about what they are thinking and feeling.

The basic premise of learning is that the learner, not the teacher is responsible for the learning. The teacher, or trainer, however, must create an environment in which the participant wants to learn because he or she sees the value in learning, feels safe in asking questions and participating, and feels respected both personally and professionally. Adults generally respond well to a variety of teaching methods, especially including a “hands-on” section, as it promotes retention. As adults are self-motivated, it is generally unproductive to be overly formal in your training approach. Adults prefer to receive on-going feedback regarding their progress and performance.

Training process

You are ready now to begin the training process. Like everything else in life, success depends on good planning. Set some long-term training goals with the objective of maximum task qualification for all assigned personnel. Then, using your long-term planning as the framework, you and the trainee need to set some short-term goals. It is a good idea to meet monthly to review the goals and to possibly set new ones. Use the CFETP to determine specifically what tasks to train.

Take note of these considerations as you plan your training session. Make sure you have the following:

1. A clear objective.
2. QTP checklists for tasks to be trained.
3. All training materials and equipment needed.
4. A training method (lecture, demonstration, performance).

Objective

You need to decide on your objective ahead of time, that is, know exactly what task you will be training. Many clinical tasks are actually subtasks of larger procedures so be sure the training has a clear beginning and completion point. Setting up a treatment room and turning it around for another patient are different tasks, but they have common tasks within them (i.e., disinfection). The best training can be ruined if distractions prevent trainees from focusing the task at hand. An effective trainer must minimize distractions by carefully preparing ahead of time. Use QTP checklists to be certain that no details are overlooked.

QTP checklists

QTPs are instructional packages designed to help you conduct and evaluate your field training. Once you begin upgrade training you are required to use the QTPs. QTPs provide continuity to the trainee’s upgrade training and ensure all tasks are covered during training.

Prepositioned materials and equipment

Do not make the mistake of beginning training without all of the pieces in place. Having the proper equipment ready to use greatly increases the effective use of time during a training session. Make sure all training equipment and dental materials are available and pre-positioned. You and the trainee may produce nothing more than frustration if the training process is stopped repeatedly to locate needed items. A trainer who is well prepared is more able to focus on task, which is the next step in becoming an effective trainer.

Training methods

Variation of training methods promotes learning, as each individual may have a different learning style. Different styles, when used in conjunction with good learning aids, stimulate more of the trainee’s senses, which in turn will help the trainee internalize the learning.

The most common method of training is the traditional *lecture method*, whereby the trainer talks and the trainees listen. Lecturing can be effective when concepts need to be conveyed. However, exclusive use or over-use of lecturing can be boring and ineffective. Lecturing should be used in conjunction with other techniques which allow the learner to participate more actively in the learning. Remember that training is about learning, not about being the star of the show.

Discussion, a second method, promotes more active involvement. Discussion is used in an informal setting where trainees can apply their prior experience and knowledge to the topic at hand. It is important for the trainer to keep discussions focused.

A third method of training is *demonstration/performance*. If you are training on a process or a technique, it is often more effective to show how to do it rather than trying to explain it. This method is effective when the training objective is the development of new manual skills. When at all possible, it is also good to let the trainee practice doing it themselves. This hands-on approach allows the trainee to perform and you to effectively critique during the training process.

A variety of training methods are at your disposal. Three methods are discussed here. In each case, conduct training from what is known to the unknown and from easiest to difficult.

When it comes to selecting a training method, consider how many technicians are being trained. Most dental clinic OJT is done one-on-one using the demonstration and performance method. This “watch one, do one” training works well with tasks that demand motor skills.

When people attend training, they often bring anxiety and other negative emotions with them. This can especially be the case if they didn’t enjoy or excel in school, or if they don’t believe in the value of the training being offered. Your job as a trainer is to help trainees overcome these obstacles. Each person must feel comfortable for optimal learning to occur. Assure trainees that you are there to help them, and that the training will make a difference in their ability to perform effectively, and efficiently.

The manner in which you present, question, and respond to questions is an important factor in your training. You must be able to probe trainees and challenge them to think without coming across as arrogant or antagonistic. When questioning, use concise questions that will allow the respondent to elaborate. Acknowledge all answers, and if they do respond incorrectly, respond with further probing to minimize embarrassment.

When responding to questions, be specific as possible. It is better to admit that you don’t know the answer and promise to find out than to ramble or evade the question.

Conduct ancillary training programs

Ancillary training is additional training provided to specific AFSCs. Each time you complete the Law of Armed Conflict briefing, Basic Cardiac Life Support, and other required training that applies to your job as a member of the armed services or as a healthcare provider, you are receiving ancillary training. There may be a time in your career that you will be tasked to provide some type of ancillary training to other base personnel; that is, Self-Aid Buddy Care.

Purpose

Ancillary training programs are administered to ensure mission completion, safety, and personnel well-being. These programs must meet Air Force needs within minimum training time and cost, while maintaining quality training and maximizing time to complete. They allow standardized training and procedures for all members that require it.

Responsibilities

Ancillary training programs (ATP) are designed by various organizations across the Air Force; every base has an organizational flowchart that depicts how implementation of each individual training program will be accomplished. Each level has distinct responsibilities to the success of the training.

Conduct continuing education programs

You will definitely find yourself arranging and sometimes conducting continuing education for your staff. Air Force dental assistants are required to maintain 12 hours continuing education units each year. Continuing education will enhance a technician's career field knowledge for use on the job. It also provides a means for a certified dental assistant to maintain certification.

You will need to turn to a variety of sources for continuing education material. Here are some common resources to consider:

- ADAA website.
- Workshop attendees.
- Clinical consultants.
- Community medical personnel.
- Videos.
- Dental personnel.

Although you will find it challenging to provide the time for continuing education, it is an integral part of the training program and can provide job enrichment through the presentation of new ideas and techniques. As a supervisor, it is important to keep track of your subordinate's continuing education hours to make sure their 12 hours are met each year.

The American Dental Assistant Association

The ADAA website has agreed to allow active duty Air Force dental technicians free access to their continuing education training via their website <http://www.dentalassistant.org/>. From the homepage, click on member login, and use the Air Force Dental Assistant Account button to create your account.

011. Monitoring training effectiveness

A training program, no matter how elaborate, is no more effective than its end result. If your personnel have not been prepared to complete the mission, you have failed. For this reason, you will want to be sure that your training is effective.

Evaluate effectiveness of training programs

Recall that your training program is the foundation of the dental clinic's most important resource—the people. For this reason, you will want to be sure that your training is effective. Your ultimate goal is to make certain new personnel receive training on their job requirements as quickly and comprehensively as possible. Use these goals to evaluate your training program:

- Provide maximum training in minimum time.
- Strive to achieve 100 percent task coverage.
- Maximize available resources.
- Establish an efficient and flexible schedule.
- Follow a logical, orderly process.

Is *your* training program accomplishing its objective? Ultimately, the results will be measured by job performance evaluations. Seeing the actual performance of your trainees is the most effective means of evaluating your training program.

Evaluating trainee performance

To determine if effective training has taken place, you need to have some means to identify a change in behavior or performance. As part of developing any training event in the AF, establish training “objectives” to assist in identifying the changes that should take place.

Providing feedback

Timely and accurate feedback is critical to trainee performance. Feedback is not limited to only after the task is completed. It is important to correct errors and encourage the trainee throughout the performance portion of the training. Once the trainee is allowed to go “solo”, you need to check the trainee’s work frequently. As you provide feedback, remember you are not evaluating the *individual* but rather the individual’s behavior (task performance). Be objective and do not allow your own personal opinions and feelings about the trainee or the task being evaluated affect your evaluation or feedback.

Nature of evaluation

Evaluation in training is constant throughout the teaching and learning process. When a trainee has learned to do a task, there has been a change in behavior that can be defined, observed, and measured. Evaluation judges the quality of that new behavior. Evaluation is a systematic process of determining how well a trainee has reached the objective. Anything seen, heard, or otherwise sensed can serve as the basis for evaluation. In a large spectrum, evaluation can tell you how well both the trainer and trainee have progressed toward the goals and objectives.

Objectives

Performance of a task and learning to perform a task are distinctively different. You need to change those OJT tasks into clearly stated objectives to specify what the trainee should be able to do after receiving training. Objectives contain three parts: conditions, performance, and standards.

1. Conditions—The conditions of the objective consist of the items you will provide for the trainee to use during training (the givens); for example, QTP checklists, tools, materials, or equipment. The condition may also indicate how much help the person will receive during the task performance or indicate if the task regularly requires more than one person. The conditions you use in training must *mirror the conditions used* during performance of the task on the job.
2. Performance—The performance of the objective closely mirrors the task statement and consists of an action verb and object. The verb will reflect actions that are observable, measurable, verifiable, and reliable. The performance during training will *mirror the performance* of the task on the job.
3. Standards—The standard reflects a clearly stated, measurable standard of performance. Standards specify the accuracy and completeness required for accomplishing the objectives. In other words, how well, how fast, how accurate trainees must perform a task before the trainer or supervisor certifies them in their training record.

Go/no-go standards

Recall the USAF OJT program defines the “Go” standard as capable and competent to perform tasks in terms of procedures, timeliness, performance, and so forth. Apply this standard as you evaluate personnel.

Evaluations or tests

Evaluations or tests are for use after training to determine if training was successful. They also let trainees know how well they are progressing. OJT frequently uses oral and written tests to measure knowledge and attainment of training objectives. Oral questioning techniques are an often overlooked method of evaluating training. Trainers/supervisors should utilize questioning in conjunction with more formal methods to determine effectiveness of training whenever possible.

Performance tests

A performance test is a formal appraisal of trainees’ accomplishment of an objective based on observation of their performance against a predetermined standard. To ensure the standards of an

objective are met, the evaluator will watch the trainees perform. Performance evaluations may judge the process (steps actually performed), the product (end result of procedure) or both. There is no standard format or form for preparing performances; however, the most common is nothing more than a checklist. A performance test should contain:

- The objective.
- Any materials required.
- Instructions required for the evaluator.
- Instructions for the students to perform the task(s).
- Any mandatory failure items such as safety or security violations.
- Any other measurement standards such as time, not included in the objective.

Utilize QTPs to evaluate tasks to make sure each step is accomplished. When determining how to measure each element of the task, ask yourself these questions. Will you simply watch the performance? Will you ask questions and have the trainee explain why the elements are necessary? Will you physically check measurements or specifications? What is being evaluated, the process, the product or both?

When you develop instructions for the evaluator and trainee, keep these facts in mind. The trainee must know exactly what to expect before starting the evaluation. Key factors here include requirements for speed, accuracy, neatness, procedures, and so forth. The evaluator must have a clear understanding of standards to prevent misinterpretation. You may even wish to review the objective before and after the evaluation.

As you can see, there is a lot to evaluating the performance of your trainees. Take the time to determine that your training programs are fulfilling their objectives so the technicians you train will have the skills they need.

The type of evaluation used is tied directly to what you are teaching. If you are teaching task or subject knowledge, use a written or verbal evaluation. But if you are teaching task performance, the best evaluation method is to actually have the technician perform the task. A good method of checking both performance and knowledge is to verbally question the trainee while he or she is performing the task. By correctly answering your questions shows that the technician has mastered the skills and concepts for task completion. Your ultimate goal is to ensure new personnel receive training on their job requirements as quickly and comprehensively as possible. Does your training program meet the following criteria?

Initiating action to correct substandard performance

Your training process should be dynamic: that is, constantly improving. You will learn much about the effectiveness of your training as you evaluate your personnel. Poor trainee performance may not reflect upon your trainee as much as it may indicate a need for altering the training techniques and/or materials. That being said; and assuming you have an efficient training program in place; let's examine methods to correct substandard trainee performance.

You will first need to determine the true cause of the substandard performance. Did the trainee fail to understand the objective or the standard? Did the trainee fail to develop the necessary motor skills? Did the trainee fail to take enough time to accomplish the task? Did the trainee simply lack the motivation to do a good job?

Once you have identified the reason for substandard performance, you then conduct further training emphasizing the area of the task that was substandard.

012. Using training resources and maintaining records

Now that you and the trainee have determined/discussed specific tasks that will need to be trained, you can determine and assign training resources.

Training resources

Training resources include the trainer, training equipment, training materials, training references, time, as well as QTPs.

Trainer

Make sure you assess each trainer's ability to conduct training and assign training accordingly. You will want to choose a qualified trainer who meets all of the following requirements:

- Possesses a 4Y0X1 AFSC or DOD equivalent.
- Is certified on the tasks they will train.
- Is recommended by his or her supervisor.
- Has completed the Air Force Training Course.
- Is appointed in writing by the unit commander.

Training references

Another valuable training resource is the training reference that applies to the specific STS task. The training reference will be listed in Column 1 of the STS beneath the task. These are most often an AF or commercial publication. These written documents provide the technical procedures to perform a task. Many tasks will also have a QTP module. A QTP module will contain step-by-step instructions for hands-on OJT. They are excellent training aides and are mandatory when available.

Time

Another resource, one that is often the most difficult to acquire, is time. Most clinics are very busy making sure that the patient is treated in a timely manner. Nonetheless, it is necessary that you allow time for effective, meaningful training. Do this by planning ahead and scheduling the training session. Make sure that the trainer and trainee know that they are expected to conduct and receive training. Emphasize accuracy and understanding rather than speed.

Presenting an effective training session requires both preparation and skill. Using these tips can help you increase the amount of learning that takes place during training. Set goals for yourself and ask your supervisor or peers to help in evaluating your progress. By increasing your effectiveness as a trainer, you cannot only enhance your own career, but you can help your clinic to more effectively reach its goals of performance and compliance.

Training records

Have you ever heard the saying "No job is finished until the paperwork is done"? This is definitely the case when it comes to training. Now we discuss the training record, its contents, and how you will maintain the record.

Training documents

You will use a variety of tools to record training. We have already discussed the electronic training record (AFTR) to include: CFETP, STS, and JQS. Some additional resources from AFTR are described below.

AF Form 797, Job Qualification Standard Continuation/Command JQS

An AF Form 797 is another tab in AFTR used to document training. You will create this tab by listing tasks not listed on the JQS but which are required in the current duty position.

Here is some guidance for creating and documenting an AF Form 797:

- A task must be an observable and measurable unit of work with a definite beginning and end.
- A task must show action on the part of the worker, start with an action verb, and be specific.
- Create sub-tasks for tasks that have numerous elements.
- Number each task consecutively and letter the sub-tasks.
- Show training references (TR) directly beneath each task or sub-task.
- Document training the same as for a JQS.

AF Form 623a, On-the-Job Record Continuation Sheet

Another tool in AFTR used for documenting training is the AF Form 623a tab. This form is used to document training progress (or lack thereof). Typical entries would include assignment of a trainer, a change in duty position, issuance of a CDC volume, entry into UGT, or award of a skill level. It is important to document trainee's skills, weaknesses and attitudes concerning their training. All entries must be acknowledged with digital signature by the trainee.

AF Form 1098, Special Task Certification and Recurring Training

You may use the AF Form 1098 tab to document selected special task qualifications of critical nature, selected tasks requiring recurring training or evaluation, or selected tasks where someone outside the normal training channels validates the individual's qualification.

Maintaining training records

The training record is very important to the individual and the Air Force. It must be properly documented and available for quick reference. If there is no documentation, it didn't happen; therefore, always maintain accurate training records in AFTR in order to ensure optimal training for your subordinates.

Certification

Although trainers can certify all non-core/non-critical tasks, certifiers must certify all core/critical tasks. In some circumstances, dental officers may substitute as trainers or certifiers. Certifiers must:

- Be at least a SSgt.
- Possess a 5-skill level.
- Be certified on tasks they will certify.
- Have completed the Air Force Training Course (licensed/credentialed healthcare providers do not need to attend this course).
- Be appointed in writing by the unit commander.

Some find the certification process confusing. Keep this in mind when certifying tasks; the STS element is certified with the trainee and trainer only for non-core and non-critical tasks. On the other hand, the core and critical tasks are certified with both the trainer and certifier and digitally signed by the trainee.

NOTE: No digital signature is used in the trainer column of the STS for core/critical tasks. No digital signature is used in the certifier column of the STS for non-core/non-critical tasks. For current guidance on certification procedures, see AFI 36-2201.

Disposition

You will give an exported version of the AFTR record back to the individual upon separation, retirement, or commissioning unless otherwise directed by the AFCFM.

Preparing written job descriptions

What exactly is a job description and how does it apply to the job that we perform day-to-day? This section will discuss the purposes and uses as well as how to go about developing a comprehensive job description.

Purposes/uses

The purpose of a job description is what the term itself implies; it describes what the person does. The key here is detail. Let's imagine that you have created the Pulitzer Prize of job descriptions. Where can you use it? First and foremost it provides valuable guidance to the person who is doing the work. It literally tells your worker what to do! A good job description serves as the foundation for the development of performance standards.

Job descriptions may also be used as reference tools. All of us have struggled from time to time with various award packages. The first section on the AF Form 1206, Nomination for Award, is Leadership in Primary Duties. What better way to identify those characteristics in your personnel than to examine their job descriptions in the light of the specific award package and start from there. As you can see, solid, tight, and concise job descriptions can go a long way toward helping you run a more productive clinic. How exactly do you develop a job description?

Development of job descriptions

A good source for development is the Air Force's idea of a general job description for each career field. AFI 36-2101 provides job descriptions for every AFSC in the Air Force. The problem is, though, the job description provided in AFI 36-2101 is generic. In other words, it applies to all dental assistant apprentices, journeymen, and craftsmen at all locations around the world. Each description should include as a minimum, the job title, reference to source documents, tasks performed, scope and level of responsibility, and the number of people supervised. The more specific you can be the better.

With this information in mind, the next step in developing a job description is basically a "fill in the blank" exercise. The first item in the list, the job title, is the logical starting point. There may be a standard title, or you may create your own. Accuracy is important here since you will want the title to give an idea of what tasks are required in this position. The title (Dental Assistant) leads us to believe the individual performs duties related to assisting a dental officer in patient treatment. If there is specific guidance that the position must adhere to, then you will want to reference it as a source document. What are some of the specific tasks that the individual will perform; state the actual duties in a logical and natural order. Where does this position fit into the organizational makeup? Who does this person report to and from whom does this person acquire information?

Civilian employee job descriptions may be developed by using the Air Force standard core personnel documents through AFPC. The civilian job description has four major components; introduction, duties and responsibilities, controls over work, and other significant facts. Contact the Civilian Personnel Office at your base for further assistance.

Until now you have probably been thinking in terms of just dental assisting for your job descriptions. However, in a large clinic, it may be beneficial to have job descriptions for many of the "additional" duties that constantly need attention. For Example, Biopsy Log or Class 3 Monitor.

Self-Test Questions

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

009. Types of training

1. For what are the U&TW participants responsible?

2. How soon after a newcomer's arrival should the supervisor conduct the initial training evaluation?
3. How may training evaluators detect deficiencies and excesses in training?
4. What are the standards that the OJT program must meet?
5. What are the two types of OJT?

010. Conducting training

1. What is the ultimate goal of training?
2. What is the objective when setting long-term training goals?
3. What do you use to determine what specific tasks to train?
4. List the four elements you need in your training session.
5. What two training methods are used the most when providing dental clinic OJT?
6. What is the purpose of ancillary training?

011. Monitoring training effectiveness

1. What is the most effective means of evaluating your training program?
2. What is critical to trainee performance?
3. What are you evaluating when you provide feedback to the trainee?

4. What does the systematic process of evaluation determine?
5. What is a performance test?
6. What do performance evaluations judge?
7. What type of evaluation do you use when you are teaching task or subject knowledge?
8. What type of evaluation do you use when you are teaching task performance?

012. Using training resources and maintaining records

1. What six things should be included in training resources?
2. What do you create on the AF Form 797?
3. Which form is used to document training or lack of training progress?
4. Which form documents special task qualifications of a critical nature?

1-5. Workload Management and Standards

In a nutshell, this is why we are here. The dental mission depends on proper management of the clinic workload. Although you will find this to be a challenge, there are many rewards in knowing that you are managing a successful, productive clinic.

013. Conducting orientation for new personnel

To help your personnel get started on the right foot in the dental clinic, you will want to sit down and give them a formal orientation. Orientations have two primary purposes. First, they familiarize all newcomers with local base facilities and conditions as expeditiously and conveniently as possible. Secondly, they are used to aid the transition of first-term airmen who are new to the Air Force and are experiencing the base environment for the first time.

The newcomer's organizational environment makes the greatest impact on his or her impression of the Air Force and the base. For this reason, the orientation is a vital step and should be well planned and executed.

Unit orientation

During this orientation the commander re-emphasizes the mutual responsibilities to both the supervisor and the subordinate and reinforces the commitment to standards and self-discipline at the local level.

Work center orientation

The supervisor's orientation is a continuation of the process initiated by the commander with more detailed information. An organized written program exists at each duty section and provides orientation for newly assigned personnel in department policies and procedures, job descriptions, and performance expectations. Orientation begins with a sponsor being assigned to all incoming personnel. The sponsor provides sufficient information pertaining to the base and surrounding area. The superintendent or NCOIC, Dental Services appoints the sponsor.

Upon arrival, the newcomer is met by his or her sponsor and given a brief tour of the operations and introduced to key personnel.

The newcomer is scheduled for base and hospital in processing. When this is completed he or she will report to the NCOIC, Dental Services where a supervisor and duty assignment will be assigned. The supervisor ensures the new member is properly oriented to the items in the following list (in no particular order). Please note that this list is not all-inclusive, your clinic may have other responsibilities for the supervisor to cover:

- | | |
|--|---|
| - Mission, goals, and objectives. | - Duty hours. |
| - Chain of command. | - Time off/illness/leave. |
| - Roster of assigned personnel. | - Off-duty employment/education. |
| - Supervisor/reporting official. | - Dental operating instructions (OI). |
| - Duty responsibilities. | - Documentation of care. |
| - Dress and appearance. | - Infection control. |
| - AF fitness program. | - Location of emergency equipment. |
| - Fraternalization. | - Continuing education. |
| - Fraud, waste, and abuse. | - Readiness training. |
| - Drug and alcohol use. | - Disaster teams. |
| - Discrimination/sexual harassment. | - Local customs and courtesies (overseas). |
| - Local policies and procedures. | - DOD/ Dental Charge of Quarters Patient Log (DCQ). |
| - Clinic attire and personal protective equipment (PPE). | - Flying/Personnel Reliability Program (PRP) personnel. |

Newcomer's orientation is conducted in a defined time period and documented in AFTR.

014. Planning work assignments and priorities

Managing a section's workload goes hand-in-hand with managing people. You must not only consider what and when work will be done, but also by whom. Let's examine how to plan and schedule your own personal work assignments and then see how to manage work performed by others.

Planning and scheduling personal work assignments

The organizational assets of the Air Force Dental Care System are our facilities, personnel, equipment, and supplies. We leverage all of these to maximize the use of our most valuable asset – our professional time. Effective planning and scheduling of personnel assignments is vital to the smooth function and success of the dental care system.

Managing your time

Time management is using time wisely, effectively, and efficiently. There are only 60 minutes in one hour and 24 hours in every day. How you manage the available time you have determines whether you find yourself working overtime or not. You can improve your time management by making a list of tasks at hand, assigning priorities, doing top priorities first, and avoiding interruptions.

Making a list

While this may seem incredibly simple, it's also an extremely effective way to see what kind of progress you have made on your tasks at hand. Include tasks in addition to actual chair-side assisting; the more you supervise, the more administrative tasks will show up on your list.

Daily lists

Find the time to put down on paper what has to be done for the day. You can do this before you go home the night before or you can perform this task first thing in the morning. List all the things you need to do that day. Remember, this is a daily list; some things may carry on for a few days until they are completed. Put everything down. Do not leave something off the list just because you think it's not important; otherwise, it may not get done.

Weekly lists

Weekly lists can help you see the status of tasks that are being carried from day-to-day. You can use a weekly list as a handy reference tool throughout the week for task accomplishment. For example, most NCOs do not have the time to sit down and write an entire Enlisted Performance Report (EPR). With the EPR listed as a task on your weekly list, you could put the different sections of the EPR down as daily tasks. Do two bullets one day, two bullets another day, and the suggested endorsements another day. Before you know it, the EPR is done.

Monthly lists

Monthly lists serve mainly as memory ticklers. They provide the checklist to ensure that monthly recurring tasks are being done. The week prior to a new month, review your monthly list and begin to add needed items to your daily to-do lists. Things like recurring quality activities, monthly reports, and safety inspections are sometimes easily forgotten if you're not careful.

This list idea works. A way to make it more effective is to assign some sort of priority to the tasks on your lists.

Assigning priorities

Remember when you assign your priorities that you won't have to live or die with the choices you make. If you do not like the way your initial priorities work out, you can modify them. Remember, these are *your* priorities. Within reason, do not let other people dictate your priorities for you. Obviously you must heed your supervisor and command level requests, but if you let everyone else dictate what has to be done first, you may find yourself going in circles.

Daily priorities

Look at what has to be done on your list. Keep in mind the due dates and times for all the tasks for which you are responsible. You will need to have a good estimate of the time required to accomplish each task to get a really good estimate of which is top priority.

Another method of prioritizing is to do the tasks that are quick and easy first. You can cross these tasks off your list without a lot of work. The advantage is that you can immediately see progress on your list. The disadvantage is that you may have a difficult time getting around to the more intensive tasks on your list.

Weekly priorities

As we noted before, your weekly priorities are a reflection of your daily priorities. There may be things that cannot be completed within the time span of a single day but need to be done within four to five days. Again, stay aware of all due dates; you may choose to track due dates on a desk calendar or in your Outlook calendar. The key to using a weekly task listing is to remember that there are five days in a week. Break down the task at hand into smaller, more manageable pieces that fit inside a week.

Monthly priorities

Monthly tasks always seem to fall into two categories that are completely opposite each other. Usually they are so small that you forget about them, or they are so large that you never seem to get started. It seems that no matter how much time there is, you could always use more. An example of this is DMSHRi timecard reporting. If you accomplish it daily, it takes about one minute per day. However, if you forget and try to do this task at the end of the month, it is difficult and takes a lot of time.

Remember, the key to properly using priorities is to stick with a task until it's time to move on to a new task. Try not to let yourself get diverted from your assigned priority. Once you assign those priorities, stick to them. Jumping from task to task without planning results in very little to nothing getting accomplished.

Avoid interruptions

This principle of time management is probably one of the most difficult with which you have to deal. You should constantly be aware of potential interruptions and do not allow them to rule your work schedule. Once you identify a problem area, work toward solving that problem. Although many times you personally do not have the power to prevent interruptions, if you are running a clinic with sufficient technicians, you may let them handle the interruptions. They need to be trained in how to deal with many of the situations that you normally handle yourself. This works well for records or reception interruptions. Encourage your fellow workers to resolve situations on their own if you are busy.

The three common interruptions are you, your co-workers, and technology.

Yourself

Many times we are our own worst enemy. Work to identify your personal weaknesses in work interruption and begin to correct these things. If other personnel in your area have free time, do you allow them to sit and visit with you at length even if you have things you need to do? Do you go to another section in person to get information that you could have obtained with a quick phone call, or better yet, with e-mail? Do not place needless interruptions in your workday. There will be enough interruptions without your help in creating more of them.

Co-workers

Often times we encourage our co-workers to interrupt us. This is usually an unconscious act, but it's still done. You should establish some ground rules concerning your time. Do not be afraid to let people know that you have work to get done.

Technology

In this age of technology, often we can get caught up in email, phone calls and/or social media surfing. While technology has made our jobs much easier, it can serve as a trap that will take up large

portions of your day if not handled appropriately. Schedule time to check your email, and then leave it alone while you complete prioritized tasks. Stand up when talking on the phone, it will remind you of the sense of urgency you have to complete other tasks at hand and you will not engage in unnecessary or less important conversations. Limit time on social media. While it is a good tool to keep up-to-date on duty related subjects, it is also easy to stray to personal communication that can take up large quantities of time; utilize your personal time to catch up with friends on social media, and duty time to perform prioritized tasks.

Planning work assignments and priorities

Let's now move beyond managing your own workload and see how to best plan and prioritize a section's or a clinic's workload.

Determining the due date or suspense

Every task that is assigned to you should have a suspense. In the case of chair-side assisting, the dental provider determines the suspense. Patient care will usually take care of itself, but if you do not get the impressions to the lab in time, or fail to call the patient for a periodontal recall appointment, situations can get out of hand quickly. Do not allow a task to not have a suspense. The inevitable result will be a task that never gets done!

Determining how long a task will take

Your experience as a dental assistant will prove extremely valuable here. You must be able to closely approximate how much time will be needed to complete a task. Setting up a room for a general operative patient does not take nearly as long as it does to set up a room for an IV sedation procedure. You must consider all the technical details of the procedure to determine how to schedule your time.

Scheduling work assignments and priorities

It would be great if the only thing you had to worry about was your own schedule. As a journeyman, you may be in charge of a section in the clinic. At some larger clinics, you could be in a position to actually supervise multiple personnel. These technicians vary tremendously in skill level and ability. It is your job to ensure that each knows his or her responsibilities and prioritizes for maximum task accomplishment.

Absences

You need to take into account any appointments, meetings, and scheduled leave that your staff may have as you make assignments. Coordination is the key. Always keep the lines of communication open with other technicians so that your scheduling will be dynamic and able to respond to changes quickly. Although work can sometimes be juggled around short meetings and appointments, this is not the case for leave and TDYs. Careful planning may be required to ensure all projects are complete on schedule.

Skill

Another variable to consider is the proficiency and speed of the technicians. You must be very familiar with each individual's talents so that you can intelligently assign work. Do not make the assumption that all technicians have the same proficiency. The fact is that most technicians will be stronger in one area than another.

015. Evaluating work methods and performance standards

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

Evaluating work methods

Establishing a standard is the easy part. Developing work methods and ensuring proper performance to meet the standard can be a bigger challenge. Work methods describe the details of how a job is done. They break the job down into a series of small tasks. Then you can analyze each task by asking:

- Why is this task done?
- What is its purpose?
- How is it done?
- Why is it done this way?
- Could it be done differently?
- Would different instruments or materials work better?
- Could the layout of the work area be improved?

We have several tasks in the clinic that can be considered processes and are worthy of being frequently analyzed to verify the validity of each step.

What is a performance standard?

A performance standard literally allows you to see if someone “measures” up to the standard. Imagine having a measuring stick that you could hold up against your worker’s ability to check-in patients or perform disinfection procedures. That is all a performance standard is designed to do. It makes your daily job of supervising in an equitable manner much easier. Good performance standards are measurable and realistic. They make it easier to gauge the quality of patient care that you provide. While some differences are unavoidable, your goal should be for all patients to receive high quality care from everyone in the clinic. A patient should not receive good care one day from one technician and the next day receive poor care from another technician. Lastly, good performance standards take the work out of writing any type of evaluation.

Development of performance standards

Performance standards are really just an end result of a multi-step process. Prior to developing performance standards, you must ensure that the job duties are clearly stated. Of course, if you have already done that in the job description (remember the earlier lesson), this is no additional work. Once you outline the actual duties, you can begin to develop a criterion that allows you to accurately measure whether or not the work is being done to the required standard.

Performance criterion

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

Qualitative

A qualitative criterion is exactly that, a criterion that defines the quality of an item. How well is it done or how accurately was it done?

Quantitative

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

Combined

A task where you are concerned not only about the accuracy of a task but also how quickly that task can be done. For example: students at the Dental Assistant Apprenticeship Course can accurately perform disinfection techniques when they graduate. However, the time it takes for them to achieve that accuracy would not be tolerable in a busy clinic. The speed needed comes from practice.

Basis for performance criteria

Performance criteria must be based on what is actually possible and also what is reachable. They must also provide a way of being measured. For example, it would be great to have 100 percent appointment utilization every month. The facts do not support this. In the Air Force today, it is not really (remember reality) possible to expect every appointment to be filled when patients cancel or fail to show. Since this is not realistic, it is not reachable. It is measurable though, and your measurements will repeatedly show that you cannot meet the standard. To expect 100 percent appointment utilization every month is a poor standard.

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

A good appraisal statement is *clear and concise*. Avoid ambiguous references. A good statement also comments *only* on the observable factors. If it is not observable, do not guess. Avoid absolutes if possible, such as "always, never, everyone, all staff." Rarely are they true and they can set you up for making untrue statements. State what the person did, how they did it, and last but certainly not least, the impact on the mission.

Self-Test Questions

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

013. Conducting orientation for new personnel

1. What makes the greatest impact on the newcomer's impression of the Air Force and the base?
2. Name at least six topics that the supervisor should discuss with a new clinic member.

014. Planning work assignments and priorities

1. What is time management?
2. How can you improve your time management?
3. Which principle of time management is the most difficult with which you have to deal?

015. Evaluating work methods and performance standards

1. What is the purpose of a performance standard?

2. What are the three types of performance criteria, and give a brief description of each?

1-6. Dental Service Inspections

Inspections ensure that we are efficient, productive and prepared to fulfill our mission. You should take inspections seriously as you fine-tune your clinic to its maximum potential.

016. Types of inspections

You will be involved in two major inspections directly related to dental/healthcare. We will examine self-inspections, Health Services inspections (HSI), and TJC or Accreditation Association for Ambulatory Health Care (AAAHC) inspections. There are other inspections conducted at the wing level that the medical group is responsible for maintaining and enforcing the standards of the key inspectable areas.

Self- inspection

In order to continuously accomplish the mission and remain in compliance with published directives, each dental facility must participate in self-inspection of their organization. The unit self-inspection program is an ongoing program designed to indicate all administrative and professional requirements for the operation of dental services and personnel administration, and the scheduled completion of these requirements. The MTF and Wing will have a self-inspection program established for the entire organization, and each dental squadron/flight will be involved in the process. The Management Internal Control Toolset (MICT) will be the program used for unit self-inspection.

Available guidance from applicable inspection agencies (TJC, AAAHC and the Air Force Inspection Agency (AFIA)) should be utilized and incorporated into a self-inspection activity for each dental organization. Self-inspections are critical to ensure that all specific requirements are being met (compliance), or that weak areas are identified and methods for improvement are being implemented (quality improvement). Self inspections should be accomplished within 60 days of assuming command and re-evaluated according to the local MTF commander's discretion.

Health Services Inspection

HSIs are conducted by AFIA to provide Air Force leaders with independent assessments to improve the readiness, discipline, and efficiency of their unit. HSIs assure compliance with laws, directives, and standards of practice by examining processes and outcomes. They also provide staff assistance when needed. Specifically, their functions include the following:

- Evaluate the preparedness of active duty and reserve component medical units to fulfill their readiness mission.
- Provide an objective appraisal of management and make recommendations for improvement to commanders and higher headquarters.
- Identify instances of fraud, waste, and abuse.
- Evaluate the effectiveness and efficiency with which health care resources are managed.

The Joint Commission or Accreditation Association for Ambulatory Health Care Inspection

The TJC or AAAHC evaluates and accredits more than 17,000 health care organizations and programs in the United States depending on the size of your organization. They are independent, not-for-profit organizations. Both organizations are the nation's predominant standards setting and accrediting bodies in health care. TJC and AAAHC use professionally based standards to evaluate the compliance of health care organizations.

Standards

TJC and AAAHC standards are organized by chapter according to functions. These standards focus on functions and aspects of quality patient care. They state objectives and principles, rather than specific mechanisms for meeting requirements. These guidelines are applicable to all organizations and all patient services, both military and civilian. Their standards represent a consensus in expected organizational performance.

Competence assessment

The TJC and AAAHC standards for competence assessment apply to all members of the medical group staff who are not subject to the credentialing and privileging process. Air Force wide health care processes meet the intent of some competence assessment standards. Examples of existing Air Force processes follow:

- Performance feedback and performance appraisal system.
- OJT programs.
- AF Form 55.

017. Preparing for facility inspections

You need to always be ready for an inspection. But realistically, most units will need to “ramp up” prior to an HSI or TJC/AAAHC inspection. Not to worry, you will be made aware of inspections well ahead of time and have either a checklist or guidelines with which to prepare.

Documents used to prepare for facility inspections

To prepare for various inspections such as HSI or TJC/AAAHC, each facility develops a self-inspection process for their organization. A variety of documents can provide guidance as you prepare for these inspections.

Management Internal Control Toolset

The MICT is designed as a tool for inspectors to use while performing inspections. Still, you will find this document useful to prepare for your inspection as it does focus on common problem areas.

TJC Manual

A TJC Manual contains hospital standards, intent statements, and accreditation policies and procedures. You will want to compare your processes and procedures to these established standards.

Air Force directives and policy letters

Of course, an HSI will be checking for compliance with all directives that apply to your operations. Refer to and maintain Air Force directives and policy letters to be sure you are in compliance—odds are your inspector will.

Documents from previous inspections

You will use documents from previous inspections to check on your status. Reports from other bases are also very helpful, especially if they are recent. Some sources include the following:

- IG – (HSI updates published by AFIA/Surgeon General [SG]).
- Staff assistance reports.
- TJC surveys.

Other sources to draw from are articles in Medical Service Digest, articles in TIG briefs, dental OIs, and commander’s newsletters. Also, do not forget your own self-inspection program. Use all of these tools to prepare for your inspections and you will ensure that you have a program that meets or exceeds the mission.

Prior to the inspection

There are several things that you should do prior to an inspection. Take note of these so that you can put your best foot forward at inspection time.

Prepare documentation

Prepare documentation requested by the inspection team. You may be asked to provide some pre-inspection material that will be used by HQ AFIA for its review in designing your MTF's inspection. In addition, an inspection team will ask you to prepare on-site documents/ records for inspectors to review when they arrive.

Ensure that key personnel are present

You may have key personnel working for you who are involved in programs that will be inspected. Let these people know ahead of time that they must be present during the inspection and to plan accordingly.

Brief inspectors

If you are in a position of leadership, you can expect to be called upon to brief inspectors on one or all of the following:

- Personnel.
- Budget data.
- Problem areas.
- Education and training.
- Mission and objectives.
- Dental Health Program.
- Broken appointment data.
- Significant accomplishments.
- Dental health status of base personnel.

And perhaps most importantly, you need to stress outcomes and results of your programs and activities.

Inspection procedures

So the long awaited day arrives and the inspection begins. Here are some procedural steps that you may need to do:

- Conduct an in-briefing for the team.
- Introduce your key personnel.
- Familiarize the team with the facility.
- Make yourself available to the inspectors but do not follow them around.
- Expect executive feedback conferences to be conducted every morning of the inspection period.

Final report

A final report will come from the inspection team and includes a Composite Facility Score and a Field Memorandum Report. These items identify your organizational strengths and also the areas that need improvement.

Self-Test Questions

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

016. Types of inspections

1. Which type of inspections is critical to ensure that all specific requirements are being met (compliance), or that weak areas are identified and methods for improvement are being implemented (quality improvement)?
2. Which type of inspection is conducted by the Air Force Inspection Agency to provide Air Force leaders with independent assessments to improve the readiness, discipline, and efficiency of their unit?

017. Preparing for self-assessments and facility inspections

1. Which documents can provide guidance as you prepare for an inspection?
2. What steps should you take prior to a facility inspection?

Answers to Self-Test Questions

001

1. Achieve oral health to ensure readiness, achieve best value, and achieve excellence in all we do.
2. The CDS.
3. The CPA&I program.

002

1. Dental CFM.
2. Director, Dental Programs and Resources.
3. Provide diagnostic and preventive services, comprehensive dental treatment, and assure professional oversight in support of worldwide missions.
4. Civilian employee leave, on-the-job injury/illness, disciplinary action, labor relations, Civilian Performance Program, awards, and employee work folders.

003

1. It is the primary manpower planning tool, it reflects quarterly manpower authorizations by fiscal year for each FAC in the organization, and it does *not* identify individuals by name.
2. The FAC code is a four-digit code, the first digit represents the major type of work performed; for example, 5000 is the major area of MTFs. Broken down into subgroups, dental clinics are 5421, dental laboratories are 5422 and ADLs are 5423.
3. Resource Management Office.
4. It lists authorized and assigned military manpower allocations by fiscal year, quarter, and name and grade of personnel assigned. Incoming personnel and those outbound will also be reflected.

004

1. They need to share in its development and it meets their needs.
2. (1) Listen carefully to the patient; (2) ask questions to find the root problem, demonstrate concern; (3) listen actively to the patient's answers to your questions; (4) ask questions that require some thought from the patient, suggest alternatives to answer their concerns; (5) be empathetic; (6) solve the problem or find someone who can.

005

1. The processes, changes, and any structure that influences the group personality.
2. Members express a high level of trust among themselves, share common goals, and are involved in accomplishing the goals. Leadership is shared as needs emerge.
3. They can minimize the negative impact of highly aggressive or passive team members.
4. 7 percent verbal, 38 percent vocal, 55 percent facial expression.
5. Use open-ended questions that permit the responder to elaborate.
6. List any five of the following: Put aside personal concerns while the person is talking; Concentrate on what the person is really saying; Cue in on nonverbals; Be sensitive to what the person is expressing in terms of feelings and needs; Let the person take the conversational lead; be sensitive to the signals that are being sent; Should not be busy formulating a reply; Avoid responses that may hurt the individual (e.g. Critical—a put-down that does not help anyone; Irrelevant—has nothing to do with the feelings behind what the person has just said; Hitchhiking—use any opening to start their favorite topic; diverts from the issue at hand).
7. (1) It brings hidden problems to the surface where they may be confronted and resolved, (2) makes change more acceptable because personnel recognize that there is a need and may have more of a buy-in, (3) and paves the way to innovation and improvement.
8. (1) Intrapersonal conflict (within oneself)—occurs when a person is expected to perform a task that does not meet his or her personal goals, values, beliefs, or expertise. (2) Interpersonal conflict—occurs between two or more staff members when they disagree on an issue. (3) Intragroup conflict (with the group)—occurs between members at the same level (assistant to assistant, dentist to dentist). (4) Intergroup conflict—occurs between two or more groups with conflicting goals.
9. Avoiding, forcing, accommodating, compromising, and confronting/problem-solving.

006

1. To help our subordinates grow in self-confidence, understanding, self-control, and perform the job effectively.
2. Purpose, flexibility, respect, communication, and support.
3. Event-oriented, and performance and professional growth.
4. The non-directive, the directive, and the combined techniques.
5.
 - a. Identifying the need for counseling.
 - b. Preparing for counseling.
 - c. Conducting the counseling session.
 - d. Following-up.

007

1. Chair-side assisting, dental radiology, and patient records and reception.
2. Dental Craftsman.
3. Manage dental functions and assist the CDS in managing and operating the dental activity. Typically they review correspondence, reports, and records for accuracy. They also develop, manage, and conduct self-assessments, hazard communication, and dental training programs. They are responsible for manpower and staffing issues. The superintendent and CEM inspect and evaluate dental activities and administrative and paraprofessional practices used in the dental service.

4. Maximize the mission readiness capability of the AFMS through a combined effort of active duty, Reserve, and National Guard by sharing values and principles, optimizing a total force strategy, using technology effectively and efficiently, training for joint taskings, and creating a dynamic environment which maximizes everyone's potential.

008

1. Occurs automatically upon completion of basic military training.
2. The 5-skill level must be awarded and the following requirements must be met: technical education; leadership, management, and military studies; physical education; general education; and program electives.
3. 30 semester hours.

009

1. Revising training requirements, establishing skill-levels and proficiency codes to achieve training objectives, and updating the STS.
2. Within 60 days of assignment.
3. Evaluation and analysis.
4. Support the organization's mission; the focus should be on what personnel need to know to do their jobs, build on previous training, avoid duplication, and to use simple, easy-to-understand policies and procedures.
5. UGT and QT.

010

1. For trainees to become fully qualified as quickly as possible.
2. To have maximum task qualification for all assigned personnel.
3. CFETP.
4. Clear objective; QTP checklists for tasks to be trained; all training materials and equipment needed; and a training method (lecture, demonstration, performance).
5. Demonstration and performance.
6. To ensure mission completion, safety, and well-being of personnel.

011

1. Seeing the actual performance of your trainees.
2. Timely and accurate feedback.
3. The individual's behavior (task performance).
4. How well a trainee has reached the objective.
5. A formal appraisal of trainee's accomplishment of an objective based on observation of his or her performance against a predetermined standard.
6. The process (steps actually performed), the product (end result of procedure) or both.
7. Written or verbal evaluation.
8. Have the technician perform the task.

012

1. Trainer, training equipment, training materials, training references, time, and QTPs.
2. You will list tasks not listed on the JQS but which are required in the current duty position.
3. AF Form 623a.
4. AF Form 1098.

013

1. The newcomer's organizational environment.

2. Any six of the following: mission, goals and objectives; duty hours; chain of command; time off/illness/leave; roster of assigned personnel; off-duty employment/ education; supervisor/reporting official; DOD/DCQ; duty responsibilities; dental OIs; dress and appearance; documentation of care; clinic attire and PPE; flying/PRP personnel; AF fitness program; infection control; fraternization; location of emergency equipment; fraud, waste, and abuse; continuing education; drug and alcohol use; readiness training; discrimination/sexual harassment; disaster teams; local policies and procedures; local customs and courtesies (overseas).

014

1. Using time wisely, effectively, and efficiently.
2. By making a list of tasks at hand; assigning priorities; doing top priorities first; and avoiding interruptions.
3. Avoiding interruptions.

015

1. It literally allows you to see if someone “measures” up to the standard.
2. Qualitative – How well is it done or how accurately was it done? Quantitative – Measures the quantity of something done, how much, how fast, or how often. Combined – A task where you are concerned not only about the accuracy of a task but also how quickly that task can done.

016

1. The self-inspection program.
2. Health Services Inspections.

017

1. MICT, TJC Manual, Air Force directives and policy letters, and documents from previous inspections.
2. Prepare documentation, ensure that key personnel are present, and be prepared to brief inspectors.

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

Unit Review Exercises

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

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

1. (001) What are the three parts to the USAF Dental Service mission?
 - a. Integrity first, service before self, and excellence in all we do.
 - b. Integrity first, readiness through oral health, and excellence in all we do.
 - c. Achieve oral health to ensure readiness, best value, and excellence in all we do.
 - d. Achieve oral health to ensure readiness, service before self, and excellence in all we do.
2. (001) What is used to import the personnel expenses into the Expense Assignment System (EAS)?
 - a. Clinical Performance Assessment and Improvement (CPA&I).
 - b. Defense Medical Logistics Standard Support (DMLSS).
 - c. Defense Medical Human Resources System-internet (DMHRSi).
 - d. Medical Expense and Performance Reporting System (MEPRS).
3. (001) How does the Dental Service offer excellence (customer satisfaction) to Air Force members and their families?
 - a. Via commitment to service leadership.
 - b. By systematic review of over and underutilized programs.
 - c. Through quantifying the amount of work accomplished through MEPRs.
 - d. By ensuring all local dental programs support dental readiness of military members.
4. (002) Which individual(s) advise the Air Force Medical Operating Agency (AFMOA)/SGD on the management of dental programs and policy compliance as appropriate?
 - a. AFMOA/SGD division chiefs.
 - b. Chief of Dental Services.
 - c. Dental consultant to the AF surgeon general.
 - d. NCOIC/superintendents.
5. (002) Who advises Air Force career field manager (AFCFM) and Air Force Personnel Center (AFPC) on management of dental enlisted programs?
 - a. Dental major command (MAJCOM) functional manager.
 - b. Assistant Surgeon General for Dental Services.
 - c. Chief, Dental Enlisted Manager.
 - d. Command Dental Surgeon.
6. (002) Which dental flight provides diagnostic and preventive services and comprehensive dental treatment?
 - a. Dental Support.
 - b. Clinical Dentistry.
 - c. Dental Laboratory.
 - d. Clinical Treatment.

7. (002) Which organization is set up specifically to solve operational problems and to evaluate methods, techniques, procedures, equipment, and materials as identified by military dental activities and by the office of the Air Force Surgeon General?
 - a. Dental Evaluation & Consultation Service.
 - b. Dental Infection Control program.
 - c. Dental Clinical Flight.
 - d. Dental Support Flight.
8. (003) What is the *primary* manpower planning tool that reflects quarterly manpower authorizations by fiscal year for each functional account code (FAC) in the organization, and it does *not* identify individuals by name?
 - a. Unit personnel management report (UPMR).
 - b. Dental Service Report (DSR).
 - c. Unit manpower document (UMD).
 - d. Work schedule.
9. (003) Functional account code (FAC) 5421 includes which of the following flight(s)?
 - a. Clinical Dentistry Flight.
 - b. Dental Support Flight.
 - c. Clinical Dentistry and Dental Support flights.
 - d. Clinical Dentistry, Dental Support, and Dental Laboratory flights.
10. (003) What workload factor is used in the standard man-hour equation to determine the number of dental officers earned at a given dental clinic?
 - a. Beneficiaries.
 - b. Active duty population.
 - c. Individuals on flying status.
 - d. Individuals on Personnel Reliability Program (PRP) status.
11. (004) Which of the following is the most ideal tactic to deal with an upset patient?
 - a. Do not participate in fault finding.
 - b. Shift the blame.
 - c. Use personal feelings to empathize.
 - d. Directly challenge the patient.
12. (004) If an active duty dental patient refuses treatment, who contacts the member's commander?
 - a. Provider.
 - b. Dental Records and Reception.
 - c. Chief of Dental Services (CDS).
 - d. Superintendent/ (noncommissioned officer in charge NCOIC).
13. (004) If an active duty dental Class 3 patient refuses treatment, what form must be completed?
 - a. AF Form 174.
 - b. AF Form 469.
 - c. AF Form 988.
 - d. SF 88.

14. (005) Since being assigned to 123 Dental Squadron, MSgt Smith has worked to increase the flexibility, creativity, and growth of his dental staff. In what area does this make a more effective dental team?
- Confidence.
 - Job satisfaction.
 - Participation.
 - Success.
15. (005) Upon taking supervision of your clinic, you immediately notice there are members that almost “bully” several others into taking care of tasks that should be shared; like instrument processing and filing dental health records. What can *minimize the negative impact* of highly aggressive or passive dental team members?
- Cohesiveness.
 - Flexibility.
 - Arguments.
 - Ground rules.
16. (005) What can unprofessional relationships lead to in a dental facility?
- Favoritism in the organization.
 - Abandonment of unit goals.
 - Free communication.
 - Poor morale.
17. (005) Which statement is a characteristic of conflict?
- It is harmful and must be avoided.
 - It is inevitable and can result in constructive outcomes.
 - It is avoidable and cannot result in constructive outcomes.
 - It prevents hidden problems from being brought to the surface.
18. (006) When conducting a counseling session with an airman within your dental clinic, which counseling style views each subordinate as a unique, complex individual, with a distinct set of values, beliefs, and attitudes?
- Support.
 - Respect.
 - Flexibility.
 - Communication.
19. (006) A1C White was cleaning her room without gloves when TSgt Greene walked by and observed the discrepancy. TSgt Greene instructed her to wash her hands and put on gloves before proceeding. Which counseling technique did TSgt Greene use in this counseling scenario?
- Directive.
 - Combined.
 - Nondirective.
 - Supportive.
20. (006) Which counseling technique tends to move the focus of the issue away from the counselor and counselee, while involving both in the solution?
- Directive.
 - Combined.
 - Nondirective.
 - Supportive.

21. (006) Which stage of the counseling process can either be quick or time consuming?
 - a. Identifying the need for counseling.
 - b. Preparing for counseling.
 - c. Conducting the counseling session.
 - d. Following up.
22. (007) At what level do the 4Y0X1 and 4Y0X2 career paths merge?
 - a. MSgt with five years dental experience.
 - b. MSgt that has attended SNCOA.
 - c. SMSgt.
 - d. CMSgt.
23. (007) Who is the *primary trainer* for those trainees working toward advancement to the 5- and 7-skill level?
 - a. Helper.
 - b. Apprentice.
 - c. Craftsman.
 - d. Journeyman.
24. (008) An Air Force member is automatically enrolled in the Community College of the Air Force (CCAF) upon completion of
 - a. technical training.
 - b. initial skills training.
 - c. basic military training.
 - d. a permanent change of station.
25. (008) What is the *maximum* amount of examination credit hours (i.e., DANTES) that the Community College of the Air Force (CCAF) will apply toward requirements?
 - a. 21.
 - b. 24.
 - c. 27.
 - d. 30.
26. (009) Which Air Force comprehensive core-training document identifies life-cycle training and education requirements, training support resources, and minimum core task requirements?
 - a. Master Task Listing.
 - b. Job Qualification Standard (JQS).
 - c. Specialty Training Standard (STS).
 - d. Career Field and Education Training Plan (CFETP).
27. (009) The tasks in the specialty training standard (STS) are developed by
 - a. the Utilization and Training Workshop (U&TW) voting members guided by their years of experience.
 - b. the Medical Education & Training Campus.
 - c. the Dental Enlisted Career Field Manager.
 - d. information from job inventories.

28. (009) You have a brand new supervisor in your duty section who has just been assigned her first subordinate. She quickly explains she has no idea what the “a, b, or 2a” in the training record means and she is afraid she will lead her airmen in the wrong direction. Where can she find a complete explanation of the Proficiency Code Key?
- Front of the specialty training standard (STS).
 - Back of the STS.
 - Front of the Career Field Education and Training Plan (CFETP).
 - Back of the CFETP.
29. (009) Which document identifies all tasks required in a duty position?
- Master Task Listing (MTL).
 - Job Qualification Standard (JQS).
 - Specialty Training Standard (STS).
 - Career Field and Education Training Plan (CFETP).
30. (010) Within how many days of assignment must an initial evaluation be conducted on dental technicians?
- 30.
 - 60.
 - 90.
 - 120.
31. (010) Which training method is effective to develop new manual skills?
- Lecture.
 - Practice.
 - Discussion.
 - Demonstration.
32. (011) MSgt Snyder was recently appointed as the dental education and training monitor as an additional duty. What is the most effective way she could evaluate the dental training program?
- Review training records for accuracy.
 - See the actual performance of trainees.
 - Follow a logical, orderly process for training.
 - Use the maximum training performed in minimum time inspection.
33. (011) What are the three parts of a dental training evaluation objective?
- Evaluation, condition, and feedback.
 - Introduction, standard, and feedback.
 - Condition, performance, and standard.
 - Performance, evaluation, and introduction.
34. (011) Before certifying A1C DeJesus in dental instrument processing, SSgt Walker must complete a task evaluation. What *must* A1C DeJesus know before the evaluation begins?
- Exactly what is expected.
 - How to teach another trainee.
 - A thorough knowledge of the written evaluation.
 - Where and when the evaluation is to take place.

35. (011) What is a good method to check *both* performance and knowledge a dental trainee has on a task?
- Administer written evaluation.
 - Observe trainee teach another trainee.
 - Verbally question trainee while trainee performs the task.
 - Verbally question the trainee while trainer performs the task.
36. (012) The training reference for a specific Specialty Training Standard (STS) task is listed in
- Part 1 of the Career Field Education and Training Plan (CFETP), directly beneath the task.
 - Part 2 of the CFETP, directly to the left of task.
 - Column 1 of the STS, directly beneath the task.
 - Column 2 of the STS, directly to the left of the task.
37. (013) After SrA Martin arrived at his second duty location, the superintendent immediately scheduled him for a clinic orientation. What is the *primary purpose* for offering an orientation?
- So SrA Martin can be assigned to his primary duties as quickly as possible.
 - To establish a community rapport with little or no cost to the government.
 - To familiarize SrA Martin with base facilities and conditions expeditiously.
 - To free other enlisted members for rotation training and supervisory functions.
38. (013) Why should a newcomer's orientation be well planned and executed?
- It familiarizes the member with the local base facilities expeditiously.
 - The organizational environment makes the greatest impact on the member.
 - Frees other enlisted members for rotation training, and supervisory functions.
 - It will make the transition to permanent party smoother for the first-term airmen.
39. (014) SSgt Williams is adjusting to his new role as the noncommissioned officer in charge (NCOIC) of the residency section. With his new promotion he has been presented with new responsibilities and subordinates that require his guidance/attention. Which statement expresses the *best* way SSgt Williams can improve his time management?
- Address the most obvious tasks first and avoid interruptions.
 - Make a list of tasks at hand, assign priorities, and avoid e-mail.
 - Make a list of tasks at hand, assign priorities, do top priorities first, and avoid interruptions.
 - Address the most obvious tasks first, assign priorities, do top priorities first, and avoid interruptions.
40. (014) What is the *most difficult* principle of time management?
- Assigning priorities.
 - Managing your time.
 - Avoiding interruptions.
 - Scheduling work assignments.
41. (015) When evaluating a trainee's ability to perform a task, which terms make a "good" performance standard?
- Measurable and quantitative.
 - Measurable and realistic.
 - Qualitative and realistic.
 - Qualitative and quantitative.

42. (015) Which term is a *performance criterion* that measures the accuracy and timeliness that a task is completed?
- a. Qualitative.
 - b. Measurable.
 - c. Quantitative.
 - d. Combined (qualitative and quantitative).
43. (015) TSgt Phillips is preparing feedback for a newly assigned subordinate. Which statement is descriptive of a “good” appraisal statement?
- a. Clear and concise.
 - b. Keeps comments ambiguous.
 - c. Uses absolutes (always, never etc.).
 - d. Comments on observed tasks and unobserved tasks.
44. (016) Which medical operations inspection is conducted by the Air Force Inspection Agency to provide Air Force leaders with independent assessments to improve the readiness, discipline, and efficiency of their unit?
- a. Nuclear Surety Inspections (NSI).
 - b. Health Services Inspection (HSI).
 - c. Operational Readiness Inspection (ORI).
 - d. The Joint Commission (TJC) Inspection.
45. (016) Which type of inspection uses professionally based standards to evaluate the compliance of health care organizations?
- a. Unit self-inspection.
 - b. Health Services Inspection (HSI).
 - c. Operational Readiness Inspection (ORI).
 - d. The Joint Commission (TJC) Inspection.
46. (017) What document(s) contains hospital standards and intent statements to assist the dental service in preparing for an Accreditation Association for Ambulatory Healthcare Inspection?
- a. The Joint Commission (TJC) Manual.
 - b. TJC checklist.
 - c. Medical Service Digest.
 - d. Commander’s newsletter.

Please read the unit menu for unit 2 and continue ➔

Student Notes

Unit 2. Dental Clinic Administration

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AS SUPERVISORS, it is important to teach your subordinates the importance of maintaining an accurate Air Force Dental Readiness Assurance Program. A well maintained program takes attention to detail from all members of the dental team. Records must be reviewed and patient status should always be scrutinized by each provider that sees a patient to ensure the dental mission is complete. Everyone plays a part in a successful AFDRAP program.

2–1. Air Force Dental Readiness Assurance Program

The AFDRAP is designed to ensure that USAF Dental Service programs and activities that support maintaining a high level of Air Force readiness receive maximum attention.

018. Understanding Air Force Dental Readiness Assurance Program

The Chief of Dental Services (CDS) makes sure that all local dental programs and activities supporting the dental readiness of military forces are incorporated into the AFDRAP. At a *minimum*, this program includes:

- Periodic dental examinations for military members.
- Dental Readiness Classification for military members.
- Monitoring availability and accessibility of dental services for active duty personnel.
Monitoring Dental Readiness Classifications 3 and 4.
- Active duty dental clearances.

Periodic dental examination

Each member’s record is first reviewed to update dental classification and to assure proper custody of the record. All members’ *dental readiness status* is evaluated and updated when treated. The AFDRAP monitors the dental health status of active duty Air Force personnel. Each member is scheduled for at least a periodic dental exam (PDE) to include hypertension screening. The AFDRAP program is the primary focus for dental personnel to support the overall USAF mission.

Organizational responsibilities

AFDRAP is a comprehensive program and many individuals must work to make it a well-oiled machine. This portion of the lesson will discuss who is responsible for overseeing the intricate parts.

AFDRAP management

Proper management of the AFDRAP takes a considerable amount of time and requires an individual who displays a clear attention to detail. When a new month is opened, several actions within and

outside the computer system will occur, so the person assigned this task needs good multi-tasking skills. AFDRAP management in the Corporate Dental Application (CDA) system “talks” directly to the Aeromedical Services Information Management System (ASIMS) to report dental readiness for the USAF. An accurate report is essential to ensure mission readiness.

AFDRAP monthly processing

When an AFDRAP month is activated, the CDA system checks the ASIMS database for all personnel who are due for a periodic examination. CDA allows two months to be active at one time to allow flexibility in scheduling and managing the patient load. Only the current month and the following month may be active at one time. The AFDRAP monitor cannot forecast further than the coming month for individuals who are due for their periodic examinations. The system will also check the ASIMS database and on the first day of the 14th month will change all personnel to Dental Readiness Class 4 whose DATE OF LAST UPDATE is more than 13 months. Starting an AFDRAP month while the previous month is still open is an option and *should be* used when necessary. No repeat names, including the class 4s, will appear on a second available AFDRAP month’s roster.

The AFDRAP monitor coordinates the available AFDRAP months to try to get the greatest number of personnel examined (updated) before the system closes on the 7th of the following month. All personnel who were not updated and have surpassed the 13-month window will automatically be updated to Dental Readiness Class 4. For example, if the AFDRAP monitor is working to schedule the month of July and there were 100 members due for an exam, but only 95 of them could come in for the appointment during July, the remaining five could be scheduled in early August. The AFDRAP monitor has until the 7th of August at midnight Central Standard Time (CST) to update; otherwise, the overdue patient carries over to the following month. But, if one or more of the individuals due in July fail to complete the appointment before the August Dental Service Report (DSR) is closed on the 7th of September, these individuals will automatically update to class 4 in the system. Upon DSR closing, ASIMS updates the no show personnel in the database and creates a final patient status roster. Any updates made after the close of the month will not be reflected against these reports.

019. Maintaining dental readiness

Maintaining dental readiness is more than just getting members in for a periodic examination. It also incorporates having availability and accessibility for other treatments, monitoring of Dental Readiness Class 3s and 4s, as well as performing clearance examinations.

Availability/access to care

The CDS ensures that comprehensive dental services are readily available. These services consist of diagnostic, preventive and corrective treatments, and procedures necessary to maintain or restore oral health and function. The CDS determines availability of dental services, including cosmetic and elective procedures based on staffing, facilities, and mission requirements. The CDS will also establish local procedures to ensure AD personnel maintain optimal dental health. Dental services and treatment at USAF dental facilities are prioritized in the following order:

1. Authorized beneficiaries with bona fide dental emergencies.
2. AD personnel in Dental Readiness Classification 4.
3. AD personnel in Dental Readiness Classification 3.
4. AD personnel in Dental Readiness Classification 2.
5. All others IAW AFI 41–120, *Tricare Operations and Patient Administration Functions*. Non-AD beneficiaries may only be treated on a *space-available basis*, except emergency dental.
6. Command-sponsored AD family members may receive dental treatment at OCONUS (outside the continental US) locations IAW current DOD and Air Force policy.

Dental Readiness Class 3 and 4 monitoring

Dental Readiness Class 3 and 4 programs are very important to the AFDRAP. Members identified in these categories of dental health must continue to receive expedited care. Clinics may assign an individual to monitor class 3 members to ensure that they are receiving priority appointments.

The monitor will utilize the tools available to them through the Air Force rosters menu to ensure the Dental Class 3 and 4 patients are properly taken care of. First, the monitor will generate a dental class roster through CDA. They use this list to see if the patients are scheduled appointments. Next, they follow up as necessary. Finally, they keep the CDS and NCOIC/superintendent informed of the dental readiness of their base.

If your base has a high Dental Readiness Class 4 count, it indicates a lack of readiness. Individuals in Dental Readiness Class 4 are in an unknown status; they may require only minimal treatment or it could be more substantial, but their status is indefinite because it has been so long since their last examination.

Active duty dental clearances

Upon notification of a member's permanent change of station (PCS) to an overseas location, remote site or geographically separated unit (GSU), the Dental Service will process the dental clearance as specified in AFI 36-2102, *Base-Level Relocation Procedures*. Upon notification of a deployment to a remote site or GSU, the Dental Service will follow the MAJCOM or base processes for clearances. Observe these clearance requirements:

- A. Members in Dental Readiness Classification 3 are normally not dentally cleared for PCS to a remote site or GSU. It is recommended they receive all treatment necessary to return to Dental Readiness Classification 1 or 2 prior to departure. In the event that all treatment cannot be completed prior to departure, it is recommended that the losing CDS contact the gaining CDS to determine if required treatment can be provided at the gaining DTF. If required treatment cannot be provided at the gaining DTF, the CDS of the losing DTF should contact the losing SGH (Chief of the Medical Staff) to determine if a delay in reporting date is necessary. The dental readiness status of members in Dental Readiness Classification 4 is unknown and they must receive a dental examination to determine their suitability for a PCS to a remote site or GSU.
- B. When scheduling and resources permit, members with a PCS assignment to an overseas base with an established DTF should at least be in Dental Readiness Classification 2 prior to PCS. A record review by dental personnel is required for this determination. Graduates of Basic Military Training and Technical Training may proceed to their first PCS assignment in Dental Readiness Classification 3 or 4 provided their base of assignment has an established DTF.
- C. Members being assigned to remote or GSU locations where routine dental care is limited:
 1. Require a dental examination unless a periodic or comprehensive dental examination was done within 90 days of the notification letter. If an examination was accomplished within 90 days of the notification letter, a dental record review by dental personnel will suffice.
 2. Should be given a high priority of care.
- D. When members are being deployed, the current dental readiness classification is verified in CDA/ASIMS. Follow these guidelines as *minimum*:
 1. Members in Dental Readiness Classification 1 or 2 are qualified for deployment. When it is determined the member's dental readiness classification may change to Dental Readiness Classification 4 while deployed, a Type 2 dental examination should be

completed before departure. Dental clinics are encouraged to provide services to ensure deploying personnel are in optimal dental health before deployment.

2. When it is determined that a member is in Dental Readiness Classification 3, clinics should complete treatment of all disqualifying dental conditions.
3. Placement into Dental Readiness Classification 3 is communicated to the member's commander by way of the AF Form 469, completed in ASIMS. Dental personnel must check the Mobility Restriction box on AF Form 469 if it is recommended that the member should not deploy. The estimated date of return to Dental Readiness Classification 1 or 2 is annotated on the AF Form 469. The member's commander has the option to concur/non-concur with the provider's recommendation.
4. (ANG Only) When members are being activated for extended AD, a record review is completed to determine the current dental readiness classification. Follow these guidelines as *minimum*:
 - a. Members in Dental Readiness Classification 1 or 2 are qualified for duty.
 - b. When it is determined that a member is in Dental Readiness Classification 3, the dental officer completes an AF Form 469, noting any restrictions and instructions, and forwards it to the MTF section that oversees the physical profile process.
 - c. When it is determined a member's dental readiness classification will change to Dental Readiness Classification 4 while activated, if time permits, a periodic examination should be completed.

Patient recall programs

Some patients need to be monitored more closely for care. Regardless of how difficult the task may be, it is important that we monitor their oral health to keep them worldwide qualified. Not all patients' treatment will consist only of a Type 2 exam and prophylaxis. Some patients require enrollment into a recall program. The two programs offered are the Caries Risk Assessment and Periodontal Maintenance Recall programs.

High Caries Risk Program using caries risk assessment

A caries risk assessment (CRA) must be performed at the periodic dental examination for all USAF active duty, National Guard, and Reserve Component personnel. The level of risk (low, moderate, high) is entered in CDA and annotated on the Standard Form (SF) 603/603A.

You record the population-based health metrics at every periodic dental examination performed on an AD Air Force patient. Follow the CRA guidelines in the most current edition of the *USAF Dental Population Health Metrics Guidelines*. Include appropriate radiographs with clinical examination using current acceptable methods for caries detection and diagnosis. The risk levels and assessment descriptions are shown in the following table:

Caries Risk Assessment	
Caries Risk	Description
Low	<ul style="list-style-type: none"> - No incipient or cavitated* primary or secondary carious lesions during the last three years and no factors that may increase caries risk. Adequately restored surfaces and/or coalesced/sealed pits & fissures. - Good oral hygiene. - Regular dental visits.

Moderate	<ul style="list-style-type: none"> - 1 or more incipient or cavitated* primary or secondary carious lesions in the last three years OR no incipient or cavitated* primary or secondary carious lesions in the last three years but presence of at least one factor that may increase caries risk. - Fair oral hygiene. - Irregular dental visits.
High	<ul style="list-style-type: none"> - 3 or more incipient/cavitated* primary or secondary carious lesions diagnosed during current exam. - Presence of multiple risk factors. - Suboptimal fluoride exposure. - Xerostomia. - Poor oral hygiene. - Irregular dental visits (< 1x/yr).

*A cavitated carious lesion is a lesion that has penetrated the tooth's solid surface and is no longer considered reversible through remineralization.

Factors that increase the risk of developing caries include, but are not limited to:

1. Localized white spots and/or incipient interproximal radiolucencies.
2. Deep pits and fissures.
3. Past root caries / large number of exposed roots.
4. Frequent sugar intake (> 5x/day).
5. Inadequate or no systemic or topical fluoride exposure.
6. Inadequate salivary flow, as determined from past medical history or unstimulated salivary flow testing (< 0.2 mL/min) (Xerostomia may require medical referral.)
7. Generalized white spots and/or incipient interproximal radiolucencies with appliances (removable partial dentures, orthodontics).
8. Streptococcus Mutans levels > 5.5x10⁵ CFU (colony forming unit)/mL in whole stimulated saliva.
9. Saliva pH < 5.0.
10. Developmental or acquired enamel defects.
11. Many multi-surface restorations
12. Eating disorders.
13. Restoration overhangs and open margins.
14. Chemotherapy or radiation therapy.
15. Drug or alcohol abuse.
16. Active orthodontic treatment.
17. Medication-, radiation- or disease-induced Xerostomia.

The caries risk assessment requires the provider to look at the patient's history of carious lesions over the past 3-year period. If the dentist determines that the patient is at a greater risk of active dental disease, the patient may be placed in a caries recall program. The patient will return to the clinic for preventive care such as recall intervals and fluoride protocol.

Appropriate caries prevention procedures should be implemented based on the patient's risk category and as dictated by the provider. Preventive options as outlined in the CRA guidelines should be considered including more frequent 3-month recall visits for the high caries risk patients. Patients can be removed from the high caries risk program once they receive a periodic exam in which it is determined that they are no longer considered at high risk for oral caries development.

Periodontal Maintenance Recall Program

Caries control through the recall program is essential, but another area that requires close scrutiny is the Periodontal Maintenance Recall System. The responsibility of the periodontal recall program typically is designated to the periodontal assistant, periodontal therapist, or dental hygienist. Patients who have had periodontal disease are rarely motivated to achieve efficient and perfect daily oral hygiene practices, which is why periodontal recall programs are necessary.

Through CDA, the periodontal recall program can be tracked. Patient recall programs form the foundation of long-term prevention of dental disease. The adage, “an ounce of prevention is worth a pound of cure,” summarizes the theory of preventive dentistry.

In the first year following active periodontal therapy, it is important to assess the patient’s periodontal tissues and provide maintenance therapy at intervals dictated by the provider. For some patients, this interval of scheduling maintenance visits will continue throughout the rest of their lives. However, for stable periodontal patients—those who have excellent oral hygiene, no inflammation of the periodontal tissues and only shallow pockets remaining—the recall interval may be extended. In essence, the frequency of recall visits must be adjusted to patients’ individual needs. Factors that influence the length of the recall intervals include:

- Patient’s plaque control.
- Individual tendency to form calculus.
- Severity of initial disease.
- Whether the patient is a smoker.
- Degree of control of inflammation achieved by the periodontal treatment.
- Host response to bacterial infection.
- Presence of some systemic conditions that may disrupt the host-bacterial response.
- Age of the patient.

One of the major goals of recall appointments is to intercept and treat problems before they become serious.

020. Maintaining and retiring dental records

Dental records play a vital role in managing the treatment received and required for every patient. They serve as the memory of every patient’s visit, a record of past events, and the basis for future care. Records managed systematically are complete, easily accessible, properly arranged to serve current and future needs, and enhance effectiveness and economy of patient treatment. This lesson will cover maintaining dental records through inventory, movement, and their retirement.

Maintaining dental records

Each facility determines a particular method for filing and securing the various types of records in its facility. This may include filing flying, non-active duty, PRP or any other special circumstance records separately in order to manage these records more effectively. Limit access to dental health records to authorized personnel. To manage this, dental health records must be located in an area where they can be secured.

Maintain records of other Uniformed Service members treated in Air Force facilities in the manner in which they were received. Record treatment rendered in an Air Force facility using Air Force approved forms. File Air Force approved forms in the manner most consistent with the existing record.

Inventorying dental records

Inventories of dental records will be conducted at least annually. The purpose of the inventory is to:

- a) Identify and forward retained records of departed personnel IAW AFI 41–210, *TRICARE Operations and Patient Administration Functions* (Chap 5.7).

- b) Identify and retire non-AD records that have not been seen in two years since the end of the calendar year of the last date of treatment. Dispose of IAW AFI 41-210 Chap 5.7.
- c) Verify dental classification and date of last update information of assigned Air Force members.

NOTE: The entire inventory can be done at one time or systematically throughout the year to ensure that all records are inventoried every 12 months (i.e. one color every month).

Records identified during the inventory of personnel not assigned must be forwarded to their current servicing dental facility. Each DTF has access to the Worldwide Locator (WWL) and/or the global directory on their email to determine the member's current assignment. Records of individuals who have retired or separated are forwarded to the Military Personnel Flight (MPF). If neither of the previously mentioned circumstances applies, refer to AFI 33-364, *Records Disposition-Procedures and Responsibilities*.

While completing the inventory of records, personnel may also perform a cross-reference of family members' records. If a family member of active duty or retiree has received treatment within the time limits, you may annotate the year of last treatment for all family members and retain them in the files.

Transfer of records for members assigned to other uniformed services should follow guidance in AFI 36-2608, *Military Personnel Records Systems*.

Transferring records

There will be times of PCS, TDY/deployments, separations, and retirements, when the dental record must be moved from one geographic location to another. Each time has a specific method that needs to be followed. Dental personnel need to make a quality control check of the record before forwarding it to the gaining treatment facility. Make sure the record is in the proper order and any extraneous material has been removed.

PCS

Military personnel (with the exception of flying personnel or personnel PCSing to Korea) *may not hand carry their medical/dental records between PCS assignments*. When the military personnel and their family members are within five days of their PCS, they may outprocess from the dental clinic with a copy of their military orders. The dental clinic will transport their record to Medical Group (MDG) Records section. MDG Records will forward their dental health record to the gaining facility.

TDY/deployed

Deployed members *will not hand-carry their dental health records unless the deployment is expected to last longer than 12 months*. The gaining treatment facility determines if the member must hand-carry dental records. The facility in the deployed area is responsible for the return of dental health records to the home station IAW AFI 41-210. Dental records generated due to treatment rendered while on deployment are consolidated into the existing dental record. A dental officer reviews the record, annotates treatment provided in Block 10 of SF Form 603, charts treatment in Block 8, and determines the need for further evaluation or treatment.

Separations/Retirements

A common fallacy among military members is that their medical and dental records belong to them because they contain personal information regarding their health. It is a fallacy because health records are the property of the United States government, not the individual. Dental health records of separating/retiring individuals are forwarded to the MPF. Members may request copies of their records prior to their separation/retirement date, after that, the records are sent to the Veterans Administration (VA) via AFPC, and must be requested by the DTF.

Before outprocessing for separation/retirement, determine if a dentist provided the member a complete dental examination and placed the patient in class 1 within 90 days of separation or release. A periodic examination should be completed as a minimum. If so, enter, "*Separation: Examination*

and treatment completed within 90 days of separation or release,” as the last entry on SF 603/603A. Date and sign the entry. After the record is screened, it is ready for separation/retirement.

Records of personnel who retire or separate are forwarded to the MPF upon request. Dental health records on all personnel separating or retiring from active duty must be screened prior to forwarding to the MPF. The MPF ensures records are processed to AFPC for disposition to the VA.

Disposition of retiree records depends on the last date of treatment rendered. If the last date of treatment is three years or more, the record may be retired to the VA via AFPC. The dental health records of family members of active duty, retirees, retiree’s family members and non-NATO foreign nationals are destroyed three years after the year of the last recorded treatment. If any family member of active duty or retired personnel receives treatment, annotate all family member records with that year of last treatment and retain all the records in the file.

Self-Test Questions

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

018. Aspects of Air Force Dental Readiness Assurance Program

1. What criteria are required to be included in the AFDRAP?
2. How many AFDRAP months does CDA allow to be active at once? Why?

019. Maintaining dental readiness

1. Who determines the availability of dental services and on what is the decision based?
2. What does a base’s high Dental Readiness Class 4 indicate?
3. For whom must a CRA be performed at the periodic dental examination?
4. What are some factors that influence the length of the recall intervals?

020. Maintaining and retiring dental records

1. Why are annual record reviews required?
2. How soon before a member’s PCS can a member out-process from the dental clinic? What must they have with them?

3. What is the determining factor when deciding on the disposition of a retiree's dental record?
4. When is it acceptable to retain records of a family member that has not received treatment in the last three years?

2-2. Dental Service Requirements

There are many requirements to maintain the day-to-day operations of a dental clinic. These requirements are clarified by many resources available to the dental leader. Maintaining reports, updating classifications and providing first class dental care are just a few of the requirements a dental leader must ensure daily. This section will discuss some tools the dental leader can use to successfully manage a dental clinic.

021. Using and preparing Air Force and Dental publications

Isn't it amazing how many publications exist in the Air Force? How are we to keep them all straight? Luckily, technology has improved the methods we use to manage and reference our resources. This lesson will address methods of locating and developing certain publications.

Air Force Departmental Publishing Office

The Air Force Departmental Publishing Office (AFDPO) is the official source for Air Force administrative publications and forms. The office is responsible for all Air Force electronic publishing and maintains the AF e-Publishing Web site, which provides access to these publications. You will find several indexes as well as the Master Catalog at this site. At the time of print, the AF e-Publishing Web site address is <http://www.e-publishing.af.mil/>.

Master Catalog

The Master Catalog is a full electronic listing of all products available through AF e-Publishing. It lists products that are grouped by key association: organization, subject area, and product type. You will use the Master Catalog when searching for a publication that you cannot find elsewhere.

Short title

The short title of a publication is its publication number. The short title is very useful when searching the Master Catalog for a particular publication. AFI 47-101 is an example of the short title for AFI 47-101, *Managing Air Force Dental Services*.

If you are not sure precisely where on the AF e-Publishing Web site a publication is located, you may use the "short title search" field to locate it. Enter the short title of the publication into the field using no spaces—only a hyphen if needed.

The search function will only work properly if you enter the EXACT short title of the item you need or a portion of the *exact* title. You cannot use any spaces in the search field. The short title must be *exact* or no results will be found. You may find the most successful way to search is to broaden the search. For example, if you are looking for AFMAN36-2223, you must type it into the search field as shown. If you type in AFM36-2223 or AF36-2223 or AFMAN362223, *no* results will be found.

Long title

The long title of a publication is its title or name; for example, *Managing Air Force Dental Service* would be the long title in our example of AFI 47-101.

Accessing publications

You will be able to access a large variety of Air Force publications through AFDPO to include:

- Air Force policy directives (AFPD).
- Air Force instructions (AFI).
- Air Force manuals (AFMAN).
- Air Force pamphlets (AFPAM).
- Air Force handbooks.
- Air Force catalogs.

In addition to Air Force publications, you will also find DOD publications, Air Force Occupational Safety and Health (AFOSH) standards, and standard forms:

- Locating standard forms—SFs are linked to the AF e-Publishing Web site.
- Locating Department of Defense (DD) forms—DD forms are linked to the AF e-Publishing Web site.

It is always a good idea to type in a portion of the title if you are not sure what the title is. Type in 36-2223 and every Air Force publication with such numbers will come up, whether it is an AFMAN, an AFI, or an AFPAM. If you type in 2223, you will broaden your search even more. The same principle applies to AFMAN; if you enter the prefix into the search, it will call up every Air Force manual.

Preparing/reviewing operating policies and instructions

Where would we be without guidance? As much as you may dislike instructions or guidelines, they do provide a structured environment that helps to maximize your efficiency and define your mission.

Reviewing operating policy and instructions

You will manage a clinic or a laboratory according to instructions and policies. It is very important to review all instructions, as they do drive your section's daily activities. Let's examine types of publications and methods of review.

Directive publications

Although there are many types of publications such as CDCs, QTPs, or CFETPs, our focus here is on those that are directive in nature. Directive publications include instructions, manuals/guides, and operating instructions. The following table describes each:

Directive Publications	
Publication	Description
Instruction	Announces policies, assigns responsibilities, directs actions, and prescribes procedures.
Manual/Guide	Provides guidance, lists procedures, and contains examples for performing standard tasks.
Operating Instruction	Assigns responsibilities, directs actions, and prescribes procedures within local organizational elements.

Reviewing instructions and guidelines

You may want to keep hard copies of the instructions that apply to your section readily available. You should occasionally review these instructions. Your reputation as a competent leader and supervisor is now on the line. A supervisor must be able to quote or quickly find answers from instructions for subordinates, peers, and even commanders.

The first occasion to review these documents is when you are newly assigned to a duty section. At that time, you must thoroughly study each instruction that applies to your duties and responsibilities. This will be time-consuming, but will pay great dividends in the future.

You will often find a need to reference an instruction to solve a problem or answer a question. This is why you will want to keep the publications most often referenced handy in your duty section. The review process under these circumstances will be a short one. You should be able to scan the document and quickly locate the desired paragraph that will answer your question. The ability to do this will depend on how familiar you became with the instruction previously. Remember, take the time to read the document thoroughly when first assigned to the section.

Another occasion when you will need to review these instructions will be prior to inspections and during each self-inspection. This is very important to ensure you are properly carrying out the instructions as they are written. Sometimes what a clinic is doing is not properly portrayed within an instruction and needs to be corrected.

Preparing operating policy and instructions

Have you ever asked, “Who writes these things?” Well, sometimes the author of an operating policy is someone just like you. An operating instruction may be written at any level from the group down to the flight.

Publication objectives

Virtually every aspect of your job, how the clinic runs, how your career progresses, and even how you get paid is dictated by a publication. This makes for mountains of documents that must be readily accessible. The overall goal of publication management is to economically develop quality Total Force publications. Specifically, the material must be accurate and logically organized, written clearly, adequately illustrated, and free of irrelevant and duplicate information. These goals apply equally to locally-generated operating instructions as well as Air Force instructions.

Writing an OI

You may be tasked to write an OI for your clinic or flight. Use these guidelines in the following table to develop an OI; although, local organizations sometimes have specific guidance on the format of their instructions. The format of the document is a primary concern.

Formatting Guidelines	
Font	12-point Times New Roman font.
Paragraph	Double space, full-measure format, NOT dual-column format. Keep paragraphs 7–9 sentences; divide into subparagraphs or main paragraphs, if needed.
Margins	Use 1-inch left, right, top, and bottom margins.
Title page heading	Refer to heading of AFI 47–101 for correct format of title page heading.
Publication number	Assign OI number based on series number from AFI 33–360, volume 1. The control number after hyphen begins with Arabic 1 and continues sequentially with each OI.
Effective date	Assign effective date on heading as of the issuance date the approval authority assigns.
Purpose statement	Write a 2–4 sentence purpose statement outlining the reason for the OI and who must comply.
Antecedent policy directive and title	Include in the purpose statement the antecedent policy directive and title, the parent instruction (e.g., AFD 47–1, <i>Dental Services</i>).
OSHA standard requirement	For material relating to an Occupational Safety and Health Administration (OSHA) standard, include “This instruction is consistent with Air Force Occupational Safety and Health (AFOSH) standard or Department of Labor OSHA standard (or standards) (number).”
Titles	Develop titles for main paragraphs, no more than 10 words.

Formatting Guidelines	
References	List "References" in a single paragraph if more than 10, then create an attachment.
Terms Explained	Create "Terms Explained" paragraph to spell out acronyms and abbreviations. Refer to forms/publications by number and long title the first time used.
Paragraph numbering	Number main paragraphs consecutively, Arabic numerals; for example, 1, 2, and so forth. Subparagraphs use Arabic numerals in sequence, separated by periods, progressing from the main paragraph number.
Supersession Line	Give the publication number and date of superseded publication.
Office of Primary Responsibility (OPR)	Include writer's office, duty section, rank, and name.
Signature block	<ul style="list-style-type: none"> • Include signature block of approval authority on last page of publication, before attachments. • Position first line 5 lines below last line of OI. • Position 4.5 inches from the left edge of the page or three spaces to the right of page center. • Include name, rank, grade, and service in uppercase on first line. • Use uppercase and lowercase on second line for duty title.

You will need to conduct research and verify that all resources are current. Write in a direct, active voice with simple, grammatically correct, concise sentences. Then edit the OI for accuracy, currency, integrity, and expected compliance. Also check for proper spelling, punctuation, capitalization, and proper use of references, abbreviations, acronyms, and terms.

Important Dental guides and references

The Dental career field has a plethora of guides and references to use when managing a clinic. These references will help whether you are located at a small clinic with two dentists or a large clinic with twenty or more providers. These guides are all located on the Dental Knowledge Exchange and should be referenced when drafting local operating instructions. Some significant references used by dental leaders almost daily are:

- AFI 47-101, *Managing Air Force Dental Services*.
- *Clinical Practice Guidelines*.
- *Dental Management Guide*.
- *USAF Guidelines for Infection Control in Dentistry*.
- *USAF Dental Service Digital Diagnostic Imaging Guidelines*.

NOTE: Always make sure you have the most current reference before including in any guidance for you clinic.

022. Using the Corporate Dental Application

The CDA is an enterprise solution that provides access to workload, readiness and appointment data through the Army Dental Command (DENCOM). CDA is comprised of two separate components: the scheduler application and the CDA Web site. While each provides unique functionality, both components are designed to work together to allow users to perform their required tasks. The CDA scheduler application is installed on each computer in the clinic from which appointment scheduling and workload entry tasks are performed.

As a seasoned 5-level and soon 7-level dental assistant, you already have a clear understanding of how to function all aspects of appointment scheduling; however, it is important to know the functionality of workload entry and how that data is used in the dental clinic. This will allow you to process and maintain automated dental treatment data.

Workload input

To enter workload for a patient appointment in CDA Web Scheduler, do the following:

1. Locate the appointment on the CDA Web Scheduler grid for which you need to enter workload data (fig. 2-1).

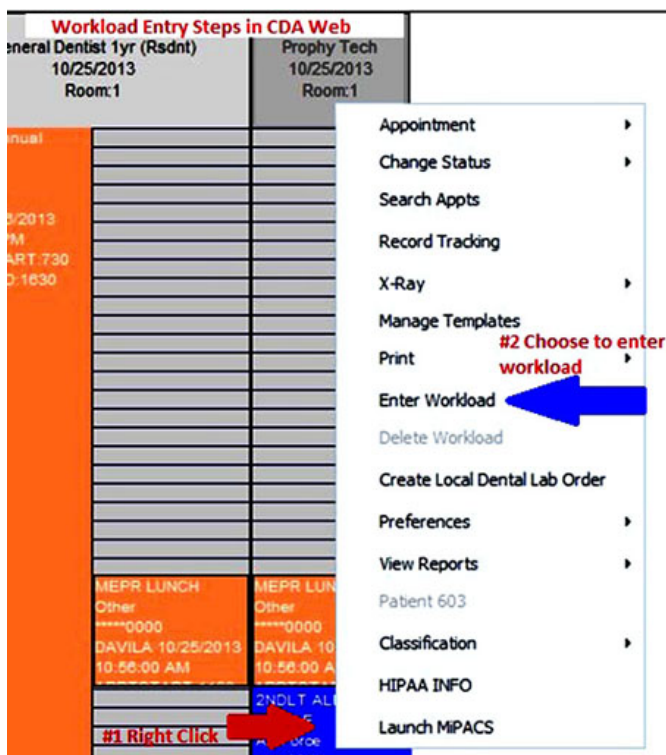


Figure 2-1. Screenshot CDA Web Scheduler grid.

2. Right-click the appointment, then click Enter Workload. The Workload Interface dialog opens with the Provider name, Date of appointment, Time of appointment, Patient Name, and Patient Type displayed on the form. These are non-editable form fields.
3. Complete the information fields using the table below for the patient appointment (fig. 2-2).

Entering Workload Data	
Field	Description
Project Code	<p>Select one of the following project codes for the appointment. These codes are mandatory for Air Force clinics.</p> <ul style="list-style-type: none"> • Routine Care: Provides patient with medical, surgical, or restorative evaluation, examination, and/or treatment of oral diseases, injuries, or deficiencies not requiring immediate attention. • Preventive Dentistry: Provides patient with preventive services not falling under AFDRAP or the Clinical Preventive Dentistry Program for Dependent Children. • Children's Preventive Dentistry: Provides preventive services to eligible child as part of Clinical Preventive Dentistry Program for Dependent Children. This can be used only with Beneficiary Type 50 or 90. • Emergency Care: Evaluates and/or treats patient in need of immediate attention, such as one with pain, with uncontrolled bleeding, with acute septic condition, or with injuries to oral-facial structures.

Entering Workload Data	
Field	Description
	<ul style="list-style-type: none"> • AFDRAP: Provides periodic dental examination to active duty Air Force member as part of AFDRAP. This can be used only with Beneficiary Types 12, 92, and 93. • Medically Adjunctive: Provides dental care essential to control and treatment of primary medical condition of eligible family member. This can be used only with Beneficiary Types 41, 50, and 90.
	<ul style="list-style-type: none"> • Pre-Post Deployment Care: Provides dental treatment accomplished in direct support of contingency operations that is beyond the workload normally performed during peacetime operations. This includes pre/post deployment exams and treatment scheduled to support contingency operations (Do not use for any other purpose). • Battle Related: For use in the deployed theater only. • Pre-existing CL 3 Condition: For use in the deployed theater only.
Treatment Location	<p>Select one of the following locations from the Treatment Location drop-down list.</p> <ul style="list-style-type: none"> • Clinic: This is the default location. Workload entry for dental procedures performed in the DTF on out-patients or same day surgery patients. • Operating Room: Workload entry that is performed in the MTF's or facilities on out-patients or same day surgery patients. (NOTE: Dental procedures performed in the OR on inpatients are recorded as in-patient care.) • In-Patient Care: Workload provided on a patient between the time the patient was formally admitted to the MTF and formally discharged from the DTF. The period of admission must be for a period greater than 24 hours.
Caries Risk*	Select NA (Default), Low , Moderate , or High to specify the patient's propensity level in developing cavities.
Tobacco Risk*	Select No Use (Default), Smoke , Smokeless Tobacco , or Both from the drop-down list.
Class Out	Select the number that corresponds to the patient's current dental readiness classification in the Class Out box. (NOTE: If the patient's current dental class requires treatment needs, but you select a higher dental class, you will be prompted to update the treatment needs on the Treatment Needs -Modify form.)
Consult Appt	<p>To create a ten-minute consult appointment on another provider's schedule for this patient, do the following:</p> <ol style="list-style-type: none"> 1. Click the Consult button. 2. Select the appointment hour and minute when the appointment should be scheduled using the Appointment Time drop-down lists. The default time displayed is set to the start time of the original patient appointment. The consult time can be different from the appointment time. 3. Do one of the following: <ul style="list-style-type: none"> • If you are creating a consult appointment on one provider's schedule, select the provider from the Select Consultation Provider drop-down. • If you are creating a consult appointment on more than one provider's schedule, do the following: <ul style="list-style-type: none"> • Select the Select Multiple Providers check box. • Press CTRL and then single click each provider, or press SHIFT and then select the first and last provider in a range. • Click the Submit Multiple button to save all new consult appointments to the selected providers. 4. Click OK at the message prompt confirming creation of the new consult appointment(s) for the selected provider (s). 5. A ten-minute appointment is then added to the specified provider appointment schedule(s) in CDA Web Scheduler at the start time of the patient's appointment.
Blood Pressure*	Enter the systolic and diastolic results in the fields provided. This is an optional entry and is not required for workload entry.
PSR Screening*	<p>Periodontal screening and recording (PSR) is a method for screening and tracking a patient's periodontal soft tissue health through exam workload.</p> <p>To document a patient's PSR Score for an exam, do the following:</p> <ol style="list-style-type: none"> 1. Click the PSR Screening button. 2. From the PSR Screening dialog, do any of the following to document a PSR Score:

Entering Workload Data	
Field	Description
	<ul style="list-style-type: none"> For each sextant reviewed, select the overall PSR Score. Only the highest score indicating periodontal issues should be documented. If the patient has other clinical abnormalities present in addition to the score, select the asterisk * button in addition to the score. (NOTE: The asterisk should not be selected without first selecting a score. A score of 0 and an anomaly * may be applied to the same sextant.) If the patient is missing two or more natural teeth in a sextant, select the X button.
	<p>3. Click the PSR Screening button again to save the PSR changes, close the dialog, and continue completing the Workload Entry form.</p> <p>4. To make changes to the PSR scores already selected prior to entering workload, click the PSR Screening button.</p> <p>5. To clear all PSR scores prior to entering workload, click the Clear button.</p>

* Field denotes an area that is required if the patient received a periodic oral examination or a comprehensive evaluation.

Provider: [Redacted] Patient Name: [Redacted] Patient Type: Air Force

Date: 10/25/2013 Project Code: [Redacted] Treatment Location: Clinic

Time: 12:30 Caries Risk: N/A Tobacco Risk: N/A

Class Out: [Redacted] EFDA Provider: [Redacted]

BP: [Redacted] PSR Screening: [Redacted]

Procedure Groups: Exam

Assigned Procedures:

EFDA?	Code	Description	Remove Procs	Qty
#1:	09999	PATIENT SEATED	All	1
#2:	D0120	PERIODIC ORAL EVALUATION - ESTABLISHED PA	+ -	1
#3:	D0274	BITEWINGS - FOUR RADIOGRAPHIC IMAGES	+ -	1
#4:	D0330	PANORAMIC RADIOGRAPHIC IMAGE	+ -	1
#5:			+ -	
#6:			+ -	
#7:			+ -	
#8:			+ -	

Narrative: (Optional)

Provider Password Narrative Verification: [Redacted] Validate

Submit Submit/Print Close Window

Areas in yellow required for periodic and comprehensive exams

Figure 2-2. Screenshot CDA Web Workload Entry interface.

- Specify the procedure codes and/or procedure groups to submit with the appointment workload in any of the following ways:

Procedures Codes and Groups	
Add Procedures by...	How...
Selecting a Procedure Group	Click the Procedure Groups drop-down list and then select the group to use. The procedure codes within that group are listed in the list of procedures on the Workload Entry form.
Selecting an Individual Procedure Code from a Provider's Assigned Codes	Select an individual procedure code from the Assigned Procedures drop-down list.
Selecting an Individual Procedure Code Not Assigned to a Provider	Enter the numeric procedure code in the Code column of the displayed table and then press the Tab key or Enter key to see the full code Description .
Searching for a Procedure Code Using a Full/Partial Description	<ol style="list-style-type: none"> 1. Search for a procedure code by clicking the Find button next to the Assigned Procedures drop-down list. The Find Procedure Code dialog box is displayed. 2. Type a full or partial code description (e.g., surface, resin, etc.). A list of related code descriptions is displayed. 3. Select the applicable code from the search results to add it to the Workload Entry page. The Find Procedure Code dialog will remain open so that more codes can be added. 4. Click Close to close the dialog and return to the Workload Entry form.

5. Modify the number of procedures on the form as necessary in any of the following ways:
 - Remove all procedures by clicking the “all” button under the Remove Procedures column.
 - Delete individual procedure codes by clicking the delete button next to the procedure.
 - Change the quantity field of a procedure by clicking the (=) or (-) button increasing/decreasing the number.
6. For each procedure that was assisted or performed by an EFDA (expanded function dental assistant) provider, do the following:
 - a. Select the name of the EFDA provider from the **EFDA Provider** drop-down list.
 - b. Select the **EFDA** check box next to the procedure code. If the EFDA field was selected in error, click the field again to uncheck the box.
7. Providers can enter optional narrative details with the appointment workload by typing the narrative in the text box provided and then clicking the **Validate** button to save the narrative with the workload entry using the provider’s password.
8. To complete appointment workload, do one of the following:
 - To complete appointment workload without printing the SF-603A form, click **Submit** and then click **OK** at the message, **Your record has been received by CDA**. You will then be returned to the Workload Entry form.
 - To complete the appointment workload and print the SF-603A form, do the following:
 - a. Click **Submit/Print** and then click **OK** at the message, **Your record has been received by CDA**.
 - b. Click **Open** to open the Adobe PDF document in a new window.
 - c. In the PDF window, click the **Print** button to print the SF-603A for the appointment.
 - d. Close the SF-603A window to return to CDA Web Scheduler.

In addition to entering patient workload, users can view past workload entries, delete workload, manage programs and review reports in CDA. All actions available via CDA are included in the *CDA User Guide* linked on the login page of the CDA Website.

As a leader/supervisor, CDA capabilities will be a valuable resource often referred to on a daily basis; therefore, it is very important to familiarize yourself with the tools available at your disposal.

CDA reports

The data entered into the CDA system comes from different sources. Dental procedures and patient information are input to document dental records of attendance, administrative updates, and DD Forms 2322, Dental Laboratory Work Authorizations.

Dental procedural information is stored in the system by base, clinic, provider, beneficiary type, and encounter type. Although local users will determine when to input workload, daily input is recommended. Daily processing is desirable because it reduces the length of time since the encounter, reducing the potential for error. Also, if the system should be unavailable for a few days, it will take less time to catch up if workload has been entered daily. Unsubmitted workload must be completed no later than the midnight on the 7th of the following month. Once the month “closes” the workload/data is no longer reportable. After the information is entered into CDA, several reports may be produced.

Daily Tick Sheet

The Daily Tick Sheet serves two purposes. First, it provides a means of verifying that all transactions entered during the day were actually processed by the system. Second, it serves as an audit trail for detecting and correcting errors occurring during the workload entry. This list (fig. 2-3) is a product that can identify any discrepancies as they are input into the system before any monthly reports are generated. You should do periodic accuracy checks to ensure workload integrity. This is accomplished by comparing the dental health record narrative to the respective tick sheet.

Provider Ticksheet: (23 OCT 2013)

<p style="text-align: center;">This is applicable only for 2322 Lab Slip Ticksheets: If a procedure is taken multiple times AND with more than 1 encounter, the total will be automatically multiplied. For example: (L0001) ... x 3 with 4 Encounters will show as (L0001) ... x 12</p> <p style="text-align: center;">Print this Ticksheet / Jump to total DWV / Back To Main Menu</p>	
71 MDOS/SGOD-Vance (DMISID - 7274) / Appt Date: 23 OCT 2013 / DELETE WORKLOAD	
Patient: McGEE, TIMOTHY R SSN: xxx-xx-8480	Provider: SRA MALLARD, DONALD L (7274)
Procedures: <ul style="list-style-type: none"> • (09999) Patient treated x 1 • (D1110) Prophylaxis - adult x 1 • (D1208) Topical application of fluoride x 1 • (D1330) Oral hygiene instructions x 1 	
Project Code: Preventive Dentistry - AF6	CDA Input Location: New Web Workload (Through Web Scheduler)
Patient Type: Air Force	
Tobacco Risk: N/A	Caries Risk: N/A
Treatment Location: CLINIC	
Blood Pressure: N/A / N/A	PSR: MAX Right() - Ant() - Left() MAN Right() - Ant() - Left()
Completed by: SRA MALLARD, DONALD L	Date Submitted: 23 OCT 2013
Narrative : DNIF: No. Exam T-4. Reviewed/initialed AF Form 696. Reviewed Digital images dated: BW: 09 Oct 2012. Antimicrobial pre-rinse given. Disclosed plq: No. OHI reviewed with demo. Plq: Slt. Cal: Slt. Stain: Slt. Scale: Full mouth cavitron; flossed all 4 quadrants; polished w/ nupro. OH status: Good. Fluoride: CPTNaF x4minutes. Disposition: Oper, perio maintenance	
Dental Readiness Classification Out: 2 / DWV: 1.62 / CLV: 0	
71 MDOS/SGOD-Vance (DMISID - 7274) / Appt Date: 23 OCT 2013 / DELETE WORKLOAD	
Patient: VANCE, LEON G	Provider: SRA MALLARD, DONALD L (7274)
Procedures: <ul style="list-style-type: none"> • (09999) Patient treated x 1 • (D1110) Prophylaxis - adult x 1 • (D1208) Topical application of fluoride x 1 • (D1330) Oral hygiene instructions x 1 	

Figure 2-3. Sample, Daily Tick Sheet.

DENTAL SERVICE REPORT												
PREPARED 25 Oct 2013	CLINIC: 1	Vance AFB	FROM 2012/10/01 TO 2012/10/31									
CLINICAL SERVICES:	AIR FORCE	ARMY	NAVY	MARINE	GOV OTR	DEP OF AD Air Force	DEP OF AD Army	DEP OF AD Navy/Mar	RETIRED	OTHER	TOTAL PROC	TOTAL PRODUCTIVITY
00100-00999 Diagnostic												
Clinical Oral Evaluations												
D0120 Periodic oral evaluation - established patient	153	0	3	0	0	0	0	1	1	21	184	8832
D0140 Limited oral evaluation - problem focused	22	0	1	0	0	0	0	0	3	6	32	2592
D0150 Comprehensive oral evaluation - new or established patient	9	0	0	0	0	0	0	0	0	3	12	1020
Clinical Radiographic Imaging (including interpretation)												
D0220 Intraoral - periapical each additional film	9	0	0	0	0	0	0	0	3	0	12	324
D0230 Intraoral - periapical first film	4	0	0	0	0	0	0	0	0	0	4	96
D0270 Bitewing - single film	2	0	0	0	0	0	0	0	0	1	3	81
D0272 Bitewing - two films	0	0	0	0	0	0	0	0	0	1	1	43
D0274 Bitewing - four films	99	0	1	0	0	0	0	1	0	20	121	7381
D0330 Panoramic film	58	0	0	0	0	0	0	1	0	13	72	7920
D0350 Orafacial photographic images	1	0	0	0	0	0	0	0	0	0	1	59
Test and Examinations												
D0460 Pulp vitality tests	6	0	0	0	0	0	0	0	1	0	7	329
01110-01555 Preventive												
Dental Prophylaxis												
D1110 Prophylaxis - adult	150	0	5	0	0	0	0	0	1	17	173	15570
Topical Fluoride Treatment (Office Procedure)												
D1204 Topical Application of Fluoride - Adult	148	0	5	0	0	0	0	0	1	18	172	6192
D1208 Topical fluoride varnish; therapeutic application for moderate to high caries risk patients	13	0	0	0	0	0	0	0	0	2	15	810
Other Preventive Services												
D1310 Nutritional counseling for control of dental disease	3	0	0	0	0	0	0	0	0	0	3	138
D1320 Tobacco counseling for the control and prevention of oral disease	1	0	0	0	0	0	0	0	0	0	1	50
D1330 Oral hygiene instructions	140	0	4	0	0	0	0	0	1	13	158	10112
D1351 Sealant - per tooth	10	0	1	0	0	0	0	0	0	0	11	572
02000-02999 Restorative												
Amalgam Restorations (including Polishing)												
D2150 Amalgam - 2 surfaces, primary or permanent	5	0	0	0	0	0	0	0	0	3	8	1480
D2160 Amalgam - 3 surfaces, primary or permanent	1	0	0	0	0	0	0	0	1	2	4	900
D2161 Amalgam - 4 or more surfaces, primary or permanent	1	0	0	0	0	0	0	0	0	0	1	274
Resin-Based Composite Restorations - Direct												
D2330 Resin - 1 surface, anterior	8	0	0	0	0	0	0	0	1	0	9	1278
D2331 Resin - 2 surfaces, anterior	5	0	0	0	0	0	0	0	0	0	5	905
D2332 Resin - 3 surfaces, anterior	1	0	0	0	0	0	0	0	0	0	1	222
D2335 Resin - 4 or more surfaces or involving incisal angle, anterior	2	0	0	0	0	0	0	0	0	0	2	526
D2391 Resin-based composite - 1 surface, posterior	22	0	0	0	0	0	0	0	0	2	24	4008
D2392 Resin-based composite - 2 surfaces, posterior	6	0	0	0	0	0	0	0	0	0	6	1308
D2394 Resin-based composite - 4 or more surfaces, posterior	1	0	0	0	0	0	0	0	0	0	1	333
Other Restorative Services												

Figure 2-4. Sample, Dental Service Report.

Dental Service Report

The DSR (fig. 2–4) contains consolidated data from the main base dental clinic, its sub-clinics, the base dental laboratory, and where applicable, the ADL. This report is produced in copies for both base and clinic level. CDA produces the DSR upon manual request using the Readiness dropdown tab on CDA Web. It is highly encouraged to review the DSR before the month closes out to ensure no discrepancies to the data that has been input during the month. The following reviews the different parts of the DSR.

NOTE: CDA will not allow you to cross fiscal years (FY) when generating a requested DSR.

Detailed Workload Report

Dental managers must be able to determine quickly and accurately the productivity level of the dental clinic at any time during the reporting month and must also have an efficient means of verifying the accuracy of the monthly DSR before the report is actually produced. The Detailed Workload Report (fig. 2–5) allows dental managers to quickly review up-to-the-minute base- and clinic-level productivity, patient information, and procedural information for the current month. When this program is used, the data stored in CDA for the current reporting month is displayed on the screen in a format similar to that of the DSR.

Additionally, the Detailed Workload Report can be used to view several months. Any month and any year can be requested; unlike the DSR, this report can cross fiscal years.

Detailed Workload Report

71 MDOS/SGOD-Vance (From: SEPT - 2013 To: SEPT - 2013)

Level	Total Patients Seated (09999)	Total Procedures Performed	Total Dental Weighted Value	Total Lab Procedures Performed	Total Lab Weighted Value
71 MDOS/SGOD-Vance	339.00	781.00	616.60	No Data	No Data

71 MDOS/SGOD-Vance (From: SEPT - 2013 To: SEPT - 2013)

PROVIDER	AFSC	Total Patients Seated (09999)	Total Procedures Performed	Total Dental Value	Total Lab Procedures	Total Lab Value
COOPER, SHELROD C	47G3	91.00	203.00	170.26	No Data	No Data
KRIPKE, BARRY L	4Y0	63.00	193.00	104.18	No Data	No Data
TODD, ZIVA R	47G3A	156.00	290.00	289.12	No Data	No Data
BISHOP, JENNY B	UNK	13.00	35.00	22.02	No Data	No Data
GIBBS, ABBY P	4Y0	16.00	60.00	31.02	No Data	No Data

Figure 2–5. Sample, Detailed Workload Report.

Base Summary Report

This part of the DSR consists of eight sections consolidating the data from all sub-clinics, the base dental laboratory, and/or the area dental laboratory. These sections are arranged in a specific to general sequence. The following table identifies the various reports that are contained in the Base Summary Report.

Base Summary Report	
Report	Description
Clinical services	Lists clinical procedures, dental weighted values (DWV), and patients by beneficiary type, for each clinical procedure performed during the reporting month.
Laboratory services	Lists laboratory procedures and clinical lab values (CLV) of each procedure accomplished during the reporting month. This report does <i>not</i> include ADL data.
Clinical service and lab summary	Summary of clinical and laboratory services by major category of service, productivity by recipient of care, and percentages of productivity by recipient of care.
Recipient of care comparison summary	Compares cumulative productivity information by beneficiary type for the current FY-to-date to last FY-to-date. Example: Jan-Mar 13 versus Jan-Mar 14.

Encounter type summary	Summarizes primary reasons for patient encounters. It also shows in terms of percentages, how each beneficiary type used the various encounter types.
Dental class summary	Displays percentage of active duty Air Force personnel in each dental class, categorized by status. These include flying, mobility, non-flying and GSU.
Submitting laboratory summary	Only produced for ADLs and bases using clinic 8. The base must perform and report work for another Air Force dental laboratory. Summary of work performed for each of the submitting laboratories.
Clinical and lab comparison summary	Compares productivity totals and related management information for the current reporting month to the monthly average for the last 12 months. It also compares cumulative data for the current FY-to-date with the last FY-to-date.

Clinic reports

A clinic DSR is produced for each clinic that inputs productivity in a given month. This report is in the same format as the base level reports, but contains less information. The clinic report is identified by the word CLINIC at the top left corner of the report. The report generated for clinic 8 differs slightly from other clinical reports. It contains similar information as the other clinic reports, but also contains a Submitting Laboratory Summary section.

ADL Summary Report

The ADL summary report part of the DSR is produced at those bases operating an ADL. This report is generated each month; laboratory productivity is input using clinic 9.

Detailed provider reports

Detailed provider reports are not automatically generated with the monthly base and clinic reports. Instead, the provider reports must be specifically requested each month or the timeframe in question. This report will give you a span-of-time report for one or more providers; however, it is limited to current fiscal year. This can be generated to give the same details as a DSR (fig. 2-6) under the AF Reports tab in CDA, or can be generated to list by procedure description under the Command Report tab in CDA.

Reporting requirements

Dental personnel prepare the DSR by entering data into CDA. The cutoff date for workload data is the last workday of the month being reported. All workload data is “real-time” and generates productivity as it is input into the system. This automated monthly Dental Service Report must contain at least 95 percent of treatment accomplished during the reporting month.

Annual Dental Service Report

The Annual Dental Service report is a consolidation of monthly DSRs for the entire fiscal year. It is in the same format as the monthly report, except for the comparison summaries and some of the administrative input. Because this report is no longer automatically generated each fiscal year, it is important for the superintendent/NCOIC to request this report for historical data.

NOTE: CDA will not allow you to cross fiscal years when generating a DSR.

PREPARED 25 Oct 2013		DENTAL SERVICE REPORT		
PROVIDER: 1 CAPT TODD, ABBY P		Vance AFB	FROM 2013/9/01 TO 2013/9/31	
CLINICAL COMPARISON SUMMARY:		THIS PERIOD	THIS FY TO DATE	LAST FY TO DATE
CLINICAL PROCEDURES		290	3786	3839
DWVs		28912	379018	0
PATIENT ENCOUNTERS		156	1993	2024
SCHEDULED APPOINTMENTS		157	1984	1984
BROKEN APPOINTMENTS		9	49	49
BROKEN APPOINTMENT %		5.7	2.5	2.5
CANCELLED APPOINTMENTS		12	75	75
CANCELLED APPOINTMENT %		7.6	3.8	3.8
FILLED APPOINTMENTS		0	9	9
FILLED APPOINTMENT %		0.0	0.5	0.5
CLINICAL SERVICE SUMMARY:		TOTAL PROC	% TOTAL PROC	% TOTAL DWV/CLV
Oral & Maxillofacial Surgery				
Surgical Extractions (Includes Local Anesthesia, Suturing, If Needed, And Routine Postoperative Care)		3	0.7	8.56
Unclassified				
UnClassified		156	35.0	0
00100-00999 Diagnostic				
Clinical Oral Evaluations		91	20.4	52.25
Diagnostic Imaging/Image Capture With Interpretation		66	14.8	45.66
Tests And Examinations		3	0.7	1.35
00100-09999 Orofacial Pain Cpt Codes				
Service A Codes		2	0.4	23.60
01110-01555 Preventive				
Dental Prophylaxis		19	4.3	17.10
Other Preventive Services		30	6.7	11.84
Topical Fluoride Treatment (Office Procedure)		20	4.5	7.29
02000-02999 Restorative				
Amalgam Restorations (Including Polishing)		9	2.0	17.50
Crowns - Single Restorations Only		2	0.4	24.03
Resin-Based Composite Restorations - Direct		22	4.9	41.57
04000-04999 Periodontics				
Non-Surgical Periodontal Service		2	0.4	5.00
Other Periodontal Services		1	0.2	1.50

Figure 2-6. Sample, Detailed Provider Report.

Each time a month is finished reports are generated by the superintendent/NCOIC's request and archived according to the following schedule:

DENTAL SERVICE REPORT SCHEDULE	
Month	Report
All Months	Monthly Report
March, June, September, December	Quarterly Report
September (end of FY)	Yearly Report

023. Interpreting automated treatment data

The automated treatment data available in the CDA Air Force Rosters menu shown in figure 2-7 are a reflection of the workload and dental data specific updates dental technicians input during the patient visit. Leadership can use the data found in the CDA Air Force Rosters menu to manage patient care in the clinic setting. The following is a short overview of the different reports offered in the menu; however, to get a clearer understanding and more detailed instructions refer to the *CDA User Guide*

for the Air Force found on the CDA Login page and/or the references section of the Dental Knowledge Exchange website.

Select a Report: Dental Class Roster

Choose a Report

- Dental Class Roster
- Dental Class Count
- Flying Status Roster
- PRP Status Roster
- AFDRAP Roster
- AFDRAP Patient Status Roster
- AFDRAP Unavailable Roster
- Recall Roster
- Caries Roster
- PSR 3 Roster
- PSR 4 Roster
- Blood Pressure Roster

Nonavailable:

Exam Due Date: [YYYY/MM]

Include Dental:

Sort Preference:

Unit:

- 3 FLYING TRAINING SQ VANCE (GSU) (VH0JFGMH)
- 4 FIELD INVESTIGATNS RG VANCE (GSU) (VH07FB3M)
- 8 FLYING TRAINING SQ VANCE (VH0JFCFV)
- 25 FLYING TRAINING SQ VANCE (VH0JFCFW)
- 33 FLYING TRAINING SQ VANCE (VH0JFSKV)
- 71 COMMUNICATIONS SQ VANCE (VH0JFFQ4)
- 71 COMPTROLLER SQ VANCE (VH0JFPCX)
- 71 FLYING TRAINING WG VANCE (VH0JFCF7)
- 71 FORCE SUPPORT SQ VANCE (VH0JFDN3)
- 71 LOGISTICS READINES SQ VANCE (VH0JFG8C)
- 71 MEDICAL GP VANCE (VH0JFB9X)
- 71 MEDICAL OPERATIONS SQ VANCE (VH0JFNCY)

Combine Units

Do Not Combine Units

Select All

Create Report

Please Select One or More Units.

Figure 2-7. Sample, CDA Air Force Rosters menu.

Dental Class Roster

The Dental Class roster lists all patients within the specified dental classification. The report may be generated for a specific unit (i.e., squadron or group) including the entire installation and can be useful if the CDS wants a list of all individuals in a specific dental class. This roster is the tool the Dental Class 3 and 4 monitor uses to generate a running list of personnel in Dental Class 3 and 4 to ensure they are being properly scheduled for needed appointments.

Dental classification is a major portion of maintaining the AFDRAP. The responsible dental technician enters classification updates into CDA to maintain an accurate account of AFDRAP data. To ensure currency of AFDRAP products, information reflected in the classification menu must be updated appropriately and timely.

Dental Class Count Report

The Dental Class Count Report is what leaders use to determine what percentages of a select group of personnel are in each Dental Class (fig. 2-8). The dropdown menu allows leadership to select anyone from certain squadrons or groups to the entire base population to generate the report that includes an accurate class count for selected units.

Flying Status Roster

Very similar to the Dental Class Count Report, is the Flying Status Roster. Because our Air Force mission is to keep flyers flying, this gives leaders a quick snapshot of the dental classification of the flying status personnel in a squadron, group, or base population.

PRP Status Roster

Leaders can access a report that gives the status of all members of the installation that are on PRP status upon request. Like flying status personnel, it is important to monitor PRP individuals closely to ensure accurate and timely care.

Dental Class Count

Dental Population Health Measures						
Category	CL-1	CL-2	CL1 + CL2	CL-3	CL-4	Total
Flying	556	101	657	5	0	662
% Flying	84.0	15.3	99.3	0.8	0.0	100.1
Mobility	273	64	337	5	1	343
% Mobility	79.6	18.7	98.3	1.5	0.3	100.1
On-Base Total	829	165	994	10	1	1005
% On-Base Total	82.5	16.4	98.9	1.0	0.1	
G.S.U.	59	8	67	0	0	67
% G.S.U.	88.1	11.9	100.0	0.0	0.0	
Non-Available ADAF	157	39	196	1	0	197
% Non-Available ADAF	79.7	19.8	99.5	0.5	0.0	
Base Grand Total	1045	212	1257	11	1	1269
%Base Grand Total	82.3	16.7	99.0	0.9	0.1	

Caries Risk

N/A	LOW	MODERATE	HIGH	TOTAL
12	1040	165	52	1269

PSR's

	Non-Eval	0	1	2	3	4	5	6	TOTAL
PSR 0	2	1219	32	5	3	2	5	1	1269
PSR 3	2	1251	6	5	1	2	1	1	1269
PSR 4	2	1265	1	1	0	0	0	0	1269

Tobacco Use

Smoke	Smokeless	Both	None	Unknown	Total
103	56	5	1093	12	1269

Figure 2-8. Sample, Dental Class Count Report.

AFDRAP management

While most of the products located within the CDA Air Force Rosters menu are driven by AFDRAP appointments, there are three specific drop-down menu options that will generate reports to actually manage the AFDRAP program.

AFDRAP Roster

Using the AFDRAP Roster, leaders can update the status of patients due during the current AFDRAP month. Using the list generated through the report, the leader will update each patient as “complete” after they have been seen for their annual examination. This roster is a good tool to screen dental records for current dental readiness classification. Additionally, there is an option to update patients as “unavailable” if they are TDY, retired, or PCSd and unavailable for the entire AFDRAP month.

AFDRAP Patient Status Roster

The AFDRAP Patient Status Roster is a product that displays patients identified as needing a periodic dental evaluation based upon the patient’s last AFDRAP status date at one or more squadrons assigned to your clinic logon location. The AFDRAP status date is a system-generated date that is 12 months after the patient’s last annual exam date. If the patient does not have an exam within 14 months for Air Force active duty or 16 months for ANG/RES after their last annual exam, their dental classification is automatically changed to Class 4. The AFDRAP Patient Status Roster can be used to view all patients needing exams in order to prevent them from turning to Class 4. This roster is the core product for managing the AFDRAP.

AFDRAP Unavailable Roster

The AFDRAP Unavailable Roster makes it easy to generate a roster of the individuals that are unavailable due to TDY, retirement, or PCS. Leaders can use this list to update upon return and ensure AFDRAP is managed appropriately.

Recall Roster

The Recall Roster is for periodontal patient management. Patients on the periodontal maintenance program are updated after each appointment and each month leaders can use this feature to generate a list of all periodontal patients due during the month. Additionally, when reviewing all periodontal patients' status, a report can be requested stating at what intervals all periodontal patients are coming due.

Caries Roster

The Caries Roster is used to manage the High Caries Risk Program. This report includes the status of each patient on the program to include their next scheduled appointment, if any. The High Caries Risk Program monitor can use this report to easily access any patients that need additional attention, needs to be scheduled for recall, or needs to be removed from the High Caries Risk Program.

PSR 3 and PSR 4 Rosters

The periodontal screening recording (PSR) 3 and 4 Rosters are used to quickly review any patients that may need periodontal care. This report summarizes how many sextants that contain a PSR of 3 or 4 respectively. Leaders can use this data to ensure their periodontal population is being served.

Blood Pressure Roster

The Blood Pressure Roster is a tool used by leaders to ensure patients within certain blood pressure parameters are being properly monitored. Using a drop-down menu, the user can choose a systolic pressure parameter (> 101, 101–109, 110–119, increasing in increments of 10 to > 160) and a diastolic pressure parameter (> 61, 61–69, 70–79, increasing in increments of 10 to > 100). These parameters will generate a report of all patients that fall within the guidelines. Leaders can check the records of patients that are included on the list to ensure the patients received proper follow up.

024. Business metrics

In March 2007, Air Force Dental established SHARP Metrics. It was revised to SHARP–7 in September 2012; goals have been established for core metrics that directly relate to the success of the dental mission.

SHARP–7 Metrics

SHARP–7 Metrics encompass the following measures:

- S: Patient Safety.
- S: Patient Satisfaction (≥ 94 percent - Question #21 on Pt Sat. Survey).
- H: Oral Hhealth, Class 1 (≥ 65 percent).
- A: Access to Care (≤ 21 Days for General Dentistry, ≤ 28 days for specialists).
- R: Readiness, Class 1 and 2 (≥ 95 percent).
- P: Performance, Clinic Productivity.
- P: Performance, Private Sector Care.

SHARP–7 metrics should be reported monthly in the clinic's Executive Function notes and used as a tool for leaders in your chain of command to show the clinic's ability to meet established goals. Metrics also help clinic leaders make decisions related to staffing, budgeting, and other matters. While striving to exceed goals/published metrics is admirable, leaders must be mindful of the AF Dental Service vision: PROUDLY SERVING AND ENJOYING OUR SERVICE...A TEAM

SPORT. Allowing time for professional development, continuing education, accomplishment of additional duties, team training, and force development opportunities are all important investments in the long-term health of the Dental Service.

SHARP-7 Metric Reports

Quarterly SHARP metrics reports (fig. 2-9 and fig. 2-10) are produced and reviewed by AFMOA/SGD to help make decisions concerning manning, budgets and other matters on a global level. Clinic leaders should contact their officer/enlisted AFMOA dental functional advisors regularly to ensure they are aware of latest operational policies and receive assistance with any local problems or issues they may be experiencing.

Calculating access to care

Access to care is calculated on the first duty day of each month. For general dentistry access to care, determine the number of calendar days (includes weekends and holidays) until the first one hour available appointment for each general dentist. Do not count blocked time for sick call, exams, or Class 3 patients as available appointments. The metric should be calculated as though a patient were presenting for care requesting a one-hour operative appointment. When is the first appointment available? Calculate the total number of days for all general dentists and the number of general dentists. Do not include squadron commanders or any dentist projected to be in the clinic for 10 duty days or less in the given month due to leave, TDY, etc. Enter the two numbers into CDA and access to care will automatically be calculated.

The instructions to calculate access to care follows:

- 1) The current month's access to care should be calculated the 1st duty day of that month (i.e. you calculate January's access on 1 January). Currently, CDA only allows the previous month's access to care to be input until the previous month's DSR closeout occurs on the 7th. Therefore, after calculation, you should store your data somewhere that is easily retrievable.
- 2) On the 1st day after DSR closeout, you may enter the current month's access to care numbers into CDA.
- 3) All clinics are required to have their numbers entered by the first duty day of the following month. Continuing from the example above, you would be required to have them entered on 1 February for January. AFMOA will check to ensure all clinics have entered their data and will notify non-compliant bases.
- 4) Determine the number of calendar days (including weekends and holidays) to the first one hour available appointment for each general dentist. Using the Dental Management Guide as a reference, use the following ground rules:
 - A) If there is an opening on the 1st duty day of the month, it is considered 0 days access to care.
 - B) Do not include sick call slots, class 3 slots that are held, or exam slots as open appointments. Think of it as "If I had a patient walk up to the desk right now, what day would I tell them the doc's next hour opening would be?"
 - C) Do not include squadron commanders in the calculation. Flight commanders should be counted, unless their current duties prevent them from seeing patients at least 10 duty days in the given month (i.e. filling in for a deployed squadron commander).
 - D) Do not include any provider that is not in the clinic (leave, TDY, etc.) for at least 10 duty days in the given month.
 - E) The same rules apply when calculating specialist access to care.

(List continued on page 2-28.)

FY 2013		S _{afety}	S _{at}	H _{health}	A _{ccess}		R _{eadiness}
Base	MAJCOM	Patient Safety Total Reports**	Patient Satisfaction Target=94%	Class 1 Target=65%	Access To General Care (Number of Days) Target=21	Access To Specialist Care (Number of Days) Target=28	Class 1 and 2 Target=95%
Altus AFB	AETC	7	97.5%	82.8	7		98.5
Andersen AB	PACAF	6	94.9%	70.5	17		98.2
Andrews AFB	AFDW	233	98.3%	70.0	16	7	95.5
Aviano AB	USAFE	20	97.1%	67.7	18	6	99.0
Barksdale AFB	GSC	7	96.0%	75.1	7	10	95.4
Beale AFB	ACC	31	97.6%	70.5	20		98.0
Bolling AFB	AFDW	1	97.3%	63.0	7	8	96.4
Buckley AFB	AFSPC		100.0%	73.2			94.3
Cannon AFB	AFSOC	5	95.3%	74.7	20		97.3
Charleston AFB	AMC	15	97.3%	73.1	5		97.5
Columbus AFB	AETC	1	98.7%	83.3	1		97.1
Davis-Monthan AFB	ACC	291	95.8%	68.8	29	29	98.7
Dover AFB	AMC	0	95.3%	66.1	24		96.6
Dyess AFB	ACC	1	96.0%	71.5	17		97.0
Edwards AFB	AFMC	201	97.9%	65.7	13		97.0
Eglin AFB	AFMC	91	98.3%	75.2	4	19	97.6
Eielson AFB	PACAF	28	96.2%	73.2	31		96.2
Ellsworth AFB	ACC	2	98.5%	79.9	4		97.5
Elmendorf AFB	PACAF	131	95.7%	72.4	19	16	97.7
F.E. Warren AFB	GSC	1	96.8%	65.2	2		95.1
Fairchild AFB	AMC	3	96.4%	69.0	2		97.6
Goodfellow AFB*	AETC	2	96.1%	52.9	2		76.5
Grand Forks AFB	AMC	14	98.0%	72.6	23		97.3
Hanscom AFB	AFMC	44	96.6%	72.7	4		95.7
Hickam AFB	PACAF	71	97.5%	74.3	14	19	98.2
Hill AFB	AFMC	9	96.9%	80.8	9		97.3
Holloman AFB	ACC	36	96.5%	65.9	17		96.5
Hurlburt Field	AFSOC	174	96.7%	63.8	16	28	93.5
Incirlik AB	USAFE	0	97.5%	70.2	9		98.1
Kadena AB	PACAF	101	97.2%	71.2	12	12	99.3
Keesler AFB*	AETC	1	95.7%	41.2	17	11	67.7
Kirtland AFB	AFMC	75	99.0%	76.2	6		96.6
Kunsan AB	PACAF	7	98.9%	72.8	5		99.1
Lackland AFB*	AETC	209	95.1%	37.8	11	6	60.8
Lajes AB	USAFE	24	100.0%	80.6	18		99.2
Lakenheath RAF	USAFE	84	96.2%	69.7	22	18	98.0
Langley AFB	ACC	497	97.6%	65.5	11	12	95.6
Laughlin AFB	AETC	0	100.0%	76.3	9		98.8
Little Rock AFB	AMC	151	97.7%	70.2	13		98.6
Los Angeles AFB	AFSPC	1	96.1%	76.5	13		98.4
Luke AFB	AETC	34	96.1%	77.7	9		98.6
MacDill AFB	AMC	0	96.8%	67.0	22	16	94.8
Malmstrom AFB	GSC	8	95.9%	78.9	13		97.6
Maxwell AFB	AETC	1	95.8%	73.2	13		98.8
McChord AFB	AMC			70.5			97.9
McConnell AFB	AMC	2	96.1%	69.2	20		98.2
McGuire AFB	AMC	21	96.4%	64.3	20	6	95.4

Figure 2-9. Sample, SHARP-7 Metrics Quarterly Report (part 1).

P _{roductivity}						P _{ri} ate Sector Care			
Productivity 3rd Quarter	Quarterly Productivity Target	Percent of Quarterly Target Achieved (Current Quarter)	Cumulative FY Production	Annual Production FY Target	Percent of Annual Target Achieved	ADDP 1st Quarter	ADDP 2nd Quarter	ADDP 3rd Quarter	Percent of Quarterly ADDP Use to Total Productivity (Clinic + ADDP) Suggestion: 0-10%
\$400,085	\$305,000	131.2%	\$986,660	\$1,220,000	80.9%	\$0	\$0	\$0	0.0%
\$433,152	\$325,000	133.3%	\$1,154,183	\$1,300,000	88.8%	\$97,813	\$30,783	\$40,416	8.5%
\$1,934,094	\$1,550,000	124.8%	\$5,132,578	\$6,200,000	82.8%	\$0	\$0	\$959	0.0%
\$1,516,186	\$1,275,000	118.9%	\$4,615,962	\$5,100,000	90.5%				
\$2,331,859	\$2,000,000	116.6%	\$6,170,962	\$8,000,000	77.1%	\$2,400	\$0	\$0	0.0%
\$778,107	\$700,000	111.2%	\$2,274,360	\$2,800,000	81.2%	\$164,469	\$154,908	\$196,988	20.2%
\$1,377,625	\$1,250,000	110.2%	\$4,002,469	\$5,000,000	80.0%	\$0	\$0	\$0	0.0%
\$837,783	\$775,000	108.1%	\$2,599,760	\$3,100,000	83.9%	\$33,542	\$36,304	\$54,762	6.1%
\$1,160,343	\$800,000	145.0%	\$3,209,861	\$3,200,000	100.3%	\$182,291	\$82,671	\$33,336	2.8%
\$309,788	\$280,000	110.6%	\$977,152	\$1,120,000	87.2%	\$46,879	\$34,253	\$31,860	9.3%
\$1,630,853	\$1,325,000	123.1%	\$4,722,068	\$5,300,000	89.1%	\$102,396	\$141,606	\$141,286	8.0%
\$888,240	\$925,000	96.0%	\$2,574,376	\$3,700,000	69.6%	\$99,866	\$89,675	\$132,212	13.0%
\$1,023,275	\$900,000	113.7%	\$2,772,064	\$3,600,000	77.0%	\$166,918	\$173,956	\$235,416	18.7%
\$432,399	\$375,000	115.3%	\$1,284,904	\$1,500,000	85.7%	\$87,401	\$78,645	\$79,996	15.6%
\$3,607,571	\$2,925,000	123.3%	\$9,745,652	\$11,700,000	83.3%	\$0	\$6,475	\$0	0.0%
\$421,678	\$412,500	102.2%	\$1,334,743	\$1,650,000	80.9%	\$119,333	\$57,308	\$56,002	11.7%
\$803,375	\$700,000	114.8%	\$2,322,987	\$2,800,000	83.0%	\$88,866	\$93,104	\$32,899	3.9%
\$2,109,506	\$1,950,000	108.2%	\$5,981,276	\$7,800,000	76.7%	\$3,666	\$108	\$83,770	3.8%
\$631,867	\$660,000	95.7%	\$1,842,944	\$2,640,000	69.8%	\$105,988	\$85,698	\$76,270	10.8%
\$649,057	\$587,500	110.5%	\$1,766,408	\$2,350,000	75.2%	\$236,621	\$181,953	\$247,245	27.6%
\$371,361	\$400,000	92.8%	\$1,115,051	\$1,600,000	69.7%	\$66,721	\$47,922	\$35,552	8.7%
\$338,317	\$312,500	108.3%	\$938,017	\$1,250,000	75.0%	\$71,719	\$44,032	\$59,592	15.0%
\$367,984	\$400,000	92.0%	\$1,185,704	\$1,600,000	74.1%	\$130,240	\$124,235	\$98,201	21.1%
\$1,049,287	\$937,500	111.9%	\$2,905,183	\$3,750,000	77.5%	\$75,401	\$58,427	\$135,054	11.4%
\$1,039,552	\$1,050,000	99.0%	\$3,110,143	\$4,200,000	74.1%	\$142,898	\$77,360	\$82,157	7.3%
\$853,270	\$750,000	113.8%	\$2,656,390	\$3,000,000	88.5%	\$79,376	\$107,476	\$140,607	14.1%
\$1,827,909	\$1,250,000	146.2%	\$5,296,734	\$5,000,000	105.9%	\$37,868	\$54,721	\$32,077	1.7%
\$329,774	\$300,000	109.9%	\$955,692	\$1,200,000	79.6%				
\$3,019,905	\$3,000,000	100.7%	\$8,627,606	\$12,000,000	71.9%				
\$3,040,627	\$2,875,000	105.8%	\$8,312,748	\$11,500,000	72.3%	\$0	\$0	\$0	0.0%
\$957,844	\$975,000	98.2%	\$2,868,375	\$3,900,000	73.5%	\$98,606	\$103,342	\$107,649	10.1%
\$330,799	\$247,500	133.7%	\$946,582	\$990,000	95.6%				
\$9,043,264	\$8,750,000	103.4%	\$26,961,906	\$35,000,000	77.0%	\$0	\$0	\$0	0.0%
\$263,656	\$300,000	87.9%	\$782,432	\$1,200,000	65.2%				
\$3,621,987	\$3,250,000	111.4%	\$10,619,453	\$13,000,000	81.7%				
\$2,623,193	\$2,185,000	120.1%	\$6,536,864	\$8,740,000	74.8%	\$0	\$0	\$0	0.0%
\$146,094	\$204,000	71.6%	\$481,630	\$816,000	59.0%	\$54,720	\$17,338	\$26,372	15.3%
\$1,229,399	\$1,062,500	115.7%	\$3,327,657	\$4,250,000	78.3%	\$231,894	\$316,393	\$340,097	21.7%
\$470,244	\$390,000	120.6%	\$1,230,813	\$1,560,000	78.9%	\$103,477	\$90,541	\$121,013	20.5%
\$1,215,174	\$1,100,000	110.5%	\$3,671,193	\$4,400,000	83.4%	\$42,637	\$31,119	\$45,003	3.6%
\$1,736,189	\$1,350,000	128.6%	\$5,173,655	\$5,400,000	95.8%	\$146,092	\$213,375	\$229,938	11.7%
\$702,078	\$700,000	100.3%	\$2,065,059	\$2,800,000	73.8%	\$74,345	\$76,649	\$83,037	10.6%
\$650,710	\$725,000	89.8%	\$1,822,015	\$2,900,000	62.8%	\$69,246	\$74,513	\$74,182	10.2%
\$905,377	\$750,000	120.7%	\$2,469,479	\$3,000,000	82.3%	\$70,156	\$31,999	\$60,495	6.3%
\$1,470,440	\$1,500,000	94.7%	\$4,159,777	\$6,000,000	69.3%	\$78,341	\$21,678	\$169,873	10.7%

Figure 2-10. Sample, SHARP-7 Metrics Quarterly Report (part 2).

5) Total the number of days for all providers. Enter the total number of available dentists and the sum of days in to CDA and press “Submit.” CDA will calculate access to care automatically (except in this exercise where you will need to calculate it manually).

6) Before DSR closeout, clinics should review their access to care numbers to ensure no changes should be made (e.g. adjustments that are required for providers that had unplanned emergency leave resulting in them not being in patient care for at least 10 duty days). Please note, in CDA, numbers can be entered as many times as needed as long as it is done *before* closeout. To complete the above example, if you entered your data on 8 January, you would be able to modify it up until closeout on 7 February.

Self-Test Questions

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

021. Using and preparing Air Force and Dental publications

1. Which office is the official source for Air Force administrative publications and forms?
2. Which electronic reference lists all products available through AF e-Publishing?
3. What is the short title of a publication?
4. What tool might you use if you are not sure precisely where on the AF e-Publishing Web site a publication is located?
5. What is the long title of a publication?
6. What are examples of directive publications?
7. On what occasions should you review instructions and guidelines?
8. What are the specific goals of publication management in regards to the material in a publication?

022. Using the Corporate Dental Application

1. What is the CDA?
2. Name the *required fields* when entering workload for a periodic or comprehensive exam.
3. When entering workload data, if the patient has other clinical abnormalities present, when do you add the asterisk (*) to the PSR score?
4. What are the two purposes of the Daily Tick Sheet?
5. What percentage of the monthly treatment must be entered before requesting the Dental Service Report?

023. Interpreting automated treatment data

1. Within how many months must a patient have had their last annual exam before being automatically changed to Class 4?
2. What is the core product for managing the AFDRAP?

024. Business metrics

1. What does the acronym SHARP-7 stand for?
2. In the acronym SHARP-7, what does the “A” represent? When is it calculated?
3. When entering access to care in CDA, how many times can you change the numbers?

2-3. Preventive Dentistry Programs

It is the goal of preventive dentistry to help people have maximum oral health throughout their lives. To realize this goal, dental providers must work together with their patients to prevent new and recurring disease. The USAF Preventive Dentistry Program constitutes the most valuable and important element of the professional service provided by the base dental activity. Each AF dental clinic must have the capability to provide a planned preventive dentistry program.

025. Community Preventive Dentistry Program

The community health phase of the USAF Preventive Dentistry Program publicizes the preventive dentistry programs through dental health displays, posters, handouts, media announcements, articles, and lectures. It also includes monitoring of fluoride levels in the base water supply and availability of home care items in the Base Exchange (BX) and Commissary. It educates the AF community, and implements procedures needed to improve the general dental health of the community. Community preventive services provide an essential complement to individual and professional one-on-one services aimed at preventing dental caries, oral and pharyngeal cancers, and craniofacial injuries: the three oral health conditions.

Oral health education

The dental diseases and problems that pose the greatest burden to most communities are dental caries, periodontal diseases, oral cancer, and trauma. These can be largely prevented through a combination of community, professional, and individual strategies. Community preventive programs, particularly community water fluoridation and school-based dental programs have proven highly effective in reducing dental caries.

For oral and pharyngeal cancers, the objectives focus on thorough clinical examinations and early detection, as well as on counseling for the prevention and cessation of tobacco use. About one person dies every hour due to oral and pharyngeal cancer. Tobacco and alcohol use are estimated to account for 75 percent to 80 percent of all oral and pharyngeal cancers. Effective community programs could make an impact on populations at risk for developing any or all of these conditions and are essential for accomplishing the oral health objectives. On-going community preventive programs must be used and new programs continually planned and implemented.

As a dental assistant, you believe in dental health and overall wellness, you know how to care for your mouth, you understand the necessity of professional dental care, and you believe in fluoridation of the communal water supply. Since you believe in all these things, it seems that if you told others, they would believe also. Promoting dental health is not that easy; it takes more than telling. Maybe you should show them and tell them, but even this may not be enough. You must persuade them. Realize that you are asking people to change or modify their habits. Many of them have been cleaning their mouths the same way for years—just telling them that your way is better most likely will not suffice. Some people are easy to sell, others are difficult. Your goal is to educate them through the sensible use of ethical publicity.

Material used in oral health education must be programmed in clinic budget planning. Avoid overt or implied endorsement of commercial products. Group education is most effective when repeated during the year. It should include the use of the following media:

- Oral health displays.
- Oral health posters.
- Oral health literature handouts.
- Military television broadcasts.
- Base newspaper articles.
- Group health talks.
- AF BX.

The community health phase activities should be coordinated with the local health promotion committee when possible. Provide information that is appropriate for the cultures and knowledge levels of various audiences to help individuals understand the decisions they can make to promote their own oral health. Provide educational experiences in community oral health for the future oral health work force.

USAF preventive dentistry displays

You can prepare simple, inexpensive displays with assistance from the base education services office and training personnel whom are responsible for training aids and graphics. Displays should be changed periodically. Obtain and share data that provides information on the community's oral health (e.g., prevalence of early childhood caries and dental caries, untreated caries, oral cancer rates).

Oral health posters and literature handouts

Oral health posters can be procured through the American Dental Association (ADA) or from other sources. Posters and handouts needed to support special projects may be prepared locally and must be coordinated with the proper officials. A variety of handouts can be procured from the ADA. Handouts may also be prepared locally to support special projects. Copyright permission can be obtained from national professional organizations to reproduce their literature. Coordinate handouts designed for specific categories of patients (such as expectant mothers and parents of young children) with the medical service having primary or collateral responsibility for these patients.

Television broadcasts

Where available, military television broadcasts may be used to publicize base programs. The base information office can help you prepare a script. In some instances, the base film library has or can obtain films and videotapes for television viewing.

Base newspaper articles

A series of articles suitable for publishing in the base newspaper may be obtained from the ADA. Articles should not be printed continually but rather periodically for maximum effect. Articles and illustrations prepared locally must be carefully edited and approved by your superintendent/NCOIC, preventive dentistry officer, and the CDS. This is done to ensure accuracy and that the article presents a favorable image of the dental services.

Group lectures

Talks may be given in conjunction with commander's call, base orientation for newly assigned personnel, staff meetings, PTA, spouses' club, schools, teen groups, scouts, and similar organizations. They may also be given for special groups such as prenatal patients, personnel on flying status, and personnel on PCS movement orders. These group talks should be brief and limited to one subject. They may be illustrated with slides or short motion pictures. The ultimate objective is to acquaint the group with the overall preventive dentistry program.

Fluoridation of the water supply

The first use of fluoride for caries prevention occurred in 1945 in the United States and Canada, when the fluoride concentration was adjusted in the drinking water supplies of four communities. This public health approach followed a long period of epidemiologic studies of the effects of naturally occurring fluoride in drinking water. Observation of dramatic declines in dental caries in the cities conducting the studies, compared to similar cities with low levels of fluoride in the water, led to fluoridation of water supplies in many other cities. The Centers for Disease Control and Prevention (CDC) has recognized water fluoridation as one of the great public health achievements of the twentieth century, since it provides an inexpensive means of substantially improving oral health that benefits all.

As you are aware, fluoride prevents tooth decay by making tooth surfaces more resistant to the demineralization caused by the acids produced by bacteria in dental plaque as they metabolize carbohydrates. It also re-mineralizes the enamel surface of teeth weakened by the decay process, reversing the cavity producing process. Through these effects on the surfaces of teeth, fluoride prevents dental caries in both children and adults. That being said, controlled fluoridation of the communal water supply is an important dental public health measure. The appropriate conditions and procedures for military water fluoridation programs are explained in AFI 48-144, *Drinking Water Surveillance Program*.

Base Exchange and Commissary

The availability of suitable home care items in the BX is essential for the success of the preventive dentistry program. The BX manager may assist in obtaining these items. Implied endorsement of particular brands must be *avoided!* Promotional emphasis should be directed toward the principal items required for good oral hygiene—the toothbrush and dental floss—and not toward supplemental aids, such as toothpaste. Many bases have BX and Commissary advisory committees representing consumers. These committees include medical and dental representatives who can influence the availability of items in the BX and Commissary.

026. Children's Preventive Dentistry Program

It is sometimes difficult to get adult patients to modify their cleaning techniques. With children, it is often easier to teach the correct oral health techniques. The children's program is a very important part of the USAF Preventive Dentistry Program.

Dental caries, an infectious disease that can be prevented by appropriate use of fluorides and pit and fissure sealants, remains the most common of chronic childhood diseases. Community water fluoridation and school-based or clinic-linked pit and fissure sealant programs are highly recommended for caries prevention.

Injuries of the face, mouth, and head are common. It has been estimated that one third of all dental injuries are sports-related. Helmets, face protection, and mouth guards can protect children from predictable events that occur during sporting activities.

Family member children's phase program

The procedures for conducting the children's phase are contained in the Dental Management Guide. This phase of the program is composed of those aspects of dental health that apply exclusively to eligible children of active duty members where the Family Member Dental Plan is unavailable. Each AF medical treatment facility having a dental capability and located in an area having a population of eligible children will establish and operate a dental health program for dependent children. To be eligible for participation, the dependent child must meet the criteria outlined in AFI 41-115. Participation in the family member children's phase is voluntary. Individuals enrolled in the family member dental plan are ineligible for most services covered by the preventive dentistry program.

Program design

At a minimum, the program annually will provide the following treatment for each eligible child:

1. An appropriate dental examination performed by a dentist.*
2. An oral prophylaxis.
3. Oral hygiene counseling.
4. Preventive dentistry education materials.
5. Pit and fissure sealants, when needed.
6. Oral hygiene aids.
7. A topical application of an anticariogenic agent to the teeth, unless contraindicated.
8. Mouthguards, when needed.

*The provider will evaluate the patient for suitability of application of pit and fissure sealants. When routine dental care is not authorized, a treatment plan will not be initiated nor will the dentist indicate the specific treatment required. It is allowable to recommend that the dependent child visit a family dentist for further evaluation and relay the degree of urgency and importance. The dental technician should also perform an oral screening procedure before prophylaxis and call any unusual conditions to the attention of a dentist.

National Children's Dental Health Month program

Base dental services should take part in this nationally recognized program. The dental service conducts oral health programs among children through dependent school and childcare programs. These programs should be coordinated with the base medical service, school authorities, and school nurses. Plan these programs as an orientation and introduction to the clinical phase of the family member children's program. They may include oral hygiene demonstrations and age appropriate school-based oral health education activities.

In the school-based preventive dental programs, the Preventive Dentistry officer serves as the program coordinator. Planning for this program takes months, so starting the planning and pre-requirement process well ahead of the February program is advised. There are many dental agencies, (i.e. the American Dental Association, etc.) that are sometimes willing to donate items and informative planning packets for your programs. Do not depend on this donation, check well in advance for budget limitations. Planning often takes creativity on behalf of the preventive dentistry team. Children love to have fun while they are learning. Teaching children about good dental health is easy with fun and educational dental activities such as, puzzles, games, printable coloring pages, brushing charts, fun facts, crafts, dental experiments, and more.

Self-Test Questions

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

025. Community Preventive Dentistry Program

1. What does the community health phase of the Preventive Dentistry Program incorporate?
2. What should be your goal in the oral health education program?
3. When is group education most effective?
4. What is an important dental public measure?
5. What oral hygiene items sold by the BX should be given promotional emphasis?

026. Children's Preventive Dentistry Program

1. What guidance contains the procedures for conducting the children's phase of the USAF Preventive Dentistry Program?
2. Under what conditions are pit and fissure sealants applied?
3. With whom must the AF dependent school oral health program be coordinated?
4. What type of activities can be used to teach children about preventive dentistry?

Answers to Self-Test Questions**018**

1. Periodic dental examinations for military members, Dental Readiness Classification for military members, monitoring availability and accessibility of dental services for active duty personnel, monitoring Dental Readiness Classifications 3 and 4, and performing active duty dental clearances.
2. Two months. To allow flexibility in scheduling and managing patient load.

019

1. The CDS; staffing, facilities, and mission requirements.
2. A lack of readiness.
3. All USAF active duty, National Guard and Reserve Component personnel
4. Patient's plaque control; individual tendency to form calculus; severity of initial disease; whether the patient is a smoker; degree of control of inflammation achieved by the periodontal treatment; host response to bacterial infection; presence of some systemic conditions that may disrupt the host-bacterial response; age of the patient.

020

1. To identify and forward retained records of departed personnel; identify and retire non-AD records who have not been seen in two years since the end of the calendar year of the last date of treatment; verify dental classification and date of last update information of assigned Air Force members.
2. Within 5 days of their PCS. They will need a copy of their military orders.
3. Depends on the last date of treatment rendered.
4. If any family member of the retiree receives treatment, you may annotate the year of last treatment for all family members and retain the records in the files.

021

1. The AFDPO.
2. The Master Catalog.
3. The publication number.

4. The “short title search” field.
5. The title or name.
6. Instructions, manuals, and OIs.
7. When newly assigned to a duty section, when referencing the document to solve a problem or answer a question, and prior to inspections.
8. It must be accurate and logically organized, written clearly, adequately illustrated, and free of irrelevant and duplicate information.

022

1. An enterprise solution that provides access to workload, readiness and appointment data through the Army DENCOM.
2. Caries Risk, Tobacco Risk, BP, and PSR Screening.
3. The asterisk should not be selected without first selecting a score.
4. It provides a means of verifying that all transactions entered during the day were actually processed by the system, and serves as an audit trail for detecting and correcting errors occurring during the workload entry.
5. At least 95 percent.

023

1. 14 months for AF active duty or 16 months for ANG/RES after their last annual exam.
2. AFDRAP Patient Status Roster.

024

1. Patient Safety; Patient Satisfaction; Oral Health Class 1; Access to Care; Readiness, Class 1 and 2; Performance Clinic Productivity; Performance, Private Sector Care.
2. Access to care; the 1st duty day of that month (i.e. you calculate January’s access on 1 January).
3. The numbers can be entered as many times as needed as long as it is done *before* closeout.

025

1. It publicizes the preventive dentistry programs through dental health displays, posters, handouts, media announcements and articles, and lectures, includes monitoring of fluoride levels in the base water supply and availability of home care items in the base exchange and commissary, educates the AF community, and implements procedures needed to improve the general dental health of the community.
2. To educate through the sensible use of ethical publicity.
3. When repeated during the year.
4. Controlled fluoridation of the communal water supply.
5. The principal items required for good oral hygiene; the toothbrush and dental floss.

026

1. Dental Management Guide.
2. When needed.
3. The base medical service, school authorities, and the school nurses.
4. Puzzles, games, printable coloring pages, brushing charts, fun facts, crafts, dental experiments, and more.

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.

47. (018) Which program item, *at a minimum*, should be included in the Air Force Dental Readiness Assurance Program (AFDRAP)?
 - a. Monitoring availability and accessibility of dental services for active duty personnel.
 - b. Periodic dental examinations for military members and their dependents.
 - c. High caries risk program management for active duty personnel.
 - d. Active duty and dependent dental clearances.
48. (018) Which database does Corporate Dental Application (CDA) check for personnel who are due for a periodic examination?
 - a. ASIMS.
 - b. AFDRAP.
 - c. DMLSS.
 - d. MILPDS.
49. (018) How many Air Force Dental Readiness Assurance Program (AFDRAP) months does Corporate Dental Application (CDA) allow to be active at one time?
 - a. 12.
 - b. 6.
 - c. 3.
 - d. 2.
50. (019) Who should the Chief of Dental Services (CDS) contact if a Dental Readiness Classification 3 patient's disqualifying defect *cannot* be corrected prior to a permanent change of station (PCS)?
 - a. losing SGH (Chief of Medical Staff).
 - b. gaining SGH.
 - c. losing CDS.
 - d. past CDS.
51. (019) What action should be taken if an active duty member's dental readiness classification will change to Dental Readiness Classification 4 while deployed?
 - a. Nothing, if the patient will return a month after the class changes to 4.
 - b. Inform the AFDRAP monitor, so an adjustment can be in the ASIMS.
 - c. Nothing, if the patient is in Class 1 when departing.
 - d. Complete a Type 2 exam prior to departure.
52. (020) Within how many days must military personnel be of PCSing (permanent change of station) before outprocessing from the Dental Clinic with a copy of military orders?
 - a. 3.
 - b. 5.
 - c. 7.
 - d. 10.
53. (020) When may dental records of family members be retained in the files, even though the date of last treatment exceeds three years?
 - a. Never, they must be destroyed.
 - b. Never, they must be boxed and forwarded to the repository.
 - c. When you know that the family member still lives in the area.
 - d. When a member from the same family has been treated in the past three years.

54. (021) Which office that is the official source for Air Force administrative publications and forms?
- Air Force Departmental Publishing Office.
 - Air Force Departmental Administrative Office.
 - Air Force Department of Information Management.
 - Air Force Department of Publications Management.
55. (021) The short title of an Air Force publication is its
- publication number.
 - index number.
 - title or name.
 - index code.
56. (021) Air Force directive publications include instructions,
- and guides.
 - manuals, and guides.
 - manuals, and operating instructions.
 - handbooks, and operating instructions.
57. (021) Review operating instructions (OI) and guidelines when you
- are newly assigned to a duty section and selected for a permanent change of station (PCS).
 - are newly assigned to a duty section and prior to inspections.
 - have been selected for deployment.
 - have been selected for PCS.
58. (021) How should you write an operating instruction (OI) or an Air Force instruction (AFI)?
- Direct, active voice.
 - Direct, passive voice.
 - Indirect, active voice.
 - Indirect, passive voice.
59. (022) Which workload entry project code is used in the deployed theatre *only*?
- Routine Care.
 - Emergency Care.
 - Medically Adjunctive.
 - Battle Related.
60. (022) The Daily Tick Sheet has two purposes. It verifies
- Dental Service Report (DSR) data for current month and verifies remarks and facility information.
 - DSR data for current month and is an audit trail for detecting and correcting data entry errors.
 - all transactions entered were actually processed and verifies remarks and facility information.
 - all transactions entered were actually processed and is an audit trail for detecting and correcting workload data entry errors.
61. (023) Which computer roster is useful if the Chief of Dental Services (CDS) wants a list of all individuals in a specific class?
- Recall.
 - Dental Class.
 - Patient Status.
 - Dental Class Count.

62. (023) Which computer product is used to screen dental records for current dental readiness classification?
- Air Force Dental Readiness Assurance Program Report on Individual Personnel (AFDRAP RIP).
 - AFDRAP Roster.
 - Pseudo Remote Listing.
 - Patient Status Roster.
63. (023) Which automated treatment data product displays patients identified as needing a periodic dental evaluation based upon the patient's last Air Force Dental Readiness Assurance Program (AFDRAP) status date at one or more squadrons assigned to your clinic logon location?
- AFDRAP Class Count Roster.
 - AFDRAP Patient Status Roster.
 - AFDRAP Unavailable Roster.
 - Flying Status Roster.
64. (024) What was established as goals for core metrics that directly relate to the success of the USAF dental mission?
- Readiness Classification.
 - Clinic Productivity.
 - Access to Care.
 - SHARP-7.
65. (024) Using SHARP-7 Metrics, what is the goal for *maximum* access to care for dental "specialist" providers?
- 21 days.
 - 28 days.
 - 30 days.
 - 45 days.
66. (025) When giving oral hygiene instructions, which toothbrush should be recommended?
- Oral B.
 - Sonicare.
 - Fisher Price.
 - No brand name toothbrush should be recommended.
67. (025) Dental articles and illustrations for the newspaper *must* be approved by whom and why?
- Superintendent/NCOIC, Preventive Dentistry officer and Dental Squadron commander; to ensure accuracy and present a favorable image of the dental services.
 - Preventive Dentistry officer and Medical Group commander; to ensure accuracy and present a favorable image of the medical services.
 - Superintendent/NCOIC, Dental Squadron commander and Medical Group commander; to ensure that it presents a favorable image of the medical services.
 - Preventive Dentistry NCO and Preventive Dentistry officer; to ensure it presents a favorable image of the dental services.
68. (026) What is the most chronic childhood disease?
- Dental caries.
 - Hormonal gingivitis.
 - Developmental cysts.
 - Primary herpetic stomatitis.

69. (026) Where can you find procedures for conducting the Children's Phase Program?
- a. AFPAM 44-155, *Implementing Put Prevention Into Practice*.
 - b. AFMS Dental Clinical Practice Guidelines.
 - c. AFPD 40-1, *Health Promotion*.
 - d. Dental Management Guide.
70. (026) What member is *not* covered by the Preventive Dentistry Program?
- a. ADAF member enrolled in Tricare prime.
 - b. Dependent wife enrolled in dental plan.
 - c. Dependent son not enrolled in dental plan with dental emergency.
 - d. Dependent son not enrolled in dental plan seeking standby appointment.

Please read the unit menu for unit 3 and continue ➔

Student Notes

Unit 3. Dental Clinic Logistics

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PROPERTY RESPONSIBILITY AND SUPPLY DISCIPLINE is everyone's responsibility. No matter how proficient you and other dental personnel are, you cannot function effectively as a clinic without proper supplies and equipment. This materiel must be budgeted, ordered, and accounted for until it is either consumed or returned to Medical Materiel. Therefore, we will cover property responsibility, and supply discipline so that you know your responsibilities. To help you understand how Dental Logistics fits into the big picture, we will begin by explaining the classification and categories of materiel, and take a look at the function of Medical Logistics Services.

3–1. Basics of Materiel

It is a given that as your scope of responsibility increases, you will also need to increase your knowledge. Because the Air Force spends billions of dollars every year on supplies and equipment, each of us needs to be cost-conscious and do all we can to get the most benefit possible at the lowest cost.

027. Basic classification and categories

Materiel is classified as either *nonmedical* or *medical*, and categorized as *supplies* or *equipment*. Medical supplies are further categorized as *consumable (expendable)* and need no authorization; and equipment as *expense* or *investment (nonexpendable)* equipment and must be authorized.

Materiel that you use is classified in the following categories:

- Investment medical equipment.
- Expense medical equipment.
- Expense equipment nonmedical.
- Supply expendable medical.
- Supply expendable nonmedical.

Materiel Classifications		
Category	Explanation	Examples
Investment Medical Equipment	-Unit cost of \$250,000 or more. -Life expectancy of 5 years or longer.	A digital x-ray machine and an automatic processor.
Expense Medical Equipment	-Unit cost greater than \$2,500 but less than \$250,000. -Life expectancy of at least 5 years.	A dental unit, oral surgery handpiece system, or a laser printer for radiographs.
Expense Equipment – Nonmedical	Items that meet the criteria established in AFI 41–209, <i>Medical Logistics Support</i> .	A computer, a desk, and other office equipment.
Supply Expendable Medical – Consumable	-Loses its identity when used; -Cannot be reused for the same purpose; OR -Is not durable enough to last 1 year.	Drugs, adhesive tape, burs, cotton items, and impression material.
Supply Expendable Medical – Durable	-Maintains its identity when used; -Usually has a life expectancy of at least 1 year; BUT -Does not qualify as an equipment item.	Instrument cassettes and instruments, such as mirrors, scissors and hemostats.
Supply Expendable – Nonmedical	Items nonmedical in nature.	Pencils, pens, paper towels, computer paper, and computer printer toner.

028. Medical Logistics Services

The Medical Logistics Flight commander (MLFC) provides medical and nonmedical materiel support. Medical Logistics is our source for all supplies and equipment. This includes everything from pencils to x-ray units. In addition, they are the source for all equipment repairs, facilities management, and linen control functions. To provide these services, Medical Logistics is divided into a Medical Materiel, Medical Equipment Management Office (MEMO), Medical Equipment Repair (MER) Activity, and Linen Control. Information regarding Medical Logistics can be located in AFI 41–209.

Medical Materiel

The Medical Material section is responsible for requesting, receipt, storage, issue, control, turn-in, disposition, safeguarding, reporting, and accounting for property according to Air Force directives. This section also includes quality control of items and delivery of supplies and equipment to the using activity.

Medical Equipment Management Office

The MEMO is responsible for programming equipment requirements, budgeting for equipment, requisitioning equipment, and maintaining an accountable equipment inventory. The MEMO equipment inventory consists of one type of equipment: medical. Each medical/dental section is responsible for their nonmedical equipment, with the use of the Ready Volume List (RVL). Remember the MEMO maintains accurate accounting and tracking of each piece of medical equipment signed out to your cost center.

Medical Equipment Repair Activity

The MER Activity provides maintenance support for all medical equipment and the facility. The MER takes action to have repairs performed by civilian contract when the need is beyond the capability of the assigned biomedical maintenance technicians. The MER officer or materiel manager

will determine when contract repair is required. MER is your only source for repairs. Never authorize repairs from an external source yourself. Also, the MER is responsible for the electrical safety program to ensure the equipment you use does not pose a danger to you or the patient.

Linen Control

The Linen Control includes the operation and management of a central linen service, laundry exchange service, and linen repair for MTF activities and specified person retention clothing items issued to medical/dental personnel. Procedures for control and exchange of linen with the using activities and the use of contract services are maintained by Medical Logistics.

Sources of materiel

Medical Logistics Services obtains equipment and supplies, both medical and nonmedical, from the Defense Logistics Agency (DLA), Prime Vendor (PV) Program, commercial sources, and the electronic catalog (ECAT). Nonmedical equipment and supplies such as desks, pencils, and paper are obtained through local contracts by Medical Materiel. Standard medical equipment and supplies are obtained from the Prime Vendor and ECAT systems. A standardized medical item is one agreed upon by all services and sold by PV or ECAT at a prenegotiated contract cost. Nonstandard medical equipment and supplies are obtained from commercial sources as requested by the Medical Logistics Service. These items are normally referred to as *local purchase* items. We will discuss local purchase and the Prime Vendor Program in more detail later.

029. Dental Logistics

You might ask, “How does the dental facility obtain supplies, equipment, and services from Medical Logistics Services?” The MTF is divided into a number of activities, such as pharmacy, medical laboratory, and dental. Each activity has a property custodian appointed to request supplies, equipment, linen, and repairs.

Dental Logistics officer/NCO

The CDS appoints a Dental Logistics officer and NCO to oversee Dental Logistics duties. This property custodian, depending on the clinic’s size and scope, may be appointed as a property custodian for more than one activity. The dental property custodian assumes responsibility for the funds, supplies and equipment assigned to the account. The assignment is a primary or additional duty for an officer, NCO, airman, or civilian. Although the individual appointed need not be senior in grade, he or she must be a mature person and well aware of the responsibilities of the position. They should be individuals who are truly interested in this area and must keep the dental manager/superintendent or NCOIC informed regarding the status of funds, equipment, and supplies. Some of the responsibilities of the dental logistics NCO include:

- Instituting efficient and practical supply procedures.
- Establishing and maintaining a realistic working level of materiel.
- Notifying medical logistics when a work stoppage is expected prior to delivery of a backordered item.
- Accomplishing turn-ins of excess and unserviceable supplies and equipment to medical logistics.
- Submitting any necessary paperwork to report materiel complaints to DECS.
- Supervising the maintenance of property records and all other documents pertinent to materiel, facility maintenance, and repair.
- Establishing and maintaining procedures to safeguard against loss, theft, or damage of materiel and facilities.
- Ensuring that personnel in the facility are aware of their responsibilities to properly store, use, conserve, and safeguard materiel.

- Instructing personnel in accepted methods of user's maintenance per manufacturer's instructions.
- Instructing personnel on reporting equipment repair problems.

The Dental Logistics NCOIC may delegate the authority to request and receive items from Medical Materiel to a supply custodian. Submit this delegation of authority in written format and forward it to Medical Materiel. The letter must contain sample signatures of the authorized personnel and be on file with the property custodian and Medical Materiel. Medical Materiel is required to obtain a signature receipt on issue of controlled substances, security items, and equipment.

Special activities

Since availability of funds determines what can be obtained, the MTF has special activities established to ensure that we make the best use of the funds. These special activities include the Medical Equipment Review and Authorization Activity (ERAA), and sometimes a local purchase review committee.

Equipment Review and Authorization Activity

The ERAA is a review panel composed of representatives of the medical facility. This review panel is responsible for reviewing medical and nonmedical equipment authorizations for the medical activities and making recommendations to the MTF commander. The CDS, or an appointed representative, must be a member of the medical facility ERAA.

Local purchase review

The MTF commander may appoint one or more individuals or committees to review and approve local purchase requests with each having approval authority for certain items. If only one individual is appointed it should be the MLFC.

030. Property accountability and responsibility

Each of us is responsible for Air Force property. Therefore, given this tremendous responsibility it is our job to be knowledgeable about various aspects of property responsibility. We have all seen the phrases "Property of the US Air Force" or "US Government" stamped on the side of equipment (e.g., everything from pens to the sheets in the hospital). The question you may have asked yourself is, "Who is the US Air Force, and how did he get so much stuff?" The serious answer to that question is that we are all the US Air Force—every one of us who wears the "blue suit." Does that mean that pen is yours? No, it is all of ours, collectively. For this reason, we each have a responsibility to one another, and to our fellow tax payers, to make the best possible use of Air Force property and resources.

Property responsibility

The Air Force requires supplies and material to properly support its weapons systems, facilities, and people; therefore, property responsibility is the obligation of Air Force members to care for Air Force property with which they are associated. The obligation to care for a particular property item is not limited to the person who has signed for the item. It includes anyone who uses, supervises the use of, or otherwise comes in contact with the item. You, as an Air Force member, must effectively manage these material resources from the time you order them until you release them to the using activities'. For example, the fact that you have not signed for the sterilizers in Dental Instrument Processing Center (DIPC) does not relieve you from the responsibility of properly caring for the units. You must take positive action to prevent the loss, damage, or destruction of the equipment. Of course, it is difficult to lose a sterilizer, but many smaller items of equipment can easily be lost if appropriate accounting steps are not taken. Property management responsibilities limit the use of government property to official purposes and include pecuniary liability. When you issue an Air Force item, the user does *not* become the owner. The Air Force retains ownership, and the user assumes responsibility for the care and protection of the item. The property you use in your duties—whether it is a desk, a copier, or a computer—is your responsibility. No matter how inexpensive the item is, and

regardless of whether the Air Force retains records on the item after its been issued, you are still obligated to take proper care of the item and use it for its intended purpose.

Public property

The terms “public property,” “government property,” “Air Force property,” or “military property” are used interchangeably. Whichever term you use, they mean *everything* owned by the United States government—from Aspirin to fighter aircraft. To ensure that all public property is correctly accounted for and properly used, protected, and safeguarded, Congress passed laws placing responsibility for public property directly on all government employees—military and civilian.

Pecuniary liability

The word pecuniary means: *pertaining to or consisting of money*, the word *liability* means *obligation*. Therefore, a *pecuniary liability* is a *monetary obligation*. Pecuniary liability applies to all persons having property responsibility. It means that you may have to financially reimburse the government for loss, damage, or destruction of government property caused by negligence, willful misconduct, or deliberate unauthorized use. Pecuniary liability may be the responsibility of one person or of several people involved in a given case. In Air Force language, the “admission of pecuniary liability” by an individual implies that he or she is willing to pay the Air Force for the lost, damaged, or destroyed property.

Now that we have defined just what pecuniary liability and public property encompasses, the next step is to talk about levels of property responsibility. The reason for differing categories is simple—they follow different levels of responsibility.

Levels of responsibility

There are three levels of property management responsibility: command, property custodian (custodial), and individual. It is possible for someone to carry more than one of these types of responsibility at the same time. In this lesson we will take a look at the levels of responsibility.

Command responsibility

Commanders at all levels are responsible for managing property in use or stored at their installations or activities. Commanders are *not* exempt from pecuniary (financial) liability. If property within their command is lost, damaged, or destroyed due to deliberate unauthorized use or anyone’s willful misconduct or negligence, they may be liable. Subordinate commanders are responsible to their commanders for prudent management of government property under their jurisdiction.

Commanders ensure that only qualified personnel are selected and assigned as accountable officers. They are also responsible for providing adequate space to properly store medical supplies and equipment, maintaining prescribed medical records, and ensuring supply discipline is understood and exercised. They promptly address all individual recommendations for preventing or correcting fraud, waste, and abuse (FW&A) actions to the individual or organization responsible for correcting the deficiency. An accountable individual is officially designated and imposed by law, lawful order, or regulation with the duty to maintain accurate records of property or documents.

Custodial responsibility

You and every other member of the Air Force, including civilian employees, have an obligation for the proper care, custody, safeguard, use, and disposition of the government property with which you are entrusted. A property custodian can be an officer, enlisted member, or civilian designated by the Chief of Dental Services or designated representative. The CDS or designee must appoint each custodian in writing, and the original appointment letter is held by Medical Materiel in a property custodian folder. Depending on the size and scope of the clinic, the same person can be appointed as property custodian for more than one activity.

1. Planning and forecasting requirements to meet mission goals.
2. Preparing and forwarding materiel requests to the proper agency or individual.
3. Signing custody receipts or custody receipt listings for property charged to his or her organization.
4. Complying with all directives and instructions pertaining to the property in his or her charge.
5. Promptly reporting any losses or irregularities relating to property in his or her charge to his or her immediate commander or accountable officer.
6. Taking action to reconcile and correct property records.
7. Reporting unusual purchase patterns to commanders.

This includes property under your supervision or care. Whether or not you sign for the item is *not* a factor. All individuals have *custodial responsibility* for property that they sign for using AF Form 1297, Temporary Issue Receipt (fig. 3–1).

[illegible]

Figure 3–1. Sample, AF Form 1297, Temporary Issue Receipt.

Recipients assume custodial responsibility while items are in their possession. It is important that you understand that some of the custodial responsibilities identified above apply equally to subordinate personnel. Subordinate personnel are responsible for maintaining custody of, caring for, and safeguarding property received.

Personnel having custodial responsibility may incur pecuniary liability for the loss, destruction, or damage to property caused by willful misconduct, deliberate unauthorized use, or negligence in use, care, custody, or safeguard.

Individual

Every member of the Air Force, military and civilian, has an obligation for the proper care, custody, safeguard, use, and disposition of the government property entrusted to him or her. This includes all public property under his or her supervision or care, whether or not he or she has signed for it.

Finder's keepers, losers' weepers may apply in some circumstances, but not to government property. You are reminded, however, that you need not have signed a temporary issue receipt in order to have custodial responsibility. The mere possession of public property places custodial responsibility on your shoulders.

You are personally responsible for such property if it is:

- Issued for your official or personal use, whether signed for or not.
- Under your direct control for storage, use, custody, or safeguard.
- Lost, stolen, or abandoned while under your personal care, custody, or protection.

Managing materiel support

Medical Material uses a top down structure (Group, Squadron, Flight, etc.) to identify its customers as either department or a service customer. Money is disbursed at the Group level from the Resource Management Office and given to each squadron. The size of the MTF determines how many squadrons there are and each squadron is identified as a department. Each department is made up of various patient treatment areas and clinics. The treatment areas and clinics are mandated to order supplies directly from Medical Material and are therefore identified as service customers. Each service customer is appointed a property custodian; this could be you sometime in the near future. In fact being a property custodian is an excellent opportunity for you to spread your wings and take on more responsibility and invaluable experience.

Custody receipt listing

Each new property custodian must sign a custody receipt for all equipment currently being used by the dental clinic. The receipt is called the Custody Receipt/Location Listing (CRLI). All medical equipment on hand and on order (due in) is listed on the CRLI and the LOG Backorder Report. The item description, approximated price, and a locally assigned item storage location code for some items on the list. Equipment items will have what is called an equipment control number (ECN). The ECN is used to identify individual equipment items during inventories and to assist Biomedical Equipment and Repair technicians during scheduled and unscheduled maintenance. The property custodian must sign for transferred property. The custodian will have to do a personal physical count for each and every item for which he or she is signing for—paying special attention to the serial numbers, index numbers, and equipment control numbers closely. All equipment should be in working condition. By signing and dating the CRLI, the new custodian is assuming responsibility for all in use items in the quantities indicated and is verifying the requirement for all items due in on the list. Before you sign the letter of transfer, STOP! LOOK! and EVALUATE! Know what you are signing for; the account you sign for is yours. Be sure you know what you are inheriting and resolve any problems before you sign. This transfer of property should not be taken lightly!

Before property custodians are relieved from duty, transferred, separated from service, or separated from their account for more than 45 days, the MEMO takes action to transfer the property or have it assigned to an authorized successor. The custodian being relieved is responsible for notifying MEMO when a change is needed. A new appointment letter must be accomplished and signed at this time. A departing property custodian is not relieved of responsibilities until the new custodian and departing custodian have inventoried and both signed the current CRLI and officially cleared by MEMO.

Performing or assisting in periodic inventories of Medical Materiel

The property custodian must ensure, by conducting spot checks and periodic inventory that all property is physically on hand or otherwise accounted for. Physical inventories of equipment must be done once each year, but may be done more frequently, if necessary, to ensure safekeeping of the equipment. These inventories are done by the property custodian or an inventory team composed of the property custodian and MEMO staff. Missing or damaged items are reported to the MEMO.

Relief from custodial responsibility

You learned that we all have a responsibility to protect the property that has been entrusted to us. If property becomes damaged, lost or damaged due to negligence or misconduct, you may be required to compensate the Air Force for the loss. This means that you may have to pay for the property that you were entrusted to protect. In this lesson we will discuss relief from custodial responsibility.

There are many ways to be relieved of responsibility for a piece of property. For example, property may be returned to Medical Materiel as excessive or defective items. Equipment items may be transferred from the responsibility of one person or organization to that of another. In this situation make a formal written record of the transfer of property responsibility at the time of transfer. Still other items may be damaged or lost due to the carelessness of the item's custodian, in which case the person may be liable and may have to pay for the item. Relief from property responsibility occurs when the liable person has paid for the item.

Any of the following documents relieve you of custodial responsibility:

- Documents or electronic/computer records, such as the custodial action list (CAL), custody receipt location list, an approved AF Form 601, Equipment Action Request, and so forth, showing turn in or transfer of item to another property custodian.
- Approved investigation documentation or certificates, schedules of collection, and other authorized adjustment documents.
- Approved reports that provide for disposition of or relief from responsibilities for items that are not needed, due to damage, loss, deterioration, obsolete, or destruction.
- Approved inventory adjustment or a prescribed document to adjust losses incidental to normal day-to-day operations.

However, if the property becomes destroyed, damaged, or lost, the procedure is not quite so simple.

Report of survey

If the property is lost, destroyed, or damaged by means other than fair wear and tear, obtaining relief from property responsibility can be costly to the individual charged with the custodial responsibility. If you admit pecuniary liability, the easiest and least troublesome way settle a monetary obligation is to make a voluntary payment with cash. You then pay the government in cash for the property. Payment must be voluntary. This method of payment can only be used if the amount of the property that was lost, damaged or destroyed was \$500 or less. If you do not have the cash, you may choose to have the money taken directly out of your paycheck. If you do not admit to pecuniary liability, are unwilling to pay, and/or the amount of the property involved is \$500 or more a whole other procedure must be accomplished. This process usually begins with a report of survey, which is an in-depth investigation performed by a designated survey officer and documented on a DD Form 200, Financial Liability Investigation of Property Loss. A report of survey is normally required for property record items lost, damaged, or destroyed. Detailed instructions for preparing DD Form 200 are found in AFMAN 23-220, *Reports of Survey for Air Force Property*. AFI 23-220 also provides guidance for determining when a report is mandatory.

Self-Test Questions

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

027. Basic classification and categories

1. What classification of materiel used by Air Force medical treatment facilities consists primarily of office and janitorial supplies and equipment?
2. List five examples of consumable supply items.
3. List some examples of durable supplies.

4. Which medical equipment items have a unit cost of at greater than \$2,500 but less than \$250,000 and have a life expectancy of at least 5 years?
5. Which medical equipment items have a unit cost of \$250,000 or more, a life expectancy of at least five years?
6. Match the category of medical material in column B with the appropriate description in column A.

*Column A**Column B*

- | | |
|---|--|
| ____ (1) Pencils, pens, printer toner. | a. Investment medical equipment. |
| ____ (2) Computer, desk, office equipment. | b. Supply expendable medical-durable. |
| ____ (3) Oral surgery handpiece system. | c. Supply expendable medical-consumable. |
| ____ (4) Impression material and drugs. | d. Supply expendable nonmedical. |
| ____ (5) X-ray machine and automatic processor. | e. Expense equipment medical. |
| ____ (6) Mirrors, scissors, and hemostats. | f. Expense equipment nonmedical. |

28. Medical Logistics Services

1. Which section of Medical Logistics Services is responsible for requesting, receipt, storage, issue, control, turn-in, disposition, safeguarding, reporting, and accounting for property?
2. Which section of Medical Logistics Services is responsible for programming equipment requirements, budgeting for equipment, requisitioning equipment, and maintaining an accountable equipment inventory?
3. Which section of Medical Logistics Services provides maintenance support for all medical equipment and the facility?
4. From what sources does Medical Logistics Services obtain equipment and supplies?

029. Dental Logistics

1. Who assumes responsibility for the funds, supplies, and equipment assigned to the dental account?
2. What panel is responsible for reviewing medical and nonmedical equipment authorizations for the medical activities and making recommendations to the MTF commander?

3. Who may appoint one or more individuals or committees to review and approve local purchase requests?

030. Property accountability and responsibility

1. What does property responsibility mean?
2. What is public property?
3. Who has responsibility for public property?
4. What does it mean to have pecuniary liability?
5. What category of property responsibility ensures that only qualified personnel are selected and assigned as accountable officers?
6. What category of property responsibility is responsible for ensuring that adequate space is provided for the proper storage of supplies and equipment?
7. Who may serve as a property custodian? Who designates this individual?
8. What type of responsibility do you assume when you sign for property using AF Form 1297, Temporary Issue Receipt?
9. If you admit pecuniary liability, what is the least troublesome way to settle a monetary obligation?
10. If you admit pecuniary liability, but do not have cash, what may you choose to do?
11. What is a report of survey?

3-2. Research, Procurement, Issue, and Turn-in of Supplies and Equipment

In dental supply the main task is to support the dental treatment facility by providing all the items required to accomplish the mission. The key to doing this is positive identification of each and every item in the dental supply system. You need to be familiar with the data that informs you how to identify, select, and account for the items in dental supply. In this section, we will cover sources of information, federal item stock numbers, local purchase procedures, procedures for managing supplies and processing issue requests.

031. Using Logistics' publications/listings

When you work in dental supply, you will need to use and become familiar with several sources of information. In this lesson we introduce several that are very important and useful in the medical/dental materiel arena.

An overview of sources

Some of the general publications with guidance and information relating to dental supply include:

- AFI 44-108, *Infection Control Program*.
- AFI 47-101, *Managing Air Force Dental Services*.
- *USAF Dental Management Guide*.

The Medical Materiel publications that you will find very important in dental supply include:

- AFI 41-209, *Medical Logistics Support*.
- AFMAN 41-216, *Defense Medical Logistics Standard Support (DMLSS) Users Manual*
- Federal supply catalogs.
- Commercial catalogs.

Let's take a closer look at these publications.

AFI 41-209, *Medical Logistics Support*

AFI 41-209 is the official publication that prescribes management procedures for Medical Materiel. The purpose of this AFI is to establish a uniform system of materiel and services management in Air Force medical activities. One way to distinguish this publication from others is to think of it as an instruction that provides policies, procedures, and guidance on how to do your job as the dental logistics NCO.

Federal supply catalogs

Both the DOD and the General Service Administration (GSA) publish federal supply catalogs. The GSA Catalog contains nonmedical items used throughout the federal government. Unlike the DOD consolidated supply publications, the GSA Catalog has a wide variety of items available from GSA supply distribution facilities. These items range from mops to file cabinets. Additionally, DOD publishes the Medical Catalog (MEDCAT) providing medical items found throughout the federal government. Both catalogs can be found on the DLA website <https://www.medical.dla.mil>.

Defense Medical Logistics Standard Support System

The Defense Medical Logistics Standard Support System (DMLSS) has replaced a multitude of logistics systems with one standard DOD Medical Logistics System. Basic functionality include stock control, Prime Vendor operations, preparation of procurement documents, research and price comparison among a variety of sources for products, property accounting, biomedical maintenance operations, capital equipment, property management, inventory and a facility management application that supports the operations of a fixed MTF physical plant and supports The Joint Commission accreditation requirements. DMLSS is a server-based system that supports the medical logistics functions of USAF medical treatment facilities.

In support of these functions, DMLSS provides:

- Procedures to account for medical and nonmedical materiel purchased for the day-to-day operation of the MTF. This includes associated functions such as requisitioning, receiving, inventory control, issuing, miscellaneous gains/losses, and identification and reporting of excess.
- Materiel programs assigned to the MTF.
- Procedures to account for in-use equipment.
- Procedures to identify maintenance requirements for equipment and supply items, and methods to record and maintain a history of maintenance performed.

Commercial catalogs

When items are not stock listed, a source must be located. Commercial catalogs and brochures supplied by local vendors can be used to locate and request the purchase of nonstock listed items. When items are purchased from local vendors, this is referred to as local purchase. We will discuss local purchase in more detail later.

NOTE: Thorough use of the DMLSS Cat Search function and ECAT should be used before resorting to commercial catalogs and new item requests (NIR).

Federal item stock numbers

Locating and ordering supplies would be almost impossible without a supply identification process. Each item listed in the federal supply catalogs is assigned a stock number—known as the national stock number (NSN)—for identification. This number is the means by which you identify, order, and store supplies. Each stock number has a minimum of 13 digits. For example, the stock number assigned to Aspirin Tablets, USP, 0.324 grams in bottles of 100 is 6505-00-100-9985.

The importance of NSNs cannot be overstated. You use stock numbers whenever an item is requisitioned through DLA or when issues are processed to one of the using activities. In fact, any time you take action against an item, that information is recorded by using the item's stock number. To help you understand the significance of the stock number, let's take a moment and look at the elements that make up the NSN.

Item group

The first two digits of a stock number identify the item group. For example, any item with a stock number containing a 10 in the first two positions is a type of weapon. A stock number beginning with a 12 identifies fire control equipment. Any stock number with a 65 in the first two positions identifies a medical item. However, all medical items do *not* necessarily begin with a 65. For example, the Federal Supply Group for *all* rubber tubing is 47. This means that the NSN for the rubber tubing used in the hospital begins with 47 rather than 65.

Supply class

The first four digits of a stock number are called the Federal Supply Class (FSC). To illustrate this, let's take a closer look at group 65. Take FSC codes 6510, 6525, and 6505. The item group code (65) indicates that these are medical items. The additional two digits give you a more specific indication of the type of medical item you have. For example: 6510 indicates surgical dressing materiel, 6525 indicates x-ray equipment and supplies, and 6505 indicates drugs and pharmaceutical items.

Although most of the items needed in dentistry are classified as 6520 items, some are not. Listed are some of the more common items in the medical supply group which you may be ordering:

- 6505—Antibiotics, Narcotics, Anesthetics, Stannous Fluoride, Disclosing Tablets, Alcohol Swabs, and Astringents.
- 6510—Cotton Rolls, Cotton Pellets, and Gauze Sponges.
- 6515—Hypodermic Needles, Sutures and Needles, Syringes, Barrels, and Plungers.

- 6520—Dental Equipment and Supplies.
- 6525—X-ray Film and Equipment.
- 6530—Sanitizers, Sterilizers, Autoclaves, Instrument Trays, Needle Jars, Soap and Detergent Dispensers, and Medicine Droppers.
- 6532—Dental Smocks and Patient Aprons.

Although most of the items you need are in the 65 group, there are items in other groups—such as the 68 group, which contains disinfectants and wetting agents—that you also may need. You can find a list of these common groups in the FSC for dental items. If you have difficulty finding the NSN of an item, ask your Medical Materiel activity for help.

North Atlantic Treaty Organization code number

The fifth and sixth digits of an NSN are used for the North Atlantic Treaty Organization (NATO) code number. The NATO code is used to indicate the country of origin for the item. For example, a NATO code of 00 or 01 indicates an item of supply made in the USA. So if you have a NSN beginning with 6510-00, the item is some type of US manufactured medical surgical dressing materiel.

National item identification number

The last seven digits of the NSN are referred to as the national item identification number (NIIN). When combined with the first six digits, this identifies the specific item. No two items have the same NSN. Recall our previous example of Aspirin Tablets, USP. For bottles of 100 tablets the NSN is 6505-00-100-9985. Suppose you need a bottle of 1,000 tablets. When you check the catalog, you will find that the NSN is 6505-00-063-5631. You have the same item, Aspirin Tablets, USP, but different quantities; hence different NSNs. The first six digits of both stock numbers are the same (6505-000) because both items are US medical drugs. The last seven digits are different to distinguish bottles of 100 from bottles of 1,000.

Dental Evaluation and Consultation Service

Another source of valuable information is the USAF Dental Evaluation and Consultation Service. DECS conducts a diversified program of investigation, test, and evaluation specifically relevant to the needs of the Air Force Dental Service, as directed by HQ USAF/SGD. They test, evaluate, and provide protocols for dental equipment, materiel, and procedures. For example, they can answer questions (the best, the most used, etc.) you have about dental delivery systems, including units, chairs, porcelain ovens, handpieces and supplies. The USAF DECS performs technical reviews on all dental equipment requests. It also provides assistance in designing or modifying dental facilities. The USAF DECS also distributes Air Force-wide newsletters and briefs that list articles and letters about dental items.

032. Preparing and submitting requests for dental material/services

There are a number of methods used to order supplies. The method used depends on urgency of the request and the frequency with which the supply item is ordered. Customers requesting supplies from Medical Materiel must first gain access to the DMLSS. This computer system allows a customer to order supplies and equipment from Medical Materiel without having to leave their duty section. Once access is gained, you can request supplies using one of two system applications in DMLSS called Customer Area Inventory Management (CAIM) and Customer Support (CS).

Using the Customer Area Inventory Management application

CAIM uses a *customer catalog* to order routine or frequently used items. It is the primary issue method for customers. The Medical Materiel office provides each Service Customer (supply account) with an Expense Center and Customer Catalog based on the customers needs. The Expense Center is a six digit alphanumeric number the customer uses to purchase supplies from Medical Materiel. The Customer Catalog shows all the expendable supply items ordered on a recurring basis by that account.

Building a customer catalog

It all begins by identifying all of the dental supplies that will be used on a routine basis, how much will be used on a monthly basis, and the location of where the supply item is to be stored. Once all of this information is gathered, the catalog can be built. Once built, the Customer Catalog can be tailored to fit your needs. The catalog will include your personal storage locations and personal item description. The catalog can be accessed at anytime, so required changes can be made. Consult Medical Logistics for assistance when editing a customer catalog is desired.

Requesting supplies

There are several ways in which the Customer Catalog is used to order supplies from Medical Materiel. As the customer, you can access the CAIM application to order routine supplies by using either a manual replenishment, or hand-held terminal (HHT) replenishment. HHT replenishment involves the use of scanners and barcodes and is the most popular method in which to order supplies from Medical Materiel.

Manual replenishment

If necessary, you may update the Customer Catalog by annotating in the “QTY” column the quantity you want to order. Mark this information on the same line as the item identification number. Once all of the annotations are made, the order is electronically submitted to logistics for processing and issue of your supplies.

HHT replenishment

Under this system, the supply custodian designates a primary supply storage area for automatic resupply. Initially, the supply custodian and Medical Materiel establish levels on routine items. Based on these levels, shortages are filled by materiel on a scheduled basis. Logistics will develop a Customer Catalog listing your recurring supply items and produce barcode labels for each item. Logistics, or you, will scan the barcode labels using a HHT to order the items. It is important for clinic personnel to understand that once the supplies are delivered to the supply point, it is the clinic personnel’s responsibility to ensure security and monitor consumption of the supplies. In addition to this method of re-supply, Logistics will screen stock for quality control standards such as destruction, suspension, and dated item control. Customers should review Customer Catalog levels monthly and coordinate any required changes with medical materiel.

Customer Support

The CS application is used by Medical Materiel customers to process requests for nonrecurring supplies, new supply items, check the status of clinic funds and open new equipment work orders.

033. Managing supplies

The effective management of supplies requires many functions. Supplies must be ordered, received, stored, and issued; excess supplies and equipment must be turned in; records must be kept; and inventories must be conducted.

Authorization for supplies

Each using activity in the medical treatment facility is authorized a maximum of a two-week level of consumable supplies. Each activity is also authorized stocks of durable supplies, as necessary, to support operations until replacement items can be obtained from Medical Materiel. The actual level of stock is based upon the average usage and resupply frequency of recurring demand consumables supplies. This level will vary with the type of commodity, the user, and location of the supply account. Medical Materiel should issue supplies to customers frequently to reduce the amount of consumable supplies maintained in the using activities. The frequency, whether daily, weekly, twice weekly, and so forth, is primarily determined by the level you require. Attention is also given to other factors including inventory reduction, time and effort in making the issues, customers’ available storage space, and the level of customer involvement in receiving the supplies, and the demand rate.

In addition, specialized service-using activities are authorized to stock, as required, those items infrequently procured, items not stocked by Medical Materiel, and when a single unit of issue is greater than 2 weeks' consumption. The only restriction is that the quantity of these items maintained in the using activity be kept to the minimum required for efficient operation.

Supply levels

Dental treatment facilities maintain levels of recurring demand, expendable supplies, such as burs, amalgam, cotton items, etc. They may maintain necessary stocks of recurring demand, durable items, such as mirrors and instruments.

A maximum level and reorder point is established for all recurring demand supplies. Record these numbers (levels) on the stock item labels in pencil so they may be adjusted as necessary. The levels are based on past issue experience and usage. Establish levels by determining the average weekly use for the last three months. Use longer historical data, if necessary, for low use items. You can obtain usage data from Medical Materiel. Based on your issue data Medical Materiel establishes and coordinates stock levels.

In some situations, you may need to know how to determine stock levels. There are several methods you can use. Add the total issues of an item from the monthly Using Activity Issue/Turn-In Summaries and divide by the number of weeks for that period. Multiply the weekly usage by the number of weeks deemed necessary for the stock level. You can also request a Using Activity Stock Status Report for your activity. This report gives the 12-month issue history of any item issued to your account. You can determine the average monthly or weekly issue of an item over a 12-month period from this report. To determine your stock level, compute the average weekly issue and multiply it by the number of weeks deemed necessary for the stock level. Under normal conditions, maintain a 2-week level; this may vary depending on local conditions.

Ordering supplies

Proper ordering techniques are critical to making the supply system work. Levels maintained by Medical Materiel are affected by the quantities and the frequency of the orders they receive from their customers. Normally, you order a supply item based on its maximum level and reorder point.

When the shelf supply reaches the reorder point, order the quantity needed to bring the shelf supply back up to the maximum level. Setting realistic levels and ordering at regular intervals ensures that supplies are on hand when needed, eliminates the delays, and excessive costs caused by misuse of the Medical Materiel System and items expiring on the shelf.

The level is established in the clinic storeroom or in the medical material warehouse for an item is directly related to the rate at which you order the item. For the system to work, your consumption rate should be consistent with your ordering rate. You order from the Medical Material section; the Medical Materiel section issues the item to you, and in turn, orders replacement materiel. This should help you understand why it is so important to establish realistic levels.

For example, suppose that your department uses twenty boxes of large examination gloves each week. You would establish a one-week level of twenty boxes. Using your weekly consumption as a guide, the DMLSS computer establishes a Medical Materiel warehouse level for the item. This level is automatically reviewed and adjusted by the computer each month. Suppose that, because you have stockpiled large gloves, you do not order the item for three months. If you have not ordered the item for three months, you will probably ask for a larger order when submitting the request. The computer may assume that the Medical Materiel section must replace all those boxes of gloves you have just ordered and generate a requisition to the source of supply to do just that. Now you have a stockpile of large gloves in your department and the Medical Materiel section also might have a stockpile of the gloves sitting in the warehouse.

The computer may also react if you do not order an item for a long period of time. Assume again that you have stockpiled large exam gloves and do not order for some time. During this time, you are

actually using the gloves daily from your stockpile and the computer is reducing the warehouse stock level because there is no recorded consumption of the item. Finally, you use your entire stockpile and submit an order to the Medical Materiel section for more gloves. However, the computer has reduced the stock level to zero; and the Medical Materiel section has no large gloves. If you extend these examples to each item in your section, the need to establish and adhere to realistic levels should be obvious. Always remember to order the amount you need, but need the amount you order.

If you order supplies once a week and use twenty boxes of examination gloves each week, order twenty. The system works better that way. Your requirement for an item may change, if it does advise Medical Materiel personnel immediately so that their level on the item can be adjusted accordingly. Medical Materiel personnel cannot function effectively without your complete cooperation. They can give you only the quality of service you give them. It is a two-way street. Regardless of your position, keep one thought in mind when working with government supplies. Consider each supply item as being paid for “out of your pocket.” If you adopt this attitude, maintaining good supply discipline will be a simple task.

Local purchases

As previously mentioned, another procurement source is direct procurement from commercial vendors or manufacturers by Medical Materiel through use of GPC or the Base Contracting Office (BCO). This method is called local purchase (LP). It is used primarily to obtain items not stocked by DLA, PV, ECAT or GSA. LP items are listed in civilian catalogs and secured by blanket purchase agreements (BPA) or GPC.

Air Force medical supplies are procured using sources of supplies established by the DLA and General Services Administration (GSA), respectively, throughout the continental United States (CONUS). Materiel procured directly from DLA is termed “stock listed” because each item is assigned a 13-digit NSN. Materiel is then requisitioned by Air Force medical treatment facilities and is shipped from one of the various materiel depots.

However, DLA has made available, several programs that are used to purchase a majority of your supplies locally. This practice is common for non-stock-listed items that are not available through PV and ECAT, or a life-threatening emergency request for a stock-listed item. Some of the various local purchase sources of supply are Prime Vender and the Electronic Catalog. LP request procedures are established by the materiel manager and are submitted using the Customer Support application in DMLSS. All customers must use the automated New Item Request module in the Customer Support application to submit requests for one time use items or for new recurring items. When filling out a New Item Request, a complete description, unit of purchase, quantity, price, full company address, and point of contact are needed to purchase non-stocklisted supplies.

It is important to give as much complete information, including pictures and brochures, as possible. As we indicated earlier, a New Item Request is used for requesting LP items. Regardless of the form used, all LP requests must be approved by the base commander or an authorized representative who could be the MTF commander, the materiel manager, or the superintendent of Medical Materiel.

The CS application also provides you with the capability of checking the status of clinic funds. This module allows you to check the funds balance to ensure funds are available to purchase supplies. The CS application also allows you to notify the Biomedical Equipment Repair section that equipment needs to be repaired. Using the Work Order module, you can fill out and submit an equipment work order request electronically.

Before the LP of an item, you will be required to submit a request for LP. Before ordering LP, consider the following at a minimum:

- Is there a stock-listed, PV or DLA item that fulfills the same function?
- Is there another LP item available that accomplishes the same function at less cost?

- Is it better to authorize routine LP of the item and should the item be recommended for stock listing?
- Is the quantity being requested excessive?

Before initiating a customer's local purchase request, review DLA and GSA catalogs and the FEDLOG or DMLSS to ensure that stocked items which have a NSN and are carried by the depot are used whenever possible. Generally, the USAF does not authorize LP for the following:

1. Non-stock listed items that differ only slightly from stock listed items of identical capability. Exception is authorized when there is a functional need for a different unit of issue and approval has been given by the approval authority.
2. Preferred trade names and proprietary products instead of stock listed items. For example, don't request "Bufferin" when any Aspirin will do. A requirement for a brand name product does not mean sole source. A requirement for brand name procurement exists when only one manufacturer's item fills a customer's need. You must provide, in writing, a specific brand name justification.

Blanket purchase agreement

The BPA is an agreement and not a contract that has been negotiated with a specific vendor to cover the recurring requirement for selected local purchase items. BPAs can also be defined as simplified methods of filling repetitive needs for small quantities of supplies and services by establishing charge accounts with qualified sources of supply. BPAs may be established locally through your BCO or by DLA. When utilized properly, BPAs can reduce issue-waiting time, provide quality supplies at a stable price, and allow you to be more selective in the items you use. There are two types of BPAs: centralized and decentralized. With a centralized BPA, medical logistics submits your requisitions to the contracting agency that places orders with the vendor. Decentralized BPAs allow medical logistics to either submit hard copy purchase orders or place orders (calls) directly to the vendor. Additional information about DLA negotiated BPAs in effect, copies of new agreements, ordering instructions, and guidance in the proper use of DLA can also be found in the Air Force Medical Logistics Letter (AFMLL).

Prime Vendor

The PV program originated out of a need to reduce stored stocks at the various DLA depots. PV provides participating MTFs with a consolidated source for a portion of their requirements. It is a rapid, cost-effective method of buying supplies. Currently, there are DLA PV programs for pharmaceuticals and for medical/surgical items.

The PV contracts are awarded by DLA. DLA uses requirement contracts with the PV program. A requirement contract provides for satisfying all purchase requirements of selected government activities for specific supplies and services during a specified contract period. When the government expects recurring requirements, but cannot predetermine the precise quantities needed, it uses requirement contracts.

The pricing for PV items comes from Federal Supply Schedules, or Distribution and Pricing Agreements (DAPA). DLA negotiates the DAPA prices directly with the manufacturers. Under DAPA the price is either a preset ceiling price or a negotiated percentage discount from the manufacturer or distributor standard price. The price shown on the PV electronic catalog includes all surcharges and represents the delivered cost to the MTF. Funds are obligated based on the actual delivery order, not the contract itself. Once implemented, Prime Vendor is a mandatory source of supply for all of the medical treatment facility's local purchase requirements for that commodity when the items are available through the program. Items not covered under the program may be purchased from any source the customer chooses. The Defense Supply Center, Philadelphia establishes these contracts annually with local suppliers who guarantee delivery within 24 hours for most items (except for OCONUS). This reduces the need to carry bulk storage in our own warehouse and saves precious clinic space.

Emergency medical purchases

Emergency medical-purchase requirements are defined as not having local materiel available required to save life, prevent undue suffering, or prevent suspension of dental services. Here we mention two types of emergency medical purchases: after-the-fact procurement and the Government Purchase Card (GPC).

After-the-fact-procurement

An after-the-fact-procurement is normally used to satisfy medical emergencies that occur after normal duty hours. If the item needed is available locally and there is not enough time to process the emergency requisition through normal channels, use after-the-fact-procurement. Although the procedure requires approval from the MTF commander or other competent authority, it does allow for Medical Materiel and other medical treatment personnel to purchase medical equipment and supplies directly from commercial vendors without routing requests through the BCO first.

Government Purchase Card

The GPC allows for the purchase of supplies and services up to \$3,000 per transaction. The government credit card has drastically changed the way we do business. It costs less to use the GPC because we do not have the administrative cost of processing a purchase order. Most vendors accept the GPC card and prefer this method because they receive payment at the time the goods or services are delivered. Another plus is that most vendors ship immediately when using the GPC, thus decreasing the time it takes to receive supplies. This card can be used when Base Supply is out of a stocked item, does not carry a particular required item, or when the item is in stock yet needs are so urgent that the system cannot respond quickly enough. At some installations, customers wishing to make a GPC purchase must obtain a control number from their Base Supply officer indicating Base Supply cannot provide the required item. Contact your local supply officer to learn local procedures.

Back orders and back order release issues

Back orders or due-outs are established as a result of Medical Materiel processing your shopping guide or non-routine issue request for an item when there is no stock on-hand or there is not enough to fill the total order. Whenever an item is not available for issue and you have funds available, a back order is established. This item appears on your using activity issue list in the section titled ****BACK ORDER ACTION****, if not, notify Medical Materiel of the omission. Do not reorder the item unless you desire an increased quantity; DMLSS will not allow you to pyramid or duplicate a back order. When the item is received and processed by Medical Materiel, the computer will generate a back order release issue. If a potential work stoppage is expected before delivery of an item or if you need an item before the projected delivery date, ask the materiel manager to give the item a higher priority.

The dental clinic also receives a monthly log back order report listing all back order transactions. Use this list to verify back ordered items are still being carried as such. Annotate and return this report to Medical Materiel if any changes are necessary (i.e., a change in quantity needed, the item is no longer needed and so forth).

Receipt of issues

When you receive supplies from Medical Materiel, check them against the Delivery List provided by Medical Materiel. Review the list to ensure that you received the correct items, quantities, unit of issues, and appropriate expiration dates. All items on the issue document are charged against your account whether you receive them or not. Identify any errors to Medical Materiel personnel immediately.

Storing issues

The items issued must be stored properly. Protect them from the weather, light, and moisture. You store items according to the manufacturer's directions or instructions. Some specific dental materials, such as cements require refrigeration. Rotate all items with expiration dates to ensure that the items

with short expiration dates are used first. Several items must be stored with safety in mind. There are several ways which items may be organized or arranged for storage:

- National stock number sequence, which aids in ordering and inventory.
- Family-type grouping, which makes supply user friendly.
- Bulk storage for large-sized, high-use items.

Examples of family-type grouping would be items such as burs, files, and hand instruments.

Regardless of the style of arrangement, stock items must be accessible and labeled at the storage location with the stock number, item name, maximum level, and reorder point.

Deteriorating items

Medical items, particularly drugs, deteriorate rapidly when exposed to direct sunlight or excessive heat, cold, or moisture. Manufacturers identify items that require storage at specified temperatures. These storage temperatures must be strictly observed to prevent the issue and use of an item which may be ineffective or dangerous. Some items require storage in a specific manner to prevent deterioration.

Expiration dated items

Property custodians are responsible for the active management of expiration dated materiel under their control. Here are some functions you can perform in the management of expiration dated materiel:

- Store expiration dated items so the materiel that expires first is issued first.
- If items are received with an extended date or the date is placed on the outer container, transfer the extension information to all individual units of issue prior to use.
- Small individual units of issue such as vials, ampoules, etc., which do not contain adequate space for adding extended expiration date information may be grouped in a suitable container.
- Turn-in expiration dated items to Medical Logistics when the expiration date has expired.
- Always obtain the actual expiration date of dental items from the product label. An item which is marked with an expiration date shown as only a month and year—for example, Jan 13—is considered to expire on the last day of the month (31 Jan 13).

Hazardous materials

Hundreds of hazardous materials (HAZMAT) are used daily in healthier settings. Examples are: ammonia, acetone, ethylene oxide, paint thinner, chlorine, solvents, glutaraldehyde, xylene, anesthetic gases, nitrous oxide, oxygen, and hazardous drugs. Toxic items must be well marked and stored in a well-ventilated area, separated from other stocked items. Flammables must be placed and stored in a flameproof cabinet separated from other stock items. Place all acids over a sandbox large enough to absorb any spills. HAZMAT has characteristics that may require items to be specially stored or handled to prevent risk to personnel or the facility in which they are stored. HAZMAT will be stored according to compatibility and not necessarily to NSN sequence. Contact between incompatible materiel will produce a reaction such as fire, explosion, polymerization, boiling or spattering, severe heat generation or the release of poisonous/hazardous vapors or gases. Review the HAZMAT inventory and Safety Data Sheets (SDS); follow applicable regulations such as Air Force Joint Manual (AFJMAN) 23-209, *Storage and Handling of Hazardous Material*, Chapter 4, and base environmental compliance and pollution prevention guidance. You can seek further guidance from the Installation HAZMAT Management Program team.

Storage areas designed to contain HAZMAT must conform to all federal, state, and local construction standards. You must periodically inspect HAZMAT storage sites for damaged or leaking containers according to base environmental compliance and pollution prevention guidance. If containers are

damaged or leaking, exercise Medical Logistics Emergency Spill Response Plan and don proper personal protective equipment (PPE).

Safety Data Sheets

A SDS is a fact sheet that provides you with information about the potential hazards of materials in your workplace. Having a complete inventory of SDS is essential to a successful Hazard Communication (HAZCOM) Program. The following are the different sections of the SDS:

- Identification.
- Hazard(s) identification.
- Composition information on ingredients.
- First-aid measures.
- Fire-fighting measures.
- Accidental release measures.
- Handling and storage.
- Exposure controls/personnal protection.
- Physical and chemical properties.
- Stability and reactivity.
- Toxicological information.
- Ecological information.
- Disposal considerations.
- Transport information.
- Regulatory information.
- Other information.

Examples of specific information found on an SDS are: hazardous ingredients; first-aid measures; what to do in case of a spill or leak; safe handling and storage; and personal protection. Supply custodians are responsible for obtaining an SDS and providing immediate access to SDSs for every hazardous chemical in their section.

Chemical manufacturers must prepare a SDS for each product containing hazardous chemicals. The manufacturer is also responsible for providing a copy of the SDS with each product. If one is not provided with the product, contact the manufacturer to obtain a copy. Also, many SDS are available on the Internet.

The OSHA HAZCOM Standard requires that all clinics maintain a SDS for every hazardous chemical in the dental office. For example, if a clinic is using two brands of disinfectants, two separate SDS are necessary—one for each product used.

The location of SDSs is determined locally and if the primary means for SDS access is electronic, a backup system for SDS access is established in case primary computer access is disrupted. Some locations choose to keep a “hard copy” paper version of the SDS. This is a local MTF/DTF leadership decision. Additionally, personnel must receive training on each SDS applicable to their job and on how to effectively use the SDS.

More information on HAZMAT can be obtained from the following references:

- AFI 90-821, *Hazard Communication*.
- AFMLL, The Air Force Medical Logistics Letter.
- Title 29, Code of Federal Regulations (CFR), Section 1910-1200, *Hazard Communication*.

- Federal Standard 313C, Material Safety Data, Transportation Data and Disposal Data For Hazardous Materials Furnished to Government Activities.

Dental issues

Issuing procedures in dental clinics vary according to local policies. Some clinics have designated times for issuing supplies to the using sections. Other clinics allow supplies to be drawn at any time of the duty day. Of course, regardless of the established procedures, emergency supply needs do occur, and someone in the clinic should have access to the supply room at all times.

Turn-in procedures for excess or unserviceable materiel

From time to time, you will need to turn in supplies and equipment to the Medical Materiel section. The materiel may be turned in as the result of a suspension notice, reduction in your workload, change in procedures or the mission of your section, unserviceable items and over stocking. Certain items may be transferred to another activity that needs them. Try not to wait until just before an inspection to start looking at your excess supplies and equipment.

Acceptable turn-in items

Only serviceable materiel may be stocked in your clinic. Turning in materiel is a separate and distinct transaction from that of obtaining a replacement item. Unserviceable and suspended items will be turned in to Medical Materiel when identified as other than serviceable. The property custodian ensures that unserviceable or excess items are not kept in your clinic. Requests for issue of items to replace unserviceable or repairable materiel turned in should be cross-referenced to the turn-in request and the two actions coordinated to provide timely replacement.

DOCUMENT IDENTIFIER			ROUTING IDENTIFIER			M & S			ITEM IDENTIFICATION* (NSN, FSCM, Part No., Other)													UNIT OF ISSUE		QUANTITY		DOCUMENT NUMBER																																							
									FSCM			PART NUMBER														REQUISITIONER																																							
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35																															
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DOCUMENT NO. (Cont.)						DATE						SERIAL						SUPPLEMENTARY ADDRESS						FUND CODE						DISTRIBUTION CODE						PROJECT CODE						PRIORITY						REQUIRED DELIVERY DAY OF YEAR						ADVISE CODE						BLANK					
36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69																																
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															65										66										*1. MANUFACTURER'S CODE AND PART NO. (When they exceed card columns 8 thru 22)																														
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3. MANUFACTURER'S CATALOG IDENTIFICATION															4. DATE (YYMMDD)										5. TECHNICAL ORDER NUMBER																																								
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8. DESCRIPTION OF ITEM REQUESTED															8a. COLOR										8b. SIZE																																								
9. END ITEM APPLICATION															9a. SOURCE OF SUPPLY										9b. SERIAL NUMBER																																								
9c. MAKE															9c. MODEL NUMBER										9d. SERIES										9e. SERIAL NUMBER																														
10. REQUISITIONER (Clear text name and address)															11. REMARKS																																																		
T Sgt Larry Brown Acct # 815987 PH: 6-6935																																																																	

DD Form 1348-6, FEB 85 Edition of Apr 77 may be used until exhausted. DOD SINGLE LINE ITEM REQUISITION SYSTEM DOCUMENT (MANUAL - LONG FORM)

Figure 3-2. Sample, DD Form 1348-6.

Turn-in procedures

It is the responsibility of the using activity to ensure the assets being turned-in are made available to Medical Materiel. Requests for issue of items to replace unserviceable or repairable materiel that have been turned in should be cross-referenced to the turn-in request and the two actions coordinated for

timely replacement. Normally, you will deliver small supply items to the Medical Materiel warehouse for turn-in. For larger bulky items, coordinate the turn-in with the materiel warehouse personnel. Medical Materiel inspects the items, so inform them of any factors that would aid in determining the condition of the item. The using activity prepares a turn-in document. For supplies the DD Form 1348-6, DOD Single Line Item Requisition System Document (Manual-Long Form), is prepared in two copies (fig. 3-2).

Enter the reason for the turn-in in the remarks block. The warehouse clerk receiving the turn-in will provide you a signed copy of the turn-in document. AF Form 601 is used to turn in equipment and requisition new or replacement equipment (fig. 3-3). Equipment will be coordinated with Medical Equipment Repair section prior to turn-in to MEMO. The price reflected on all documentation is the standard price for the item as of the turn-in date if credit is granted. If you have any questions concerning credit, you should discuss it with the Customer Service, not the warehouse. Maintain your signed copy of the turn-in until you receive a copy of the DMLSS generated Issue/Turn-In summary with the turn-in listed, this can be printed by the custodian.

Credit determination

Medical Materiel credit determination is based on the certain factors. Credit is not given for suspended or unserviceable materiel. When an item of this nature is turned in and a replacement is required, cross-reference the respective turn-in and issue documents. You will be charged for the replacement issue.

When a using activity turns in an unserviceable or suspended item and Medical Materiel later receives credit from the manufacturer for that item, the using activity is also granted credit at that time. This decision is based upon: the value of the credit, length of time the item was suspended, and administrative cost of making the adjustment.

The Medical Materiel section allows the customer full credit for serviceable supplies turned in up to the operating inventory requirements (the difference between the stock control level in normal operating stock and the total of on-hand and due-in assets). For example, if warehouse stock level for an item is 50, and they have 20 on-hand and 20 due-in, the most they could grant credit for on a turn-in would be 10, because they only need 10 to get them back up to their stock control level of 50 ($20 + 20 + 10 = 50$).

Materiel to be destroyed by the Medical Materiel section or the medical destruction officer or to be turned in to Defense Logistics Agency (DLA) can only be turned in without credit. Also, materiel suspended from issue and use is unserviceable and will receive no credit. If the Medical Materiel section gets credit for the materiel or if the materiel is released from suspension as suitable for issue and use, the Medical Materiel section may allow credit to the clinic. The decision will be based on the value of the credit, the length of time the item was suspended, and the administrative cost of making the adjustment. Since excess and unserviceable items are of no value to your clinic, turn them in to the Medical Materiel officer on DD Form 1348-6. Excess and unserviceable equipment items should be turned in to MEMO on AF Form 601.

Credit adjustments are not considered appropriate if the dollar value is \$25 or less per using activity or if the suspension time is greater than 1 year. (**NOTE:** Suspended materiel turned in to the Medical Materiel account becomes the property of the Medical Materiel account and will not be returned to the activity turning in the materiel, except by formal issue procedures.)

Disposable item turn-in

For the disposal of items for destruction, you must follow the USAF Guidelines for Infection Control. They state to place used disposable syringes and needles, scalpel blades, and other sharp items (e.g., orthodontic wire, burs, endodontic files) in appropriate puncture-resistant containers located as close as feasible to the area in which the items are used. At some locations it is required to have the container wall mounted (Medical Group Policy). These guidelines also state that the sharps container is to be puncture-resistant, color-coded, and leak-proof. The container should be closed immediately

before removal or replacement to prevent spillage or protrusion of contents during handling, storage, transport, or shipping.

TO		FROM		SIGNATURE		DATE		ACTION TAKEN																															
MEMO/ERAA 7 Medical Group		Acct 505631 7 Medical Group						APPROVED <input type="checkbox"/>																															
DBMS 7 Medical Group		MEMO/ERAA 7 Medical Group						DISAPPROVED <input type="checkbox"/>																															
HQ ACC/SGAL Langley AFB VA		7 Medical Group Dyess AFB TX						APPROVED <input type="checkbox"/>																															
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1. CUSTODIAN REQUEST NO. DYE4183-0001		10. IN-USE DOC. NO. L/E 12		11. NATIONAL STOCK NO. OR PART NUMBER 6520-L885965		20. ACTION REQUESTED																																	
2. CUSTODIAN NAME/DUTY PHONE TSgt Mark Archer 766-7008		12. USE CODE		13. PRICE \$3,525.00		14. U# EA		15. EERCO																															
3. ORG/CUSTODIAN CODE 7 MG 505784		16. EQUIP CODE M		17. NOMENCLATURE Vita Ceramic Furnace		B. ISSUE/DUE OUT ADVISE CODE () INITIAL ISSUE <input type="checkbox"/> REPLACEMENT <input type="checkbox"/> CANCEL DUE OUT <input type="checkbox"/>																																	
4. CMD ACC		5. FAD		6. UND		7. BUO		C. TURN IN (Complete all applicable blocks)																															
8. CUSTODIAN SIGNATURE		18. ALLOWANCE IDENTIFICATION		19. QUANTITY		SERVICEABLE		STATUS																															
9. SIG OF ORGN COMDR (I certify that I have evaluated this request and the action herein is required.)		ASC		COMPOSITION CODE		IN USE		CURR AUTH																															
		PART		SECT		SUB- SECT		COL																															
		NEW AUTH		NO. REQ'D		REPARABLE		COMPLETE (List missing parts in 19) Block																															
		COND/EMED		UNKNOW		CALIBRATION REQUIRED		CLEAN, PAINT, ETC.																															
		DATE AVAILABLE FOR PICKUP				DISASSEMBLY REQUIRED																																	
21. JUSTIFICATION AND ITEM DESCRIPTION Vita Vacumat 300 A computerized dental laboratory ceramic furnace.																																							
22. REVIEWING AUTHORITY COMMENTS																																							
23. ORGN																																							
24. UKC																																							
25. LEVEL																																							
26. DET																																							
27. WRM																																							
28. EMOLOC																																							
29. SUPPLY CONTROL NO.																																							
30. CEMO CONTROL NO.																																							
31. AFLC CONTROL NO.																																							
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40

Fill sharps containers only to the “Full Line” on the outside of the container and do not overfill. Once the container is full, turn it in to a central collection area within the Dental Clinic (usually Dental Logistics). The turn-in of sharps containers from Dental to the Medical Logistics is determined by local policy. How they are stored in Dental and Medical Logistics is also a local policy.

Records

You must keep a file of all supply functions of the facility, including issue and turn-in documents. The document number assigned by Medical Materiel may be used for control and filing purposes. Dispose of records in accordance with Air Force records disposition procedures.

Inventories

Consumable supplies are usually inventoried weekly when ordering and screen stock items are continuously screened for proper redistribution and excess stock disposal. Other items that require inventory include equipment, controlled substances, and precious metals.

Equipment

Inventory your equipment items annually, or more often, if deemed necessary by the Medical Materiel officer (example, Office of Special Investigations [OSI] investigation), or whenever the property custodian changes. The purpose of an inventory is to reveal whether or not:

- Items are on-hand and accountable.
- Items and quantities on-hand are adequate.
- Items on-hand are usable.
- Established levels are realistic.

Controlled items and precious metals

The CDS, or a designated officer, is responsible for requesting, safekeeping, and dispensing controlled drugs or any other controlled substance. Store all controlled drugs and all other controlled substances in a durably constructed, double-locked cabinet. Only modest stocks of controlled drugs may be maintained. Maintain a record of all receipts and issues of controlled drugs. Items must be obtained from the pharmacy according to established procedures for procuring inpatient unit pharmaceuticals. The AF Form 579, Controlled Substances Register, is used to account for controlled items. When a patient receives less than the ordered amount of a controlled drug, destroy the remainder and properly annotate in the patients dental health record.

Controlled drugs, ethyl alcohol, and precious metals, require monthly inventory. Silver alloy is not a controlled item and does not require inventory as a precious metal or alloy. The MTF commander appoints a disinterested officer, enlisted member (E-7), or civilian (GS-7) or above to perform inventories of controlled items. The term *disinterested* means that the individual should not, in any way be associated with dental treatment facility operations.

034. Managing equipment

There are several aspects of equipment management of which you should have some basic knowledge. This includes ordering, transferring, and turn-in of equipment. When any change is required in equipment assets under your control, prepare an AF Form 601. It is very important that you realize the approval process for investment equipment can take several months and it can take several more months to get the funding from your MAJCOM. Therefore, be proactive and plan well in advance to request equipment. Do not wait until the piece of equipment is worn out to replace it. In this lesson we include several areas and items previously mentioned to explain their relationship to the tasks involved with the management of equipment.

Basic custodial responsibilities for MEMO property

When custodial responsibility is to be assumed, the MEMO provides the property custodian with a custody receipt/location listing showing all property charged and due-in to the custodian's account.

Before signing the listing, you and the current property custodian need to perform a thorough inventory. All listed property should be shown to you.

Review all AF Forms 1297, for equipment on loan. You may contact the borrower by telephone or make a visual inspection. Annotate on the AF Form 1297 the date and name of the person contacted. At the same time, obtain MER verification that required maintenance and or calibration was completed. Identify and coordinate with the MEMO any property in your duty area that is not listed. Only sign for the property after the inventory has been performed and all corrective actions are documented.

Upon signing and dating the Custody Receipt/Location Listing, the custodian assumes responsibility for all in-use items in the quantities indicated and verifies the requirements for all due-ins on the listing. Return the original signed listing to MEMO; the property custodian retains a signed copy as a record of equipment authorized and on-hand or due-in. As items are “issued to” or “turned-in from” the account, a signed AF Form 601, showing the action taken, will be retained by the property custodian until the item is correctly listed on the new Custodial Action List or Custody Receipt/Locator List. After receiving a new list, the AF Form 601 may be destroyed.

The property custodian will ensure, by spot check and periodic inventory, all property in his or her account is properly charged to the account; that it is physically on-hand or that appropriate action has been taken to effect settlement for missing or damaged items.

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

Preparing and submitting requests for dental equipment

Every item of equipment, whether it is a replacement item or increased authorization, must be requested according to local policies. This requirement is for the initial issue or replacement of equipment, and involves research and justification prepared by the property custodian and/or logistics technician. Property custodians submit replacement packages to MEMO based on the equipment replacement report. The equipment replacement report tracks the age and repair cost of equipment. This report can be printed as required and shows equipment that needs to be replaced up to five years in the future. This will ensure that one or more of the items are included in the annual budget and that funds will be available.

Ordering equipment

As mentioned, the MEMO manages the medical facility’s equipment. When you wish to replace an old piece of equipment or buy a new piece that you do not currently have, submit a request according to local policies. Submit the request when the requirement is identified, and do not wait until the budget cycle.

Your MAJCOM probably has a specific format for equipment justifications which may include a requirement for a business case analysis (BCA). BCAs are financial analyses designed to determine if it is advantageous for the government to procure the equipment requested versus devising an alternative method of accomplishing the specified workload (e.g., contracting with a civilian agency). Check with your Medical Materiel section to determine the specific requirements for equipment justifications at your facility.

Sole source procurement

Many times when you are trying to obtain a piece of specialized equipment there is only one manufacturer. When this is the case, submit a letter justifying *sole source* procurement. You must realize, even if right now there is only one source, within months several competitors may have a similar product for sale. This documentation is required by Base Contracting to avoid the appearance of favoritism because other companies will not be given the opportunity to bid for the contract. The

sole source justification is separate from the justification requirements set forth by the MAJCOM, and while it has no particular format, it must include:

- A complete nomenclature and descriptive data, manufacturer, and local distributor, if any.
- An explanation of the exclusive features of the desired item or services and why these features are needed.
- An explanation that there are no known substitutes.
- A statement as to why it would not be practical to consider other sources for award.
- The extent of your research of possible sources in making the sole source determination.
- The impact without this particular item or service.
- A statement of dependability, safety, and ease of use or operation.

The approval process

The equipment request/justification is submitted to the MEMO for review and approval coordination. Equipment action requests are forwarded to the Medical ERAA for approval or disapproval. It is not satisfactory just to write a good justification for your item. You, or a well-informed representative, should attend the ERAA meeting to justify and answer any questions concerning why your item must be approved. If approved, the request is forwarded to the MEMO for processing. If the item has a cost of less than \$250,000 (expense equipment), the final approval authority is the MTF commander. Requests for dental units, chairs, and assistant carts are forwarded to DECS for review regardless of the dollar value. If the cost is \$250,000 or more but less than \$1,000,000 (investment equipment), the request must be approved by the MTF commander and your MAJCOM. The request is then forwarded to HQ Air Force Medical Logistics Office (AFMLO) for review.

Once your request is approved, it is forwarded back to the MEMO through MAJCOM and marked *approved awaiting funds*. The equipment is not placed on order until it is funded. Your approved equipment is now placed on a priority list with all other approved equipment for the MTF. Just how high up the priority list your equipment is placed depends on your justification and personal involvement in the approval process. These priorities are established by the ERAA; equipment items critical for patient care are given higher priority. Strong dental input is mandatory to ensure a priority that allows funding. So, be ready to fight for the funds to buy your equipment and do not be afraid to enlist the help of the senior person in your area. Remember, just as your local ERAA made a priority, so will higher HQ. Your request will have to compete with all of the requests submitted from other bases within your command. To aid in explaining any justification for an item, the requesting property custodian may be required to be present or have representation when equipment requests meet the MED-ERAA board or MTF commander for approval or disapproval action. So be prepared for a timely process and try to project as far in advance as possible. Once funds are received, the item is placed on order either through the depot or Base Contracting Office.

Transferring equipment

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

- Retains the original.
- Forwards four copies to base MEMO.
- Obtains MEMO approval of the relocation.
- Obtains the signature of the receiving property custodian on the AF Form 601 when the relocation is accomplished.
- Forwards the completed AF Form 601 to MEMO for processing.

The MEMO processes the document and sends a copy to both property custodians. The MEMO will also provide a Custodial Actions List containing the transfer documentation, which you will file in your equipment folder. Destroy your original AF Form 601 upon receipt of the CAL. Keep your CAL until a new CRL is printed.

Property custodians should maintain a log of all AF Forms 601 prepared using AF Form 126, Custodian Request Log. The AF Form 126 serves as the custodian's control register for tracking your AF Forms 601, and for document control when completing AF Form 601, block 1.

Equipment turn-in

The property custodian prepares an AF Form 601 to turn-in equipment. The property custodian will ensure that medical equipment is inspected by the MER activity prior to turn-in to the MEMO. The MER enters the equipment condition code on the AF Form 601 and places an inspection tag on the equipment. The comment "no longer needed" in the justification block of the AF Form 601 is not enough; indicate why the item is no longer needed (for example, mission change, reduction in patient load, unserviceable, etc.). Once the AF Form 601 is received by the MEMO, the equipment is scheduled for pickup. MEMO signs the AF Form 601 and gives a copy to you. Ensure that you place your copy in your equipment folder. The MEMO signed AF Form 601 relieves you of all responsibility for the item.

Repair and maintenance

You need to know who to contact if equipment or facility repairs or maintenance is required. Normally, the dental property custodian or dental supply custodian is the point of contact for dentistry.

Equipment repair and maintenance

When dental equipment breaks down, turn it in or report it to Dental Logistics to arrange for its repair. A Medical Maintenance Work Order is initiated in DMLSS and electronically forwarded to the medical equipment repair activity for completion. In most cases, the MER activity will do the repair. But when this activity is not available on your base, you will need to contact Medical Materiel. This office will determine if the item is under warranty and, if so, schedule repair by a civilian firm, send the equipment to a base where equipment repair facilities are available or, if necessary schedule a maintenance visit by a biomedical equipment technician (BMET) from your support base. Regardless of the action required to repair the item, follow local policies on reporting and scheduling equipment repair and preventive maintenance.

Facility repair and maintenance

The base Civil Engineering (CE) organization will complete new construction, maintenance, and repairs of the dental treatment facility. In determining your facility's work requirements, you and the facilities manager will work in coordination with the CDS, and appropriate personnel. The facilities manager or civil engineer liaison officer will coordinate your work requests with CE. Your work requests may be handled on a service call basis or a work order basis. A service call will usually remedy minor emergency repairs, such as leaky faucets, ceiling and floor tile repair, and electrical outages. If the work cannot be performed on a service call, you will need to fill out a work order request. The facility manager submits work orders using the AF Form 332, Base Civil Engineer Work Request. This form identifies the work to be done, specific justification for the work, and your priority and other miscellaneous information. Instructions for completion of this form are on the reverse side of the form.

Self-Test Questions

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

031. Using Logistics' publications/listings

1. What AFI is the official publication that prescribes management procedures for Medical Materiel?
2. What does the GSA Catalog contain?
3. What logistics system includes stock control, Prime Vendor operations, preparation of procurement documents, research and price comparison, property accounting, biomedical maintenance operations, property management, inventory, and facility management support?
4. What is the DMLSS?
5. How is an NSN used?
6. What source can answer questions (the best, the most used, etc.) you have about dental delivery systems, including units, chairs, porcelain ovens, handpieces, and supplies?

032. Preparing and submitting request for dental material/services

1. Customers requesting supplies must first gain access to what?
2. What does CAIM stand for?
3. What is a customer catalog?
4. What system of ordering supplies uses barcodes and a hand-held scanner?

033. Managing supplies

1. What is the actual level of stock based upon?
2. What report may you request from Medical Materiel that will give the 12-month issue history of any item issued to your account?
3. Under normal conditions, what stock level should be maintained?
4. What quantity of an item should you order when the shelf supply reaches the reorder point?
5. Local purchases are primarily used to obtain what type of items?
6. What are BPAs?
7. What does PV provide to participating MTFs?
8. What defines an emergency medical purchase?
9. When does Medical Materiel establish back orders?
10. What list, provided by Medical Materiel, do you check to verify that you received the supplies you requested?
11. When storing supply items, how do you label them?
12. Where do you find the actual expiration date of dental items?
13. How are hazardous materials stored?

14. The using activity normally uses which form for turn-in of supplies?

15. Which items require annual inventory? Monthly inventory?

16. Who appoints individuals to perform inventories of controlled items?

034. Managing equipment

1. What form shows the “issued to” or “turned-in from” a property custodian account?

2. How long does the property custodian retain AF Form 601, Equipment Action Request?

3. Property custodians are relieved from duties if separated from their account for more than how many days?

4. If you wish to replace or buy an old or new piece of equipment when do you submit your request?

5. When do you submit a letter justifying *sole source* procurement?

6. Why should the property custodian or a well-informed representative attend the ERAA meeting?

7. Which office must approve the transfer of equipment between property custodians?

8. Which form does the property custodian prepare to turn-in equipment?

9. What should you do when dental equipment breaks down?

10. What group is responsible for any new construction, maintenance, or repair of the dental facility?

3-3. Medical Materiel Customer Support Listings

There are several materiel listings provided to property custodians to aid in the management of their custodian account. There are listings that show how much money you spend on issues and others that show you the equipment you are responsible for maintaining. It is important for you to take the time to review the listings and reports provided and ensure that you understand the usefulness of each.

035. Employing Medical Materiel customer support listings

Two of the Medical Materiel customer support listings you should be familiar with are the Issue/Turn in Summary Report and Log Back Order Report.

Issue/Turn-in Summary Report

The Issue/Turn-in Summary Report is produced when needed by the custodian. It shows supplies that were issued and turned in during a specific amount of time, as entered by the custodian. (fig. 3-4). As mentioned previously, review the list carefully to ensure that you have received the correct items, quantities, unit of issues, and appropriate expiration dates. Items on the issue document are charged against your account whether you receive them or not. If you identify any errors, report them to Medical Materiel personnel immediately.

Issues

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

Turn-ins

This portion of the list contains all turn-ins and reversals of turn-ins processed during the specific period for your activity. The last page for each of the lists contains a dollar value summary for items turned in. Located to the right the refundable/reimbursable line is the dollar amount that you were granted credit on your turn-in. This money has been refunded to your account and can be used to make new purchases. To determine the dollar value for noncreditable turn-in, review the dollar amount to the right of nonrefundable/ nonreimbursable line. After reviewing this listing you may destroy the daily issue/turn-in lists that were generated during the month. Retain the monthly summary in your files to aid in management of your account.

Log Back Order Report

The Log Back Order Report is produced as needed for customers who have supplies due-out (owed) to their activity. The report lists all items ordered but not received, the date of order, and probable availability dates (fig. 3-5). The dental logistics NCOIC reviews the report for items requiring cancellation, follow-up status, quantity error, item error, and so forth. After reviewing the list and checking current on-hand supply levels, the property custodian returns an annotated copy to medical logistics by the 7th calendar day of the month if changes or cancellation of a due-in is required. One copy is kept for your records. Medical Materiel uses your annotated list to process cancellation requests and any other appropriate changes. Be aware, there is no guarantee that Medical Materiel will be able to cancel your due-out, but they will try.

Issue / Turn-in Summary Report
Date Prepared: 27 Feb 2007
From: 01 Feb 2007 To: 27 Feb 2007
Customer: 815903
Customer Name: 383 MED ADMIN

Section A - Issue

Item ID	Short Item Description	FY	Ref CD	Document Number	Qty	U/P	U/P Price	Surch Amt	Total Price
NON MIDWEST OFFICE NON MIDWEST OFFICE SUPPL		2007	R	81590370510087	1	EA	\$86.04	\$0.55	\$86.59
NON MIDWEST OFFICE NON MIDWEST OFFICE SUPPL		2007	R	81590370440035	1	EA	\$38.49	\$0.25	\$38.74

EOB
604
Total:

Total
\$124.53
\$124.53

Total Refundable Expenses by EOB: Sections A - B - C + D + E

EOB
604
Total:

Total
\$124.53
\$124.53

S1075547041

Figure 3-4. Sample, Issue/Turn-in Summary Report.

LOG Back Order Report								Current Date: 27-Feb-2007
Customer : 815907		Customer Name : 381 TRS DENTAL						
Item ID	Short Item Description	Ref Code	B/O Qty	U/P	U/P Price (\$)	Document Number	Status	B/O Value(\$)
7510008893519	CATALOG/MANUAL BINDER	R	1	EA	9.95	81590770100033		\$9.95
Total Dollars :								\$9.95
Total Line Items:								1
I CERTIFY THAT EACH BACK ORDER ON THIS REPORT HAS BEEN REVIEWED AND IS STILL A VALID REQUIREMENT UNLESS CANCELLATION ACTION IS INDICATED.								
SIGNATURE : _____ GRADE: _____ TITLE: _____ DATE: _____								

Figure 3-5. Sample, Log Back Order Report.

036. Utilizing equipment management lists and reports

Some of the equipment management lists and reports that you need to have some knowledge of include the CRL, the CAL, the three-year Equipment Budget Requirement List, Custodian Notification Report, Custodian Maintenance Report, and the Historical Maintenance Report. Let's take a look at each of these.

Custody Receipt/Location List

The purpose of this list is just what the name implies. It is a custody receipt and location list. It provides a list of accountable equipment records for which a specific custodian is responsible (fig. 3-6). The quantity and dollar value of assets on hand are shown in stock number sequence. The total dollar value of "in-use" assets is summarized on the last page of the list for each activity. Location, index number and serial numbers are also shown for maintenance coded equipment and maintenance significant supply items. The custodian's signature on this list indicates that all of the property listed is currently in his or her possession. Before signing for an equipment account, MEMO will provide you a copy of this listing. It will be used to perform your *initial equipment inventory*. After the inventory and any necessary adjustments are completed, you will be given a new listing for your signature. MEMO maintains a signed copy of this list in the MEMO property custodian file. The second copy is given to you. File this copy in your equipment folder.

Custodial Actions List

The CAL is an interim listing used to update the CRL. The list is produced each time Medical Materiel processes a change action affecting a custodian's account. The change may be an equipment issue, turn-in, transfer, or backorder.

When you submit an AF Form 601 to MEMO to record an equipment turn-in or transfer, you will normally receive a Custodial Actions List within five workdays. If you do not receive a CAL, contact MEMO. This is another reason why it is important to maintain a file copy of your AF Form 601s submitted to MEMO. Your signed copy of AF Form 601 serves as proof if any questions of liability arise.

The CAL is distributed, certified, and filed in the same manner as the Custody Receipt Location List. Information copies of the CAL, prepared to show maintenance and/or expandability code changes, are forwarded to you for review and filing. You may destroy the CAL upon receipt of a new CRL incorporating the changes.

DEFENSE MEDICAL LOGISTICS STANDARD SUPPORT

AS OF DATE: 28 FEB 2007

CUSTODIAN RECEIPT/LOCATION LIST

ORG ID: FM4600

ORGANIZATION NAME:55TH MED GROUP

CUSTODIAN NAME: MARIO MCNEAL

CUSTOMER NAME: DENTAL CLINIC

CUSTOMER ID: 245511

ITEM ID	EQUIPMENT NOMENCLATURE			ECN	TYPE	MANUFACTURER		ACQ. COST
	NAME/PLATE MODEL	SERIAL NUMBER	SHORT ITEM DESCRIPTION			COMMON MODEL	PERMANENT LOCATION	DATE LAST INV.
6525LSL800037	ORALIX 70	8723692	RADIOGRAPHIC UNIT, DENTAL	005680	IND	DENS-O-MAT	PHILIPS MEDICAL SYSTEMS NORTH AMERICA	\$2,665.00
6525LSL800037	ORALIX 70	8723692	RADIOGRAPHIC UNIT, DENTAL	005681	IND	DENS-O-MAT	PHILIPS MEDICAL SYSTEMS NORTH AMERICA	\$2,665.00
6525LSL800061	ORALIX 70	8723827	RADIOGRAPHIC UNIT, DENTAL	005919	IND	2F04	PHILIPS MEDICAL SYSTEMS NORTH AMERICA	\$3,630.00
NONE	NONE	NONE	HANDPIECE, DENTAL	005919	IND	2C03	WATERPIK TECHNOLOGIES	\$270.00
652520L800003	B	AC17208	ALGINATE MIXING SYSTEM	006476	IND	CADCO	ORGANIZATIONAL	\$270.00
6530LM96020002	FLEX O MATIC	NONE	SINK, SURGICAL SCRUB	007436	IND	STERIS CORP	ORGANIZATIONAL	\$5,809.46
65200012574694	2006	26-18258	ANALYZER, PHYSIOLOGIC, DENTAL PULP	007670	IND	CK DENTAL SPECIALTIES	ORGANIZATIONAL	\$464.72
6520012574694	2006	26-18266	ANALYZER, PHYSIOLOGIC, DENTAL PULP	007671	IND	CK DENTAL SPECIALTIES	ORGANIZATIONAL	\$464.72
6525LSL910004	GX-1000	1001121982DF	RADIOGRAPHIC UNIT, DENTAL, INTRAORAL	007726	IND	DENTSPLY INTERNATIONAL INC	ORGANIZATIONAL	\$3,060.00
6525LSL910004	DEA028/031	97020413	HANDPIECE, DENTAL	008187	IND	STRYKER ENDOSCOPY	ORGANIZATIONAL	\$2,121.02
6525LSL910007	90FFP	2668/6339	DENTAL ENGINE	008384	IND	NOBEL BIO CARE USA INC	ORGANIZATIONAL	\$19,217.83
6525LSL910007	90FFP	125549	ELECTROSURGICAL UNIT, MONOPOLAR	008803	IND	ELLMAN INTERNATIONAL INC	ORGANIZATIONAL	\$1,007.00
6520012574694	2006	26-21010	ANALYZER, PHYSIOLOGIC, DENTAL PULP	008922	IND	CK DENTAL SPECIALTIES	ORGANIZATIONAL	\$464.72
6525LSL910014	980150150104	9233166	RADIOGRAPHIC UNIT, DENTAL	008971	IND	PHILIPS MEDICAL SYSTEMS NORTH AMERICA	ORGANIZATIONAL	\$3,295.00
6515LM9309010	FORCE 1C	Z4D3590B	ELECTROSURGICAL UNIT, MONOPOLAR/BIPOLAR	009058	IND	VALLEYLAB INC	ORGANIZATIONAL	\$3,570.00
652001910019	32000	51842	RADIOGRAPHIC UNIT, DENTAL, EXTRAORAL	010108	IND	SIEMENS MEDICAL SYSTEMS INC	ORGANIZATIONAL	\$20,254.00

SI075547043

Figure 3–6. Sample, Custody Receipt Location List.

Three Year Equipment Budget Requirements List

The Three Year Equipment Budget Requirements list is produced as requested by the supply custodian. This list is used as a work copy in support of budget and financial plans for replacement equipment. MEMO will provide you, the equipment custodian, copies of the Three Year Equipment Budget Requirements List or Equipment Replacement Report to use in preparing your expense equipment budgets.

The Three Year Equipment Budget Requirements List contains only equipment records with a life expectancy code greater than four years and those having MEMO on hand balances. Equipment items are reviewed and items are suggested for replacement based on MEMO criteria. This report will not list any equipment currently identified in the equipment detail report as a replacement.

Each property custodian having equipment that meets the criteria for review will be given a copy of Part 1. Review the list with your officer in charge (OIC) and validate the requirements of your activity. If you determine a requirement is valid, indicate the replacement priority and prepare a supporting AF Form 601 for each replacement item required. After completing the review, the annotated copy and AF Form 601 should be sent to MEMO.

Historical Maintenance Report

Virtually every action accomplished involving medical equipment is, in some way reflected in the Historical Maintenance Report (HMR) that the MER activity maintains. It includes the age, condition, original cost, repair costs, maintenance history, and other equipment information important to the dental facility in many ways (fig. 3-7). Decisions on whether to repair or replace a particular piece of equipment depend on this data. The age of the equipment and its life expectancy help when budgeting for future equipment needs. An accurate equipment history is required to fulfill the accreditation requirements of agencies such as the TJC/AAAHHC. Maintenance history is also needed to keep track of scheduled inspections. When an initial inspection work order is processed, the general information for new equipment is recorded. When scheduled or unscheduled work orders are completed, the maintenance actions, completion dates, labor, parts, contract and man-hours are reflected in the HMR. If a part is used to repair a piece of equipment or a contractor performs maintenance, the costs are entered. To use the data stored in the HMR, you must be able to understand the information provided in the report.

General information

Let's explain the information contained in the various fields of the record (fig. 3-7). The title nomenclature simply refers to the name of the equipment. The ECN is a six-digit number and is assigned to each piece of equipment. The *device class* identifies the specific family of equipment to which the item belongs. A customer ID is assigned to duty sections in the medical facility. This customer ID is used to account for costs for supplies, equipment, maintenance, etc., to individual sections. Medical equipment is also assigned to duty sections by the customer ID for accountability. Each account has a custodian responsible for funds and equipment within each Customer ID. An *item ID* is assigned to all government equipment and assets. Also, included is specific information relating to the equipment such as, *manufacturer, model number, serial number, and unit price*. The *class risk level* identifies the electrical safety class and the *location* identifies where the equipment is used in the facility.

Maintenance information

Data required to implement these reports are captured in the reporting processes, but special attention to maintaining accurate and accessible historical records is essential. This information is divided into the following sections: *Acquisition, Life expectancy, Location, Expiration dates, Equipment assessment, Inspections, and completion dates*. Let's look at the maintenance information, which the HMR contains.

Maintenance Information	
Term	Explanation
Acquisition date	Date device was received.
Life expectancy	Total number of years a device is expected to last under normal service.
Located code	Indicates where the device is currently located.
Date maintenance contract expires	Calculated based on the start date and the length of the maintenance contract.
Date warranty/parts expires	Date calculated by adding the manufacturer's warranty period to the acquisition date. For example, the warranty expiration would be 9607 for a device with a manufacturer's warranty period of 18 months and date received of 9501.
Equipment maintenance assessment	This reflects the BMET's assessment of the equipment. The maintenance assessment is continually updated by MER to reflect the current condition of the item.
Preventive Maintenance (PM), calibration, and safety inspection intervals Last PM, calibration, and safety inspection dates	Identified by the time, in months, from one inspection to the next inspection of the same type. Identifies the completion date of the last inspection.
Date PM, calibration, and safety inspection due	Identifies the due date of the next inspection. This date is calculated using the inspection cycle and completion date.
Date last work order	Shows completion date of the last work order processed against the device.

Maintenance history

Let's look at the information provided in the maintenance section. The *down time* reflect the time that a device was not available for use for its intended purpose. This is calculated only when requested during a work order completion action. The *hours* reflect the total number of PM hours processed against the device. The *repair hours* identify the total number of repair hours processed against the device. The *repair costs* reflect the total cost of all part's usage against the device. *Contract costs* identify the dollar amount of maintenance contract costs processed against the device. *Unscheduled work orders (WO)* identify the total number of unscheduled calls performed against the device. The entries in *History to Date* section are a running total of all actions processed during the life of the equipment.

Unable to Locate Equipment Notification Report

The Unable to Locate Equipment Notification Report identifies nonlocatable equipment by stock number, item description, index number, manufacturer, model number, and serial number within a responsibility center/cost center. This report is to enable the equipment manager to provide the customer (you) with a list of equipment items that could not be found for servicing. Medical Maintenance forwards the notification report to the equipment custodian and MEMO to ensure the equipment is either located or reconciled against MEMO controlled property.

DEFENSE MEDICAL LOGISTICS STANDARD SUPPORT		
ACTIVE HISTORICAL MAINTENANCE REPORT		
DATE PREPARED: 28 FEB 2007	ORGANIZATION NAME: 55TH MED GROUP	AS OF DATE: 28 FEB 2007
DODAAC: FM4600 UIC:		ORG. ID: FM4600
ECN: 013112	NOMENCLATURE: DENTAL DELIVERY UNIT	
ITEM ID: 6520LM00050005	DEVICE CLASS: DENTAL DELIVERY UNITS	
MANUFACTURER: A-DEC INC	ACQUISITION DATE: 01 JAN 2001	
DIVISION: CORPORATE	ACQUISITION COST: \$9,637.99	MEL: \$2,214.76
NAMEPLATE MODEL: 1040	LIFE EXPECTANCY: 8 YEARS	MRLC: \$11,397.94
COMMON MODEL: 1040	ACQ. COMMODITY CLASS: EQUIPMENT-EXPENSE MEDICAL	
SERIAL NO.: K069136	ACN:	
EQUIPMENT TYPE: INDIVIDUAL	OWNERSHIP: ORGANIZATIONAL	
SYSTEM ECN:	LOCATION: 2E06	
ACCOUNTABLE EQUIPMENT: Y		
MAINTENANCE REQUIRED: Y		
CUSTOMER ORG: 55TH MED GROUP	CUSTODIAN NAME: MCNEAL, MARIO	
CUSTOMER NAME: DENTAL CLINIC	CUSTODIAN PHONE: 4-2752	
CUSTOMER ID: 245511	SUB-CUSTODIAN:	
ASSEMBLAGE NO.:	ASSEMBLAGE DESC.:	
INSTALLATION DATE:	MAINT. ACT: MEDICAL EQUIPMENT REPAIR CENTER	
WARRANTY END, LABOR: 01 DEC 2001	OGA:	
WARRANTY END, PARTS: 01 DEC 2001	CONTRACTOR:	
LAST INV. DATE: 27 APR 2006	CONTRACT END DATE:	
DATE LAST SERVICED: 11 JUL 2006	MAINT. ASSESSMENT: GOOD	
MODIFICATIONS: 0	CONDITION CODE: SERVICEABLE (ISSUABLE WITH QUALIFICATION)	
RISK LEVEL: LOW RISK		
SERVICE TYPE	INTERVAL	DATE DUE DATE LAST
INSPECTION	12	Jan 2008 Jan 2006
PREVENTIVE MAINTENANCE	12	Jan 2008 Jan 2006
CALIBRATION		Jan 2001
SCHEDULED PARTS REPLACEMENT		
HISTORY TO DATE	ORGANIZATIONAL	CONTRACT
DOWN TIME: 0.00		
UNSCHED. WO: 5		
PARTS COST:	\$320.43	\$0.00
UNSCHED. TIME:	6.20	0.50
UNSCHED. LABOR COST:	\$135.19	\$67.50
SCHED. TIME:	7.50	0.50
SCHED LABOR COST:	\$180.85	\$35.00
TOTAL COST:	\$636.47	\$102.50
TOTAL MAINTENANCE COST:	\$738.97	

Figure 3-7. Sample, Historical Maintenance Report.

Self-Test Questions

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

035. Medical Materiel customer support listings

1. When is the Issue/Turn in Summary Report produced? What data is included?
2. What report lists all items ordered but not received, the date of order, and probable availability dates?

036. Equipment management lists and reports

1. What list is used to perform your initial equipment inventory?
2. What is the CAL and when is it produced?
3. How is the Three Year Equipment Budget Requirements List used?

4. How is data from the Historical Maintenance Report used?

3-4. Financial Budgets and MEPRS

It is important that you have some basic knowledge of the budget. Your participation in budget planning will vary from clinic to clinic; but no matter who writes the final document, the squadron commander needs support from the entire clinic while the budget is being formulated. In this lesson we will look at two areas: budgets and Medical Expense and Performance Reporting System that commanders use to make resource allocation decisions.

037. Understanding preparation of the financial budget

The purpose of a financial budget is to plan for the expenditures of funds in a manner that will meet mission objectives within financial limitations. The submission of a budget is not a procedure that can be performed in a few hours. The budget sets the final pattern for the financial operation of the clinic for an entire year. If planning is inadequate, funds received will also be inadequate, and thus, adversely affecting mission performance.

Cost Centers and Responsibility Centers

The budget process is broken down into centers of control. The lowest level, the cost center (CC), is where the supplies are used. The CC is the budget term given to a work center of an organization where you are most likely assigned. The CC manager monitors the day-to-day consumption of supplies, equipment, and services required to perform the unit's mission. This places the CC manager in the best position to make budget estimates and forecasts. They must, however, be aware of possible changes in the mission or work load if they expect to make accurate predictions.

The next higher level is the responsibility center (RC) which coordinates the budget of several CCs. RC managers generally include the wing/base commander, group commanders, medical facility commander, and others depending on the local management structure. RC managers take the leading role in encouraging good financial management within their unit. Each RC manager appoints a resource advisor who monitors the overall budget, the use of resources in day-to-day operations and acts as the primary point of contact with agencies on matters pertaining to resource management. When preparing a budget, the resource advisor specifically monitors the preparation of budget estimates, and participates in the development of expense targets.

Cost Center Management Program

It is the responsibility of the Resource Management Office to conduct a vigorous and active Cost Center Management Program. The RMO are required to provide cost center managers with an analysis of workload and resource consumption data on a recurring basis. The RMO normally publishes a small booklet entitled *Cost Center Manager's Guide*. This gives each CC manager a ready reference as to the Resource Management System, the responsibilities of the cost center manager, products available to the cost center manager, and the element of expense investment codes (EEIC) used by the CC managers at the medical facility. A locally developed training program is usually required to acquaint new cost center managers with the responsibilities of their job. Each CC has an active participation in the budget process.

Medical treatment facility budget

The MTF commander budgets and manages financial resources through the medical RMO. AFI 41-120, *Medical Resource Operations*, provides additional information. The budget compiled by Air Force MTFs is called the Operations and Maintenance (O&M) Operating Budget. The budget is a part of the Resource Management System. It is based on the past experience of the cost centers in the MTF and anticipated changes in the forthcoming year. The MTF is broken down into cost centers by major areas of resource of consumption, such as the dental cost center. The MTF's budget becomes a chapter of the base's budget. Medical facilities may have up to 250 cost centers depending on their

size. The RMO is responsible for monitoring the expenditure of funds by the medical facility cost centers. The medical portion of the base operations operating budget provides the financial resources required to operate all the medical cost centers in the medical treatment facility.

Dental treatment facility budget

Probably the most important activity other than patient care is budget development. The CDS plans for the financial requirements needed to operate dental cost centers and provides these requirements annually to the RMO for inclusion in the medical portion of the base operating budget. In addition to the CDS, the superintendent/manager or NCOIC and property custodian must be actively involved in the formulation of the clinic's budget.

Budget development

The budget program operates on a fiscal year basis. FY represents the period beginning the first day of October and ending the last day of the following September (1 Oct–30 Sep). The RMO requests specific information from the various cost center managers including the dental clinic. Such information includes projected workload and expense estimates. The RMO consolidates the budget for the facility and puts it in the proper format. The CDS, the superintendent/manager or NCOIC, and property custodian plans and budgets for travel requirements, continuing education, supplies, equipment, and so forth.

The Three Year Equipment Budget Requirements List

The dental treatment facility should receive a computer printout of the long-range investment equipment program developed by the RMO and Medical Materiel officer. This is developed as the Three Year Equipment Budget Requirements List. The printout lists all equipment (by nomenclature, stock number and quantity) projected for replacement over a 3-year period. The CDS, superintendent/manager or NCOIC, and property custodian become key players in this process by identifying required items. During the budget preparation, consult the replacement list to ensure all equipment projected to be replaced is included in dental budget. The expense equipment program is not as detailed as the investment equipment program. Expense equipment should be identified throughout the budget year.

038. Medical Expense and Performance Reporting System

The MEPRS is a DOD-wide system used to manage MTFs. MEPRS was developed to fill a need to unify the military medical system and to improve the overall effectiveness of military treatment facilities. It is the primary tool we use for making budgetary, manpower, and other important resource allocation decisions. As discussed in unit one of this volume, MEPRS is reported in the MTF by using the DMHRSi system.

Basic concepts

Each daily activity occurring in the MTF is assigned a code, or in some other way, registered into the MEPRS. This includes everything from a patient visit to the time you spend doing administrative chores. Almost every type of transaction that takes place in the MTF is assigned a MEPRS code. When the Resource Management Office merges data from the medical facility's operating budget (how much the MTF spends on equipment, supplies, etc.) with this extensive breakdown of coded activities, a final product is produced that reflects how much it costs to perform a particular lab or how much it costs one of your technicians to perform a procedure. MEPRS also gives data regarding how well your personnel are being utilized. Let's say that your civilian secretary quits or gets reassigned somewhere else. You have to take one of your technicians, who would normally fabricate appliances or treat patients, and have him or her perform administrative activities like answering the phone. If you don't annotate this change by using a different reporting code, the MEPRS thinks that your technician is treating patients and does not have a clue that your secretary is gone. After all, the secretary's work still gets done.

As you can see, accurate MEPRS reporting is crucial. All of this data eventually makes its way up the chain of command to the DOD where it is used to assist in the allocation of resources to each MTF.

MEPRS program manager

Most MTFs have a MEPRS program manager (MPM) assigned in the RMO. This person is usually a health services management journeyman or a qualified civilian employee. Large MTF's may have several MPMs responsible for the program. The MPM is the focal point for all of the MEPRS data collection and reporting activities occurring in the MTF.

Expense assignment system

As the MEPRS developed over the years, program managers at DOD and Headquarters USAF designated specific hardware and software applications to further automate the MEPRS system. One system was developed to handle the personnel utilization data and another was developed to handle ancillary data, and so on. The expense assignment system (EAS) consolidates these hardware and software applications into one system. EAS allows the MTF MEPRS program manager to perform much of the processing formerly done at the MAJCOM level and streamlines the reporting process.

MEPRS coding system

The MEPRS places a monthly reporting requirement on each military MTF. MEPRS also specifies a set of standard work center definitions that are used to develop a quarterly report. The DOD has issued standard MEPRS/work center codes. These codes are an integral part of the computerized EAS that each MTF uses. Understanding MEPRS coding structure is essential to collect workload data and prepare the Medical Expense and Performance Report.

MEPRS work center

A work center is a distinct functional or organizational subdivision of a MTF for which provisions are made to accumulate and measure its expenses and determine its workload performance. A work center is a clinic or duty section that has an identifiable mission, expenses, and takes up space somewhere. Here's a list of criteria used to establish a work center:

- Identifiable expenses.
- Allocated/assigned manpower.
- Allocated physical space.
- A valid work output.
- A valid workload measure.
- A uniqueness of service provided or expenses incurred when compared to other established work centers.
- Compatibility with the MTF organizational structure.

Full time equivalent

Manpower is expressed in terms of full time equivalents (FTE). An FTE equals the number of work hours in a 1-month period. For MEPRS, this figure is set at 168 hours. Divide the number of hours a person works in one month in each functional category by 168 to arrive at the FTE total. MPMs add each month's FTE figures together to determine the quarterly FTE figure.

Performance

Each work center is also assigned a standard unit of measure, called a performance factor, to identify and report its workload and allocate its expenses. An example of a performance factor for an inpatient related work center is "occupied bed days." Outpatient visits are used to report workload related to outpatient (ambulatory) activities.

Work center versus account

When personnel perform authorized functions that generate expenses and have a measurable output, we can call that function a work center. However, some functions or activities can be a MEPRS

account without meeting the criteria established for a work center. These types of MEPRS accounts accumulate expenses that are not chargeable to direct patient care but are a result of that MTF's military mission. Using this rule, we can establish that every work center is a MEPRS account, but not all MEPRS accounts have a corresponding work center.

Cost pools and X codes

There are situations when work centers share physical space and personnel. Without some sort of special identifier, it would be difficult to identify specific expenses. Since the actual use of supplies from the closet cannot be practically determined, a cost pool is set up for the unit. Cost pools are identified by MEPRS with an X at the third position of a MEPRS code, followed by a letter. A cost pool is the only use of the letter X at the third level of a MEPRS code.

The MEPRS program manager and budget analyst

To ensure expenses are correctly reported in MEPRS, work closely with the MTF budget officer or analyst. Both of you must know what the other is doing to make certain you track and report MEPRS information correctly. Lack of coordination with the budget people can result in major discrepancies in the MEPRS reporting system, as well as the budget preparation and reporting process.

Self-Test Questions

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

037. Financial budget

1. What will be the result of inadequate planning of the financial budget?
2. Why is the CC manager in the best position to make budget estimates and forecasts?
3. Which office provides cost center managers with an analysis of workload and resource consumption data on a recurring basis?
4. What is the O&M and what is it based on?
5. Who, in addition to the CDS, must be actively involved in the formulation of the clinic's budget?
6. You should plan and budget for what items?

038. Medical Expense and Performance Reporting System

1. How is the MEPRS used to get a product that reflects how much it costs to perform a particular lab or how much it costs one of your technicians to perform a procedure?

2. Why is understanding the MEPRS coding structure important?
3. What is an FTE in the MEPRS?

Answers to Self-Test Questions

027

1. Nonmedical materiel.
2. Drugs, adhesive tape, burs, cotton items, and impression material.
3. Instrument cassettes, mirrors, scissors, and hemostats.
4. Expense medical equipment.
5. Investment medical equipment.
6. (1) d.
(2) f.
(3) e.
(4) c.
(5) a.
(6) b.

028

1. Medical Materiel.
2. MEMO.
3. MER Activity.
4. DLA, PV Program, commercial sources and the Electronic catalog (ECAT).

029

1. The dental property custodian.
2. ERAA.
3. The MTF commander.

030

1. The obligation of Air Force member to care for Air Force property with which they are associated.
2. Everything owned by the US government.
3. All government employees—military and civilian.
4. You may have to financially reimburse the government for loss, damage, or destruction of government property caused by negligence, willful misconduct, or deliberate unauthorized use.
5. Command.
6. Command.
7. Officer, enlisted member, or civilian; appointed by the CDS or designated representative.
8. Custodial responsibility.
9. Make a voluntary payment using cash.
10. You may have money taken directly from your paycheck.
11. An in-depth investigation on the cause of loss, damage or destruction of property.

031

1. AFI 41-209, Medical Logistics Support.
2. Nonmedical items used throughout the federal government.

3. DMLSS.
4. A server-based system that supports the medical logistics functions of the MTFs.
5. It is the means by which you identify, order, and store supplies.
6. DECS.

032

1. DMLSS.
2. Customer Area Inventory Management.
3. Shows all the expendable supply items on a recurring basis by that account.
4. HHT replenishment.

033

1. The average usage and resupply frequency of recurring demand consumables supplies.
2. The Using Activity Stock Status Report.
3. A 2-week supply.
4. Normally, you will order a supply item based on its maximum level and reorder point.
5. Those items not stocked by DLA, PV, ECAT or GSA
6. An agreement that has been negotiated with a specific vendor to cover the recurring requirements for selected local purchase items.
7. A consolidated source for a portion of their requirements. It is a rapid, cost-effective method of buying supplies.
8. Not having available locally material required to save life, prevent undue suffering, or prevent suspension of dental services.
9. When there is no stock on-hand or there is not enough to fill the total order.
10. The Delivery List.
11. With the stock number, item name, maximum level, and reorder point.
12. The product label.
13. Compatibility and not necessarily to NSN sequence.
14. DD Form 1348-6, DOD Single Line Item Requisition System Document, in two copies.
15. Annually—Equipment; Monthly—controlled drugs, ethyl alcohol, and precious metals.
16. The MTF commander.

034

1. A signed AF Form 601, Equipment Action Request.
2. Until the item is correctly listed on the new Custodial Action List or Custody Receipt/Location List at which time the AF Form 601 may be destroyed.
3. 45 days.
4. When the requirement is identified, do not wait until the budget cycle.
5. When you are trying to obtain a piece of specialized equipment and there is only one manufacturer.
6. To justify and answer any questions concerning why an item must be approved.
7. MEMO.
8. AF Form 601, Equipment Action Request.
9. Turn it in or report it to Dental Supply to arrange for its repair.
10. CE.

035

1. When needed by the custodian. It shows supplies that were turned in during a specific amount of time, as entered by the custodian.
2. Log Back Order Report.

036

1. The CRLL.

2. It is an interim listing used to update the CRLL. It is produced each time Medical Materiel processes a change action (equipment issue, turn-in, transfer, or back order) effecting a custodian's account.
3. As a work copy in support of budget and financial plans for replacement equipment.
4. Assists decisions on whether to repair or replace equipment. Assists budgeting for future equipment needs. Fulfills the accreditation requirements of agencies such as TJC. Tracks scheduled inspections.

037

1. Funds received will be inadequate, and thus, adversely affecting mission performance.
2. Because the CC manager monitors the day-to-day consumption of supplies, equipment, and services required to perform the unit's mission.
3. RMO.
4. The budget compiled by Air Force MTFs. It is based on the past experience of the cost centers in the MTF and anticipated changes in the forthcoming year.
5. The superintendent/manager or NCOIC and property custodian.
6. Travel requirements, continuing education, supplies, and equipment.

038

1. The Resource Management Office merges the extensive breakdown of coded activities in MEPRS with data from the medical facility's operating budget (how much the MTF spends on equipment, supplies, etc.).
2. Understanding is essential to collect workload data and prepare the Medical Expense and Performance Report.
3. FTEs are an expression of manpower. An FTE equals the number of work hours in a 1-month period. For the MEPRS, this figure is set at 168 hours.

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

Unit Review Exercises

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

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

71. (027) Into what two *categories* are Air Force materiel classified?
 - a. Supplies and equipment.
 - b. Expense and investment.
 - c. Essential and nonessential.
 - d. Perishable and nonperishable.
72. (027) The following are all examples of durable supplies *except*
 - a. gloves.
 - b. mirrors.
 - c. instruments.
 - d. instrument cassettes.
73. (027) What classification of materiel used by Air Force medical treatment facilities consists primarily of office and janitorial supplies and equipment?
 - a. Medical materiel.
 - b. Expensive materiel.
 - c. Investment materiel.
 - d. Nonmedical materiel.
74. (028) Which section of Medical Logistics Services is responsible for requesting, receipt, storage, issue, control, turn-in, disposition, safeguarding, reporting, and accounting for property according to Air Force directives?
 - a. Medical Materiel.
 - b. Facility Management.
 - c. Medical Equipment Repair (MER) Activity.
 - d. Medical Equipment Management Office (MEMO).
75. (028) Which section of Medical Logistics Services is responsible for programming equipment requirements, budgeting for equipment, requisitioning equipment, and maintaining an accountable equipment inventory?
 - a. Medical Materiel.
 - b. Facility Management.
 - c. Medical Equipment Repair (MER) Activity.
 - d. Medical Equipment Management Office (MEMO).
76. (029) The Dental Logistics noncommissioned officer in charge (NCOIC) is responsible for the management of the
 - a. Dental Logistics section and reports to the Dental commander.
 - b. Environmental Health and Safety Program and reports to the Dental commander.
 - c. Dental Logistics section and reports to the Dental manager/superintendent or NCOIC.
 - d. Environmental Health and Safety Program and reports to the Dental manager/superintendent or NCOIC.

77. (029) Delegation of authority from the Dental Logistics noncommissioned officer in charge (NCOIC) to a supply custodian to request and receive items from Medical Materiel *must* be submitted in written format,
- a. be indorsed by the medical treatment facility commander, and filed by the close out of the fiscal year.
 - b. be indorsed by the dental commander, and filed by the close out of the fiscal year.
 - c. contain sample signatures of the authorized personnel, and forwarded to Medical Materiel.
 - d. contain sample signatures of the authorized personnel, and forwarded to the Medical Equipment Review and Authorization Activity (ERAA).
78. (030) What form, when signed, establishes an individual's custodial responsibility for property?
- a. AF Form 126, Custodian Request Log.
 - b. DD Form 1297, Property Issue Receipt.
 - c. AF Form 1297, Temporary Issue Receipt.
 - d. DD Form 1131, Cash Collection Voucher.
79. (030) Which document relieves you of custodial responsibility?
- a. Ready Volume List.
 - b. Custodial Action List.
 - c. DD Form 1131, Cash Collection Voucher.
 - d. AFMAN 23-220, *Reports of Survey for Air Force Property*.
80. (031) Which logistics system will include stock control, Prime Vendor operations, preparation of procurement documents, research and price comparison among a variety of sources for products, property accounting, biomedical maintenance operations, capital equipment, property management, inventory and a facility management?
- a. The MEDLOG System.
 - b. The MEDCAT Accounting System.
 - c. Defense Medical Logistics Standard Support System.
 - d. General Service Administration Support and Acquisition System.
81. (031) Locating and ordering supplies would be almost impossible without a
- a. Federal Supply Class code.
 - b. dental identification number.
 - c. supply identification process.
 - d. North Atlantic Treaty Organization code number.
82. (031) The Dental Evaluation & Consultation Service (DECS) does all of the following *except*
- a. performing technical reviews on all dental equipment requests.
 - b. investigating inappropriate use of dental facilities and/or funds.
 - c. providing assistance in designing or modifying dental facilities.
 - d. distributing Air Force wide newsletters and briefs that list articles and letters about dental items.
83. (032) Once you have gain access to Defense Medical Logistics Standard Support (DMLSS), which system's application can you use to request supplies?
- a. Prime Vendor (PV).
 - b. Medical Catalog (MEDCAT).
 - c. General Services Administration (GSA).
 - d. Customer Area Inventory Management (CAIM).

84. (032) Once all the information for your dental supplies is gathered, what catalog may be built and tailored to fit your needs?
- Customer Catalog.
 - Dental Catalog.
 - Medical Catalog.
 - Federal Catalog.
85. (032) Which supply replenishment option can be utilized using scanners and barcodes?
- ECN.
 - HHT.
 - QTY.
 - LP.
86. (033) Local Purchase (LP) allows for direct procurement from commercial vendors or manufacturers by Medical Materiel through the
- Medical Catalog (MEDCAT).
 - Base Contracting Office (BCO).
 - Defense Medical Logistics Standard Support System.
 - Medical Logistics On-line Computer System (MEDLOG).
87. (033) What list should be reviewed when supplies are received to ensure receipt of correct items, quantities, unit of issues, and appropriate expiration dates?
- Delivery List.
 - Log Back Order List.
 - Dental Activity Issue List.
 - Using Activity Action List.
88. (033) Which form is normally used and how many copies *must* the using activity prepare to turn in supply items?
- AF Form 601, Equipment Action Request; two copies.
 - AF Form 601, Equipment Action Request; three copies.
 - DD Form 1348-6, DOD Single Line Item Requisition System Document (Manual-Long Form); two copies.
 - DD Form 1348-6, DOD Single Line Item Requisition System Document (Manual-Long Form); three copies.
89. (033) For a controlled items inventory, who does the medical treatment facility (MTF) commander appoint to perform the inventory and why?
- Any interested officer, enlisted member, or civilian; they have an interest in the dental treatment facility operations.
 - Any disinterested officer, enlisted member, or civilian; they should not be associated with the dental treatment facility operations.
 - An interested officer, senior enlisted member, or senior civilian; they have an interest in the dental treatment facility operations.
 - A disinterested officer, senior enlisted member, or senior civilian; they should not be associated with the dental treatment facility operations.
90. (034) What form shows the issue to or turned-in from a property custodian account?
- AF Form 106.
 - AF Form 601.
 - Standard Form 306.
 - Standard Form 603.

91. (034) Submit a letter justifying *sole source* procurement when there is
- only one fund site.
 - only one manufacturer.
 - more than one fund site.
 - more than one manufacturer.
92. (035) Why is it important to review the Issue/Turn-In Summary report after each issue?
- To ensure that funds are available for items charged against your account.
 - To ensure that no items received have been identified in the Medical Materiel Complaint System.
 - Because items on the issue document are not charged against your account until you verify receipt.
 - Because items on the issue document are charged against your account whether you receive them or not.
93. (035) To whom do you report any errors identified on an issue/turn-in summary report?
- Medical treatment facility (MTF) commander.
 - Chief of Dental Services (CDS).
 - NCOIC, Dental Support Flight.
 - Medical Material personnel.
94. (036) Which report indicates each specific item for which a specific custodian is responsible and the quantity and dollar value of assets on hand?
- Custodial Actions List.
 - Custody Receipt/Location List.
 - Historical Maintenance Record.
 - Three-Year Equipment Budget Requirement List.
95. (036) Which equipment publication is produced each time Medical Logistics processes a change affecting a custodian's account, such as, equipment issue, turn-in, or transfer?
- Custodial Actions List.
 - Custody Receipt Location List.
 - Historical Maintenance Record.
 - Three-Year Equipment Budget Requirement List.
96. (037) Cost Center (CC) managers are in the *best* position to make budget estimates and forecasts because they
- monitor the overall medical treatment facility (MTF) budget.
 - coordinate the budget of several CCs.
 - monitor the day-to-day consumption of supplies, equipment, and services.
 - are the primary point of contact with agencies on matters pertaining to resource management.
97. (037) The Operations and Maintenance (O&M) Budget for medical treatment facilities (MTF) is based on the past experience of
- resource centers and anticipated changes in the forthcoming year.
 - cost centers in the MTF and historical data from the previous year.
 - resource centers in the MTF and historical data from the previous year.
 - cost centers in the MTF and anticipated changes in the forthcoming year.

98. (037) Who, in addition to the Chief of Dental Services (CDS), *must* be actively involved in the formulation of the dental clinic's budget?
- a. Medical Resource Management Officer.
 - b. Medical Resource Management Officer and the medical treatment facility (MTF) commander.
 - c. Dental superintendent/manager or non-commissioned officer in charge (NCOIC), and the MTF commander.
 - d. Dental superintendent/manager or NCOIC, and the property custodian.
99. (038) How is the Medical Expense and Performance Reporting System (MEPRS) used to get a product that reflects how much it costs a technician to perform a procedure?
- a. The Resource Management Office (RMO) merges coded activities in MEPRS with data from the medical facility's operating budget.
 - b. The Department of Defense (DOD) merges coded activities in MEPRS with data from the medical facility's operating budget.
 - c. The RMO merges coded activities in MEPRS with data from the medical facility's Allowance Standard.
 - d. The DOD merges coded activities in MEPRS with data from the medical facility's Allowance Standard.
100. (038) How does the Medical Expense and Performance Reporting System (MEPRS) express Manpower?
- a. Full time equivalents (FTE).
 - b. Full time derivatives (FTD).
 - c. Field man-hour equivalents (FME).
 - d. Field man-hour derivatives (FMD).

Student Notes

Glossary

Terms

Air Education and Training Command (AETC)—Conducts basic training for all Air Force enlisted personnel, produces skilled flying and ground personnel, and trains many of the world's military forces.

Blanket purchase agreement (BPA)—A BPA is a simplified method of filling repetitive needs for supplies and services. A BPA may be centralized (Contracting places the orders) or decentralized (Medical Logistics places the orders). Any contracting officer may establish a BPA.

Career Field Education and Training Plan (CFETP)—A comprehensive, multipurpose document encompassing the entire spectrum of education and training for a career field.

Core task—Tasks that Air Force Career Field Managers (AFCFM) identify as minimum qualification requirements within an AFSC.

Directive publication—Publications that are necessary to meet the requirements of law, safety, security, or other areas where common direction and standardization benefit the Air Force.

Initial evaluation—An evaluation which must be accomplished within 90 days of assignment to determine what qualifications a member possesses.

Initial skills training—A formal resident training course which results in award of a 3-skill level AFSC.

Instructions—Instructions are orders of the Secretary of the Air Force, usually drafted at the MAJCOM and FOA level, and provide essential procedural guidance necessary to implement Air Force policy in the field. Instructions are used to direct action, ensure compliance, or give detailed procedures to standard actions across the Air Force.

Major Command (MAJCOM) Functional Manager (FM)—A person appointed as the senior representative for an Air Force Specialty (AFS) within a specific MAJCOM. Among other responsibilities, MAJCOM FMs work with the AFCFM to develop, implement, and maintain the CFETP.

Manuals—Manuals are guidance documents for procedures that usually contain examples for performing standard tasks, or supporting education and training programs.

Master Catalog—A full listing of all products available through the Air Force Departmental Publishing Office web site.

Master task list (MTL)—Document maintained within the work center that identifies all tasks performed in the work center. This includes core, critical, position qualification, and wartime tasks.

Mirror Force—A concept of maximizing the mission readiness capability of the Air Force Medical Service through a combined effort of Active Duty, Reserve, and National Guard by: sharing values and principles, optimizing a total force strategy, using technology effectively and efficiently, training for joint taskings and creating a dynamic environment which maximizes everyone's potential.

On-the-job training (OJT)—A training method used to certify personnel in both upgrade (skill level awarding) and job qualification (duty position certification) training. It is hands-on, over-the-shoulder training conducted at the duty location by a qualified trainer.

Operating instructions (OI)—OIs assign responsibilities, direct actions, and prescribe procedures within a headquarters or within an organizational element such as a flight, detachment, squadron, department, division, or similar units.

Qualification training (QT)—Hands-on performance-based training designed to qualify a trainee in a specific duty position. This training program occurs both during and after upgrade training. It is designed to provide the performance skills training required to do the job.

Qualification training package (QTP)—An instructional package designed for use at the unit by supervisors and trainers to qualify or aid qualification in a duty position, on a piece of equipment, or on a performance item identified for competency verification within this CFETP. QTPs establish performance standards and are designed to standardize skills verification and validation of task competency.

Specialty training standard (STS)—An Air Force publication that describes an Air Force Specialty in terms of tasks and knowledge, proficiency requirements, and identifies the training provided to achieve a 3-, 5-, and 7-skill level within an enlisted AFS.

Task certifier—A person whom the commander assigns to determine an individual's ability to perform a task to required standards.

Trainer—A trained and qualified individual who teaches a trainee to perform specific tasks on-the-job.

Training reference—A resource listed with a specific task or knowledge item in the STS.

Upgrade training (UGT)—A mixture of mandatory courses, tasks qualifications, QTPs, and CDCs required for award of the appropriate skill levels.

Utilization and training workshop (U&TW)—A forum lead by the AFCFM that incorporates the expertise of MAJCOM FMs, subject matter experts (SMEs), and AETC training personnel in order to determine career ladder training requirements.

Abbreviations and Acronyms

AAAH	Accreditation Association for Ambulatory Health Care
AAS	Associate in Applied Science
AD	active duty
ADA	American Dental Association
ADAA	American Dental Assistant Association
ADL	area dental laboratory
AETC	Air Education and Training Command
AFI	Air Force instruction
AFCFM	Air Force career field manager
AFCOOL	Air Force Credentialing Opportunities On-Line
AFDPO	Air Force Departmental Publishing Office
AFDRAP	Air Force Dental Readiness Assurance Program
AFIA	Air Force Inspection Agency
AFMLL	Air Force Medical Logistics Letter
AFMLO	Air Force Medical Logistics Office
AFMOA	Air Force Medical Operating Agency
AFMS	Air Force Medical Service or Air Force Manpower Standard
AFOSH	Air Force Occupational Safety and Health
AFPC	Air Force Personnel Center
AFRC	Air Force Reserve Component
AFSC	Air Force specialty code
AFTR	Air Force Training Record
AFVEC	Air Force Virtual Education Center
ALC	Air Logistics Centers
ALS	Airman Leadership School
ANG	Air National Guard
ARC	Air Reserve Component
AS	allowance standard
ASIMS	Aeromedical Services Information Management System
ATP	ancillary training programs
BCA	business case analysis
BCO	Base Contracting Office
BMET	biomedical equipment technician
BPA	blanket purchase agreement

BX	base exchange
CAL	custodian action list
CAIM	Customer Area Inventory Management
CC	cost center
CCAF	Community College of the Air Force
CDA	Corporate Dental Application
CDC	career development course and Centers for Disease Control and Prevention
CDS	Chief of Dental Services
CDT	certified dental technician
CE	Civil Engineering or continuing education
CEM	chief enlisted manager
CERT	Credentialing and Education Research Tool
CFETP	Career Field Education and Training Plan
CFR	Code of Federal Regulations
CFM	career field manager
CIC	Community College of the Air Force (CCAF) instructor certification
CLEP	College-Level Examination Program
CLV	clinical lab values
CONUS	continental United States
CPA&I	Clinical Performance Assessment and Improvement
CRA	carries risk assessment
CRLL	Custodian Receipt/Locator List
CS	Customer Support
DANB	Dental Assistant National Board
DANTES	Defense Activity for Non Traditional Support
DAPA	Distribution and Pricing Agreements
DCQ	Dental Charge of Quarters Patient Log
DDB	Deliberate Development Board
DECS	Dental Evaluation and Consultation Service
DENCOM	Dental Command (Army)
DIPC	Dental Instrument Processing Center
DLA	Defense Logistics Agency
DMHRSi	Defense Medical Human Resources System-internet
DMLSS	Defense Medical Logistics Standard Support System
DOD or DD	Department of Defense

DSR	Dental Service Report
DT	development team
DTF	dental treatment facilities or flight
DWV	dental weighted values
EAS	Expense Accounting System
ECAT	electronic catalog
ECN	equipment control number
EEIC	element of expense investment codes
EPME	Enlisted Professional Military Education
EPR	Enlisted Performance Report
ERAA	Equipment Review and Authorization Activity
FAC	functional account code
FEQ	Field Evaluation Questionnaire
FHP	force health protection
FM	functional manager
FSC	Financial Services Center or Federal Supply Class
FTE	full time equivalent
FW&A	fraud, waste, and abuse
FY	fiscal year
GSA	General Service Administration
GSU	geographically separated unit
GPC	Government Purchase Card
GRD	(authorized) grade
GSA	General Service Administration
GSU	geographically separated unit
HAZCOM	hazardous communication
HAZMAT	hazardous materials
HHT	hand-held terminal
HMR	Historical Maintenance Report
HSI	Health Services Inspection
HQ	headquarters
IAW	in accordance with
ISD	instructional systems development
JQS	Job Qualification Standard
LP	local purchase
MAJCOM	major command

MEDCAT	Medical Catalog
MEMO	Medical Equipment Management Office
MEPRS	Medical Expense and Performance Reporting System
MER	Medical Equipment Repair
METC	Medical Education & Training Campus
MFC	Medical Facility commander
MICT	Management Internal Control Toolset
MLFC	Medical Logistics Flight commander
MPF	Military Personnel Flight
MPM	Medical Expense and Performance Reporting System (MEPRS) program manager
MTF	medical treatment facility
MTL	Master Task List
NATO	North Atlantic Treaty Organization
NBC	National Board for Certification
NCO	noncommissioned officer
NCOIC	noncommissioned officer in charge
NIIN	national item identification number
NIR	new item request
NSN	national stock number
O&M	operations and maintenance
OCONUS	outside the continental United States
OI	operating instruction
OJT	on-the-job training
OSHA	Occupational Safety and Health Association
PCS	permanent change of station
PDE	periodic dental exam/examination
PE	programs and evaluation
PM	preventive maintenance
PMC	professional manager certification
PME	Professional Military Education
PMEL	Precision Measurement Equipment Laboratory
PPE	personal protective equipment
PRP	Personnel Reliability Program
PSR	periodontal screening and recording
PV	prime vendor

QT	qualification training
QTP	Qualification Training Package
RC	responsibility center
RGR	required grade
RMO	Resource Management Office
RVL	Ready Volume List
SACS	Southern Association of Colleges and Schools
SF	standard forms
SKT	skill knowledge test
SME	subject matter expert
STS	specialty training standard
TDY	temporary duty
TIG	time-in-grade
TIS	time-in-training
TJC	The Joint Commission
TR	training references
U&TW	utilization and training workshop
UGT	upgrade training
UMD	unit manpower document
UPMR	unit personnel management roster
VA	Veteran's Administration
WAPS	Weighted Airman Promotion System
WO	work order
WWL	Worldwide Locator

Student Notes

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