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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.

THIS IS THE fourth and final volume of CDC B4N151. By this time in your Air Force career, you have become quite proficient at the routine scrub, circulate, and transport duties. If you are not already doing so, you will soon be training junior airmen, helping inventory supplies and equipment, and assisting with some of the paperwork and other administrative functions of surgery.

This volume is designed to give you some of the tools to understand and perform some of the basic management and administrative duties associated with the operating room and ancillary areas. Unit one begins with an overview of supervision, paying particular attention to the newly assigned surgical service apprentice. The unit continues with a look at publications and other written correspondence, and finishes with one of the key processes in the medical facility-quality assurance and risk management. Unit two centers on resources; it begins with a look at the medical Resource Management Office, and ends with medical logistics. Unit three, the final unit of the volume, and of the course, focuses on administrative procedures of ancillary areas of surgery such as sterile processing department and the various clinics. The final subject of the volume deals with medical readiness and specific contingency roles of the surgical service technician.

A glossary is included for your use.

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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. Administration and Management in the Surgical Service Career Field

DO YOU REMEMBER THE DAY you met your first supervisor? A good supervisor prepares Airmen to fill his or her shoes someday. You may not be filling a supervisory position today, but you will eventually. You should be preparing for that day by learning all you can now. There are so many things a supervisor must take care of for their newly assigned troops (i.e., safety briefings, identifying performance standards, on-the-job training (OJT), and orientations); the list seems endless! This unit is designed to introduce you to the world of being a supervisor of surgical service personnel. Being a good supervisor requires integrity, time, patience, and sometimes, just having the courage to let subordinates make and learn from their mistakes.

1–1. Supervision

Leadership, management, and supervision are key elements in nearly every aspect of life. When we were children, parents, guardians, or other adults provided these traits. Teachers, coaches, bosses, and even friends assume these roles at different times or for different activities. Even as a first term Airman, you may, from time to time, be placed in a position to supervise less experienced Airmen. Leadership and management of personnel and resources are also important for you to learn. At specified intervals during your career you will attend professional military education (PME). PME is designed to teach you the skills needed to be an effective leader and manager.

601. Supervising the newly assigned surgical technician

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

Orientation of the newly assigned surgical technician

When notified of the projected assignment of a newly graduated Airman, the superintendent, or noncommissioned officer in charge (NCOIC) should determine and assign an immediate supervisor. To prepare for the inbound airman, the supervisor should begin gathering and assembling the various records and documents required to create a training folder. The specific records required, as well as procedures for creating the training folder, are listed in the 4N1X1X *Career Field Education and Training Plan* (CFETP). Some of these records include:

- AF Form 623, Individual Training Record Folder.
- 4N1X1X Career Field Education and Training Plan.
- AF Form 623a, On-the-Job Training Record—Continuation Sheet.

- Any locally developed overprints of the AF Form 797, Job Qualification Standard Continuation/Command JQS.
- Any locally developed orientation checklists.
- AF Form 55, Employee Safety and Health Record.
- AF Form 931, Airman Comprehensive Assessment (AB thru TSgt).

NOTE: The AF Form 931 is *never* maintained in the training record; the ratee gets a copy and the rater may keep a personal copy, but it does *not* go in the AF Form 623 record folder. In addition to creating the training folder, the supervisor should also coordinate with the NCOIC and the training manager to work out a training schedule.

Upon notification of the assignment, the NCOIC should also coordinate with the commander's support staff to assign the individual a sponsor. The sponsor's job is to welcome the new arrival to the base and to help make the relocation process easier for all involved. Sponsor's duties include the following:

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

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

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

Part of the in-processing procedure includes an orientation phase. This includes familiarization to the base, the facility, and work center (duty section). Most facilities have newcomers' briefings which include briefings ranging from the facility commander down to the various offices he/she will deal with on a day-to-day basis. When you're assigned to orient an individual, be sure to introduce the young airman to other work center personnel and those in his/her chain of command. Walk the individual through the work center, discuss and show them the physical layout of the operating rooms (OR), post anesthesia care unit (PACU), and the sterile processing department (SPD). In addition to these areas, take them on a tour of the facility and show them where the nursing units, clinics, lab, x-ray, pharmacy, and other important areas are located. Pay particular attention to fire and disaster evacuation plans and clinic/work center operating hours. Include a brief overview of what he or she may be doing on the job, and so forth.

The orientation period varies from one individual to another, but it should always cover the essential information. Most work centers, facilities, and bases, provide the airmen with an orientation checklist. Once this checklist is complete, it should be given to the supervisor to maintain in the individual's file. Checklists from the facility and base must also be forwarded to the appropriate office of primary responsibility (OPR).

As the newly graduated Airman's supervisor, there are a number of other areas you must address (these are included in the following lessons). As we proceed, we will discuss the supervisor's role in explaining the Airman's duty schedule, work standards expected, and required safety related briefings

and documentation. Before we discuss these areas, let's discuss the supervisor's role in evaluation of newly assigned airman arriving from technical training.

Assigning personnel to work areas

As a surgical technician, you may be expected to work various shifts and possibly pull "call." Furthermore, as a member of the Air Force, you must remember that the mission comes first. You are subject to duty 24 hours a day, including weekends and holidays. If directed by your leadership, you must report for duty at any hour, at any location, and remain as long as necessary to get the job done unless excused by your leadership. Duty schedules must provide adequate surgical coverage and distribute working hours so the best use is made of available personnel. The superintendent or NCOIC is usually responsible for scheduling enlisted personnel, but the task may be delegated to a mid-level supervisor. Once prepared, the schedule is also reviewed and approved by the officer in charge (OIC).

Policies

There are many rules and policies the NCOIC must take into consideration when preparing duty schedules. One such policy is Air Force Instruction (AFI) 36–3003, *Military Leave Program*, which contains information pertaining to leave and administrative absence policy. The medical treatment facility (MTF) and your duty section may also have written operating instructions (OI) regarding scheduling. As NCOIC, or designated scheduler, it is your responsibility to consult these resources and to know and follow appropriate guidelines for scheduling personnel.

Considerations

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

Another consideration is equity. Always be fair; treat the entire staff the same, this means avoiding favoritism. Schedules should *not* be used as tools of control or discipline. Trying to please everyone drives the scheduler crazy because it's impossible! If you remain consistently equitable to all staff, you will at least be respected. Post your schedule as early as possible, at least two weeks in advance and maintain a record book of past schedules. Keeping past schedules gives you a record, so when a technician complains, "You've put me on call every Friday for three months!" you've got documentation to prove otherwise—unless of course it's true!

"Call" can be a scheduler's nightmare! No matter how hard you try, you won't make everybody happy—about the only people happy with a call schedule are those whose names aren't on it! This is an area where judgment and equity are crucial. Supervisors and trainers must judge carefully when deciding when a surgical service apprentice is ready to "pull call." The length of time in training is often used as a guideline, but this should not be the only guideline. Some 3-level technicians are call-ready in three months, others not for six months. Ability and expertise, as well as experience, maturity, and personal initiative are all factors to consider, but it all boils down to the supervisor's judgment. If manpower allows, it's a good practice to schedule an inexperienced technician to pull call with an experienced technician for the first few times.

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

Cyclic scheduling

One of the most equitable methods of distributing hours of work and time off is cyclic scheduling. In this type of scheduling, a basic pattern is established and then repeated. Cyclic scheduling allows staff members to project their off-duty time into the future. This contributes to staff satisfaction and reduces the number of requests for special time off. Because of the military lifestyle, it doesn't always work, but you can adapt the framework.

Many facilities have computer–generated templates that make scheduling much easier than hand writing or typing them out. Excel is an excellent program that will allow supervisors to develop duty schedules templates in minimal time. To give you an idea of the scheduling process, we've provided the following duty schedule example. Refer to the example as we discuss the process.

Place staff names in the wide left-hand column by date of rank. Record the days of the week on the top line, starting with whatever day the first of the month falls on; in the example it is Friday. Write the actual calendar dates in the row below the days. Mark all holidays for the month you are scheduling, then other personnel absences such as temporary duties (TDY), leaves, PME classes, details, small arms training, and so forth. Develop and print a legend of codes used to designate scheduled events. Examples of legend codes are shown in the bottom left block of the example.

Surgical Suite Duty Schedule

NOVEMBER	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S
2016	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
MSgt Williams	D	OF	OF	D	D	D	D	D	OF	OF	H	D	D	D	D	OF	OF
TSgt Johnson	D	OF	OF	D	D	D	AD	D	OF	OF	HC	D	D	D	HO	OF	OF
SSgt Smythe	D	OF	OF	D	D	D	D	OF	C	OF	H	LV	LV	LV	LV	OF	OF
SSgt Kyle	D	OF	C	OF	D	D	D	D	OF	OF	H	D	D	D	D	OF	OF
SrA Hanks	E	OF	OF	E	E	E	E	E	OF	OF	H	E	E	E	E	OF	OF
SrA Robinson	D	OF	OF	D	D	D	D	D	OF	C	H	OF	D	D	D	OF	OF
A1C Hyde	OF	C	OF	D	DT	OF	D	D	OF	OF	H	D	D	D	D	OF	OF
A1C Marks	D	OF	OF	D	D	D	D	D	OF	OF	H	D	D	D	D	OF	OF
AB Stemple	D	OF	OF	E	E	E	E	E	OF	OF	H	D	D	D	D	OF	OF
# ON DAYS	7			6	6	6	7	6				6	7	7	6		

D = Days **OF = off** **Marion Smith, NCOIC,**

E = Evenings **HO = holiday comp day** **Surgical Suite**

C = Call **LV = leave**

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

1. Enter the days you know each individual won't be available for duty because of *mandatory* prior commitments such as PME, small arms training, TDY, and details.
2. Enter projected and approved leave dates.
3. Enter any special requests you intend to honor if possible.
4. Enter holidays or military compensatory holidays. (Civilians are off on the actual holiday, or they work it. They don't have compensatory time.)

5. Complete the evening shift, one technician at a time, in turn, all the way across the schedule with appropriate time off before and after the evening tour.
6. Enter the night shift personnel in the same fashion.
7. Enter the "call" shifts, ensuring adequate coverage for each period required. Enter projected compensatory time for the call shift.
8. Enter the day shifts, one technician at a time, with days off, etc., all the way across the schedule.
9. Add up, and enter in the bottom of each daily column, the total number of technicians on each shift. Ensure at least the locally established minimum staff members for each shift cover each day.
10. Adjust deficiencies by moving "comp days" and requested time off first. Leave requests should be honored if possible. Mandatory military duties may not routinely be canceled or moved.
11. Sign the completed schedule. Forward it to the OIC for review and signature.
12. Post the schedule in the designated conspicuous area.

The daily surgery schedule

Another type of schedule you will be routinely involved with is the surgery schedule (schedule of operations). Normally, the OR supervisor develops the surgery schedule from individual patient information transmitted to the surgical suite by the various surgical clinics. This doesn't mean the OR supervisor types the schedule; this task is often delegated.

The information for the surgery schedule may be electronically transmitted or may be taken from individual scheduling request slips. The surgeon requests the specific date of the proposed operation, then coordinates with the OR supervisor and the chief of anesthesia to establish the order in which the procedures will be done. To determine this order, they consider factors such as available resources (manpower, supplies, equipment, etc.), the patient's age, the urgency of the surgery, and difficulty of the proposed procedure. This coordination and prioritizing process is done with each surgeon requesting operating time as the OR supervisor develops the surgical schedule for each day.

Schedule contents

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

- Date and day of the operation.
- Time of the operation. Usually, a specific time is allocated to only the first cases of the day in each operating room; all others are scheduled "to follow" or simply "TF."
- Designated operating room number or letter (OR 4, OR D) for the procedure.
- Patient identification information:
    - Name.
    - Hospital register number or Social Security number.
    - Age.
    - Sex.
    - Military status or rank (D/W, E–3, O–5, Capt, Amn).
- Patient location or nursing unit designation (3B, 2W, ASU, ICU).
- Operation to be performed (entries may be abbreviated to save space).
- Primary surgeon (assistants and residents or interns are sometimes listed).
- Type of anesthesia (general, local, spinal, or the anesthesia provider's "choice").

- Name of anesthesiologist or anesthetist who will administer the anesthesia.
- Units of blood required, if applicable.

Schedule distribution

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

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

Additional copies may also be sent to other persons or areas determined by local policies, such as: the laboratory (especially the pathology lab), blood bank (if units of blood will be typed and cross-matched in advance), and the radiology department (if intraoperative, X-rays will be taken). With the proliferation of computerized information systems in Air Force hospitals, many surgical suites are now developing and distributing the surgery schedule via computer.

Scheduling personnel on a daily basis

After the surgery schedule is approved and typed, the NCOIC (or designee) schedules individual technicians to provide coverage for each procedure. Most times, technicians are assigned to work in a specific operating room, and they are responsible for helping with all procedures in the room throughout the day. Sometimes a technician is assigned to a particular surgical case. This may be at the surgeon's request, the nurse's request, or because the procedure is a unique one and the NCOIC feels the technician is right for the job.

Exactly how individuals are scheduled to provide case coverage is a local decision. Some operating rooms have "teams" devoted primarily to a surgical specialty. Other departments schedule personnel to a specific operating room for a period; personnel handle all cases in their assigned room regardless of the specialty. Some even schedule personnel on a case-by-case basis.

Regardless of the method used to provide coverage, one principle must be kept in mind. As a military surgical technician you are required to maintain a "war-readiness" posture. This means you must be able to assist with a variety of procedures in a variety of specialties.

Strict specialization is highly discouraged. In a contingency, a technician who "only does hearts" isn't going to be very effective when called upon for emergency orthopedic surgery. Even in non-contingency situations, strict specialization can cause problems. For example, let's say a technician specializes in only one surgical specialty. That person is then assigned to a facility that doesn't offer that specialty. In this case, the leadership at the originating assignment has failed to fulfill its duty to the gaining facility. Strict specialization is also detrimental to the individual. The Air Force promotion system is designed to promote well-rounded people with a broad base of experience as its future leaders.

602. Career field surveys

At some point in time throughout your career you may be asked to complete career field surveys or questionnaires. If you or one of your coworkers is asked to participate in this survey, please be accurate and honest. You may want to stress to your peers and subordinates the importance of completing these surveys. Keep in mind, the information provided to the training command will influence the 4N1 career field for years to come.

Evaluation of surgical formal course graduates

The supervisor of a newly assigned surgical service apprentice will be asked to provide feedback to the Surgical Service Apprentice Course located at Joint Base San Antonio-Fort Sam Houston, Texas. Providing feedback to the school is the only way to help the school improve the quality of training. If graduates aren't learning what's needed to perform on-the-job, then you, as the supervisor, should communicate this fact to the course. There are various methods used to gather this data. These include the following:

- Field evaluation questionnaires (FEQ).
- Field interviews via telephone.
- TDYs from training evaluators at the training group.
- Customer service information line (see your CFETP for details).
- Graduate assessment surveys (GAS).

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

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

Job inventory survey

Have you ever heard of an "Occupational Survey Report (OSR)?" An OSR is a survey used to collect data for evaluation of career field training and to update training documents, specifically, the career field specialty training standard (STS) portion of your CFETP. The OSR specifically provides the training community with a comprehensive data base to support anticipated training decisions for the career ladder. An OSR is accomplished by surveying at least 50 percent of personnel throughout the career field and is represented in terms of major commands (MAJCOM), pay grade, and total active federal military service time. To compile data for the OSR, The Occupational Measurement Squadron, located at Randolph AFB, TX, puts together a tool called a *job inventory*. The 4N1X1X job inventory is a composition of all tasks specifically accomplished by the 4N1X1X career field, and lists any equipment commonly used by 4N1X1X personnel. The job inventory also asks background questions related to type of duty section, job satisfaction, and so forth. Upon compilation of the data, a thorough report is sent out to training personnel and to those who request a formal report.

603. Performance standards and evaluations

One of the most important aspects of supervision, and one that is often overlooked, is establishing job descriptions and performance standards to help provide objective measurement criterion, then using these tools to assist in objective evaluation. Do you know what standards and expectations your supervisor uses to evaluate you? Let's take a brief look at some of these tools.

Job descriptions

Job descriptions define the duties and responsibilities of each designated position. A job description should be written in objective terms and should do what it says—describe the job. It should *not* describe how the job should be done or to what measurement standard. A formal job description has these four basic parts:

1. Job title.
2. Source or reference.
3. Qualifications for the job.
4. A summary of the duties and responsibilities.

A job description is part of your Enlisted Performance Report (EPR). You may want to ask your supervisor to review your job description with you during one of your performance feedback sessions. Ensure the job description says what you do—if the job description talks mostly about scrubbing and circulating, and you are working mainly in central sterile supply, it isn't an accurate description. You may not feel the job description is very important, after all, you know what you do, but—the job description is usually the first thing a promotion or recognition board looks at. If you have more duties and responsibilities than a coworker does, but your job descriptions are identical, how will a "below-the-zone (BTZ)" or "stripes for exceptional performance (STEP)" promotion board determine the difference?

Federal civilian job descriptions are known as *position descriptions*; as such, they are more complex and very detailed. Position descriptions are broken down into specific performance elements that describe each duty. If you are ever assigned to supervise a civilian employee, consult with your civilian personnel office for specific job descriptions and duties. It would also be wise to seek out an experienced civilian supervisor. To get an idea just how complicated civilian supervision can be, you should read the section on civilian personnel in Air Force Pamphlet (AFPAM) 36–2241, *Professional Development Guide*.

Performance standards

The performance standard complements the job description—it tells how and how well you are expected to do the key tasks in your job. You can say performance standards are the building blocks for job descriptions. In addition, they should form the basis of performance appraisals (such as your EPR). In essence, they're descriptions of what you are expected to do, and how well you should do it, in any given setting.

Performance standards for surgery are often based on national standards from sources such as the following:

- Association of Operating Room Nurses (AORN).
- The Joint Commission.
- Association of Surgical Technologists (AST).
- Association for the Advancement of Medical Instrumentation (AAMI).

In addition, they're also derived from your CFETP, quality training packages (QTP), and local requirements.

Like job descriptions, performance standards should be objective; that is, they should allow for measurement of competency and quality regardless of the individual. For example, SrA Smith is being evaluated on how well he assembles an instrument set; the same performance criteria should be applied to evaluate A1C Johnson when she assembles a set.

Like civilian job descriptions, civilian performance standards are more complicated to manage. Each performance element in the position description is described as to exactly how the duty is to be accomplished. Objective standards must be set to allow for fully successful performance. Again, if you are ever assigned to supervise civilians, seek experienced help!

Evaluating performance

Performance evaluations should be based on the job description and performance standards that apply to the individual being evaluated. To be an effective evaluator, you must also develop self-awareness; that is, you must know and recognize your own values, beliefs, attitudes, and opinions, and be able to put them aside to evaluate the performance of the individual objectively. It may be difficult for you to evaluate someone objectively, particularly someone you personally like or dislike, but it must be done. This is when all the time spent developing accurate job descriptions and performance standards pays off. If the elements in your job description are specific enough, and the elements in your performance standards are objective and measurable, your evaluation becomes a matter of applying the standard to the individual.

For Example: Let's see how an accurate job description and portion of a performance standard can help evaluate a surgical service apprentice on the performance of a relatively simple duty with the job description line: Transports surgical patients from nursing unit to surgical suite.

Performance Standards	Measurement
Reports to unit nursing station.	GO/NO GO
Identifies self and notifies nursing unit personnel of identity of patient for transport.	GO/NO GO
Obtains patient's chart.	GO/NO GO
Verifies identification on chart matches pick-up slip.	GO/NO GO
Review surgical checklist/contents of chart.	GO/NO GO
Check informed consent.	GO/NO GO
Requests assistance from unit personnel.	GO/NO GO

Using the example provided, you can see each individual step is described, and the measurement is "go/no go." A go/no go standard is used for critical elements or for items that must be accomplished; if the individual fails to accomplish the step, he or she fails the evaluation.

In the example, if the trainee you are evaluating forgets to check for informed consent, the trainee fails the evaluation. If the evaluation was being conducted to certify the individual on patient pick-up, you would *not certify* the individual until he or she successfully passed an evaluation. If you were evaluating a trainee on a noncritical task, your measurement standard might allow for a percentage of accuracy, a specific number of assists, or acceptance if the trainee recognizes the mistake and takes corrective action. By using measurable elements in performance standards, you can point out exactly where the trainee went wrong, and the individual can focus attention on learning that particular aspect of the duty.

Counseling the surgical technician

One of the duties most often associated with supervision is counseling. While most people associate counseling as a negative action, counseling can (and often should) also be positive. Your professional development guide (PDG) discusses counseling techniques and situations; you should review them when you are initially assigned as a trainer or supervisor. Given some of the surgery specific topics—both positive and negative—you may have to counsel your subordinates.

Education policies while in training

Many facilities have specific policies that prohibit or restrict off-duty education while members are in upgrade training. Some require the trainee to complete their CDC before enrolling; others simply require the trainee to demonstrate he she can successfully handle both simultaneously. You should teach and counsel your trainees on the department or group policy. You should also ensure the trainees understand they will have to reimburse the government for their tuition assistance if they withdraw from, do not complete, or fail a college course.

Call procedures and expectations

"Call" is a foreign experience for most surgical apprentices. As the trainer or supervisor, you should stress the nature and the seriousness of the trainees' responsibilities when on-call. Ensure they know their time reporting limits and geographical area. Stress the need for adequate rest and physical conditioning to handle the sometimes demanding rigors of call. Ensure they know what behaviors and activities are allowed—and which are *not*. One basic point is often neglected—the on-call technician should maintain regular contact with whoever is responsible for making the call. They should also ensure that the "beeper" is *not* the sole method of contact for extensive periods.

Training progression

Periodically evaluate and appraise the trainee of their progress—this includes dating and initialing the appropriate STS elements in the CFETP. Too many trainers and supervisors let a trainee go for months with no feedback, yet their CFETP will have all items dated and "closed out." They often tell the trainee to initial next to the date without explaining what the trainee is indicating by the initials. It is critical that trainees understand by placing their initials after an item on an STS they are certifying they know how to do and are completely trained on the specific item.

Safety

Safety should be integrated into the day-to-day work environment. Counsel trainees on personal protective equipment, on hazards associated with specific tasks or equipment, and on high-risk off-duty activities. Some high-risk activities (such as parachuting or hang-gliding) require the commander to counsel the individual. Members under 25 years old must be counseled, or receive a safety briefing, before any three-day weekend and before departing on leave. These safety briefings should be documented in the department safety book.

Career Job Reservation

One area often neglected by supervisors is explaining the re-enlistment process, especially the Career Job Reservation (CJR). According to AFPAM 36–2241:

> "All eligible first-term airmen must have an approved CJR in order to re-enlist. There is a specific time-frame during which airmen may apply for a CJR. Four-year enlistees may request a CJR no earlier than the first duty day of the month during which they complete 35 months on their current enlistment, but no later than the last duty day of the month during which they complete 38 months on their current enlistment. Six-year enlistees may request a CJR no earlier than the first duty day of the month during which they complete 59 months on their current enlistment, but no later than the last duty day of the month during which they complete 62 months on their current enlistment. Generally, airmen forfeit their CJR eligibility if they do not apply during these time-frames. There are exceptions for airmen who require additional retainability for PCS assignments, overseas tour extensions, and the like."

You should apply for (and encourage any subordinates to apply for) a CJR even if you fully intend to separate from the Air Force after the first enlistment. Without an approved CJR, you can't re-enlist. Approval of a CJR does *not* mandate re-enlistment; it simply keeps the option open. Why burn a bridge if you don't have to?

Mentoring

Mentoring is leading or guiding your subordinates to reach their full potential; it is a form of positive counseling. It helps fulfill your responsibility to "train-up" the next generation of Air Force leaders—your replacements. Mentor counseling is often conducted in conjunction with feedback sessions. Topics you should discuss include those covered in this section, as well as items like promotion requirements, PME eligibility, unit/base/community involvement, medical and physical fitness, equal opportunity, assignment policies and procedures, personal and financial planning, and numerous other subjects to help the subordinate become a well-rounded Air Force member.

These are only some examples of the areas you may want to focus on during counseling. Put yourself in your subordinate's place—if your supervisor doesn't discuss these issues with you, who will?

604. Written correspondence

Paperwork! Some consider it the bane of civilization. Nevertheless, to be effective in today's Air Force, everyone, not just supervisors, needs to know how to prepare written correspondence, reports, records, procedures, and policies. You can get a great deal of help when you get ready to write by consulting the primary reference for everyday Air Force writing, Air Force Handbook (AFH) 33–337, *The Tongue and Quill*. In this lesson, we briefly look at some of the routine paperwork you'll see in the surgical environment. We'll start with memorandums and letters.

Memorandums and letters

To provide greater continuity, the Air Force has adopted standardized formats for letters and memorandums. You can find specific guidance on these formats in the *Tongue and Quill*; however, two important guidelines involve the use of letterhead. You should use plain paper (not letterhead) for intra-departmental memos and letters. Local policy may also require plain paper for intra-group or squadron letters and memos. If you are writing to an agency or individual outside the organization, use letterhead. Use letterhead for official correspondence only—not to write letters home or to friends.

Reports

We discuss numerous reports at various areas throughout this course. Some common reports you may be involved with are reports of survey, medical expense and performance rating system (MEPRS) and other manning reports, various infection control reports, equipment status reports, and end-of-month surgical case reports. Many reports are required locally, and the format for the report is prescribed locally. If the format is not prescribed, use the standard "memorandum for" format.

One report of particular significance and importance to Air Force enlisted members is their EPR. Detailed guidance on evaluating subordinates and preparing the EPR can be found in your PGD manual. When you are assigned as a supervisor for the first time, attach yourself to a mentor. Find out who has a reputation for being an effective EPR writer. Which supervisor's people consistently win recognition boards or BTZ boards? Ask them for guidance on conducting and reporting performance feedback, and to help draft the EPRs you write.

Records

The records you most frequently deal with are patient care records; these have been discussed at various points throughout this course. Most Air Force medical records are self-explanatory, you simply print or type the information requested in the appropriate block. There are two important points to remember about patient medical records.

1. They may be used as legal documents at some time in the future. For this reason, if you make a mistake on a patient record, draw a single line through the erroneous information, make the correction, and initial the error. Never completely obliterate an error; it will look conspicuous to an attorney.

2. Medical records document the care the patient received and, sometimes, why they received it. For this reason, you must ensure the information is legible and clearly understandable; avoid the use of abbreviations.

Policies and procedures

Policies provide guidance and boundaries for making decisions—for thinking. Formal policies are developed and *written* at various levels throughout the Air Force, from the Pentagon to your duty section. Formal policies may define consequences for failure to follow them. There are six basic purposes for writing a policy:

1. Define and guide the general direction and scope of activities to achieve the policy maker's goal.
2. Provide authority to guide decision making.
3. Create standardization or unity for similar or recurring operations.
4. Settle conflicts.
5. Delegate authority.
6. Ensure objective and equitable treatment of personnel.

If you are tasked to solve a problem in your section, and you can't fit the problem into one of these six purposes, you probably do not need to develop a policy; you may need to develop a written procedure.

Procedures provide the "how to" of a task. Written procedures generally detail exactly how a particular job or duty is to be accomplished. A properly written procedure leaves little room for error or doubt—it is specific. There are many reasons for writing a procedure, but the most common is to standardize the way something is done. Through standardization, we ensure everybody does the procedure the same way. The goals of a written procedure should be to inform, teach, and/or reduce error.

Self-Test Questions

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

601. Supervising the newly assigned surgical technician

1. Define the term supervision.

2. Who determines and assigns an immediate supervisor to a newly assigned airman?

3. What is the sponsor's job?

4. Describe some of the actions you can take to help orient a new assignee.

5. Who is responsible for scheduling enlisted personnel for duty?

6. Who reviews and approves the duty schedule?

7. List, in order, the procedures for completing a monthly duty schedule.

8. Where can you find information pertaining to leave and administrative absence policy that may help when scheduling?

9. List some considerations when planning a schedule.

10. Why should you *not schedule* someone to work a double shift (16 hours)?

11. Who normally develops the daily schedule of operations?

12. List some of the information found on a typical daily surgery schedule.

602. Career field surveys

1. Why do supervisors provide feedback to the Surgical Service Apprentice Course?

2. List the methods used to collect data regarding the training that trainees receive.

3. What is an OSR?

4. What tool is used to collect the data need to compile an OSR?

603. Performance standards and evaluations

1. What is the purpose of job descriptions and performance standards?

2. Describe a job description.

3. What are civilian job descriptions called?

4. What is a performance standard?

5. List some of the national organizations that set standards for surgery.

6. Why must you develop self-awareness to be an effective evaluator?

7. What is a “go/no go” standard?

8. Why should all surgical technicians apply for a CJR?

604. Written correspondence

1. What is the *primary* reference for everyday Air Force writing?

2. Describe the guidelines for using letterhead in correspondence.

3. How should you correct a medical record if a mistake was made while filling in a block?

4. Describe the difference between policies and procedures.

1–3. Performance Improvement and Risk Management

To lead in an era of dramatic world change and revised national priorities, the Air Force must use modern innovative management practices like streamlining organizations, empowering people, and removing barriers to continuous performance improvement (PI).

This section is devoted to a brief overview of PI and risk management (RM). We'll define PI and RM and look at the Air Force PI and RM program. Finally, we cover PI as it relates to the operating room.

605. Performance improvement, risk management, and the Air Force program

We've mentioned performance improvement in various sections throughout this course, mainly because quality patient care is all encompassing. For our purposes, performance improvement may be defined as "any and all efforts to improve the quality of patient care." In contrast, risk management is "the identification and action taken to resolve problems or potential problems in the health care setting." PI/RM is an important part of the Air Force's health care delivery system and probably has the most widespread impact on your job. PI not only pertains to how you do your job, but it also covers the identification and resolution of patient care problems. The medical facility safety program, the infection control program, and other facility-wide programs are directly linked into the quality assurance and risk management program.

The Joint Commission and performance improvement

PI and RM has been around for over 20 years; however, the new and improved quality process has helped us to take yet a closer look at how we do business. The Joint Commission is the lead agency for establishing quality and accreditation standards for the medical profession. In recent years, Joint Commission has changed its focus from just looking for problems (traditional quality improvement) to improving the process (PI). AFI 44–119, *Medical Quality Operations*, specifically directs Air Force medical treatment facilities to meet Joint Commission standards. To ensure compliance, Joint Commission surveyors look at the planned approach to improvement, the design of new or revised process, data collection, assessment of data, and PI. Joint Commission's transitions to performance-focused standards are organized around important functions, which were completed with the *1995 Accreditation Manual for Hospitals (AMH).* For more information about Joint Commission standards related to the PI, see the current AMH edition.

Unit self-assessment program

Unit self-assessment is conducted within the unit using the Air Force criteria as the framework for improving overall organizational performance. Sometimes referred to as a unit self-inspection, the self-assessment's primary purposes are to identify problems at the lowest management level, implement solutions, and provide a feedback system to track problems until they are resolved.

Each wing, group, squadron, and section develops unit self-assessment checklists or guides by using current directives, policy letters, performance improvement reports, etc. To ensure coverage of all areas of responsibility, the checklist should be tailored to each organization's structure and mission. Each checklist should list the prescribing directive or policy authority for each item to be inspected or assessed. Checklists are reviewed at least annually to ensure accuracy and for inclusion of any additional items. If you are selected to be the section or unit self-assessment monitor, you will conduct the assessment on a regular basis, usually annually.

Performance improvement

PI is a program used to ensure the resolution of real and potential problem areas related to patient care through the use of formal mechanisms. The main purpose of any PI program is to improve the quality of health care.

Risk management

RM is the means to identify and act on problems in the health care setting. These are problems that have caused (or may cause) harm to patients, visitors, employees, or property and may result in

hospital liability or loss of hospital resources. The main purpose behind RM is controlling medico-legal liability and reducing the incidence of medical malpractice suits. The RM function is an integral part of the medical treatment facility PI and RM programs.

Air Force PI and RM programs

In Air Force medical treatment facilities, AFI 44–119 is the primary directive governing PI and RM. The program is designed to meet or exceed current Joint Commission and other civilian health care standards.

Within the MTF, PI and RM activities are combined under one committee. This committee reviews and directs the overall PI and RM program. The Chief of Hospital/Clinic Services chairs the committee, which may be a subcommittee of the executive committee. This committee formulates the PI and RM plan that establishes responsibilities for each department and service in the group.

Some of the major objectives include, but are not limited to the following:

- Improving the quality of health care delivery and enhancing practitioner clinical performance.
- Reducing risk-creating incidents and adverse effects to patients.
- Improving provider-patient communication and patient satisfaction with the health care provided.
- Enhancing coordination and communication between providers and services.
- Educating and sensitizing all MTF personnel on program objectives (that’s why you are reading this!).
- Requiring adequate supervision of nonphysician providers (physician assistants (PA), nurse practitioners, nurse midwives, etc.).
- Assuring performance-based credentialing for each practitioner.
- Assuring that identified problems are resolved.

To accomplish these objectives, Air Force PI and RM programs use a variety of monitoring and evaluation tools to determine if the care provided meets, exceeds, or fails to conform to established standards of surgical and nursing practice. Among the tools used are:

- Medical records reviews.
- Reviews of patient complaints.
- Patient questionnaires.
- Patient interviews.
- Peer reviews.
- Supervisor evaluations of worker performance.

The basic purpose of all these evaluation tools is to provide early identification of negative trends and determine the best corrective action before major problems occur.

To serve the purpose of the PI and RM program best, improving the quality of patient care, emphasis is placed on corrective actions that expand the knowledge, skills, and performance of health care personnel. Some examples of effective corrective actions include continuing education, in-service training, peer pressure, management changes, and changes in the work environment.

606. Performance improvement in the operating room

We’ve discussed the basic structure, major objectives, and monitoring and evaluation methods used in the Air Force PI and RA programs, but how is PI implemented in the operating room? What type of activities enable surgical team members to monitor, evaluate, and improve the quality of care provided to surgical patients? Now, we’ll discuss some examples of performance improvement related activities that pertain to operating room functions.

Surgical case review

One of the PI tools outlined by Joint Commission and AFI 44–119 is surgical case review. This review is a method the hospital medical staff uses to evaluate the justification and appropriateness of all surgical procedures performed by staff surgeons. The MTF quality/PI manager collaborates with the patient safety manager, risk manager, and credentials manager to integrate results of data analysis, outcomes of risk management reviews/analysis, and patient safety assessments into the performance improvement process for safe, quality healthcare.

As a part of the review process, this "team" does the following:

- Evaluates the consistency or inconsistency of preoperative, operative, and post-operative diagnoses.
- Evaluates whether or not the surgery was actually necessary. One way the reviewers can assess this is by analyzing the results of tests and examinations done on any tissue specimens removed from the patient.
- Evaluates surgical errors or misjudgments. This includes such incidents as operating on the wrong patient, operating on the wrong area of the patient's body, or performing experimental surgery without proper authorization.
- Evaluates cases where patients are unexpectedly returned to the operating room. For example, the reviewers take a close look at a case where a hernia patient had to be rushed back to the OR because of postoperative bleeding.
- Ensures that operative reports are completed in a timely manner. This refers to the report the surgeon dictates describing the operation, not the basic information filled out by the circulating nurse.

In addition to patient medical records, the surgical procedure logbook or computer log maintained by the OR supervisor is a vital source of information that facilitates tissue committee review since it contains data on all surgical procedures done in the MTF. The PI and RM committee sends a written report of the surgical case review to the PI and RM coordinator for review. Corrective actions must be initiated for any problems identified by the review, and documentation of these actions must be included in the report.

Infection control

Another PI mechanism that directly relates to a broad range of activities performed in surgery and sterile processing is infection control. Infection control programs are developed to identify and evaluate nosocomial (hospital acquired) infections and monitor aseptic techniques and sanitation practices. This is the area of performance improvement that directly relates to your daily duties the most. We say this because infection control affects just about every aspect of your job as a surgical service technician. In this regard, infection control programs monitor the following:

- Sterilization and disinfection practices.
- Housekeeping activities.
- Laundry handling.
- Disposal of waste materials.
- Isolation procedures.
- Aseptic technique.

Infection control personnel monitor patient infection rates and attempt to determine and eliminate sources of infection. They are also responsible for providing infection control training to new employees. Since infection control is so important to your job, it deserves to be covered separately. We devoted an entire volume to infection control in the 4N151A CDC.

Performance improvement in perioperative nursing

Up to this point, we've looked at two areas where performance improvement directly affects surgical patient care, but we haven't mentioned the methods used by operating room nursing personnel to evaluate and improve patient care. Instead of listing every conceivable PI related activity performed by surgical nursing personnel, we will provide some common examples of activities to which you can readily relate.

Personnel performance appraisals

One very effective way to improve the quality of care provided to surgical patients is to have experienced supervisors directly observe their subordinates' duty performance. This allows for immediate detection and correction of deficiencies before they result in harm to the patient. By observing the duty performance of the OR nurses and technicians, the OR supervisor and NCOIC can also determine whether further training is required or if existing training programs need modification. The close supervision you are experiencing during your OJT is not only helping you learn your job, it is also acting as a PI tool by preventing you from making serious mistakes that may hurt your patients.

Preoperative interview

Another PI tool used in the operating room is the preoperative patient interview. This interview, conducted by OR nurses prior to the surgical procedure, serves several purposes. First, it provides the nurses with valuable information that enables them to finish their preoperative assessment of each patient's individual needs. Once the assessment is complete, the nurses can develop a perioperative nursing care plan tailored for each patient they will care for in the operating room.

It also enables the nurse to determine any inconsistencies in the patient's record regarding information the patient originally gave to admissions or anesthesia personnel and the surgeon. For instance, the nurse asks the patient if he or she is allergic to any medications or chemical sol or she is allergic to iodine, the nurse records this in the chart and now knows iodine-based soaps and antiseptic solutions cannot be used on this patient. Because the information is now recorded for all health care personnel to see, the risk of harm to the patient is reduced. The interviewing nurse also verbally passes this information on to other members of the surgical team to ensure iodine-based solutions are kept away from the patient.

Another benefit of this interview is that it gives the nurse an opportunity to do some preoperative teaching to ensure the patient fully understands what is going to happen before, during, and after surgery. The fully informed patient is generally much more cooperative, less apprehensive, and less likely to criticize the care they receive. Also, because the patient is more relaxed and less fearful, postoperative recovery will normally be improved.

Finally, the preoperative interview allows the patient a chance to meet someone on the surgical team, other than the surgeon, who will be with them in the operating room. This one-on-one personal contact between patient and nurse establishes a bond that helps nurses personalize their care and contributes to the overall rapport the patient will have with other surgical nursing personnel.

The information the nurse gains from the preoperative interview is recorded on a special form known as the perioperative nursing record. This form is available in the operating room for you to read until the time the patient is operated on. The written information on this form, along with the nurse's verbal explanations of the patient's special needs, will help you assist the nurse in providing quality care. It also reduces the chances of someone on the surgical team making a mistake because of lack of knowledge about the patient.

Patient observation and records review

Direct observation of the patient and review of the patient's chart immediately before surgery also contribute to PI. You will become involved in this process when you perform patient transport duties.

When you pick up the patient from the nursing care units, you are required to check the patients' identity and review their charts to ensure certain mandatory preoperative checklist items have been accomplished. At this time, you are able to talk to the patient while observing their overall physical and mental condition. If you notice anything unusual, report it to a nurse or doctor immediately, thereby reducing the risk of harm to your patient.

You have probably noticed that a senior nurse (often the OR supervisor) immediately talks to patient and reviews their records after you have transported them to the surgical suite. The nurse also verifies the patients' identities, checks their charts very thoroughly, and observes and notes their physical and mental status. Additional checks of this nature are performed by anesthesia personnel, the circulating nurse (usually the same nurse that conducted the preoperative interview), and the surgeon. All these record checks and patient observations are designed to minimize the possibility of oversights and errors. In other words, they help prevent problems from occurring—one of the main thrusts of the PI program.

Surgical conscience, aseptic technique, and teamwork

During the operation, all surgical team members have the same ethical responsibilities to:

- Perform to the best of their trained abilities.
- Adhere to the strictest standards of aseptic technique.
- Maintain good surgical conscience.
- Work together as a team.

If someone on the team breaks technique or makes a mistake recognized by other team members, the break or mistake should be identified and corrected immediately. For example, if you see a hole in the surgeon's glove and he/she hasn't asked for a new one, you should tell the surgeon immediately and obtain another sterile glove.

NOTE: Surgical conscience dictates you never remain silent when you know something is wrong—this is not only unethical, but illegal. Remember, any unusual occurrence, incident, or accident that happens during the operation should be reported and an incident form filled out.

During the procedure, the nurse is responsible for filling out many forms, including the perioperative nursing record. These forms, which become part of the patient's permanent medical record, provide valuable data that can be reviewed and analyzed after surgery to determine if any negative trends or problems exist.

You can contribute to PI during an operation by remaining alert, anticipating other team member's needs, communicating effectively, and performing your duties safely and efficiently.

Postoperative nursing care monitoring and evaluation

Immediately after surgery, most patients are taken to the recovery room. The circulating nurse accompanies the patient to the recovery room and briefs the recovery room nurses on the patient's status. The recovery room nurses also receive a briefing from the anesthesiologist or anesthetist. During this critical post-anesthesia phase, recovery room nursing personnel closely monitor and record the patient's postoperative recovery from anesthesia until the patient is stable enough to be safely transported back to the nursing care unit. Normally, patients aren't discharged until anesthesia personnel review the recovery room record and certify the patient has recovered sufficiently to be removed from the recovery room. The nursing care provided in the recovery room is documented on a separate form that also becomes a part of the patient's permanent record, along with the perioperative nursing record and the operation report. This record can be reviewed any time postoperatively to assess the quality of care the patient received during the recovery period. The communication between the circulating nurse, anesthesia personnel, and recovery room nurses, coupled with the close patient monitoring and final check of patient status by anesthesia personnel, are routine PI procedures used in the recovery room.

Another PI tool used in surgical nursing practice is the postoperative patient interview. Before patients are discharged from the hospital, an OR nurse visits them on the nursing care unit and asks them several questions to determine the patient's perception of the care they received immediately before, during, and after the operation. The nurse also evaluates the medical and surgical products used on the patient in surgery and assesses the patient's mental state. The information gathered during this postoperative interview is recorded on the perioperative nursing record and is disseminated to other nursing personnel during staff meetings.

The perioperative nursing record is evaluated by the OR supervisor. The data recorded on this form provides the OR supervisor with an outline of what was done to and for the patient. This outline is compared to accepted standards of surgical nursing practice and to existing policies and procedures. If discrepancies are noted in the documentation or in the quality of care provided, the OR supervisor and NCOIC of the operating room work together to determine the best course of corrective action.

Performance improvement and change

One thing that is inevitable in any operating room where an active PI program exists is change. When policies and procedures are revised, it is usually because patient care data from a variety of sources indicated a problem exists and corrective measures are required. By accepting these changes and understanding why they are necessary, you contribute to effective PI. You can also contribute by being an innovator and providing your supervisors with ideas on how to improve patient care and work methods.

Performance improvement in surgery takes a total team effort and dedication to providing the best patient care possible. It is often summed up as "PI is everyone's responsibility." The methods we use to implement PI and RA may differ dramatically from those used in other areas of the hospital, but the goal is the same. Remember, while performing your duties in the operating room, you and the nurses you work with become the patient's advocate. In this role, you become personally responsible for the patient's safety and well-being as long as that individual is under your care. Everything you do from the moment you enter the operating room at the start of the duty day until you go home will in some way affect the quality of surgical patient care. Performance improvement is a broad concept, but you should have no trouble promoting it if you always strive to provide the type and quality of care you would expect if you or a loved one suddenly became a surgical patient.

Self-Test Questions

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

605. Performance improvement, risk management, and the Air Force program

1. Define performance improvement and risk management.

2. What directive governs performance improvement and risk management in the Air Force?

3. What PI tool serves as the framework for improving overall organizational performance?

4. What are the primary purposes of self-assessment?

5. List some of the monitoring and evaluation tools used to accomplish the objectives of the PI and RM program.

6. What type of corrective actions is emphasized in the PI and RA program?

606. Performance improvement in the operating room

1. What is the purpose of surgical case review?

2. Identify three reasons for developing a hospital infection control program.

3. How do personnel performance appraisals contribute to improving the quality of perioperative nursing care?

4. Besides helping nurses personalize care and improving the rapport between the patients and surgical nursing personnel, cite three ways the preoperative patient interview contributes to performance improvement.

5. Identify four surgical team members who directly observe patients and check their charts before surgery.

6. What should be done if a surgical team member breaks technique or makes a mistake during a surgical procedure and another team member notices the error?

7. What is the PI tool used by OR nurses to determine the surgical patient’s perception of the care they received immediately before, during, and after surgery?

8. How can you contribute to performance improvement when patient care data indicates a need for changes?

Answers to Self-Test Questions

601

1. The process of reviewing, observing, and accepting responsibility for the actions and services provided by subordinates.
2. The superintendent or NCOIC.
3. To welcome the new arrival to the base, and help make the relocation process easier for all involved.
4. Introduce the young airman to other work center personnel and those in his/her chain of command. Walk the individual through the work center, discuss with and show them the physical layout of the ORs, recovery room, and central supply. Take them on a tour of the facility and show them where the nursing units, clinics, lab, X-ray, pharmacy, and other important areas of your facility are located. Pay particular attention to fire and disaster evacuation plans, clinic operating hours. Include a brief overview of what he/she may be doing on the job, etc.
5. The superintendent or NCOIC is usually responsible for scheduling all enlisted personnel, but the task may be delegated to a mid-level supervisor.
6. The OIC.
7. The procedures are as follows:
   1. Enter the days you know each individual won't be available for duty.
   2. Enter projected and approved leave dates.
   3. Enter any special requests you intend to honor if possible.
   4. Enter holidays or military compensatory holidays.
   5. Complete the evening shift, one technician at a time.
   6. Enter the night shift personnel in the same fashion.
   7. Enter the "call" shifts, ensuring adequate coverage for each period required.
   8. Enter the day shifts, one technician at a time, with days off.
   9. Add up, and enter in the bottom of each daily column, the total number of technicians on each shift.
   10. Adjust deficiencies by moving "comp days" and requested time off first.
   11. Sign the completed schedule. Forward it to the OIC for review and signature.
   12. Post the schedule in the designated conspicuous area
8. AFI 36–3003, Military Leave Programs.
9. Plan so most of the staff is available during peak workload periods. Distribute staff according to experience and ability; ensure there are enough experienced staff members to not only cover the required tasks, but to train and supervise inexperienced personnel. Another consideration is equity. Post your schedule as early as possible. Maintain a record book of past schedules.
10. Research has documented that after 12 hours, performance is significantly reduced.
11. The OR supervisor.
12. Some of the information found on the schedule is: Date and day of the operation; Time of the operation; Designated operating room number or letter; Patient identification information; Patient location or nursing unit designation; Operation to be performed; Primary surgeon; Type of anesthesia; Name of anesthesiologist or anesthetist; Units of blood required (if applicable).

602

1. Providing feedback to the school is the only way to help improve the quality of training.
2. Some methods used are: FEQs, field interviews via telephone, TDYs from training evaluators at the training group Customer Service Information Line, and GAS.
3. An OSR is a survey used to collect data for evaluation of career field training and to update training documents, specifically, the career field STS portion of your CFETP. It specifically provides the training community with a comprehensive data base to support anticipated training decisions for the career ladder.
4. A job inventory.

603

1. To help provide objective measurement criterion and serve as tools to assist in objective evaluation.
2. Job descriptions define the duties and responsibilities of each designated position. A job description should do what it says—describe the job, but should *not* describe how the job should be done or to what measurement standard. It should also be written in objective terms. A formal job description has four basic parts: a job title, a source or reference, qualifications for the job, and a summary of the duties and responsibilities.
3. Position descriptions.
4. The performance standard complements the job description—it tells how (and how well) you are expected to do the key tasks in your job. Performance standards are building blocks for job descriptions, and they should form the basis of performance appraisals (such as your EPR). They are descriptions of what you are expected to do, and how well you should do it, in any given setting.
5. AORN, Joint Commission, AST, and AAMI.
6. You must know and recognize your own values, beliefs, attitudes, and opinions, and be able to put them aside to objectively evaluate the performance of the individual.
7. A "go/no go" standard is used for items that must be accomplished; if the individual fails to accomplish the step, he/she fails the evaluation.
8. Without an approved CJR, the member can't re-enlist. Approval of a CJR doesn't mandate re-enlistment; it simply keeps the option open.

604

1. AFH 33–337, The Tongue and Quill.
2. If you're writing to an agency or individual outside the organization, use letterhead. Use letterhead for only official correspondence.
3. Draw a single line through the erroneous information, make the correction, and initial the error. Never completely obliterate an error.
4. Policies provide guidance and boundaries for making decisions. Procedures provide the "how to" of a task.

605

1. Performance improvement may be defined as any and all efforts to improve the quality of patient care. Risk management is the identification and action taken to resolve problems or potential problems in the health care setting.
2. AFI 44–119, *Medical Quality Operations.*
3. The unit self-assessment.
4. To identify problems at the lowest management level, implement solutions, and provide a feedback system to track problems until they are resolved.
5. Medical records reviews, reviews of patient complaints, patient questionnaires, patient interviews, peer reviews, supervisor evaluations, or worker performance.
6. Corrective actions that expand the knowledge, skill, and performance of health care personnel.

606

1. To evaluate the justification and appropriateness of all surgical procedures performed by the staff surgeons.
2. (1) Identify and evaluate nosocomial infections.

   (2) Monitor aseptic techniques.

   (3) Monitor sanitation practices.
3. They allow for immediate detection and correction of deficiencies before they result in harm to patients. They help supervisors determine whether further training is required or if existing training needs modification.
4. (1) It provides nurses with information that enables them to finish their assessment of the patient's needs and develop a care plan tailored to each patient.

(2) It enables nurses to determine if there are any inconsistencies in the patient's record regarding information the patient gave to admissions or anesthesia personnel and the surgeon.

(3) It allows nurses to conduct preoperative teaching to ensure the patient understands what is going to happen before, during, and after surgery.

5. Any four of these: The transport specialist or technician, a senior nurse or OR supervisor, the circulating nurse, anesthesia personnel, and the surgeon.
6. The break or mistake should be identified and corrected immediately.
7. The postoperative interview.
8. Accept the changes and understand why they are necessary.

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

Unit Review Exercises

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

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

1. (601) When are surgical service apprentices (3–levels) are allowed to pull call duties?
   a. After completing their CDCs.
   b. Never. 3-level technicians do not pull call.
   c. When the supervisor judges the apprentice is ready.
   d. 1-year after graduation from technical school.

2. (601) What is the *first thing* a supervisor should do when notified of the projected assignment of a new airman?
   a. Create a training folder.
   b. Coordinate a work schedule.
   c. Schedule newcomer's briefing.
   d. Assign an immediate supervisor.

3. (601) When developing a daily surgery schedule of operations, what should be *done next* after any manning deficiencies are adjusted by moving "comp days" and requested time off?
   a. Rotate any mandatory military duties for any remaining manning deficiencies.
   b. Forward the schedule to the office in charge (OIC) for review and signature.
   c. Post the schedule in a designated conspicuous area.
   d. Enter the "call" shifts.

4. (601) To maintain a surgical technician's "war-readiness," strict specialization in daily scheduling should be
   a. encouraged to promote a broad base of experience.
   b. discouraged to promote a broad base of experience.
   c. encouraged to increase expertise in one surgical specialty.
   d. discouraged to increase expertise in one surgical specialty.

5. (602) When assessing the quality of formal training course graduates, which feedback method is *not* evaluated by the course for required action?
   a. Surveys.
   b. Written letters.
   c. Telephone conversations.
   d. climate assessment critiques.

6. (602) What tool is used *specifically* to survey the career field when accomplishing an Occupational Survey Report?
   a. Job Inventory.
   b. Training Extract.
   c. Job Qualification Standard.
   d. Career Field Education and Training Plan.

7. (603) The tool that tells you how to do, and how well you are expected to do, a group of key tasks is called a
   a. job inventory.
   b. job description.
   c. performance standard.
   d. performance element.

8. (603) When evaluating a critical element of a task, what type of measurement standard is used?
   a. Go/no go.
   b. 90 percent accuracy.
   c. Minimal assists.
   d. Corrective action.

9. (604) The primary reference for everyday Air Force writing is
   a. AFH 33–337, *The Tongue and Quill.*
   b. AFPAM 36–2241, *Professional Development Guide.*
   c. United States Government Printing Office Style Manual.
   d. American Psychological Association Publication Style Manual.

10. (604) When writing an intra-departmental memorandum, you should use
    a. letterhead paper.
    b. plain bond paper.
    c. formal letter format.
    d. informal letter format.

11. (605) As part of the Performance Improvement Process, each wing, group, or squadron develops checklists to conduct
    a. training.
    b. accreditation.
    c. unit self assessment.
    d. total quality management.

12. (605) Who chairs the performance improvement and risk management committee?
    a. Chief Nurse.
    b. Medical treatment facility (MTF) commander.
    c. Infection control nurse.
    d. Chief of Hospital/Clinical Services.

13. (606) What area of quality assurance most *directly* relates to your daily duties?
    a. Tissue review.
    b. Infection control.
    c. Risk management.
    d. Surgical case review.

14. (606) If you see a hole in a surgeon's glove and you say or do nothing, you are violating the quality assurance ethic of
    a. peer review.
    b. empowerment.
    c. self-assessment.
    d. surgical conscience.

Please read the unit menu for unit 2 and continue ➔

Unit 2. Resource Management and Medical Logistics

RESOURCES–PEOPLE, MONEY, OBJECTS, AND TIME–are essential to perform any job! In this unit, we'll provide information on how you can control and utilize, or manage, the resources in your duty section. Managing resources is everyone's responsibility; to accomplish the tasks of your workplace and the mission effectively, you must learn to manage resources carefully. Management of resources is so important (and complex) that every medical facility has departments solely designated to managing specific resources. Two of these departments will be the topics of discussion for this unit. These are the Medical Resource Management Office (RMO) and the Medical Logistics Section.

2–1. The Resource Management Office

The RMO is the office primarily responsible for allocating all medical resources. Personnel within the RMO manage funds and manpower, collect and analyze data on resource use and requirements, and manage improvement efforts such as the suggestion program.

607. Introduction to Resource Management Office functions

The RMO is responsible to the MTF commander for effective management of medical resources. Because of the complexity of modern health services management, a full-time Director of Resource Management should be assigned to every hospital. The Director of Resource Management is a key staff advisor of the MTF Commander, and, as such, serves as a member of the MTF executive committee. The director should also be a member of the base financial working group.

Everything and anything that could increase or decrease quality concerning the resources of your MTF is of concern to the personnel in the RMO. In this regard, there are six major functions controlled by RMO personnel:

1. Financial management.
2. Manpower programs.
3. Data analysis.
4. Business office.
5. Methods improvement.
6. Computer systems (when no medical systems office exists).

Financial management

This function involves the management of financial programs and funds. Financial management responsibilities of the RMO include these five distinct, but related functions:

1. Budget to determine how much money is required for MTF operation.
2. Execution expends authorized funds (spends) to accomplish the medical mission and ensures optimum use of the facility's quarterly expense authority.
3. Account for all funds allocated for operation of the MTF. Financial management also involves accounting for expenses under MEPRS as discussed later.
4. Management of the facility's cost center management programs.
5. Fiscal analysis of the MTF's financial status; this includes developing forecasts of requirements, auditing data, and analyzing variances in quarterly expenses.

Manpower programs

Administration and management of the medical manpower programs is another function of the RMO. In the manpower area, RMO personnel recommend methods the commander can use to ensure the most effective use is made of medical manpower. Specific duties include:

- Conducting business case analysis (BCA).
- Monitoring manpower standards.
- Preparing requests for changes to manpower authorizations.
- Collecting personnel utilization data.
- Verifying authorizations listed on the unit manpower document (UMD).
- Participating in the review and validation of manpower standards.

Data analysis

Personnel performing the function of RMO provide general guidelines and procedures for data collection, reporting, analysis and interpretation. Some of the tools used in these processes are:

- The Department of Defense (DOD) MEPRS.
- Report of patients.
- MTF management summary.
- Other health care statistical reports.

Business office

Personnel in the RMO manage accounts receivable throughout the Medical Service Account (MSA), Third Party Collection (TPC) Program, and accounts payable throughout the Supplemental/ Cooperative Care Program, and Centrally Managed Allotment (CMA). They also maintain a complete and reliable financial record of the operations covered.

Methods improvement

Personnel in the RMO also manage the methods improvement programs. These include the facility's self-inspection program (or unit self-assessment) and the Air Force suggestion program.

Computer systems

When no medical systems office exists, RMO personnel act as the automated medical system's focal point for reviewing data automation requirements, preparing acquisition plans, and coordinating system installation and resource requirements for operations identified by system (computer) users.

Terminology related to resource management

To understand the way resources are managed in Air Force medical facilities, you must first have a general knowledge of the terms used in the processes.

Appropriation

An appropriation is a congressional authorization to a government agency to incur obligation for specified purposes within a certain period. In other words, an appropriation is Congress making funds available to various activities for support of their missions and giving permission to spend the funds within a specified period.

Bogey

Also referred to as the tentative operating budget, a bogey is the amount of operations and maintenance (O&M) dollars an organization or activity can expect to receive to carry out its mission for the forthcoming operating year.

Fiscal year

Fiscal year (FY) is the 12–month accounting period used by the federal government (1 October to 30 September).

Responsibility center

The responsibility center (RC) is an organization headed by a single person assigned to monitor financial management, and most often, exercises a significant degree of control of resources acquired and consumed. The RC is the focal point for exercising management control and one level of reporting for financial accountability. Normally, a larger medical facility (such as a wing or group) is considered a responsibility center. On very small installations or sites, the entire installation may be considered the RC.

Cost center

The cost center (CC) is the basic financial production unit in the chain of command. It is subordinate to the RC and denotes the basic organizational level at which aggregation of expenses is meaningful. A CC is usually a duty section or work center, but may encompass more than one section or element. In the MTF, the surgical suite is often considered the cost center, and ancillary units such as sterile processing, recovery room, and anesthesia, may fall under this cost center. In some medical facilities, especially larger ones, the ancillary duty areas are designated as individual CCs.

Cost center manager

The cost center manager (CCM) is generally the work center supervisor, NCOIC, or superintendent. The CCM is responsible for and controls the day-to-day use of work hours, supplies, equipment, and services used to perform the duty section or work center's mission. The CCM is the first link in the chain-like process of budget development. If a cost center is large, the CCM may appoint one or more resource advisors to assist in managing the CC. For example, if the Superintendent of Surgical Services is the CCM, the NCOIC of each department (Operating Room, Sterile Processing Department, and Anesthesia) may be appointed as resource advisors.

Cost account

A cost account (CA) is established to collect and identify costs below the cost center level. It is the lowest level costs may be accumulated. In the surgical service arena, each functional area (i.e., operating room, central supply, recovery room, anesthesia, and each clinic) is usually considered as a cost account. The NCOIC or section supervisor is generally appointed as *cost account custodian*.

608. Cost center manager duties

Cost center managers are appointed in writing by the MTF commander. RMO personnel are responsible for training the CCMs and are available to guide and assist them in managing their work center budgets. The personnel in the RMO should be consulted and they should provide coordination as a financial consultant in areas such as equipment upgrade, TDY funds, and supplies.

Since the cost center is the basic working level in the MTF, it is where the resources of manpower and funding are used; therefore, the director of Medical Resource Management should maintain frequent contact with the CCMs. This is usually done by periodic visits to the sections and regularly scheduled CC management meetings. The Director of Medical Resource Management should also meet with newly appointed CCMs to discuss areas such as local resource management policies and procedures, funding needs, manpower management and workload reporting (both for the report of patients and MEPRS). It is the CCM's responsibility to work with RMO personnel by attending all CCM meetings and training sessions.

A cost center manager's guide is developed locally and used as a reference and training tool for CCMs. This guide should include information about the DOD resource management system, budgeting, financial management, local resource management policies and procedures, manpower management, workload reporting, and MEPRS. When appointed as CCM, individuals should ensure they obtain the cost center manager's guide.

Budgeting is one of the major duties of the CCM. To do the job properly, the CCMs must accumulate data on costs and project future budget requirements. These processes include estimating funding requirements for supplies, equipment, and TDY. Personnel in the RMO receive budget guidance (commonly referred to as a "budget call") a few months before the start of a new fiscal year. This guidance includes the format for submitting the budget, policy guidance on budgeting, and the suspense date by which the budget must be forwarded to the base budget office. RMO personnel then task all cost center managers with projecting budget requirements for their respective cost centers. CCMs then task respective account custodians (and any other individuals with resource requirements) to submit their projected requirements. The CCMs consolidate these inputs and submit the cost center budget request to the RMO. RMO personnel consolidate inputs from the CCMs to develop a budget request for the facility before submitting it to the base (or wing) financial working group.

Another aspect of cost center manager duties involves monitoring and controlling the expenses of the cost center. The CCM must make every effort to stay within the allocated budget. If (when) emergency or other unexpected expenses arise, the CCM should keep records of the situation and work with the RMO to ensure sufficient funds are allocated to provide continued operation.

Cost analysis considerations

When you are asked for input in determining your annual budget, be sure to follow these general guidelines:

- Be aware of the requirements of your facilities program.
- Think about your budget throughout the entire year, not a single period.
- Be aware of your spending and plan for what you may need.
- Research your past needs by checking the cost center's historical report.
    - Have the cost center's needs been met?
    - Did you stay within your budget the past FY?
- Consider pending changes that influence future needs.
    - What type of upgrades in equipment and supplies are needed?
    - Will there be a change in the mission?
    - Will workloads increase or decrease?

These are just a few of the thoughts you need to consider when determining budget needs and wants. Contact your local resource management office for guidance.

609. Manpower management

In addition to managing money, the RMO is also the focal point for the management of manpower resources within the medical facility. Have you ever wondered exactly who, what, and how the Air Force determines how many people (and in what Air Force specialty codes [AFSC]) are required at a given location? How many active duty personnel are needed to keep the operating room functioning? How many of these people must be nurses or technicians? How does the Air Force determine how many surgical service technicians are needed to staff the clinics? This is determined by the manpower system. This lesson is designed to simply introduce you to the Air Force system used to allocate personnel resources.

Manpower terminology and documents

The base level manpower manager is the base RMO (not to be confused with the medical RMO). The base RMO has manpower experts who work directly for the base commander. These individuals deal with manpower at the base level and act as consultants to each base facility on manpower issues, usually by working the issue through the director of the *facility* RMO. There are many layers in the process of development and approval of manpower standards. If you are ever appointed as cost center manager, the personnel in your medical RMO have the expertise to assist you in understanding the manpower system and can help you meet your manpower needs.

The Air Force Manpower System is very complex, and in today's Air Force, changes with needs. We'll start by defining some important terminology and looking at some of the manpower documents; this should give you a foundation for understanding the manpower system.

Manpower terminology

The term *manpower* refers to people; specifically the number of workers contributing to or needed for a work force. You'll use other terms defined in the following table to report manpower information, or you will see them when reading manpower documents.

Term	Definition
Man-hour	A generic measurement of the amount of work done by one individual in one hour. An appendectomy, performed in one hour that required a surgeon, a scrub technician, a circulating nurse, and an anesthetist may be considered as consuming four man-hours.
Workload	The amount of work; the number of work units or volume of work a work center is responsible for during a specific time period. The number of surgical cases performed each month is one indicator of workload; the number of instrument sets sterilized in central supply is another.
Work center	An area, usually centralized, where personnel use similar tools, methods, or processes to perform similar or related tasks. Work centers are often assigned codes to assist resource management in tracking manpower and financial consumption. The surgical suite is a work center, as is central supply, the ambulatory surgical unit, and each clinic.
Available time	The amount of hours an individual is actually performing primary duties. The time you spend working in the operating room, central supply, or a clinic is considered available time.
Nonavailable time	The amount of time an individual is performing activities, *directed, recognized, or approved* by the Air Force, that aren't considered primary work duties. The time you spend performing "details" is nonavailable time.
Manpower requirements	The calculated number of personnel (categorized by AFSC) needed to accomplish a duty, workload, mission, or program. Approved manpower requirements are also known as *manpower authorizations*.

Term	Definition
Manpower standard	This term is used in two ways. It refers to the mathematical formula used to calculate manpower requirements (man-hours required based on workload in a workcenter). Manpower standard also refers to a resource management document that contains the formula, a workcenter description, a breakdown of tasks, and skill and grade requirements of personnel.

Manpower documents

The following table includes terms that are associated with manpower documents.

Term	Explanation
Unit Manpower Document (UMD)	Manpower authorized. This document lists (by a position number) all available positions, officer and enlisted, in each workcenter. It lists the positions by number, by AFSC, and by duty title only. The UMD is one of the primary manpower planning tools for managers.
Unit Personnel Manpower Roster (UPMR) Manpower assigned	This is a list similar to the UMD, but it also has the name and Social Security number of the individual assigned to (and projected or enroute to) each position number in the MTF. All military personnel, whether assigned to an authorized position or not (such as when you have more people assigned than you're authorized), are listed on the UPMR.
Authorization Change Request (ACR) or Change Notice (ACN)	This is a request to make a change in a designated position. Situations requiring a change request include changing an active duty military position into a civilian position, changing the grade or skill level of a position, and adding or deleting a position.

Urgent manning requests

There may be times when things do not work out as it is supposed to on paper and you find yourself short on manning. This can be because your caseload has increased or, as sometimes happens, circumstances have left you shorthanded. In each of these situations the first thing you have to do is contact your facility's RMO for help.

In the circumstance of your caseload increasing, the RMO will let you know what data to provide to base manpower to justify a study to be done to determine if you earn more manning. Base manpower will look at your data and do a study over a determined period of time to analyze the data and see how many, if any, additional personnel are needed to handle the increased caseload. This type of situation is for a requested permanent staffing increase.

If a situation has occurred that has left you critically undermanned for a short period, then you need to do a manning assist request. An example could be that you have technicians deployed, emergency leave comes up, someone is hospitalized, and you can't do the case load anymore. Again, you will contact your RMO and ask for help. In this case they will work with base personnel, your MAJCOM's functional manager, and your career field manager (CFM) to get help for your facility for a short period of time. The key component here is for a short period.

610. Workload reporting

Ever wonder how the Air Force determines how many people and how much money each facility—and each section in the facility—needs to operate? Some of the key data used in the processes of these decisions is the amount and type of workload reported. How accurately your department, and you as an individual member of the department, report your workload can greatly influence whether you're adequately staffed, have enough space, and sufficiently funded.

Reporting of cost center workloads is an important part of every work center. Each fixed medical facility has a MEPRS program manager assigned to the RMO. The MEPRS manager is the focal point for all of the MEPRS data collection and reporting activities occurring in the MTF. The MEPRS

manager collects personnel, workload, expense, and other various data from within the MTF to support the MEPRS. We'll now discuss exactly what MEPRS is, and what it is designed to do.

Medical Expense and Performance Reporting System

The MEPRS is a DOD-derived system for managing DOD medical treatment facilities. It is the primary tool used to make budgetary, manpower, and other important resource allocation decisions within each MTF. MEPRS was developed to fill a need for uniformity among the military services and improve overall effectiveness of medical facilities. If you need more information than this lesson contains, consult AFI 41–102, *Air Force Medical Expense and Performance Reporting System (MEPRS) for Fixed Military Medical and Dental Treatment Facilities*.

Under MEPRS, each medical facility is required to submit a monthly report to DOD. MEPRS uses a set of standard codes, called MEPRS/work center codes, to develop this report; these codes are an important part of the computerized MEPRS. Each activity or functional area in your MTF is assigned a code, or is in some other way registered into the MEPRS, based on the type of activity and section involved. Virtually every action requiring the use of resources—from an out-patient visit to the surgery clinic through the paperwork completion at discharge after surgery—and everything in-between—can be coded and accounted for in MEPRS.

We will not cover all of the possible codes used by all services, or those used by Air Force MTFs. The key to obtaining the correct codes is to know where to get the information; `at` your RMO. However, an overview of the basic coding system may help give you a better picture of how the reporting system works.

Functional Accounts

MEPRS uses a standard coding structure to identify all activities and associated activities within or related to your MTF. The activities fall into one of seven *functional* categories.

Code	Functional category
A	Inpatient care
B	Ambulatory (Outpatient) care
C	Dental care
D	Ancillary services
E	Support services
F	Special programs
G	Medical Readiness

Summary accounts

Summary accounts are subdivisions of functional accounts and are identified by two capital letters. For example, when an "in-patient" (functional category A) is operated on by a surgeon (surgical care is code B), the summary account is AB. For the resources used during the time the patient spends on the nursing unit receiving in-patient medical care, inpatient care is identified by the capital letter A, and medical care by the capital letter A. In this case, the summary account is AA.

Subaccounts

There are third and fourth level accounts which are subdivisions of summary accounts. Subaccounts describe the actual activities in the MTF. They are designated by three and four capital letters. For example, the summary account for inpatient surgical care is AB; the subaccount for inpatient surgery performed by a general surgeon is ABAA.

Look at the following chart to see the relationship between functional categories, summary accounts, and subaccounts. The chart doesn't contain all summary accounts within the medical facility, within each functional category, or within each summary account; it simply shows a few select examples.

Functional Category	Summary Account	Sub-account
A Inpatient Care	AA Inpatient Medical Care	AAAA Inpatient Care by Internal Medicine
	AB Inpatient Surgical Care	ABAA Inpatient Care by General Surgery
	AE Inpatient Orthopedic Care	AEAA Inpatient Care by Orthopedics
B Ambulatory Care	BA Outpatient Medical Care	BAAA Outpatient Care by Internal Medicine
	BB Outpatient Surgical Care	BBAA Outpatient Care by General Surgery
	BE Outpatient Orthopedic Care	BEAA Outpatient Care by Orthopedics

It isn't necessary for you to remember the code of every account in your organization; the people in your RMO maintain a list of all the codes used in the facility. If you are delegated to report MEPRS data for your department, your RMO will make these code lists available to you.

Reporting department workload

In the surgical environment, a monthly report is generated and sent to RMO to help account for the resources used during that month. The report is broken down and reported by the specific users; the code for each using activity is used to report items such as number of procedures performed, time for all procedures, number of surgical staff required, anesthesia time, anesthesia personnel required, and other measurable resource items.

For example, let's consider a typical herniorrhaphy performed by a general surgeon. Two surgical technicians, one circulating nurse, and one anesthetist assist the surgeon. Anesthesia administration began at 0745. The procedure from skin incision to dressing application lasted from 0800 to 0845. The patient was transported to the recovery room at 0855. To report the department's workload for the procedure under MEPRS, code ABAA (Inpatient General Surgery) would be charged for:

- Three surgical personnel (scrub techs/circulator only—the surgeon is assigned to general surgery).
- One anesthesia personnel.
- Forty-five surgical minutes.
- Seventy anesthesia minutes.

Every procedure performed in the operating room is accounted for in this manner, and then the total for each account is summarized and reported to the RMO at the end of the month.

The Sterile Processing Department and the outpatient clinics also report workload data by sub-account. In SPD, each item is assessed to determine a processing time as well as the time and number of staff required to process it. All items processed for each sub-account are totaled and reported to the RMO monthly. The clinics report their data also, but they generally report under only one or two sub-accounts, and they report other data, such as number of outpatient visits.

Most surgical technicians use only a select few codes and report their individual time, or personnel utilization data into the Defense Medical Human Resources System internet (DMHRSi) program.

Reporting individual workload

How important is this task? Did you know that approximately 60–75 percent of an MTF's total operating expense is from personnel salaries? So I'm sure you can imagine that bogus, pencil-whipped personnel utilization data will lead to an inaccurate, useless MEPRS report.

Medical facilities collect personnel utilization data after all MTF personnel enter their labor hours (by MEPRS code) into the DMHRSi program. The personnel responsible for accurately documenting and reporting this information in accordance with established Air Force policy outlined in AFI 41–102 are listed:

- Military personnel.
- Federal civilian employees.
- Personnel "borrowed" from another facility (i.e., manning assistance).
- Students.
- Contract personnel.
- Volunteers.
- Reservists and Air National Guard.
- Foreign national employees.

Personnel must submit their timecards no later than (NLT) close of business (COB) the first duty day after timecard period ends (Monday). If Monday is a federal holiday, the timecard must be submitted the duty day prior to the holiday. Timecard approvers must approve or reject timecards NLT COB the third duty day after timecard period ends (Wednesday). All rejected timecards must be corrected, re-submitted and approved NLT COB the fifth duty day after the timecard period ends (Friday). Upon rejection of a timecard, timecard approvers must immediately notify the individual that their timecard was rejected along with the reason for the rejection.

A large portion of workload data is captured through the use of the Composite Health Care System (CHCS). Listed are some examples of workload data that CHCS reports:

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

When MEPRS data is gathered and merged from throughout the MTF, the actual operating budget with the breakdown of coded activities will reflect how much it costs to operate a particular work center and how people are utilized. Other important information gathered is your patient treatment cost. All this data eventually makes its way up the chain to DOD where it is used to assist in the allocation of resources to each MTF.

Self-Test Questions

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

607. Introduction to Resource Management Office functions

1. What are the six major functions performed in the RMO?

2. List the five distinct, but related functions, of RMO personnel in regards to financial management?

3. What RMO area maintains a complete and reliable financial record of operations?

4. Match the definition in column A with the proper term in column B.

Column A	*Column B*
____ (1) An organization headed by a single person assigned to monitor financial management, and most often, exercises a significant degree of control of resources acquired and consumed.	a. Appropriation.
____ (2) Is responsible for and controls the day-to-day use of work hours, supplies, equipment, and services used to perform the unit's mission.	b. Bogey.
____ (3) Is usually a duty section or work center, but may encompass more than one section or element.	c. Cost account.
____ (4) The 12-month accounting period.	d. Cost center.
____ (5) The amount of O&M dollars that an activity can expect to receive to carry out its mission for the forthcoming operating year.	e. Cost center manager.
____ (6) Funds made available to various activities for support of their particular missions.	f. Fiscal year.
	g. Responsibility center.

608. Cost center manager duties

1. Who is responsible for appointing a cost center manager?

2. Who meets with newly appointed cost center managers to discuss local policy and procedures?

3. What information is contained in a "budget call" or "budget guidance"?

4. What should the cost center manager do when emergency or other unexpected expenses arise?

609. Manpower management

1. What office manages manpower at the base level?

2. Define the following terms.
   a. Man-hour.

b. Workload.

c. Work center.

d. Available time.

e. Nonavailable time.

3. Describe the two ways the term *manpower standard* is used.

4. What are the main differences between the UMD and the UPMR?

5. What's the purpose of an authorization change request?

610. Workload reporting

1. What system is used to report cost center workload data in fixed medical facilities?

2. How often does each medical facility report its workload data to DOD?

3. What program is used to record and report individual workload data?

4. Who is required to report individual workload data?

5. When must personnel submit their timecards?

2–2. Medical Logistics

How could you perform surgery, sterilize instruments, or treat patients in a clinic without the proper supplies and equipment? You couldn't. To function properly, each using activity must have the necessary equipment and supplies. In essence, supplies are a major part of the operation of a medical facility. The department who has the mission to help obtain these vital resources is known as Medical Logistics (commonly called medical supply).

In this section, you will become acquainted with various aspects of Medical Logistics. Keep in mind the materiel system is ever changing. Although MAJCOM and specific facility procedures may vary, the principles in this section can be applied to most situations.

We'll begin by discussing the accountability and responsibility you have for management of public property. This will be followed by categories of materiel, procedures for issues and turn-ins, and finally some of the various medical logistics (MEDLOG) listings and documents.

611. Management of public property

Management of public property includes the proper allocation, control, care, use, and safeguarding under control of the Air Force. This process applies to each individual, whether or not the property is signed for or issued to that individual for care or custody. Such responsibility includes pecuniary liability. Pecuniary liability means you must pay for property you lose, damage, or destroy due to negligence, willful misconduct, or deliberate unauthorized use. We'll have more on this later.

As an example of accountability and responsibility, let's look at two scenarios. When you buy an article from any store, the moment the sales clerk completes the sale, the store drops accountability. The item then becomes your property, and you are accountable and responsible for it. Similarly, when a stock clerk in medical supply issues an item to you, accountability is transferred to you. However, you don't become the owner of the item; instead, the Air Force retains ownership, and you assume responsibility for the care and protection of the item as provided by the applicable directives.

Categories of responsibility

We must be aware of our responsibilities for the proper management of public property. While this lesson looks at five specific categories of responsibility, it is possible for one person to carry more than one of these categories of responsibility at one time.

Command responsibility

Commanders at all levels are charged with the responsibility of ensuring only qualified personnel are selected and assigned as accountable custodians. In addition, commanders are responsible for ensuring adequate space is provided for proper storage of medical supplies and equipment, the prescribed records are maintained, and supply discipline is understood and practical.

Supervisory responsibility

This responsibility applies to any person who exercises supervision over property received, in use, in transit, in storage, or undergoing modification or repair. Supervisors are responsible for selecting qualified personnel to perform the duties under their control and for properly training them. The supervisors issue instructions in supply procedures to ensure compliance with Air Force and DOD directives governing public property. Supervisors are also responsible for introducing, training, and monitoring all personnel under their control in the principles of supply discipline.

Custodial responsibility

Any individual who has acquired possession of government property has custodial responsibility for that property. The individual is personally responsible for such property if it is issued for official use. This applies whether or not he/she has signed a receipt for it. In addition, the individual is personally responsible for storage, use, custody, and safeguarding of any property under his or her direct control.

As a custodian, you are required to comply with all directives and instructions relating to the handling and prompt, accurate documenting of property in your charge. You must promptly report to your immediate commander and, if appropriate, accountable officer, any losses or other irregularities relating to property in your charge. In addition, you must initiate the paperwork to reconcile and correct property records. These responsibilities apply equally to subordinate personnel receiving property for their use. For a complete list of current custodial responsibilities see, AFI 41–209, *Medical Logistics Support*.

Responsibilities of all personnel

Effective management of property must start with, and be applied by, each individual within the Air Force, regardless of assignment. This applies to all civilian and military personnel, retired or active duty. Each person is charged with providing proper custody, care, use, and safeguarding of all Government property under their control whether or not they have signed a receipt. Property issued to individuals does not become their private property by act of issuance or possession; instead, it remains public property. As such, it must always be properly used, cared for, and safeguarded.

Supply discipline

Supply discipline is required to conserve and protect Air Force supplies and equipment for operational requirements. This fact must be repeatedly impressed on all military and civilian personnel of the Air Force, regardless of their specific career field or duty assignment.

The mission of the Air Force makes it imperative that all equipment and supplies are operational and maintained in the best possible condition, in constant readiness, and in the absolute minimum quantity necessary to accomplish the assigned mission. This is accomplished only through diligent application of the principles of supply discipline:

- Maximum economical use of available equipment and supplies for their intended purpose.
- Effective safeguarding and preservation of public property.
- Adherence to procedures contained in established regulations and directives governing requisition, storage, issue, and turn-in of property, and the control of sensitive and classified items.
- Continuous screening of stocks and prompt reporting, redistribution, and disposal of excess.
- Scrupulous avoidance of issue requests exceeding minimum essential supplies and equipment needed to perform the assigned task.

All personnel must exercise supply discipline to ensure requests for supplies and equipment are valid and available in minimum quantities necessary to perform the assigned mission. All personnel must also ensure these assets are protected, conserved, and maintained in the best possible condition to meet Air Force commitments. When people fail to exercise supply discipline, they are often guilty of fraud, waste, and/or abuse of government resources.

Fraud, waste, and abuse

It is your and every other Air Force member’s responsibility to prevent, detect, and report fraud, waste, and abuse (FWA). You were introduced to this topic in technical school, but to refresh your memory, we’ll revisit the basic definitions of the terms:

- Fraud: *An intentional deception* designed to achieve something to which the individual (or section) isn’t entitled.
- Waste: Needless, excessive, or *careless use* of Air Force resources.
- Abuse: *Intentional wrongful use* of Air Force resources.

Your primary responsibility under the fraud, waste, and abuse program is personal prevention. To do this effectively, you should ensure you obtain, use, and maintain all supplies, equipment, and resources in the manner in which they are intended. For example, don’t take an “asepto” syringe

home to baste a turkey, don't use a hemostat as a pair of pliers, and don't order or use medical/non-medical supplies for personal use.

Another responsibility you have under the Air Force policy on FWA is to report any known or suspected incidents. In most cases, if you see an incident, you should use your chain of command to report it. Alternative methods to report it include notifying your facility FWA representative, notifying the security police, or using the "FWA Hot-Line" established at each base by the inspector general. The Air Force specifically protects any individual from reprisal for reporting FWA. See AFI 90–301, *Inspector General Complaints Resolution*, for further information regarding fraud, waste, and abuse programs.

Pecuniary liability

Pecuniary liability, as defined in Air Force Manual (AFMAN) 23–220, *Reports of Survey for Air Force Property*, is "The statutory obligation of an individual to reimburse the government for loss, damage, or destruction of government property arising from his/her negligence." As we said earlier, *you* must pay for property that you lose, damage, or destroy as a result of your negligence, willful misconduct, or deliberate unauthorized use.

Report of Survey

When Air Force property valued at $500 or more is lost, damaged, or destroyed, and an individual does or doesn't admit pecuniary liability, an investigation known as a Report of Survey is conducted to determine if pecuniary liability exists. The commander appoints a disinterested (no personal involvement, risk, or accountability) individual, in the rank of Master Sergeant or above, to investigate the incident to determine if any liability exists.

The purposes and findings of a Report of Survey include the following:

- Assess pecuniary liability when Air Force property is lost, damaged, or destroyed.
- Relieve all concerned from pecuniary liability when there is no evidence of negligence, willful misconduct, or deliberate unauthorized use.
- Authorize adjustment of property control records.
- Document corrective action to ensure nonrecurrence of the loss, damage, or destruction.

All Air Force employees can be held pecuniary liable for loss, damage, or destruction of property resulting from negligence, willful misconduct, or deliberate unauthorized use. If doubt exists, the individual is not held liable.

NOTE: Pecuniary liability is assessed *without* proof of negligence or willful misconduct where an individual has deliberately made *unauthorized* use of Air Force property, and the property is thereby lost, damaged, or destroyed.

Relief from liability

Relief from liability and responsibility for property lost, damaged, or destroyed by causes other than fair wear and tear requires the preparation of one of three different forms.

1. Department of Defense (DD) Form 1131, Cash Collection Voucher.
2. DD Form 362, Statement of Charges/Cash Collection Voucher.
3. DD Form 200, Financial Liability Investigation of Property Loss.

The use of each form is dependent on whether the individual admits pecuniary liability, and has the ability to pay.

Voluntary payment

Air Force employees can voluntarily reimburse the government for lost, damaged, or destroyed property when the amount is less than $500. The following procedures would be used in the case of voluntary reimbursement.

The simplest way to settle the monetary obligation is to pay in cash. When an individual admits pecuniary liability and is willing to pay in cash, a DD Form 1131 is prepared by either the unit commander or the Report of Survey program manager to record the payment. Some of the more important entries on this form are the item stock number, complete description, unit price of the affected property, the reason the collection was made, and the name, rank, and social security number of the individual making the payment.

Accounting and Finance stamps the document when payment is made, and one copy is given to the individual making payment as a receipt. Officers, enlisted, and civilian employees may use the DD Form 1131.

If an individual admits pecuniary liability, but doesn't have enough money to pay cash for the damaged or lost property, a DD Form 362 is prepared. This document requires essentially the same information as the DD Form 1131, but authorizes payroll deductions to pay for the property in question.

Other relief

The two forms we just covered are used when the individual admits pecuniary liability, is willing to pay, and the amount is less than $500. However, if the person refuses to pay, refuses to admit pecuniary liability, or if the amount is over $500, a Report of Survey for Air Force property is conducted and documented on DD Form 200. In the event the individual is determined to be pecuniary liable, the completed DD Form 200 is forwarded to Accounting and Finance, and the total dollar charges are withheld from the person's pay. You will find details on the preparation of DD Form 200 in AFMAN 23–220.

Materiel complaints

Occasionally, you may receive an item or package that is unsatisfactory, or a salesman may call to inform you of a problem with a product you use. AFI 41–209 offers guidance for reporting and processing materiel complaints, as well as disposition of the items. The personnel in your medical logistics section will also assist you in this procedure.

To help you determine how serious a problem is, and how rapidly you should report it, you should know the two types of medical materiel recalls.

Category I

This category includes a supply or equipment item, which has been determined by use or test, to be harmful or defective to the extent that has caused or may cause illness or death. You must immediately report such an item and remove it from using activities and serviceable inventories.

Category II

Category II includes equipment items that are determined to be unsatisfactory because of malfunction, design deficiency, defects, or performance. Complaints of this type may or may not require suspension of the item.

Another type of complaint you may need to file is known as zero overpricing. If you notice items procured from supply, which appear to be overpriced when compared to local purchase items, report it to the folks in Medical Logistics through the Defense Medical Logistics Standard Support (DMLSS) system, as shown in figure 2–1. If they find you are correct, they will submit a challenge and ensure corrective action is taken, including obtaining a price reduction and refund from the vendor if applicable.

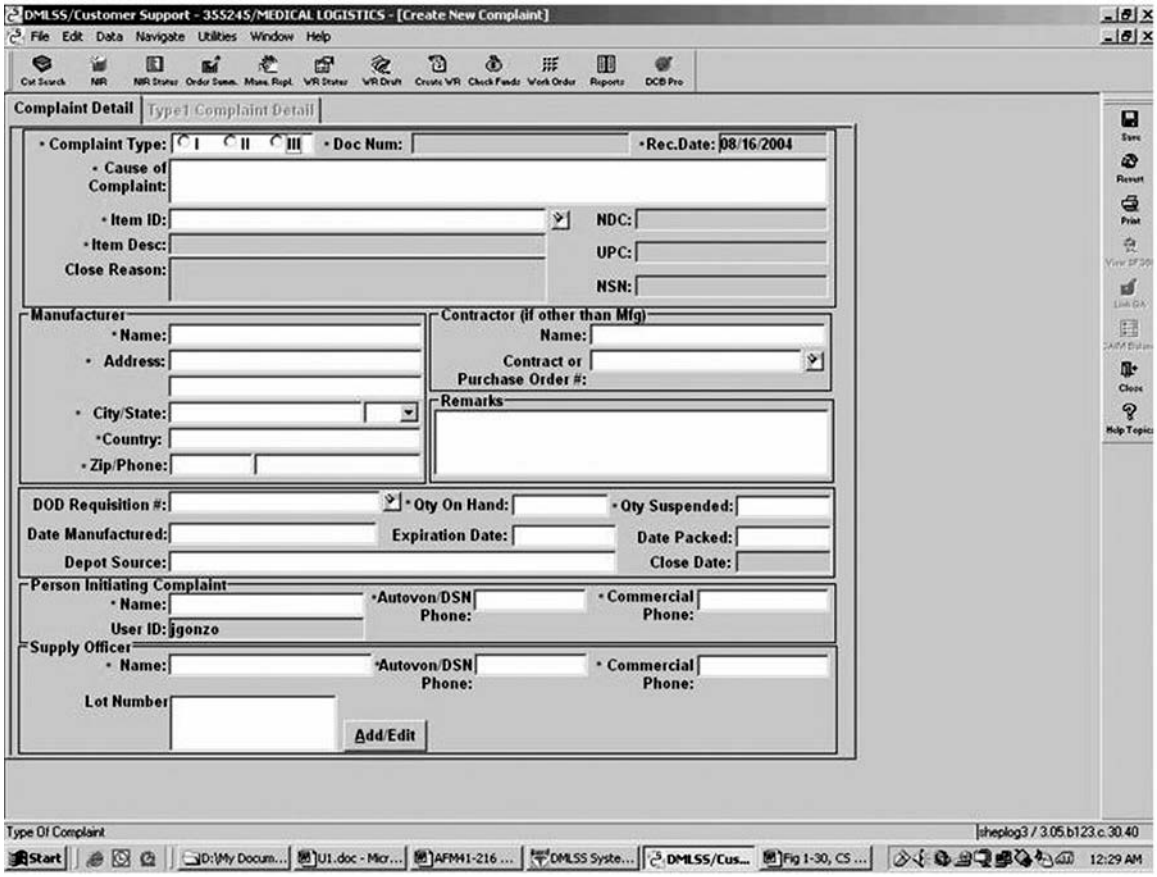

Figure 2–1. Example of creating a new item complaint.

612. Procurement categories and sources

There are several different categories of materiel and they are procured from various sources. To do your job effectively, you should be able to differentiate between categories and sources. AFI 41–209 contains more information on medical logistics categories and procurement procedures.

Categories of materiel

Medical materiel is classified in two major categories—supplies and equipment. Medical equipment is further classified as expense or investment/capital equipment; and supplies, as medical or nonmedical and, consumable or durable. The following definitions should make these divisions clear.

Medical investment (capital) equipment

An item of medical equipment with a unit cost of $250,000 or more, has a life expectancy of at least five years, and maintains its identity during use.

Medical expense equipment

An item of medical equipment with a unit cost greater than $2,500, but less than $250,000, has a life expectancy of at least five years, and maintains its identity during use. Expense equipment under $100,000 is funded with local MTF operations and maintenance funds. Expense equipment with a unit cost of $100,000 to $249,999 is referred to as high cost medical expense equipment and is funded with either local MTF O&M funds or centrally provided O&M funds.

Maintenance significant supply item

A medical supply item with a unit cost of less than $5,000 is durable and requires maintenance is classified as a maintenance significant supply item. Examples of this would be a cast cutter, portable x-ray viewer, or a biological sterilization indicator incubator.

Medical supply item

A medical supply item refers to any item not classified as equipment. There are two types of medical supply items: consumable and durable.

1. *Consumable* items are medical items that lose their identity when used, and cannot be reused for their original purpose. Drugs, adhesive tape, and X-ray film are examples of consumable supply items.

2. *Durable* medical supply items that maintain their identity when used, and may be reused for their original purpose. Forceps, laboratory glassware, and stethoscopes are examples of durable supplies.

Nonmedical materiel

This materiel consists of two major categories—supplies and equipment. Nonmedical materiel used by AF medical treatment facilities consists primarily of office and janitorial supplies, and equipment. The classification criterion for nonmedical equipment differs markedly from that of medical equipment, and is too detailed to be discussed here. If you have a question about materiel classification, contact the folks in your Medical Logistics office.

Sources of procurement

There are multiple sources that can be used for obtaining supplies—government sources such as, prime vendor (PV), and the electronic catalog (ECAT) system used by the Defense Logistics Agency (DLA) and nongovernmental sources that include local purchase (LP) and the Government Purchase Card (GPC) Program.

Government sources

The majority of Air Force medical supplies are procured and stocked by using the PV and ECAT systems; the majority of nonmedical supplies are procured and stocked by the General Services Administration (GSA). Supplies are stored at DLA and locally approved PV locations throughout the continental United States (CONUS). Materiel so procured is termed “stock listed” because each item is assigned a 13–digit national stock number (NSN). Materiel is then requisitioned by Air Force medical treatment facilities and shipped from one of the various PV locations.

Another procurement source is direct procurement from commercial vendors or manufacturers by the personnel in Medical Logistics through the GPC Program, also known as *local purchase*. This procedure is used primarily to obtain items not stocked by PV, DLA or GSA.

If you notice items procured from PV, DLA or GSA appear to be overpriced (when compared to similar LP items) you should challenge the difference. To do this, notify the folks in medical materiel of the situation. Logistics personnel will investigate to validate your findings, and if justified action will be taken to obtain a price reduction and refund, where appropriate.

Local purchase

As mentioned earlier, LP is a method of ordering supplies and equipment directly from commercial vendors rather than using PV stock-listed items. Ordering supplies through LP has become a major part of the medical materiel job, with unlimited potential for the future. The LP section of medical materiel is your key focal point for ordering nonstock-listed medical supplies. Nonstock-listed items are those items which are not stocked by PV or ECAT. Local purchase allows you to be more selective in requesting specific supply needs. Initially, LP procedures can be a little more involved than normal PV ordering procedures, but don’t let that scare you. It’s not that complicated. There are

unique management procedures, authorizations, and restrictions governing the procurement of local purchase items and nonpersonnel services that medical materiel personnel in your facility can explain.

NOTE: Generally, centrally managed (depot stocked) items, with a line item value not greater than $25,000 may be local purchased if such action is in the best interest of the government in terms of quality, timeliness, and cost. Certain war reserve items are excluded from this option.

Before using LP, there are certain questions you need to ask yourself:

- Will the administrative overhead cost associated with contracting, accounting and finance, and medical logistics exceed expected savings?
- Will the local purchase surcharge decrease expected savings?
- Will the order and ship time be greater than depot order and ship time?
- Will transportation costs decrease the expected savings?
- Will the work hours required for additional documentation/justification which must address a combination of quality, timeliness, and cost be justifiable?

For example, the item may have a short delivery time, but is inferior in quality. The item may cost too much, or the quality and cost are acceptable, but the delivery time is unreliable. It's important that you become familiar with the criteria for using LP to requisition depot stocked items.

You should be prepared to provide input on the logic of purchasing an item from a commercial source versus depot stocked items. This will help make the approval process easier and quicker.

Except in a bonafide emergency, your LP request must be *reviewed and approved* by the Medical Logistics Flight commander, an authorized representative, or review activity. The only exceptions to this policy are drugs and biologicals, which are reviewed for approval by the Medical Therapeutics Committee. If your request is disapproved, you may resubmit the request with additional information or justification, or if local procedures permit, appeal the decision to the director of base medical services (DBMS).

Emergency medical purchases

Emergency requirements are defined as items required to save life, prevent undue suffering, or prevent suspension of medical services. These items are normally kept on hand, but in the instances when they are not available, there are two methods of emergency medical purchases. The first method involves the folks in Logistics submitting your emergency request to DPSC or the base contracting office (BCO) for emergency purchase action. This method is used when logistics personnel determine your urgently needed item can be obtained through DPSC or BCO in adequate time to satisfy the emergency.

The second type of purchase is called "after-the-fact-procurement." This procedure is normally used to satisfy medical emergencies that occur after normal duty hours. If the item needed is available locally, and the DBMS or your medical staff has determined there is *not* enough time to process the emergency requisition through normal channels, you should use "after-the-fact-procurement." If time allows, contact the Medical Logistics on-call person before initiating procurement. The on-call person can check the warehouse to make sure no stock is on-hand, or may be able to find an in-stock item that can be used as a substitute. Again, the key factor is TIME. If time doesn't permit prenotification, inform the logistics folks of your emergency purchase action as soon as possible.

There are two restrictions when using this procedure:

1. This authority is *not* used when there is time to process an emergency requisition, or to route an urgent purchase request through normal supply/LP channels.
2. You must purchase only enough to cover that particular emergency.

Within one duty day after the emergency purchase, the individual who made the purchase must initiate an "after-the-fact procurement" action as follows: A DD Form 1348–6, DOD Single Line Item

Requisition System Document (Manual-Long Form) is prepared by the property custodian, and forwarded to medical logistics.

You should become familiar with the different local sources of supply. If you're new to the medical facility, you may want to request a tour of the medical logistics warehouse for a better knowledge of stocked items. Knowing what items are available locally helps you make the correct decision when responding to emergency patient care situations, and knowing which emergency purchase procedure to use.

Blanket purchase agreements

Blanket purchase agreements (BPA) are contracts negotiated with a specific vendor to cover the recurring requirements for selected local purchase items. 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. BPAs are being used less today than in the past due to the increased use of previously mentioned resupply methods. DMM online (Directorate of Medical Materiel Online) provides the military medical community information regarding medical products and services supplied by DLA. It also contains information about DLA negotiated BPAs in effect, copies of new agreements, ordering instructions, and guidance in the proper use of DLA negotiated BPAs.

613. Issues and turn-ins

At one time or another, you will be issued medical materiel. Although this may seem to be a very simple procedure, there is more to it than meets the eye. Also, from time to time, you may have to turn excess items back in to Medical Logistics.

Issue authorization

The commander appoints property custodians in writing based on the recommendation of the section OIC. After they've been appointed, the property custodians are authorized to request and receive medical materiel. If you are appointed as a property custodian, you may delegate military and civilian personnel as authorized representatives (supply representatives) to request and receive medical supplies, but you cannot delegate equipment responsibility. Even though you've delegated people as your representative, you (the property custodian) still assume full responsibility for all materiel requested and received.

If at any time a supply custodian will be gone for more than 45 days due to deployment, TDY, or permanent change of station (PCS) a new custodian must be appointed before the old custodian departs. If an equipment account is involved in the transfer, a complete inventory must be accomplished by both the incoming and outgoing parties.

To authorize a representative, you are generally required to prepare a delegation of authority letter signed by the authorized individual(s) and yourself. After signing, make a copy for the property custodian's file and forward the original to the Medical Materiel section.

Establishing stock levels

Each using activity in the medical treatment facility is encouraged to establish an appropriate stock level of consumable and durable supplies to support operations. The actual level of stock is based on average usage and resupply frequency of recurring demand supplies. This level varies with the type of commodity, the user, and location of the supply account. Medical Logistics personnel should issue supplies to customers frequently. Doing this reduces the levels of consumable and durable supplies maintained in the using activities. This frequency (daily, weekly, twice weekly, etc.) is primarily determined by the level you require. Attention is also given to other factors:

- Inventory reduction.
- Time and effort in making the issues.

- Customer's available storage space.
- Level of customer involvement in receiving the supplies.
- Demand rate.

In addition, specialized service-using activities (such as surgery) are authorized to stock (as required) those items infrequently procured, those not stocked by Medical Logistics, or items whose single unit of issue is greater than two–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.

Routine issue requests

There are two primary methods used by medical logistics personnel to support customers routine supply requests—automatic resupply method, such as forward logistics, and the manual shopping guide DMLSS order method. Let's discuss how the two methods work.

Forward logistics

This system is an automatic resupply system; that is, medical logistics personnel replenish supplies automatically, so the customer seldom has to inventory them. Under this system, you work with Medical Logistics to designate a primary supply storage area and establish reasonable levels on routine items for automatic resupply. Once the listing is established, logistics personnel automatically inventory balances and deliver routine supply requirements to their customers via an established delivery schedule. Once the supplies are delivered to your supply point, it's your responsibility to ensure security and monitor consumption of the supplies. In addition to this automatic resupply, logistics folks screen stock for quality control standards, such as destruction, suspension, and dated item control. You should review stock levels monthly and coordinate with your account rep or contact customer service with any required changes.

In addition to being an automatic resupply system, the method also allows Logistics to issue less than the standard unit of issue. For example, an item with a standard unit of issue of "box," containing 12 tubes, with a total cost of $1.44 may now be issued as an individual tube costing 12 cents. This could drop operation costs significantly.

Defense Medical Logistics Standard Support

The DMLSS is major program developed to provide the best medical logistics support at reduced costs to MTFs and field medical units. It is utilized by the Army, Navy, and the Air Force, and integrates all aspects of the supply and equipment process. The following are key features of DMLSS:

- View and modify your customer catalog (aka shopping guide).
- Retrieve transaction history.
- Check pending transactions.
- Search database for supplies.

Our discussion of DMLSS will not include a tutorial; you receive training at your local MTF, but, you do need to become familiar with some of the most used modules in the DMLSS software.

Customer Area Inventory Management

Customer Area Inventory Management (CAIM) enables the customer to identify materiel required for patient care and clinical support by providing automated support for requesting materiel, physical inventory, ordering, storage, receipt, and tracking of patient care-related materiel up to the point of use. This application provides a user-friendly inventory management tool a materiel manager can use to establish and maintain local storage of items in the customer area.

Inbox

The inbox opens automatically when accessing the CAIM module when there are pending actions for users to complete. Pending actions are listed by the "As of" dates. Users may also gain access to the

inbox by selecting *Utilities* from the menu bar and clicking on *Inbox* or by using the hotkey. Review and work processes in the inbox daily to ensure proper management of the customer's area.

To initiate a process or report, click the "Jump To" icon located at the bottom of the window. Make changes as required and save actions to complete the process. Print required reports as needed. When processes are complete; close the window to return to the inbox. Delete pending actions once they are completed.

Customer support

Customer support (CS) provides MTF personnel a convenient and efficient means of managing requests for materiel and maintenance work. In CS, you can search extensively for products in the database and retrieve detailed data on pharmaceutical and medical/surgical items, including pricing information. You also have online ordering capabilities if you have the appropriate privileges. In addition, CS lets you create, submit, and monitor work requests online.

Customer catalog

This module is accessed from the *Search* feature from the CS module, and is the most useful feature to you, the property custodian (fig. 2–2). This "shopping guide" lists all items you have authority to order and the specifications for the products in your inventory (fig. 2–3). You must coordinate with the supply customer service section on your catalog's contents to ensure it is a workable list. When ordering a new item, you need to specify if it will be a recurring supply item so it shows up on the catalog (fig. 2–4). I cannot stress enough the importance of this part of DMLSS.

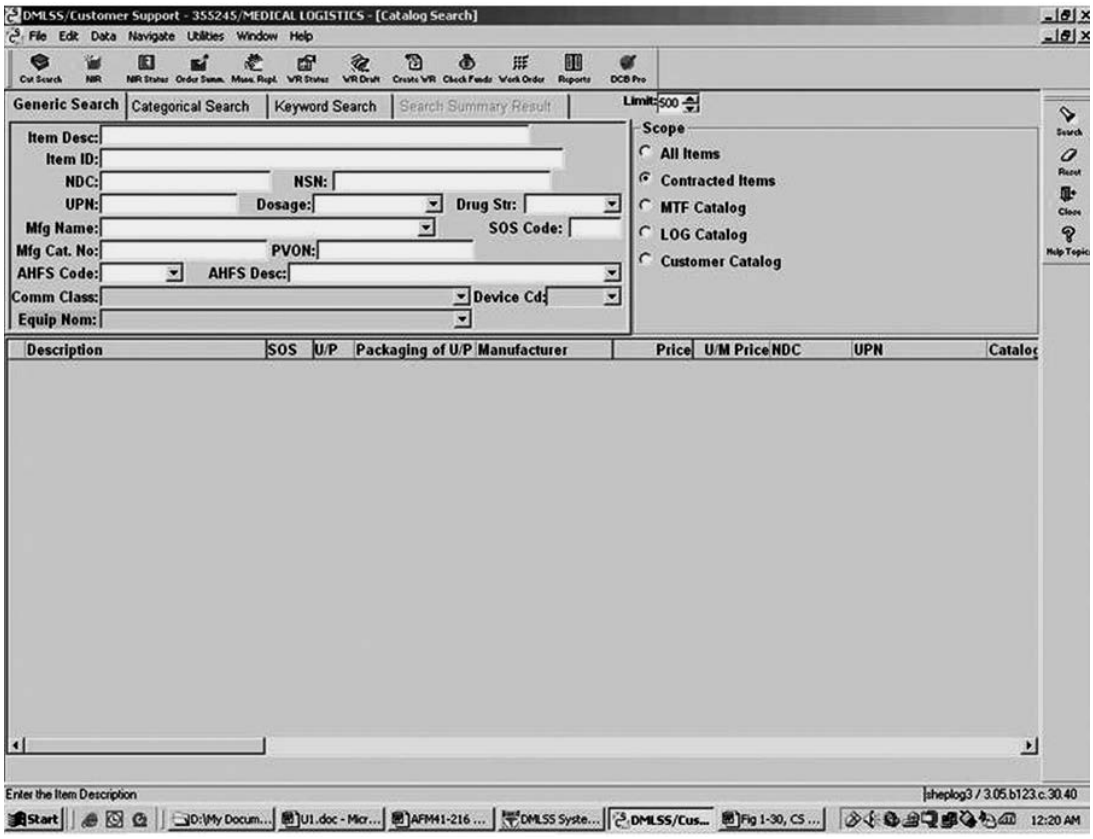

Figure 2–2. DMLSS screen shot. Catalog search window.

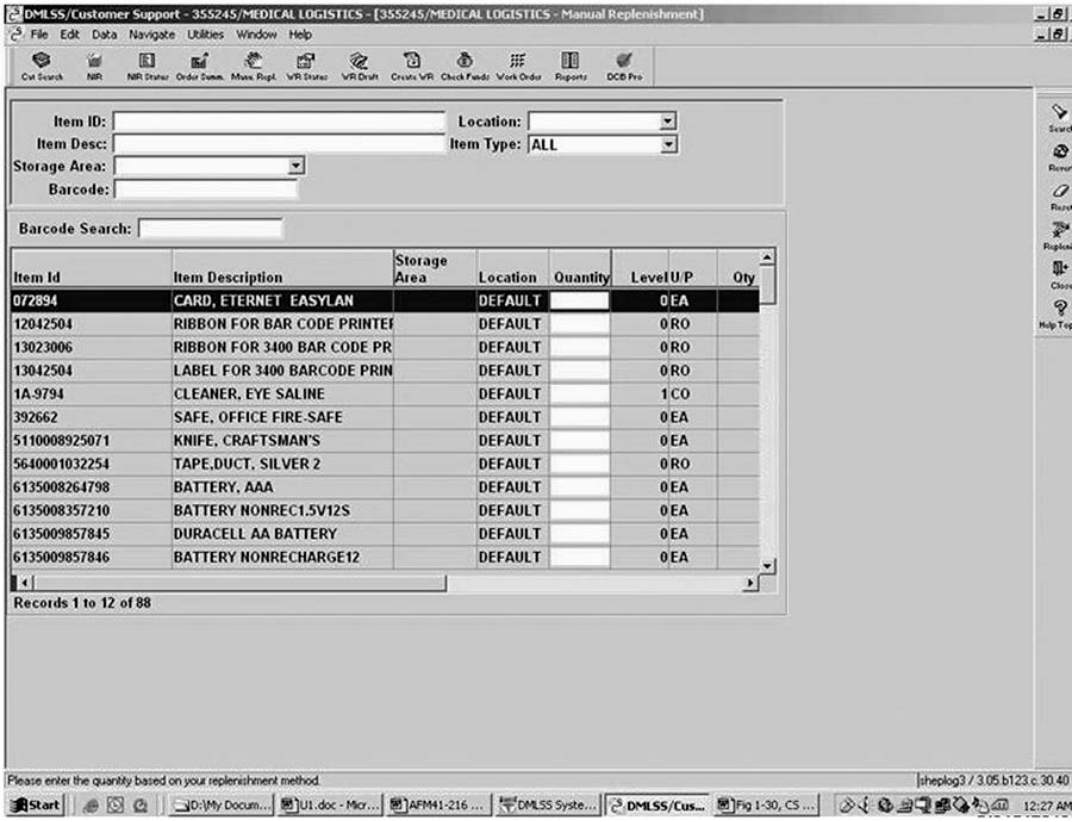

Figure 2–3. DMLSS screen shot. Shopping guide window.

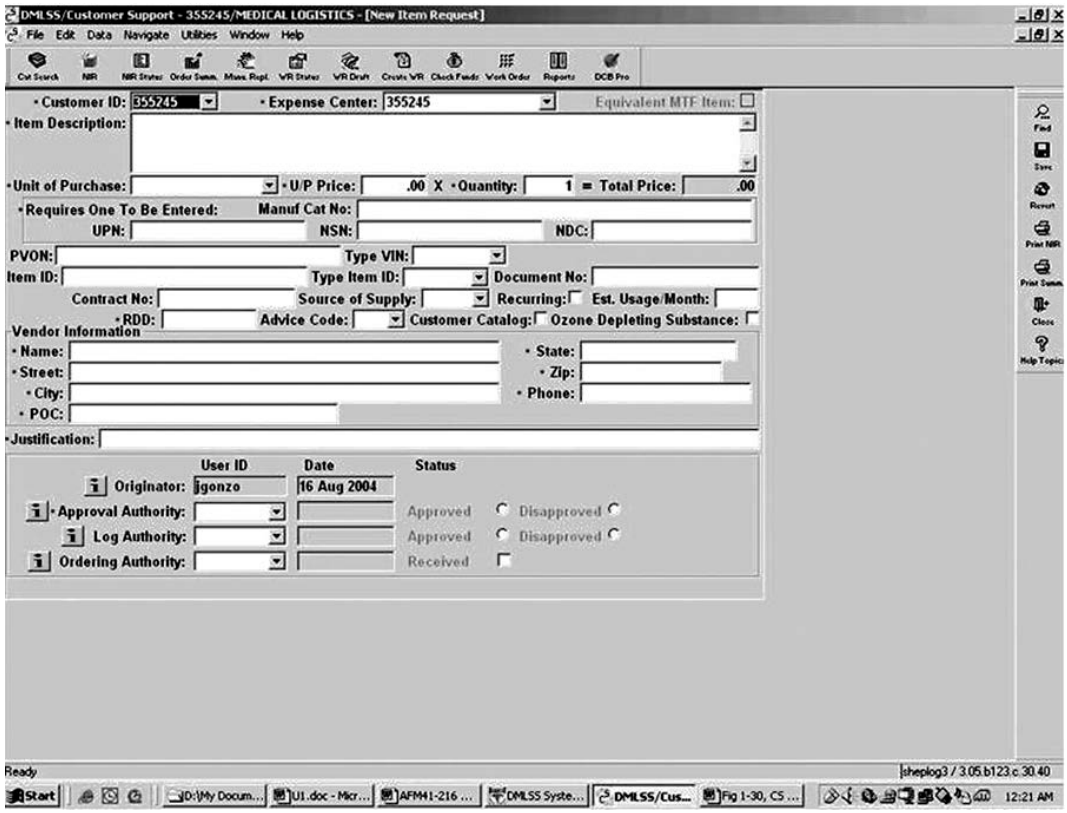

Figure 2–4. DMLSS screen shot. New item request window.

MTF catalog

This catalog is another searchable database in the CS module, but it contains every product processed through the entire DMLSS system. This includes all MTF accounts and as you can guess, the listing is rather extensive. You will want to search this catalog for items not currently in your *customer catalog*. For instance, if you notice the intensive care unit using a really good sticky tape, and you wish to use it for the OR, find the item in the MTF catalog and simply add it to your customer catalog.

DMLSS is a very useful tool once you learn to navigate the modules properly. Your medical logistics section has training available and the customer service desk is more than willing to help you. The whole purpose of the DMLSS system is to provide superior customer support while lowering the ever-increasing costs of medical supplies and equipment. Another added benefit is complete operating inventory control, which reduces stock level overhead.

Nonrecurring demand supplies

As-required or one-time requests for durable or consumable supply items are considered a nonrecurring requirement. These items are coordinated with the folks in Medical Logistics on an item-by-item basis. Normally, such items are not stocked by the Medical Logistics account. This category includes items requested on a one-time basis with no foreseeable demand for one year. To request nonrecurring issues, the supply custodian can use the customer catalog or fill out a new item request within DMLSS.

Nonroutine issue requests

Nonroutine issues can generate a tremendous amount of paperwork for both you, as the customer, and the medical logistics folks. Every effort should be made to establish effective procedures that keep these issues to a minimum.

Emergency issue

This method is used to satisfy your urgent, unexpected needs. Normally, issue requests are submitted on a regular basis. Urgent requests needed between regular schedules are completed within DMLSS, but the key issue is for the custodian to coordinate verbally with logistics so the request is processed as a priority.

Preissue

Preissues are items physically issued to the using activity prior to processing the issue transaction. It’s like buying on credit, or delayed payment. This method is used when issue transactions can’t be processed through DMLSS (i.e., when the computer is down or during annual supply inventories).

Back orders and back order release issues

Back orders are established when no stock is on-hand or when there is not enough stock to fill the total order. With prime vendors guaranteed next day delivery most logistic accounts carry very small inventories. DMLSS can be used by the supply custodian to view items currently on back order or being processed for back order release. Back order reports are discussed later in this unit.

Turn-in and credit policies

From time to time, you will need to turn-in supplies and equipment. The materiel may be turned in as the result of a reduced workload, change in procedures or mission of your section, clerical error, or over stocking. Credit is rarely issued for items being turned in. The rule is the item must be able to be reissued to another account within 30 days for your account to be credited.

NOTE: Do not wait until before an inspection to start looking at your excess supplies and equipment.

In this lesson segment, we are only concerned with the turn-in of supplies. Equipment turn-ins is processed through the Medical Equipment Management Office (MEMO), and will be discussed later in this unit.

Acceptable turn-in items

Unserviceable and suspended items will be turned in to Medical Supply and identified as "other than serviceable." Serviceable items may be turned in when they no longer fit your requirements. Requests for replacement for unserviceable items are a separate transaction, but should be coordinated closely to ensure timely issue.

Turn-in procedures

It is the user's responsibility to coordinate delivery and complete applicable paperwork to the customer service section for all supply items large or small needed to be turned in. To do this, most medical logistics activities have local turn procedures. Rarely do turn-in items receive credit, but if granted, medical logistics can complete the actions in DMLSS while the customer waits. Once the action is complete, the custodian will be provided a copy of the delivery list showing the turn-in.

Credit determination

If you have any questions concerning credit, review AFI 41–209, or discuss them with the people in the Logistics office—not the warehouse. Generally, credit is not given for suspended or unserviceable materiel. When an item of this nature is turned in and a replacement is required, you must cross-reference the respective turn-in and issue documents. You must then reorder the item through DMLSS.

NOTE: When credit is allowed for local purchase items, the LP surcharge isn't used in the credit computation. Materiel to be destroyed or turned-in to a Defense Logistics Agency (DLA) Disposition Services site is accepted *without* credit.

NOTE: Suspended materiel turned in to the medical supply account becomes the property of the medical supply account, and won't be returned to the activity except by formal issue procedures.

614. Equipment custodian responsibilities and procedures

One individual, generally the NCOIC, in your section is designated and appointed by the commander as the property custodian (sometimes called equipment custodian). The property custodian is responsible for equipment, and must work closely with the personnel in the MEMO. The property custodian does *not* have to be the NCOIC; it may be you, your supervisor or one of your coworkers. Regardless of who is appointed, acceptance of and relief from custodial responsibility is a very serious matter, and can lead to major problems if not properly managed.

Responsibility for MEMO property

When you assume custodial responsibility, MEMO personnel will provide you with a custody receipt/locator listing (CRL) showing all property charged and due-in to your custodian account. Before signing the listing, you and the current property custodian should perform a thorough inventory. During the inventory, you should physically see and identify all property listed on the CRL. In addition, you should review all AF Forms 1297, Temporary Issue Receipt, for equipment on loan to patients or other duty sections. (If there are any questions concerning loaned equipment, contact the borrower by phone. Annotate on AF Form 1297 the date and the name of the person contacted.) Also during the inventory, you should obtain medical equipment repair verification that any required maintenance and calibration has been completed. Any property discovered in your duty area, but not listed, should be identified and coordinated with the people in the MEMO. You should also review and verify the requirements for all due-ins on the listing.

Only after the inventory has been performed, and all corrective actions documented, should you sign for the property. Upon signing and dating the CRL, you assume responsibility for all items listed.

Remember, as custodian, the equipment becomes your administrative and financial responsibility, so don't take the word of the previous custodian—verify all items and their stock numbers. After signing the inventory record, return the original to MEMO; keep a signed copy as a record of equipment authorized, on hand, or due-in.

As a property custodian you should ensure (by spot check and periodic inventory) all property in your account is properly charged to the account; the property is physically on hand, or appropriate action has been taken to effect settlement for missing or damaged items. Verify all serial and index numbers as you do the inventory.

Before a property custodian (you) can be relieved from duty, transferred, separated from service, or absent from the account for more than 45 days, MEMO personnel must take action to transfer the property or have it assigned to an authorized successor.

Ordering equipment

The office that manages the equipment within the medical facility is the MEMO section of Medical Logistics. The Equipment Request module in DMLSS is used for tracking equipment requests through the process of requesting, approving, funding, ordering, and receipt of equipment. It is very important for you to realize that the approval process for investment equipment can take several months, and it can take several more months to get the funding from your MAJCOM.

When you wish to replace an old piece of equipment, or buy a new piece, which you don't currently have, you should submit an online equipment request form via The Integrated Global Equipment Request System (TIGERS) on the Air Force Medical Logistics (AFML) Website. Submit the request when the requirement is identified; don't wait until the budget cycle.

The DMLSS equipment request is designed to be an electronic process. However, if you have any supporting documentation, (i.e, brochures, catalogues) identify these attachments in the main tab, and hand deliver the documents to MEMO. MEMO personnel must retain these documents in the Equipment Request file. When completing an equipment request in TIGERS, you must include a description of the equipment or change required, along with a complete justification answering some of the following questions:

- A description of where this item will be used, and what function it will accomplish.
- What is the current and projected workload?
- Who is, or will, be qualified to use the equipment?
- How will equipment be maintained; by contract or biomedical equipment repair?
- What are the savings or benefits of having the equipment?

These only represent a few of the areas that should be addressed. For your local procedures, consult the logistics personnel in your facility.

Many times, when you're trying to obtain a piece of specialized equipment, there is only one manufacturer, or only one manufacturer's product will do. When this is the case, you must submit a letter justifying "sole source" procurement. Even if the manufacturer is the sole maker of the item, you must submit a sole source justification. The reason for this is the fact that in a matter of months several competitors may have a similar product for sale.

Because other companies won't be given the opportunity to bid for the contract, the sole source documentation is required by base contracting to avoid the appearance of favoritism. The sole source justification has no particular format, but it must include the following:

- 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.
- Why it isn't practical to consider other sources for award.
- The extent of your research of possible sources in making the sole source determination.
- What the impact would be without this particular item or service.
- A statement as to its dependability, safety, eases of use or operation, etc.

The completed TIGERS form is submitted to the MEMO personnel for further action. The MTF commander (or designated Equipment Review Authorization Activity [ERAA]) has final approval authority for all expense equipment submitted by MEMO.

Just as your local ERAA establishes a priority, so does higher headquarters.Your request will compete with other equipment requests submitted from other bases within your command. Unfortunately, you have no verbal interaction at this level. At the headquarters level, the better the written justification, the higher the priority it is likely to get. As you can see, equipment purchases are complicated and can take a very long time; try to project your needs as far in advance as possible.

Equipment transfer and turn-in

At the request of a customer or during an equipment inventory, the user may find it necessary to change accountability for equipment items from one work section to another. When approved by MEMO personnel, users can also transfer equipment between organizations supported by the same equipment manager

615. Customer support listings

Several Medical Logistics listings are available to you as a property custodian. These are used as aids in the management of your custodian account. For example, there are listings that show you the equipment you're responsible for maintaining. In addition, other listings show how much money you spend on issues. You should take the time to review the supply listings provided and ensure you understand the usefulness of each.

Equipment authorization list

Also known as *allowance standard* (AS), the equipment allowance document prescribes basic allowances of organizational equipment and provides the control to develop, revise, or change Equipment Authorization Inventory Data (EAID). In laymen's terms, it is used to assist you in determining what equipment you can and cannot have within your facility or unit. This can be a complicated procedure, so it is best to seek assistance from personnel in the medical logistics office.

Custody receipt/locator list

The CRL was discussed previously, but it is important enough to warrant repeating. The purpose of this list is just what the name implies; it indicates each specific item for which a custodian receives and is responsible, and where the item is supposed to be located (fig. 2–5). The quantity and dollar value of assets on-hand are shown in item ID number sequence. The total dollar value of in-use assets is summarized on the last page of the list for each activity. The location, index number, and serial number are also shown for maintenance coded equipment and maintenance significant supply items. The custodian's signature on this list indicates that possession of property is transferred. Before signing for an equipment account, MEMO personnel provide you with a copy of this listing to help you perform your initial equipment inventory. After the inventory is completed and any necessary adjustments have been completed, you are given an updated listing for your signature. MEMO personnel maintain a signed copy of this list in the MEMO property custodian file. The second copy is given to you, and filed in your equipment folder.

DEFENSE MEDICAL LOGISTICS STANDARD SUPPORT

DATE PREPARED: 12 NOV 2004 — **CUSTODIAN RECEIPT/LOCATION LIST** — **AS OF DATE:** 12 NOV 2004

DODAAC: FM4852 **UIC:** — **ORGANIZATION NAME:** MIKE O'CALLAGHAN FED. HOSP. NELLIS AFB — **ORG ID:** FM4852

CUSTOMER ID: 125245 **CUSTOMER NAME:** MATERIEL MANAGEMENT SERVICE **CUSTODIAN NAME:** MARK SALEEN

ITEM ID / NAMEPLATE MODEL	SERIAL NUMBER	EQUIPMENT NOMENCLATURE / SHORT ITEM DESCRIPTION	ECN / COMMON MODEL	TYPE	MANUFACTURER / PERMANENT LOCATION	OWNERSHIP	ACQ. COST / DATE LAST INV.
6685L90150001		RECORDER, GRAPHIC	010637	IND	OMEGA ENGINEERING INC		$662.00
CT485B	800906153W1	RECORDER, CHART TEMP/HUMD	CT485B		WRM	ORGANIZATIONAL	07 JUN 2004
6685L90150001		RECORDER, GRAPHIC	012023	IND	OMEGA ENGINEERING INC		$736.00
CT485B	CT210707655	RECORDER, CHART TEMP/HUMD	CT485B		WHSE	ORGANIZATIONAL	07 JUN 2004
6730L500031		AUDIO-VISUAL, PHOTOGRAPHY EQUIPMENT	005776	IND	3M VISUAL SYS DIV		$545.00
2770 AJB	737843	PROJECTOR, OVERHEAD			CONF RM	ORGANIZATIONAL	07 JUN 2004
7045LN9007000		SHREDDER, PAPER	011492	IND	INTIMUS		$1,443.72
671-68	671114.00766	SHREDDER, PAPER			MEMO	ORGANIZATIONAL	07 JUN 2004
7320L500002		FAX MACHINE	010026	IND	BROTHER		$611.98
MFC 4450	H73679084	FAX MACHINE	MFC-4450		WRM	ORGANIZATIONAL	07 JUN 2004
7320LM2099002		OVEN, MICROWAVE	012314	IND	PANASONIC CONSUMER ELEC CO.		$99.95
NN-5309A	AW921601507	OVEN, MICROWAVE				ORGANIZATIONAL	07 JUN 2004
7490L500034		AUDIO-VISUAL, PHOTOGRAPHY EQUIPMENT	008245	IND	IN FOCUS SYSTEMS		$6,899.00
550LS	4D05191	PROJECTOR, LITEPRO			WHSE	ORGANIZATIONAL	07 JUN 2004
7490L500604		FAX MACHINE	010524	IND	XEROX		$2,480.00
PRO 745	HIK-006101	FAX MACHINE	WORK CENTRE PRO		RECORDS	ORGANIZATIONAL	07 JUN 2004
7520LM1256004		FAX MACHINE	012764	IND	BROTHER		$314.54
FAX2800	456577K2J732515	FAX MULTI-FUNCTION	FAX2800			ORGANIZATIONAL	07 JUN 2004

TOTAL DOLLAR VALUE ON HAND: $70,374.90
TOTAL QUANTITY ON HAND: 24

I CERTIFY THAT THE ITEMS LISTED ABOVE ARE CORRECT.

E-6 MARK SALEEN _____ DATE _____

Figure 2–5. Custody receipt/locator list.

Custodial actions list

The custodial actions list (CAL) is an interim listing used to update the custody receipt/locator list. The list is produced each time medical logistics personnel process a change action affecting a custodian's equipment account. The change may be an equipment issue, turn-in, transfer, or backorder. The custodial actions list is distributed, certified, and filed in the same manner as the custody receipt/locator list. Information copies of the CAL are prepared to show maintenance and/or expendability code changes. The information copy is forwarded to you for review and file. You may destroy custodial actions lists on receipt of a new custody receipt/locator list incorporating the changes.

Equipment Replacement Report

This Equipment Replacement Report list is produced in DMLSS and used for budgetary and financial plans for replacement equipment. During equipment budget cycles, this report can be produced for Capital or Expense equipment types by organization or selected customer. You also have the option to print replacement projections for up to five years out from the current date. The report will not list any equipment currently identified in the equipment detail record as replacement. Equipment items are reviewed, and items are suggested for replacement based on MEMO (and other) criteria. If you are the custodian, you should review the list and validate the requirements of your activity. If you determine a requirement is valid, indicate the replacement priority and prepare a request through TIGERS.

Back order report

This report is no longer produced by medical logistics personnel and sent to the supply custodian. Instead, the custodians can generate it through DMLSS at any time they wish to view it. You should review the report frequently checking for items requiring cancellation, follow-up status, quantity

error, item error, or other changes in status. If changes, or cancellation of items due-in are required, there is no guarantee logistics will be able to cancel your due-out, but they will try. It is important you accurately review the list so logistics personnel can make appropriate changes.

Using activity issue/turn-in summary

The using activity issue/turn-in summary is produced at the end of the month for each activity supported by MEDLOG that had issue action during the month. This listing contains all the issues, reversals, and turn-ins for your using activity**.**

Issues

This portion of the list contains a summary of all issues and reversals of issues made during the month for each activity. During the month, each order or other action requiring the warehouse to issue an item is documented on the using activity issue list. At the end of the month, all issue actions are summarized and reported on the using activity issue/turn-in summary report. This summary is produced by activity code in stock number sequence. When you receive this report, you should compare all your issue lists to ensure all transactions are accurate and accounted for.

The last page of each using activity report contains a dollar value summary issued by refundable/reimbursable and nonrefundable/nonreimbursable for medical and nonmedical supplies and equipment. This is helpful in managing your account funds.

Turn-ins

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

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

The Air Force Medical Logistics Website

The objective of this Website is to provide timely medical materiel support data to all Air Force medical activities. This Website includes suspense dates for the return of information or attachments to the medical materiel section for a consolidated response to the Air Force Medical Logistics Online (AFMLO). The AFML Website includes attachments on items to be suspended, destroyed, or returned for credit. It is your responsibility to ensure your stocks are screened against these attachments. The Medical Logistics office will screen recurring stocks. These are the attachments:

- The Clinical Engineering and Technical Services Brief attachment contains information on modifications, recalls, or complaints related to equipment items. Use this attachment to determine if your equipment is affected.
- The DPSC backorder attachment is used to identify items delayed for issue. Please notify logistic if the delay will cause problems for your activity. This allows timely action for ordering a substitute or replacement item through LP channels.
- The Recall/Hazard Alert Notices, Item Suspension, Item Destruction, Release from Suspension, and Extension of Expiration Dated Items attachment should be checked against stock on hand in your using activity. After this action has been completed, notify the Medical Logistics Office of your findings.
- The Excess Materiel Available for Redistribution listing is very important. Items on this list can be obtained at no cost to your account. Screen the list for items needed for your facility. Annotate the quantity, your activity code, and signature; then forward to the personnel in logistics. They will review your request to ensure the items can be used without causing

existing warehouse stock to expire or become excess. Use the list wisely, and remember the stock currently on hand in your facility must also be properly utilized.

Self-Test Questions

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

611. Management of public property

1. Match the category of responsibility in column B with the appropriate statement in column A. Column B items may be used once or more than once.

Column A	*Column B*
____ (1) Responsibility for training personnel.	a. Command.
____ (2) Ensures qualified personnel are assigned as accountable officers.	b. Supervisory.
____ (3) Indoctrinates personnel in principles of supply discipline.	c. Custodial.
____ (4) Responsibility assumed when acquiring possession of government property.	d. All personnel.
____ (5) Charge Custody, care, use, and safeguarding all government property under their control.	

2. Why is supply discipline required?

3. List the five principles of supply discipline.

4. Define “pecuniary liability”.

5. An airman signed out a DVD recorder from a surgical suite and then lost it. The airman admits pecuniary liability. The DVD recorder costs $480 and the airman can’t pay cash. In this case, what form should be used to provide relief from responsibility?

6. If the airman in question 5 doesn’t admit pecuniary liability, and refuses to pay; what action is taken, and what form is used to document the action?

612. Procurement categories and sources

1. Define the following:
   a. Medical investment equipment.

   b. Medical expense equipment.

c. Medical supply item.

d. Consumable.

e. Durable.

2. Who are the main sources for the majority of Air Force medical and nonmedical materiel?

3. If an item isn't stock listed; what procurement source is available to you?

4. What method allows supply to order items directly from commercial vendors?

5. Who reviews and approves standard LP requests? What are the exceptions?

6. When is "after-the-fact procurement" normally used?

613. Issues and turn-ins

1. Who has responsibility for all materiel requested and signed for a specific account?

2. Explain the stock level of consumable and durable supplies a using activity is authorized?

3. What are the two primary methods used by medical logistics personnel to support customers routine supply requests?

4. What's a preissue and when is it used?

5. When is a back order action established?

6. What items are acceptable for turn-in to Medical Materiel?

7. What credit do you receive for materiel turned in for destruction by Medical Materiel?

614. Equipment custodian responsibilities and procedures

1. What listing do MEMO personnel provide if you are a newly appointed property custodian getting ready to assume custodial responsibility?

2. During an equipment inventory, what documentation should you review for equipment on loan?

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

4. How do property custodians ensure property in their account is properly charged to the account, it is physically on hand, or appropriate action has been taken to effect settlement for missing or damaged items?

5. What section in the hospital manages medical equipment?

6. What system is required to request a piece of equipment?

7. When should you submit a request for purchase of a piece of equipment?

8. What type of letter must be submitted to purchase a piece of specialized equipment where there is only one manufacturer's product that will do?

9. Who has the final approval authority for equipment requests submitted by MEMO?

615. Customer support listings

1. What's the purpose of the custody receipt/locator list?

2. What does the custodian’s signature on the CRL list indicate?

3. Where should you file your signed copy of the custody receipt /locator list?

4. What’s the purpose of the custodial actions list?

5. When is the custodial actions list produced?

6. What’s the purpose of the Equipment Replacement Report?

7. What monthly report is supported by MEDLOG and contains all the issues, reversals, and turn-ins for a using activity?

8. What information should you look for when you’re screening the back order report?

9. What should you do with the Recall/Hazard Alert Notices?

10. What type of information is contained in the Excess Materiel Available for Redistribution listing, and how would you use this information?

Answers to Self-Test Questions

607

1. Financial management.
   (2) Manpower programs.
   (3) Data analysis.
   (4) Business office.
   (5) Methods improvement.
   (6) Computer systems (when no medical systems office exists).
2. (1) Budgeting.
   (2) Execution.
   (3) Accounting.
   (4) Cost center management.
   (5) Fiscal analysis.
3. Business office.
4. (1) g.
   (2) e.
   (3) d.
   (4) f.
   (5) b.
   (6) a.

608

1. MTF commander.
2. The director of Medical Resource Management.
3. The format for the budget, policy guidance on budget submissions, and the date the budget must be forwarded to the base budget office.
4. Keep records of the situation and work with RMO personnel to ensure sufficient funds are allocated to provide continued operation.

609

1. The base RMO.
2. (a) A generic measurement of the amount of work done by one individual in one hour.
   (b) The amount of work; the number of work units or volume of work a work center is responsible for during a specific time period.
   (c) An area, usually centralized, where personnel use similar tools, methods, or processes to perform similar or related tasks.
   (d) The amount of hours an individual is actually performing primary duties.
   (e) The amount of time an individual is performing activities, *directed, recognized, or approved* by the Air Force, that aren't considered primary work duties.
3. In one sense, manpower standard refers to the mathematical formula used to calculate manpower requirements (man-hours required based on workload in a workcenter). It also refers to a resource management document that contains the formula, a workcenter description, a breakdown of tasks, and skill and grade requirements of personnel.
4. The UMD lists *manpower authorized*. This document lists by a *position number all available* positions, officer and enlisted, in each workcenter. It lists the positions by number, by AFSC, and by duty title only. The UPMR lists *manpower assigned*. This is a list similar to the UMD, but it also has the *name* and social security number of *the individual assigned* to (and projected or enroute to) each position number in the MTF. All military personnel, whether assigned to an authorized position or not (such as when you have more people assigned than you're authorized), are listed on the UPMR.

5. This is a request to make a change in a designated position.

610

1. MEPRS.
2. Monthly.
3. DMHRSi.
4. Each individual assigned to the MTF:
   (1) Active-duty members.
   (2) Federal civilian employees.
   (3) Personnel "borrowed" from another facility (i.e., manning assistance).
   (4) Students.
   (5) Contract personnel.
   (6) Volunteers.
   (7) Reservists and Air National Guard.
   (8) Foreign national employees.
5. NLT COB the first duty day after timecard period ends (Monday).

611

1. (1) b.
   (2) a.
   (3) b.
   (4) c.
   (5) d (a, b, and c, as well).
2. To conserve and protect Air Force supplies and equipment for operational requirements.
3. (1) Maximum economical use of available equipment and supplies for their intended purpose.
   (2) Effective safeguarding and preservation of public property.
   (3) Adherence to procedures contained in established regulations and directives governing requisitioning, storage, issue, turn-in of property and the control of sensitive and classified items.
   (4) Continuous screening of stocks and prompt reporting, redistribution, and disposal of excesses.
   (5) Scrupulous avoidance of issue requests for or use of any, but minimum essential supplies and equipment needed to perform the assigned task.
4. The statutory obligation of an individual to reimburse the government for loss, damage or destruction of government property due to personal negligence.
5. DD Form 362, Statement of Charges/ Cash Collection Voucher.
6. *Report of Survey* for Air Force property is conducted and documented on a DD Form 200, Financial Liability Investigation of Property Loss.

612

1. (a) An item that costs $250,000 or more, has a five-year life expectancy;, and maintains its identity during use.
   (b) An item that costs from $2,500, but less than $250,000; has a five year life expectancy, maintains its identity during use.
   (c) An item that doesn't qualify as an equipment item.
   (d) An item that can't be reused—loses its identity.
   (e) An item that can be reused—retains its identity.
2. PV and the ECAT system—medical; GSA—nonmedical.
3. Local purchase.
4. Local purchase.

5. Medical Logistics Flight commander, an authorized representative, or review activity and approves local purchase requests, with the exception of drugs and biologicals which are approved by the Medical Therapeutics Committee.
6. For emergency requests when there isn't time to wait for "normal" supply channels. Such an instance would be a request made after duty hours when "first thing in the morning" would be too late.

613

1. Property custodian.
2. The actual level of stock is based on average usage and resupply frequency of recurring demand supplies. This level varies with the type of commodity, the user, and location of the supply account. Medical logistics personnel should issue supplies to customers frequently.
3. Automatic resupply methods, such as forward logistics and the manual shopping guide DMLSS order method.
4. Preissue is like being issued an item on credit. You're issued the item, and the transaction is entered in DMLSS at a later time. This might happen if the DMLSS system is "down."
5. An item is put on back order when there's no stock on-hand, or there isn't sufficient stock to completely fill your order (in this case, the unfilled balance goes on back order).
6. Serviceable, unserviceable, and suspended items.
7. No credit.

614

1. A CRL showing all property charged and due-in to the custodians account.
2. AF Form 1297, Temporary Issue Receipt.
3. Only after the inventory has been performed and corrective actions documented.
4. Perform spot checks, and periodic inventories to verify serial and index numbers.
5. MEMO.
6. TIGERS.
7. When the requirement is identified. Remember, your requirements drive your budget; don't let your requirements be determined by your budget.
8. You must submit a letter justifying "sole source" procurement.
9. MTF commander or designated ERAA.

615

1. Identifies all items the custodian is responsible for and where each item is located.
2. Indicates possession of equipment taken by custodian.
3. File the signed copy of the custody receipt/locator list in your equipment folder.
4. It's an interim listing used to update the custody receipt locator list.
5. Each time medical logistics personnel process a change action affecting a custodian's account.
6. Help you with budget and finance plans for replacing equipment.
7. Using activity issue/turn-in summary.
8. Canceled items, follow-up status, quantity errors, and item errors.
9. Check the items listed in this attachment against your on-hand stock. Notify the logistics office of your findings.
10. Items listed in this attachment are available at no cost to your activity. Annotate the quantity and your activity code. Sign the attachment then forward your request to the medical logistics folks. Remember the basic rules regarding authorized stock levels when ordering.

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

Unit Review Exercises

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

Do not return your answer sheet to AFCDA.

15. (607) What term means determining how much money is required for operating a medical treatment facility (MTF)?
    a. Executing.
    b. Bogeying.
    c. Budgeting.
    d. Accounting.

16. (607) From a resource management perspective, what is a duty section is known as?
    a. Bogey.
    b. Cost center.
    c. Business office.
    d. Responsibility center.

17. (607) What is the *lowest* level at which costs may be accumulated in the resource management chain?
    a. Cost center.
    b. Cost account.
    c. Responsibility center.
    d. Responsibility account.

18. (608) What office is responsible for training cost center managers?
    a. Medical Materiel Office.
    b. Resource Advisory Office.
    c. Resource Management Office.
    d. Medical Equipment Management Office.

19. (609) Which resource management document contains a manpower formula, a workcenter description, a breakdown of tasks, and skill and grade requirements of personnel?
    a. Manpower Standard.
    b. Unit Manpower Document.
    c. Authorization Change Request.
    d. Unit Personnel Manpower Roster.

20. (610) Under the Medical Expense and Performance Reporting System (MEPRS), how often is each duty section or department workload reported to the Resource Management Office (RMO)?
    a. Daily.
    b. Weekly.
    c. Monthly.
    d. Quarterly.

21. (610) Each individual assigned to the medical treatment facility (MTF) is required to report their individual workload using
    a. UPMR.
    b. DEERS.
    c. DMHRSi.
    d. MEPRS code DFBA.

22. (611) Any individual who has acquired possession of government property has what category of responsibility for that property?
    a. Material.
    b. Custodial.
    c. Command.
    d. Supervisory.

23. (611) What is the distinction between fraud and abuse?
    a. Fraud is intentional deception for gain.
    b. Fraud is careless use of Air Force resources.
    c. Abuse is a reportable offense and fraud is not.
    d. Abuse is *not* intentional, but excessive use of AF resources.

24. (611) The statutory obligation of an individual to reimburse the government for loss, damage, or destruction of government property arising from his or her negligence is
    a. fraud.
    b. waste.
    c. abuse.
    d. pecuniary liability.

25. (611) An Air Force employee can voluntarily reimburse the government for a damaged monitor if the cost is
    a. $250.
    b. $500.
    c. $750.
    d. $1000.

26. (612) An item of medical equipment with a unit cost greater than $2,500 but less than $250,000, has a life expectancy of at least five years is classified as
    a. medical expense equipment.
    b. a durable medical supply item.
    c. medical investment equipment.
    d. a maintenance significant supply item.

27. (612) The type of emergency medical purchase that restricts the customer to purchasing only enough of an item to cover the particular emergency is known as
    a. pre-issue.
    b. consignment.
    c. after-the-fact procurement.
    d. a blanket purchase agreement.

28. (613) Who assumes full responsibility for all materials requested and received by a using activity?
    a. Flight chief.
    b. Charge nurse.
    c. property custodian.
    d. supply representatives.

29. (613) How can you request a nonrecurring routine issue from supply?
    a. Use your shopping guide to order the item.
    b. Submit a AF Form 601, Equipment Action Request.
    c. Order the item through the Internal Distribution Operation.
    d. Order them from your customer catalog or fill out a new item request within the Defense Medical Logistics Standard Support (DMLSS) system.

30. (613) What type of non-routine issue is used when issue transactions *cannot* be processed through the Defense Medical Logistics Standard Support (DMLSS) system?
    a. Preissue.
    b. Backorder.
    c. Local purchase.
    d. Emergency issue.

31. (613) Medical materials turned-in to the Defense Logistics Agency (DLA) Dispostiion Services site to be destroyed are
    a. never accepted.
    b. accepted without credit.
    c. accepted with full credit.
    d. accepted for partial credit.

32. (614) Before signing the custody receipt/locator listing to assume custodial responsibility for equipment, you should first
    a. perform a thorough inventory.
    b. prepare your three-year budget.
    c. submit an AF Form 601, Equipment Action Request.
    d. submit DD Form 1348–6, DOD Single Line Item Requisition Document.

33. (614) When should you submit an online equipment request form via The Integrated Global Equipment Request System?
    a. The first day of each quarter.
    b. At the start of the fiscal year.
    c. When the equipment is delivered to you.
    d. When the requirement for the equipment is identified.

34. (615) What customer support listing is produced each time medical logistics personnel process a change action affecting a custodian's equipment account?
    a. Back order report.
    b. Custodial actions list.
    c. Custody receipt/locator list.
    d. Using activity issue/turn-in summary.

35. (615) Which Defense Medical Logistics Standard Support (DMLSS) report should be reviewed frequently checking for items requiring cancellation, follow-up status, quantity error, or item error?
    a. Back order report.
    b. Custodial actions list.
    c. Custody receipt/locator list.
    d. Using activity issue/turn-in summary.

Please read the unit menu for unit 3 and continue ➔

Unit 3. Ancillary Areas of Surgical Service and Medical Readiness

THE FIRST SECTION OF THIS UNIT FOCUSES ON ADMINISTRATIVE PROCEDURES of ancillary areas of surgery such as Sterile Processing Department. At some point in time you may also have to assist in the general surgery clinic or one of the specialty clinics so it's important for you to understand the administrative functions of these clinics.

With the threat of terrorist attacks, you may deploy overseas. This is what medical readiness is all about. This section will help you understand how the different programs and surgical augmentation team systems work during your involvement in mobility and contingency exercises and operations.

3–1. Sterile Processing Department

As a 4N1X1, one of your ancillary areas of responsibility is in SPD. This area of the hospital plays a pivotal role in the infection control process. Surgical technicians have a breadth of experience when it comes to sterilization and disinfection. For that reason, they are usually selected to run the SPD and to act as consultants on infection control to the rest of the facility. Throughout this CDC, we've focused on many activities performed in SPD. In this unit, we will look at more than just the tasks and duties performed by the individuals in SPD; we will also look at the organization, functions, layout, and workflow of this crucial department.

616. Organization, functions, and services of the Sterile Processing Department

The department we refer to in this course as SPD is known by many names. Depending on the facility, it can be known as Central Services, Central Supply, Central Materiel, and Materiel Management, only to name a few. Regardless of the name, most of the activities performed by the surgical technicians in SPD are related to decontamination, cleaning, and processing of instruments and other nondisposable items. However, these are not the only functions performed in most SPD departments. To get the true picture, you must be familiar with the general organization and function of SPD.

Organization

In most cases, SPD falls under the MTF's organizational umbrella of surgical services in the medical or surgical services flight. It may be under the surgical suite or it may be on the same organizational level as the surgical suite. The range of services provided by the SPD varies, depending on the needs of the particular MTF. Since no two existing MTFs are alike in physical layout, organization, and service, the SPD in each one will also vary. In all cases, the folks in the SPD render service to a highly specialized group—patients, and medical and nursing personnel.

In a facility deemed too small for a Surgical Operations Squadron, the OR, SPD, Anesthesia Services, PACU and Same Day Surgery will fall under the Inpatient Operations Squadron in the Surgical Inpatient Flight.

Mission and purpose

The SPD is a *service* organization whose mission is threefold:

1. Improve patient care by releasing the nursing staff from certain non-nursing functions.
2. Create a system whereby sterile supplies are properly controlled, distributed, maintained, and utilized.
3. Assure bacteriologically safe sterilization procedures.

In today's medical facilities, the SPD has emerged as a very important factor in the maintenance and improvement of patient care. This importance has increased as SPD personnel provide more and more assistance to patient care units, specialized areas, and off-site unit activities.

The primary purpose of any SPD is service. The specific types of service and the various procedures carried out by the personnel in the SPD vary from facility to facility, but should always reflect the overall goal of improving patient care. To this end, SPD personnel should strive to provide sterile supplies through efficient and economical means. They should also have standard practices and techniques for processing equipment and supplies.

Goals and functions

Each SPD should have specific objectives that are well-known to the personnel who work in that department. These objectives should be written specifically for that facility and reviewed annually. The objectives of a SPD should include, but are not limited to:

- Providing prompt, accurate services and supplies to nursing units, clinics, specialty areas, and medical staff. Service may also be provided to other units, on or off base, such as dispensaries, fire stations, flight medicine, occupational medicine, dental and veterinary services, and aeromedical evacuation units.
- Providing special medical equipment items.
- Maintaining high quality supplies.
- Maintaining accurate records of the effectiveness of various processes of cleaning, sterilization, and disinfection.
- Maintaining written procedures for all decontamination and sterilization activities performed in the facility.
- Maintaining a current, accurate inventory of supplies.
- Developing and contributing to educational programs within the SPD, the medical facility, and the community.

The functions of a SPD evolve from the objectives and include:

- Procure, maintain, process and dispense supplies required for patient care, diagnosis, and treatment.
- Use acceptable methods and techniques for processing materials.
- Develop and maintain controls to provide supplies economically, effectively, and efficiently.
- Take part in supply research that provides information to nursing and medical personnel.
- Provide representation on committees such as Infection Control, Performance Improvement/Risk Management, and Staff Development.

Scope and types of services

The scope of any SPD is determined by the factors on which it bases the objectives of its services. The factors involved in determining the scope of a specific SPD are as follows:

- Geographical location.
- Type of services provided by the facility.
- Size.
- Number of beds.
- Number of procedures performed in the emergency room, operating room, and obstetrical suites.
- Clinic patient load.
- Number of research areas.
- Specialties of medical officers.
- Funds available to invest in space, supplies, equipment, and personnel.

NOTE: In all cases, the SPD must be flexible and adaptable to change.

The SPD personnel offer various services to meet local needs. Listed are some of the most common services:

- Maintaining an adequate stock of sterile and nonsterile supplies. SPD personnel also provide sterile and nonsterile supplies for patient care required by all elements of the MTF and satellite activities.
- Providing a distribution and collection service. Distribution of sterile items and collection of contaminated items is a service that should be provided to the nursing units and other using areas. Each of these areas must maintain a supply level of the items needed for day-to-day operation.
- Developing, maintaining and updating a list of sterile and nonsterile supplies. The personnel in each SPD publish a list of all items they provide. These are classified in appropriate groups. For example, a partial list may look like the following:

Sterile sets and packs	Qty	Sterile instruments	Qty	Sterile dressings and bandages	Qty
Tracheostomy sets		Forceps, Allis		4 x 8 plains	
Instrument sets—Basic		Needle holders		Kerlix	
Towels		Hemostats,		Ace	

- Maintaining a current list of the contents of sets. This list should indicate the contents of all sets, and which items and sets are disposable. The contents of each set sterilized by SPD personnel should be listed on the outside of the wrapper or package.
- Providing a continuous service on a 24–hour basis (depending on your organization). In larger facilities, around the clock coverage is necessary to complete the SPD mission. Few MTFs have the staff to maintain personnel in SPD 24 hours a day; therefore, an “on call” system is adequate for emergency issue of supplies during evenings, nights, weekends, and holidays.

NOTE: The SPD doesn't store or dispense medications; the pharmacy does. It's important for SPD personnel to work with the using activities in planning their supply needs. A properly organized SPD greatly facilitates patient care.

617. Sterile Processing Department activities, layout, and workflow

The SPD personnel perform many different activities. To be efficient, the layout and workflow of the departments should ensure these activities can be performed in a logical and safe manner.

Classification of SPD activities

To be able to provide all the services previously outlined, SPD personnel must perform many different activities. The following paragraphs discuss the common activities and specific duties associated with these activities.

Receiving

This activity consists of bringing items into the SPD. These items routinely include:

- Clean supplies.
- Soiled/contaminated items.
- New/repaired equipment.
- Linens.
- Disposable/non-disposable items for sterilization.

Processing

Processing consists of handling items throughout a series of steps which are illustrated in the following table:

Processing Sterile Processing Department Items	
Step	**Description**
Disassembly	This is breaking-down components of multi-part instruments and sets to aid and allow thorough cleaning. Ideally, the majority of this work is completed at the point of use, before the item is received in the SPD.
Cleaning	The removal of gross (visible) contaminants from the item being processed.
Decontamination	Removal of bio burden to render the item safe for handling by non-protected personnel.
Assembly	Gathering the items into sets and ensuring all pieces and components are present and functioning.
Packaging	Packaging involves protecting the item in some manner so it can be handled safely by non-sterile personnel or be placed in storage but maintain its sterility.
Sterilization	Destroying all life to render the item safe for use on a particular patient.

Distribution

This entails moving items within the SPD or sending and taking supplies out of the SPD to give to a customer:

- Unloading dry, sterilized items into storage cabinets.
- Moving supplies from storage to work locations for use in processing.
- Filling orders from customers.
- Moving clean supplies and equipment throughout the SPD.
- Sorting, folding, and moving linen.
- Delivering supplies to patient units and specialized areas.
- Sending equipment out for repair.

Storage

Storage of SPD items includes the following:

1. Putting away sterile and nonsterile supplies and equipment, including storing bulk supplies on storeroom shelves.
2. Cleaning supplies and equipment in nonsterile storage areas.
3. Cleaning sterile supplies in sterile storage areas.
4. Checking sterile storage areas for inventory contents and outdated or compromised items.

Housekeeping and sanitation

The housekeeping and sanitation activity consists of keeping the work areas and equipment clean and orderly, including cleaning work areas, offices, cabinets, shelves, sterilizers, and carts.

Administration

Administration consists of the four basic activities:

Administration of the Sterile Processing Department

Activity	Description
Paperwork	Reading, filing, recording, writing, and typing information, including: • Performing clerical activities. • Developing/recording inventories and replenishing lists. • Maintaining index of sets and linen packs. • Preparing work schedules, duty tours, and daily or weekly assignments. • Calculating MEPRS man-hours and work distribution statistics.
Communication	Giving and receiving written and oral information, including: • Written orders, directives, policies, and operating instructions. • Telephone conversations. • Talking with personnel. • Meetings.
Supervision	Consists of coordinating and managing the SPD activities, including: • Planning and scheduling. • Observing and guiding work processes. • Evaluating and providing feedback to personnel. • Other administrative duties.
Training	Concerned with giving instruction to personnel in the SPD functions and activities, including: • Job orientation. • Instruction on new procedures. • Organized OJT. • Inservice educational programs. • Maintaining training documentation. • Scheduling recurring training.

Many of the activities performed by the SPD personnel are common to other functional areas in the medical facility, but the activities of receiving, processing, and distributing reusable sterile supplies are unique to the SPD. The department's physical layout and workflow should reflect this uniqueness.

Physical layout and workflow

The physical design and layout of the SPD varies greatly from facility to facility. Regardless of the size or the services rendered, the SPD should be divided into separate, distinct areas for each major

function performed. The workflow for handling and reprocessing soiled instruments are detailed in the following table:

Workflow for Handling/Reprocessing Soiled Instruments	
Activity	**Description**
Receiving	In this section, soiled instruments, supplies, and equipment are received from the various customers within and outside the facility, and sorted for intradepartmental routing.
Decontamination	This is considered one of the most critical areas in the medical facility. All reusable instruments, supplies, and other portable items coming in contact with blood, blood products, or other body fluids are cleaned and decontaminated in this area. When items leave the decontamination area of the SPD, they are biologically safe for handling without applying universal or standard precautions. This area in the workflow is unique from a ventilation "flow" standpoint; it is one of the two rooms in the SPD required to have negative air pressure. This negative pressure is required to keep microbes and other potentially infectious "bugs" contained within the decontamination area. For this to be effective, the doors to the decontamination area must be kept closed.
Processing	In this area, the decontaminated instruments and other items are sorted, inspected, assembled, packaged, and sterilized. The SPD in some facilities has a separate sterilization area.
Storage	There are generally two separate storage areas in the SPD. Nonsterile storage contains clean items such as processing supplies, wrappers, linens, and replacement instruments. Sterile storage contains sterilized items, preferably in closed or covered cabinets. When space is limited, the two storage areas may be combined, provided that sterile items are stored separately from nonsterile ones, and provided that proper storage and handling methods are strictly followed.
Distribution	The final step in the SPD workflow is distribution where the customer receives the items. Distribution involved several activities, including preparation and delivery of surgical items, filling "orders" from using activities, issuing items to patients, and providing delivery service to nursing units and specialty areas.

Self-Test Questions

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

616. Organization, functions, and services of the Sterile Processing Department

1. List some of the names by which SPD is known as in various facilities.

2. Describe the mission of SPD.

3. What is the primary purpose of SPD?

4. List some of the common services provided by SPD personnel.

617. Sterile Processing Department activities, layout and workflow

1. List the primary activities of SPD personnel.

2. Why is negative pressure required in the decontamination area of SPD?

3. If sterile and nonsterile storage areas are combined, what conditions must be met?

3–2. Clinic Administration

As you gain more experience as a surgical technician, you may be selection to work in the general surgery clinic or in one of the surgical specialty clinics–Urology, Orthopedic, or Ear, Nose, and Throat (ENT). While you cannot laterally train into the "shred" AFSC until you earn your 5–level in the basic 4N1X1 career field, you may be selected to provide manning assistance to these clinics. It is important for you to have a basic understanding of some of the administrative functions related to the clinics.

618. Patient scheduling and reception

Patients typically gain access to specialty clinics (i.e., General Surgery, Urology, Orthopedic, or ENT clinics) by a referral in the *appointment system*. The exact method used in scheduling the appointments will vary according to local needs and policy. There are, however, several types of "appointment systems" in common use at many Air Force MTFs.

Reviewing consults

Patients who need a routine (non-acute) appointment for medical care from a specialty clinic must first obtain a consultation from their primary care provider. To obtain a consult, a patient is generally seen by a provider in the Primary Care/Family Practice clinic. The provider then recommends the patient to the specialty clinic by completing a consultation request. The consultation request may be done by completing a Standard Form (SF) 513, Medical Record-Consultation Sheet.

When the appropriate clinic receives the consult, the clinic administration clerk or clinic technician will review the consult and attempt to schedule the patient with a physician appropriate for the patient's condition. The exact time of the appointment varies with the nature of the condition, and with the urgency marked on the consult sheet. The four categories of urgency are as follows:

1. Emergency.
2. Today.
3. 72 hours.
4. Routine.

Every effort should be made to honor the time request on the consult. If it cannot be done, the technician or clerk should call the referring provider for further instructions. Local policies vary greatly on how to schedule outpatient appointments, follow-up appointments, and on what to do about broken appointments. However, each MTF has specific OIs giving guidance on these subjects. Let's now take a brief look at how the clinic worker manually schedules appointments after receiving the consultation.

Manually scheduling appointments

Different clinics, most notably the specialty clinics, have other forms that they use on a daily basis for scheduling. Also, since local policy dictates (1) what types of procedures a clinic can and can't do, and (2) what additional patient data they wish placed on the form you should always consult with your chain of command if you have any dilemmas when trying to schedule a patient.

Using the Composite Health Care System to schedule appointments

If you recall, CHCS is a computer system used for many purposes within a MTF, one of which is appointment scheduling. Each MTF must have an appointment system that is responsive to the healthcare needs of the entire MTF community. Although using CHCS may be similar in each MTF, you will require further on-the-job training to perform appointment scheduling if your job requires that capability. Also, your facility may have an upgraded system, such as AHLTA, that requires additional training. Each facility should require you to have some sort of training on its appointment system before you can be issued a password to access the system. It is important to use this system for scheduling appointments so that your clinic receives proper credit for the patients you have seen. Without proper credit, you can lose resources and manning.

Your facility's appointment system may be managed or performed in one of these three ways:

1. Centralized—the appointment desk schedules all appointments for the MTF.
2. Decentralized—each clinic schedules its own appointments and coordinates with the appointment desk.
3. Combination—some appointments are scheduled by the appointment desk and some by specialty clinics.

If you're responsible for scheduling patient appointments, you must know how to make initial appointments, follow-ups, referrals, request referrals from other facilities, and how to schedule additional diagnostic and therapeutic testing. Surgeons will often require additional testing such as X-ray, cardiology, or magnetic resonance imaging (MRI) to be performed on patients to confirm a diagnosis. Each individual facility will dictate what method of scheduling is used to coordinate additional patient test. Keep in mind additional training will be provided to you at your facility regarding each individual facilities scheduling system.

End of day processing

The end-of-day CHCS option allows you to correct patient appointment history and review the status of daily appointments. The option also enables you to specify whether an appointment status is pending, kept, canceled (by facility), no-show, walk-in, telephone-consult, sick-call, occasion of service (OCC-SVC), administrative, or left without being seen (LWOBS). You can update the status of any patient who was checked in manually. The end-of-day CHCS option also provides the means by which the computer database is updated to reflect what has really happened in the clinic and which data is reported in numerous statistical reports, such as patient counts. All end-of-day processing must be completed within seven days of the appointment. In addition, all end-of-day processing must be fully completed before the monthly statistical reports can be calculated and printed by resource management personnel.

Eligibility for care

The local MPS establishes an individual's eligibility for medical care. Medical facility personnel confirm the patient's identity and verify entitlement through the Defense Enrollment Eligibility Reporting System (DEERS) and an ID "check." Direct any questions on eligibility to the Director of Patient Administration.

Individuals requesting care must show satisfactory evidence of their beneficiary status. A valid ID card and a DEERS eligibility check are the ways to establish a patient's beneficiary status. Children under age 10 must be enrolled in DEERS, but they don't need their own ID cards. MTF personnel

should not provide routine care to patients with questionable eligibility until they confirm the patient is eligible. In an emergency, always provide care first. Determine eligibility after treatment.

Eligibility verification is normally a two-step process. First, the patient presents a valid ID card. You should ensure all patients, including those in uniform, show valid IDs before they receive routine care. Acceptable forms of ID cards include the following:

- Common access card (CAC) for active duty, red for reserves, and gray or blue for retirees.
- DD Form 1173, Uniformed Services Identification and Privilege Card, (brown for family members and specifically for foreign military personnel/family members. Some separating personnel and their family members are eligible for medical benefits under the Transitional Assistance Management Program (TAMP) and also use the DD Form 1173.
- DD Form 1173–1, Department of Defense Guard and Reserve Family Member Identification Card, for family members of Reserve personnel.
- The United States Public Health Service (USPHS) ID card number is PHS 1866–1 for active duty and PHS 1866–2 for Reserve PHS personnel. Individuals in possession of these cards are authorized users of DOD medical facilities.
- Other beneficiaries may have different organizational identification. When an organization doesn't issue ID cards, its members must show some proof of organizational affiliation as well as personal identification.

The second step in verifying a person's eligibility status is the DEERS check. You should perform DEERS checks on active duty, retirees, and family members of active duty and retired, TAMP eligibles and survivors only.

Earlier, we said children under age 10 must be enrolled in DEERS, but they don't need their own ID cards. What would you do if a dependent child, over 10 years of age *without* an ID card, seeks medical care? In this case, you should perform a DEERS check. If the child is in DEERS and is with an adult sponsor or parent who has a valid ID card, provide the care.

Not all beneficiaries are enrolled in DEERS. As examples, you should provide routine care in the direct care system to the following categories of patients (even if they fail a DEERS eligibility check):

- The patient received an ID card within the last 120 days.
- The patient presents a DD Form 1172, Application for Uniformed Services Identification and Privilege Card, the Air Force issued or reverified within the last 120 days. The DD Form 1172 must have a date and a verifying authority from the MPS must have certified it. This certification includes an original signature in ink with the rank, position, and phone number of the verifying official.
- The patient's sponsor is a member of the Reserve or National Guard ordered to Federal active duty for more than 30 days and the patient has a copy of such orders. The beginning period of active duty must be within the last 120 days.
- The patient is under 10 years old and the sponsor is a reservist or guardsman called to duty (within the last 120 days) for more than 30 days. The child may use a copy of the orders to verify eligibility.
- The patient is a Secretarial Designee (use the designee letter to verify eligibility and benefits).
- The sponsor is on overseas assignment, afloat, or has an Army or Air Force Post Office (APO) or Fleet Post Office (FPO) address. The patient should present some documentation to indicate the sponsor's status such as TDY or PCS orders.

Now that you know how to ensure the patient is eligible for care, let's take a look at how to handle and maintain some medical records.

Scheduling patients in surgery

We previously discussed that patients gain access to the surgical specialty clinic through the appointment system. What happens when the surgeon sees a patient and determines the need for surgery? The answer is the patient needs to be placed on the operating schedule to have their surgical procedure performed. There are generally two ways a patient is scheduled for surgery. The first is by using an individual scheduling request slip, known as a "buck slip." The second is electronically transmitting the information from your computer. Regardless of the method used, the same information is required when scheduling the procedure.

Local policy determines the exact information that needs to be included on the buck slip. Here is a typical list of information provided to the operating room:

- Date and time of operation.
- Time and/or order of operation (1st case, 3rd case).
- Patient identification information:
    - Name.
    - Hospital register or Social Security number.
    - Age.
    - Sex.
    - Military status (i.e, Active Duty, divorced/widowed, E–6, A1C etc.).
- Patient location or nursing unit designation.
- Operation to be performed.
- Length of procedure.
- Primary surgeon (assistants may also be listed).
- Type of anesthesia.
- Units of blood required.
- Special equipment or instruments needed.
- Special radiology requirements.

Once the operating room staff receives this information, it is double-checked for accuracy and completeness. Be sure to complete the information correctly as the OR staff takes the information provided and creates the surgical schedule. Now that you have completed scheduling with the OR, you need to schedule the patient for a pre-admission visit.

Sending the patient to the pre-admission clinic is the final step in scheduling a patient for surgery. Each specialty clinic will supply the patient with a pre-admission packet containing surgical consent forms that must be completed and signed by both the patient and surgeon. The pre-admission clinic will oversee the accomplishment of all other documentation that must be completed before surgery and begin to assemble the patient's surgical chart. At this time, the patient is also educated on the proper preoperative requirements to follow. Special instructions are usually given to the patient regarding what medications should be stopped, what time they will need to show up for surgery, and most importantly when the patient can consume their last meal prior to their surgical procedure.

619. Customer service techniques

As with any organization that exists to provide service to a population, we must have good relations with our customers. This lesson may be a repeat for most of you but it does not make it any less important in your day-to-day activities. In addition, you may be appointed as the unit's customer service representative or patient advocate. If this is the case you will receive in-depth training by your facility patient advocate manager.

In the surgical suite

Although the majority of our surgical patients are heavily medicated or asleep, it is just as important to exhibit the same good customer relations as we do with our clinic patients. We should always be aware of how we or our subordinates treat our patients. The main goal of customer service to our patients is to remember the "golden rule": treat others as you wish to be treated. That patient is somebody's son or daughter, mother or father, wife or husband, and most importantly of course, a human being.

As you learned in previous units, surgical patients put themselves completely in our hands. We must do everything in our power to treat them with the utmost respect and courtesy even if it seems that they cannot hear us or understand us. Many times patients remember things that we think they were not even aware of. If you treat the patients with courtesy and respect at all times, you will never have a problem with complaints about the care you gave them. This doesn't mean you will never get complaints, it just means the patients will not be able to complain about the way they were treated by surgical personnel.

If you do get a complaint from a patient, you must be objective and evaluate the facts of the complaint. It is easy to say "We didn't do that." or "No one said that." But you must still look into any patient complaint as if it were fact. Someone may have slipped up or maybe something was overheard by the patient, but it was not about them. Think hard about the times you have heard others talk about a surgical case. We all know of times when patients have been referred to in a derogatory manner about their size or personnel hygiene. How many times have you heard a comment about the "beached whale" or the "really smelly patient"? How about the discussion of the actual procedure? Do you know who was within hearing distance? Did the room you were in, share an air duct with another room a patient may have been in? Was there someone standing just around the corner? You never know who may have overheard the conversation, do you? A true example was when several technicians were overheard talking about a really tough case and they were overheard by a patient's family member who was not related to the patient whose case they were discussing. The family member became very irate and it took a lot of effort to finally calm down the situation. In this instance, nothing derogatory was actually said about the patient, the only things being discussed were the technical matters of the case itself. As you can see, this is why we must be very careful what we do or say when we are in a patient care area. The same is particularly true if you work in a clinic.

In the surgical clinics

When you are working in a clinic environment, you are even more susceptible to getting complaints from patients. Many times the complaints will not be about the actual care they have been given, but about having to wait past the appointment time or the perceived attitude of the reception clerk or clinic personnel. If this occurs, the first thing to do is try to explain to the patients why they have to wait past their appointment time; there may have been an emergency or the provider may have had to take more time than he or she thought with another patient. In these instances try to get the patients to empathize by putting themselves in the place of whomever the provider is taking care of. Most people will calm down if they understand what is going on. Also keep in mind that your non-verbal communication skills can also add fuel to the fire when dealing with an upset patient. Do not roll your eyes or throw hands up in the air and walk away from the patient in disgust. Make sure you practice good non-verbal gestures at all times when dealing with patients.

Occasionally you will run across the unruly or angry patient who will not calm down no matter what you say or do. The most important thing for you to remember is that under no circumstances should you argue with the patient in public. It may be tempting to tell the patient that he/she is a total imbecile and can take a hike, but this will only escalate the situation. Try to get the patient to a more private area and contact your patient advocate. If this is you, then find out why the patient is upset and try to rectify the situation. If you cannot resolve the situation, then follow your facility's guidelines on who to contact next.

NOTE: There is no reason for you to be verbally or physically abused by anyone. If this occurs contact your chain of command and try to remove yourself from the situation if possible.

The protocol in some facilities is for the patient to go to the facility patient advocate next; other facilities have protocols for the patient to see the clinic NCOIC or OIC next. You need to be extremely knowledgeable in this matter. It can save you a lot of pain and heartache in the long run. Our patients are our lifeblood, without them we wouldn't have a job. We must always strive to have the best relationship possible with our customers—the patients.

Telephone etiquette techniques

Patients are influenced not only by personal contact with clinic personnel, but also by the presence or absence of good telephone techniques. Let's discuss a few rules for good telephone manners.

Answer promptly and smile

Don't ignore a ringing telephone. If you are providing care to a patient, answer the phone and ask if the caller can hold or if you can get a number and call them back.When you do answer, smile. Yes, it's true, the person at the other end of the phone line can't see you smile, but they can certainly hear you smile. It gives the patient who called the sense you are pleased he/she called and you enjoy your job. It also provides those who can see you (i.e., patients, visitors, other staff members, etc.) the same impression. This is the image you want to present.

Identify yourself and your office

Have the courtesy to let the caller know who answered the phone. Give the name of your office, then your name, and offer assistance. Something like, "Ortho clinic. Airman Razorsharp. This is an unsecure line—May I help you?" It never hurts to use sir or ma'am once you know the caller's sex. If you're too busy to carry on a conversation, answer the phone and see if the individual will hold or allow you to call him/her back. If the individual wants to hold, don't make him/her hang on too long. A minute is about all most people will tolerate before feeling like you have forgotten them. Listening to a silent, forgotten line quickly makes people angry. If you are too busy to take care of the caller in 30 to 60 seconds, return to the phone and tell the caller you will need to get his/her name and number and call him/her back. Set a time period the caller can expect to hear from you. When you finally return the caller's call, thank him/her for waiting.

Speak distinctly

How many times have you called somebody and heard just a quick mumble for the person's identification? This does not leave a good first impression. When you speak on the phone, speak distinctly. It will save time and trouble for you and the caller. I'm sure all of us have experienced the drive-through window at a fast food restaurant. The incoherent mumble-jumble over the speaker when the attendant took your order did not leave a good impression. You wonder what they said and if they understood what you said. It's irritating and frustrating. You can avoid a poor image for your clinic by communicating clearly.

Be prepared to take a message

If the person called is unable to come to the phone, take a message (include at least the name of the caller, time, and good call back number) on whatever form your clinic prefers to use, and then make sure the message is delivered. If the call is for a doctor or technician who is busy with a patient, don't interrupt the patient's treatment, but deliver the message at the earliest opportunity. It's usually better to have the person in the clinic return the call rather than having the caller phone again since the caller may once again call when the person he/she wishes to speak with is busy.

Avoid giving medical advice

Medical advice over the telephone usually leads to inaccurate self-treatment by patients and is legally risky. It is always better to see the patient and health records before making a decision or giving

advice. If in doubt, especially if you don't understand exactly what the patient is saying, have him/her come in. Never diagnose a patient's problem over the phone. General information is one thing; medical advice is quite another.

Be attentive

Listen to what the caller has to say. Don't try to listen to the phone and do something else at the same time. Your attention to both the calling patient and the other job will be degraded. Paraphrase what you think you heard back to the caller to ensure you've understood him/her correctly. Take notes if necessary.

Don't yell into the mouthpiece

If the call is for someone a little distance from the phone, put the phone down gently (or put it on hold) and approach the person, telling him/her there is a call. Don't put your hand over the mouthpiece and yell down the hall. The caller will still hear you quite clearly and won't be thankful!

Calls for the doctor

If the doctor is with a patient and receives a call and the caller can't wait, write down the caller's name and a short message and put it where the doctor will see it as soon as he/she is free. If it's really urgent, indicate that on the note. Don't interrupt an examination by sticking your head in the door and announcing a routine call. Only disturb an examination if the caller has a true emergency. Not surprisingly, the patient sitting in the doctor's chair feels the appointment time reserved for them should be used for him/her. Also, interruptions of an examination may cause your doctor to inadvertently overlook something important.

620. Management and security of medical records and controlled items

A medical record is a permanent, individual, chronological record of medical and dental examinations, evaluations, and treatments given a member of the Air Force and their dependents (or retired Air Force member and their dependents). The outpatient health record contains a concise summary of every visit made to a provider. Health records are filed numerically by using the sponsor's social security number, so both the member and their dependents have the same color coded folders. The AF Form 2100A, Health Record-Outpatient is the folder used for outpatient records; it is divided into four sections for ease in organizing its contents.

Although maintenance of these records is normally the responsibility of the outpatient records section, you, as a surgical service technician, must know the purpose of the health record and its contents.

Outpatient records

The main purpose of the health record is to ensure all information on the care of an individual is available and accessible to medical personnel. The medical summaries contained in these records provide valuable assistance to medical officers in conducting and rendering medical or dental care.

Record chargeout

The health record is the property of the Air Force, not the property of the individual. The Director of Patient Administration (or TRICARE Office) must make sure all records are maintained in the outpatient records section (except those authorized by Air Force directives to be maintained elsewhere). The record should be available each time the individual patient is seen.

If the patient has a scheduled appointment, a list is generally sent from the appointment desk to the outpatient records section the day before the scheduled appointment. The records are pulled and delivered to the appropriate clinic either the afternoon before or the morning of the appointment. The record should be returned to the outpatient records section after the provider has entered the appropriate documentation, usually late in the afternoon of the appointment date.In some facilities,

medical administration personnel deliver and collect these records; in other facilities, clinic or nursing unit personnel must retrieve them.

If the record is not in the clinic at the time of the appointment, or if the patient has a “same-day” appointment, the patient should report to the outpatient records section to retrieve his or her record. This may be done by completing an AF Form 250, Health Record Charge Out Request. In some cases, there may be a fully automated procedure such as a “bar-code” system.

When a member is hospitalized, the outpatient health record is made available to the inpatient unit and the provider responsible for that person’s care and treatment. When the member makes a move to a different duty station, either permanent or temporary, the health record is forwarded by the medical records section to the MPS. The health record is then sent to the member’s gaining duty station along with their personnel records.

Contents of health records

The two most important forms in the health record are SF 558, Medical Record—Emergency Care and Treatment, and SF 600, Chronological Record of Medical Care. As additional SF 600s are prepared, place them on top of the earlier ones, so the latest report of treatment is always on top, (interfile SFs 558 with SFs 600 in date order). Together, these two forms make up the “basic” outpatient health record for all military personnel. Every appearance for treatment must be recorded on one of these forms. This is normally done by the healthcare provider or assistant who sees the patient during a visit.All entries must be legible and in reproducible blue-black ink. Each entry should show at least the date of the visit, the pertinent history of the illness or circumstances of the injury, significant clinical findings, diagnosis or impression, treatment given, statement regarding essential follow-up care, and signature of the treating practitioner. The practitioner’s name stamp is placed below his or her signature on all handwritten documents. Each form and document to be filed in the record contains a minimum identification of patient’s name, and Social Security Number (SSN) under which the record is to be filed. Each form must contain the name and location of the MTF that maintains the patient’s health record, if other than the treating facility so the original record (or a copy, if specified) can be sent to the custodian of the patient’s record.

Arrangement of the AF Form 2100A series folder

Now let’s look at the filing arrangement in the AF Form 2100A, which is divided into four sections. Section 1 is located on the left side of the folder immediately inside the front cover. Sections 2 and 3 are located on the middle flap of the folder, and section 4 is located inside the back cover. New folders are prepared for new patients or when the present folder no longer protects the contents.

Section 1

Arrange forms in chronological sequence with the most recent action on top. The exception to this rule is DD Form 2766, Adult Preventive and Chronic Care Flowsheet, which will be the top form in section 1. File the following forms in order as listed after the DD Form 2766.

1. DD Form 2766C or AF Form 1480B, Adult Preventive and Chronic Care Flowsheet - Continuation Sheet.
2. DD Form 2795, Pre-Deployment Health Assessment Questionnaire
3. DD Form 2796, Post-Deployment Health Assessment (PDHA).
4. DD Form 2844, Medical Assessment Post-Deployment
5. DD Form 2900, Post-Deployment Health RE-Assessment
6. DD Form 2766, Adult Preventive and Chronic Care Flowsheet.
7. AF Form 3922, Adult Preventive Care – Flow Sheet - original.
8. AF Form 3923, Child Preventive Care – Flow Sheets – original.
9. Copies of inpatient forms filed in chronological order.

Section 2

Primarily, this section contains the documentation related to outpatient care and is much like the right side of the AF Form 2100 series folder except for the laboratory, X-ray, and electrocardiogram (ECG) reports. Health care providers use this part to document a patient's visit to an outpatient clinic. The forms are filed in the following order, from the top down:

1. AF Form 745, Sensitive Duties Program Record Identifier – This form is used to identify health records of patients in the Sensitive Duties Program. If used, it is the top form on the right side. Individuals may participate in more than one program. Facilities will circle the initials of the appropriate program on an AF Form 745, Personnel Reliability Program [PRP] and Presidential Support Program [PSP]). Removal of the AF Form 745 depends on the number of programs with which the individual is associated.
2. AF Form 966, Registry Record – is placed on top of the right-hand documents and under AF Form 745, if used.
3. Patient signed informed consent to the use of an electronic mail (email) format of communication with his/her provider.
4. SF 600, Chronological Record of Medical Care, is filed in date order.
5. AF Form 1352, Hyperbaric Patient Information and Therapy Record – original if treatment was on an outpatient basis.
6. SF 88, Medical Record - Report of Medical Examination – signed copy of each report. When DD Form 2161 or any other form is prepared in conjunction with the SF 88, it is filed with the SF 88.
7. SF 93, Report of Medical History – signed copy of each report. File civilian employee's SF 93 in his/her health record.

Section 3

With the exception of forms related to inpatient care, (which we file in section 1), this section is much like the left side of the AF Form 2100 series folder. File the forms in the following order:

1. DD Form 2005, Privacy Act Statement – Health Care Records and AF IMT 137, Footprint Record, is filed directly above the Disclosure Accounting Record. Most 2100A record jackets will have the Privacy Act Statement located on the outside cover on the back of the folder. Patients utilizing these jackets do not require a DD 2005 placed in section three.
2. File all other forms, unless specifically designated elsewhere, in chronological order, with the most recent form or report on top. This may include consent forms or letters and copies of reports of care from civilian sources (reports from civilian sources should be reviewed by the military health care provider responsible for the patient's case prior to filing).

Section 4

This section is where most of the diagnostic test reports are filed. Arrange forms in the following order, from top to bottom, chronologically with the most recent report on the top of each group.

1. Laboratory forms are stapled individually to the bond paper as described earlier. Approved computer-generated reports are grouped together and filed above everything else in section 4.
2. SFs 519B, Radiological Consultation Request/Report (Radiology/Nuclear Medicine/Ultrasound/Computed Tomography Examinations).
3. OF 520, Electrocardiographic Record. Electrocardiograph (ECG) records are filed directly below the radiographic reports.
4. Other diagnostic test reports.
5. Place advanced directives (Self-Determination Acts or Living Wills) in an envelope and file behind all other test reports.

Nonmilitary health records

A health record for nonmilitary personnel contains all records of outpatient services provided, including examinations, immunizations, treatments, or other medical services. Like the health record of the military outpatient, SFs 558 and 600 form the basic documents for the nonmilitary patient.

Health record maintenance

One area of responsibility you have in an outpatient clinic is performing administrative functions to include proper maintenance of health records. This often means performing quality checks on all consults, lab reports, and X-ray requests for completeness. While you won't initiate these documents (the provider must do this), you will have to make certain the following information is recorded on the document:

- Patient's name.
- SSN.
- Status.
- Home/duty phone.

Administratively, part of your job will be to see that, on follow-up appointments, any provider requested lab work or X-rays was accomplished and documented in the health record prior to the patient's being seen by the provider.

Another area of responsibility is the proper maintenance of inpatient records. When in-patients are seen in the clinic, they generally bring their records with them from the nursing unit. You should ensure the patients take the records back to the unit when they leave the clinic.

Occasionally, a physician will request an inpatient record from a previous hospital admission. To obtain, or *chargeout*, these records, you will have to go to your facility's *inpatient record library*, sometimes called simply *clinical records*. Depending on local policy, only certain people may have access to these records, so if the physician who wants the record is not on the authorization list, you may have to get special permission.

Like outpatient records, inpatient records belong to the Air Force, not to the patient. They must be safeguarded as such. When you chargeout an inpatient record, protect the record and its contents against loss, defacement, tampering, or use by unauthorized individuals.

Unlike outpatient records, you cannot add documents or notes to the inpatient record after chargeout. The contents of the record are for reference and historical use only.

Coding

Another way we have of ensuring we have accurate and complete information concerning the care of our patient is record coding. There are two main things you need to know about coding procedures. First, coding is supposed to be performed by the provider; that is, the provider is supposed to code his/her patients' records, or it should be done by personnel specifically trained and certified in coding procedures. These personnel are usually a 4AO or a civilian coder. As with many programs, each facility determines who can perform the coding procedures in the patients' medical records. Second, you must be aware which codes you can use to code patient visits where you, the technician, are the "provider" for the visit, i.e. cast changes, certain urology procedures, ear cleanings, and so forth. Even though you may do the procedure, if proper coding is not done, you won't get credit for the procedure.

Coded data must be accurate when used for reimbursement, staffing considerations, program management, and utilization control. Coded clinical encounters are used at various levels within DOD to assist in decision-making processes. To attain quality data internal or external reviews may be conducted to identify any discrepancies that may lead to improper coding of patient visits.

The main reason we do diagnosis and procedure coding is because they are an integral part of recording the patients visit and ensuring the treatment or procedure is correctly annotated in the patient's chart and proper credit is given for the patient's visit. In today's health care environment, both civilian and military, an improper coding of the visit or procedure performed can cost the clinic money and manpower, not to mention the patient's record of healthcare will not be correct. For the most part, we don't collect our money from insurance agencies. Our reimbursement comes from higher headquarters in the form of our facility's annual budget and manpower authorizations. However, we do get some money returned to our facility through third-party collections. By now you can see it is very important that the coding is done accurately, from both the patient care and the reimbursement standpoint.

Security and management of controlled items

Many medications are controlled by state and Federal laws, as well as Air Force instructions. We won't discuss state laws here because they obviously vary from one place to the next. If you are involved in medication administration, it is your responsibility to learn and comply with the laws of the state you are residing.

Federal laws

The primary forerunner of modern food and drug laws was the Federal Pure Food and Drug Act of 1906. This Act was prompted in part by public concern over unsanitary practices in the drug and food industries resulting in lack of purity. The Act designated the *United States Pharmacopoeia* (USP) and the *National Formulary* (NF) established official standards and gave power to the Federal Government to enforce these standards.

Total revision of that law came in 1938 when enactment of the Federal Food, Drug, and Cosmetic Act required the safety of an intended drug be proven to the Food and Drug Administration (FDA) by anyone who sought to market that drug. Important provisions were made in this act to protect the public health. The act requires:

- Only safe, effective, and properly labeled drugs can be introduced into interstate commerce.
- The manufacturing, processing, and packaging of drugs must comply with practices set by the FDA.
- Nonprescription, over-the-counter (OTC) drugs must be labeled for safe use by consumers.
- Prescription or "legend" drugs must be dispensed to an individual only upon receipt of a prescription or they be administered directly by the physician or other prescriber.

The law also directed medications be classified as OTC or prescription. Over-the-counter medications can be sold without a doctor's order, but the manufacturer is required to include detailed information on the label and in the container.

Prescription drugs, also classified as controlled substances, require a doctor's order and include medications that are habit-forming, have potentially harmful effects, must be administered under the supervision of a health care provider, or have a strong potential for misuse and abuse.

Controlled substances

Another important Federal law is the Controlled Substances Act of 1970. This statute consolidates Federal controls over narcotics and other drugs with abuse potential. This law is enforced by the Drug Enforcement Administration (DEA) of the US Department of Justice. The US Attorney General is responsible for designating drugs as "controlled substances." These drugs are further classified into schedules according to their potential for abuse. The following table describes the classifications, descriptions, and gives examples of controlled substances.

Controlled Substances		
Classification	**Description**	**Examples**

Schedule I	Drugs in this schedule have a high potential for abuse and are currently not acceptable for medical use. There's some controversy over the use of marijuana in treating glaucoma and cancer; however, it is currently classified as a schedule I drug.	LSD, heroin, and marijuana.
Schedule II	Drugs in this schedule have a high potential for abuse, but also have acceptable medical uses. This schedule includes narcotics, as well as certain stimulant and depressant drugs.	Opium, morphine, meperidine, codeine, cocaine, amphetamines, and secobarbital
Schedule III	Drugs in this schedule have less potential for abuse than those in schedules I and II. Schedule III includes paregoric and barbiturates combined with one or more other medicinal ingredients.	Aspirin with codeine.
Schedule IV	Drugs in schedule IV have a lower potential for abuse than the drugs in schedule III.	Phenobarbital, diazepam, meprobamate, and propoxyphene.
Schedule V	Drugs in this schedule have a lower potential for abuse than the drugs in schedule IV. Medications in this schedule are used for relief of coughs or diarrhea, containing limited quantities of certain opioid controlled	Elixir terpin hydrate and codeine and diphenoxylate with atropine.

Inventory procedures

In addition to classifying controlled substances, the Controlled Substances Act established a requirement for an initial and biannually recurrent inventory of all controlled substances. The initial requirement was established on 1 May 1971; and every two years medical facilities are required to make complete and accurate inventories of all controlled substances.

The inventory of schedule II drugs is maintained separately from the inventory of schedules III, IV, and V drugs. Each inventory contains:

- Name of the substance.
- Finished form of the substance (250 milligrams [mg] tablet or 20 mg per milliliter [mL]).
- Number of units or the volume of the finished form in each commercial container (for example, 50 tablets).
- Number of commercial containers of each finished form (for example, 22 mL amps).

Each inventory also shows the location of the drugs and the time, date, and signature of the individual performing the inventory. Inpatient unit and clinic inventories are filed in the pharmacy. Newly controlled substances are inventoried on the published effective date. Thereafter, they are included in the May biannual inventory.

Regulatory guidelines

In addition to state and Federal laws, many AFIs govern the administration and control of medications. These instructions do:

- Outline the responsibilities of the pharmacist.
- Explain storage, inventory, and dispensing procedures.
- Explain the Controlled Substances Act of 1970.
- Identify individuals authorized to prescribe drugs.
- Establish guidelines for prescribing drugs and packaging, labeling, and issuing medications.
- Establish guidelines and requirements for securing, inventorying, disposing, and recording procedures related to controlled substances.

Of these, you should be most concerned with authorized individuals, labeling requirements, issuing procedures, inventory procedures, security procedures, and disposal procedures.

Authorized practitioners

In Air Force facilities, properly credentialed active duty and civilian doctors, dentists, veterinarians, and podiatrists are authorized to write prescriptions for medications. Nurse practitioners and physician assistants are also authorized to prescribe certain medications (under the approval of the facility commander) within their assigned facility. In addition to these individuals, the pharmacy honors prescriptions written by credentialed civilian practitioners from the local area for medications routinely carried in the pharmacy. The pharmacy also honors prescriptions written by practitioners from another medical facility (if they are acting on a referral basis for eligible beneficiaries). The pharmacy maintains a current list of all assigned practitioners authorized to prescribe medications. Locally employed civilian practitioners and practitioners from other military medical facilities are not listed. The pharmacist is responsible for determining the authenticity of prescriptions by such individuals.

Labeling requirements

All drugs received or dispensed by the medical facility must be labeled and packaged adequately. What is considered adequate depends on the circumstances. Drugs dispensed from the pharmacy directly to a patient require one type of label, while drugs issued to an inpatient unit require another type of label, and prepackaged medications require still a third type of label. Proper packaging includes the use of child-resistant containers for dispensing aspirin or aspirin-containing products.

Drugs issued to a patient must have a label showing:

- Name of the patient.
- Patient education material.
- Directions for use.

In addition, the label information should also show the name, location, and telephone number of the pharmacy; the cautionary statement “Keep out of Reach of Children;” date of filling; initials of the preparer; name, dosage, and quantity of medication; and precautionary labels as required (e.g., “May Cause Drowsiness).”

NOTE: All drugs listed in schedules II, III, and IV requires this statement: “CAUTION: Federal law prohibits the transfer of this drug to any person other than the patient for whom it was prescribed.” These labels must include:

- Generic name, trade name, or both for the ingredients.
- Strength of the medication.
- Manufacturer and lot number.
- Name and address of the facility.
- Identification of the receiving unit.
- Any additional information needed to ensure drug potency and patient safety.

In addition, such information may include the expiration date and statements like, “WARNING: May be habit-forming.”

Prepackaged medications and unit doses are prepared for one-time administration to specific patients do not require prescriptions. Document the prescribed treatment on the SF 600/SF 603 and electronic equivalent (e.g., CHCS, AHLTA etc.). Dispensing outside the pharmacy is accomplished under the supervision of providers whose license allows dispensing directly to patients. The dispensing provider will ensure the accuracy of the medication order prior to dispensing to the patient.

Issuing procedures

Medications are issued to inpatient units and clinics either in stock quantities or in unit doses for specific patients. Stock quantities are medications normally maintained on a particular unit or in a particular clinic. On the other hand, unit doses are issued for specific patients on the written order of the practitioner. Currently, the use of the unit dose system is being encouraged to the maximum extent possible. This method increases drug control, reduces waste, and improves patient safety.

After receiving the issued medications, it is the unit or clinic personnel's responsibility to ensure the drugs are used properly. We outlined many rules and guidelines for medication administration in CDC 4N151A, Volume 5; review if you feel you need to. Some of the most important guidelines are as follows:

- Ensure you check expiration dates of all medications. You *should* do this each time you inventory the medications, but you *must* do this before administering the drug to a patient.
- Rotate the stock of your medications; that is, first in first out (FIFO).
- Keep needles and syringes secured and non-accessible to patients.

The guidelines discussed in the "A" course unit on surgical pharmacology also apply to the clinical environment.

Security procedures

In nursing units and clinics, schedule II drugs are stored in a double-locked cabinet of substantial construction. All other controlled drugs are stored in a securely locked cabinet of substantial construction. In addition, all schedule II drugs are counted at the beginning of each shift, and the count is verified on AF Form 579, Controlled Substance Register. The AF Form 579 should also reflect any schedule II drugs that have been given to patients. The count is verified by nurses from both the outgoing and oncoming shifts. In clinics, these drugs are accounted for at the beginning and end of each duty day, or at the beginning and end of each shift, depending on local operating hours.

Disposal procedures

When any controlled drug cannot be used because of deterioration, disintegration, or obsolescence, it may be destroyed by the narcotics destruction officer and dropped from the records.

Self-Test Questions

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

618. Patient scheduling and reception

1. How does a patient usually obtain a consult to receive care from a specialty clinic?

2. What computer system is used to schedule appointments?

3. List and describe the three common ways appointment systems are managed.

4. Describe the benefits of the end-of-day processing offered by the CHCS.

5. What is the normal two-step process to verify a patient is eligible for healthcare?

619. Customer service techniques

1. You're fitting an ankle brace on a patient. The phone starts to ring and there's no one else around to answer it. What should you do?

2. Why is it important not to give medical advice over the telephone?

3. Your doctor is running behind schedule and is with a particularly difficult patient. The phone rings and the caller insist on talking to the doctor. What do you do?

620. Management and security of medical records and controlled items

1. How are health records filed?

2. What is the main purpose of the health record?

3. Who owns a patient's health record?

4. If the patient has a scheduled appointment, how do clinic personnel normally obtain the patient record?

5. How do clinic personnel obtain the outpatient record for a "same-day" appointment?

6. Where do you obtain the inpatient record from a patient's previous hospital stay?

7. What determines the classification or schedule of a controlled substance or drug?

8. In Air Force facilities, who is authorized to write prescriptions for medication?

9. How are schedule II drugs stored in nursing units and clinics?

3–3. Medical Readiness

As you know, the threat of war or terrorist attack is very real. You may even deploy to a third world country in support of a humanitarian mission. As a member of the Air Force Medical Service, it is important for you to be capable of functioning in a contingency environment. This simply means you can do your job under less than perfect or even dangerous conditions. You also need to keep up with your training to be ready when you are deployed. This is what medical readiness is all about. Now that you are permanently assigned to a medical facility, you need to understand how the Readiness Skills Verification Program (RSVP), Expeditionary Medical Support (EMEDS), and the surgical augmentation team systems work during your involvement in mobility and contingency exercises and deployments.

621. Readiness Skills Verification Program

As medical personnel, we take care of patients in our home base hospitals and clinics as a normal part of our daily routines, but our main purpose is to sustain the war-fighting force. That means we go where we are needed and do whatever it takes to get the job done. One of the main areas you will need to become familiar with is your mobility training cycles. This highly visible program is as important to your mission as your regular day-to-day job. Let's begin with the Readiness Skills Verification Program, more commonly known as the RSV program, and how it pertains to you.

Concept

The concept behind the RSV program is to ensure you are trained in the tasks needed to perform your job in wartime or contingency environments. This training is also works directly with the QTPs to ensure all members with a fully qualified AFSC maintain their skill currency.

Qualification training packages

QTPs make the training easier because you have an objective "go/no-go" standard.The great thing about being a surgical technician is that most of the tasks listed in the RSVP task list are done as a routine part of your job, so you will not need formal training after you upgrade to the 5-skill level. This means you don't have to have formal lessons on how to do these tasks unless you don't do that particular task at your facility.

You must remaining current in those skills related to your AFSC and skill level. You will be evaluated every 20 months on the QTPs and have it documented on an RSV checklist that can be downloaded from the knowledge exchange website and placed in your electronic training record. You will need to be able to perform these skills if you are ever deployed. As a surgery technician, you will likely deploy as part of a hospital package known as the EMEDS force package.

622. Expeditionary Medical Support

In a contingency environment, your role as a surgical technician may lead you to deploy directly in support of a hospital force package.

Purpose

EMEDS and AFTH (Air Force theater hospital) packages provide individual bed-down and theater-level medical services for deployed forces or select population groups. The primary mission is to provide forward stabilization, resuscitative care, primary care, dental services, and force health protection and prepare casualties for evacuation to the next level of care. These packages are also designed to support Air Expeditionary Forces (AEF) during major combat, contingency, humanitarian assistance (HA), disaster relief (DR), defense support of civil

authorities (DSCA), and stability operations. Now we'll look at the basic concepts of the EMEDS system and the surgical technician's role.

Expeditionary Medical Support, Health Response Team

The EMEDS concept of operations begins with the EMEDS HRT (health response team). It provides a maximum of 40 personnel organized within various unit type codes (UTC) and can stabilize and hold four patients (three of which can be critical) for 24 hours. Designed for rapid mobility and efficient setup, EMEDS HRT can deploy within 24 hours of notification, establish emergency room (ER) capability within two hours, operating room capability within four hours, and critical care capability within six hours. It can reach full operational capability (FOC) within 12 hours of arrival. Its primary goal is to stabilize patients and prepare them for movement to the next level of care. Patient evacuation within 24 hours is critical to mission success. EMEDS HRT is designed to support the early phases of military operations and requires reinforcement of personnel and equipment for operations longer than 10 days. Specialty care includes internal medicine, obstetrics/gynecology (OB/GYN), and pediatrics.

Expeditionary Medical Support +10

There are two increments of the EMEDS that build on the basic EMEDS —the EMEDS + 10 and the EMEDS +25. Both modules increase the capabilities of the facility to do more surgeries and hold the patients for a longer time.

EMEDS+10 is the *second increment* of EMEDS capability and builds on EMEDS HRT. This combined capability has a total of 10 medical/surgical beds and can support a population at risk of 3,000–5,000. EMEDS+10 provides medical/surgical and critical care augmentation. Laboratory service is added, as well as additional Bioenvironmental, public health, administration, and medical logistics support. EMEDS+10 can reach full operational capability within 36 hours of arrival.

Expeditionary Medical Support +25

EMEDS+25 is the *third increment* of EMEDS capability and builds on EMEDS+10 and EMEDS HRT. This combined capability has a total of 25 medical/surgical beds and can support a population at risk of 5,000–6,500. EMEDS+25 provides expanded medical/surgical care, emergency/trauma care, dental care, and ancillary services, as well as additional medical command and control (C2), logistics, and patient administration support. It adds basic physical therapy and enhanced dietary services. EMEDS+25 can reach full operational capability within 60 hours of arrival. By the time an EMEDS is upgraded to a + 25 package you might see equipment start coming in like you are used to using at your home station. For instance as things settle down and the medical facility becomes more permanent, you might see endoscopic surgeries increase or become the "norm" again instead of all surgeries being done through an extended open incision.

Additional capabilities

The surgical area for EMEDS HRT and EMEDS+10 consists of one surgical tent and one operating table. When fully operational, EMEDS HRT and EMEDS+10 can perform 10 major surgeries or 20 non-operative trauma resuscitations. FFEP5, Surgical Augmentation Team and FFEE3, EMEDS+25 Equipment provide a second surgical team, operating table, anesthesia machine, and additional surgical equipment and supplies to the EMEDS+25 level. Surgical capability increases to 20 major surgeries or 20 non-operative trauma resuscitations. Each operating table requires 100 square feet of operating space. The EMEDS configuration does not allocate separate space for pre-operative care.

Personnel UTCs

EMEDS UTCs are postured against units in the unit type code availability (UTA) database and medical resource letter (MRL). EMEDS equipment and facility infrastructure packages may be pre-positioned in theater based on requirements from geographic combatant commanders (CCDR) and the Commander, Air Force Forces (COMAFFOR).

The FFEP3 10-bed personnel augmentation team provides additional physician, surgical, nursing, critical care, medical logistics, and administration personnel to support the increased population at risk. Expanded capabilities include advanced cardiac life support (ACLS), advanced trama life support (ATLS), medical ward, and lab. At least one nurse (046N) must be a Major or above.

The FFEP4 25-bed personnel augmentation team provides additional physician, nursing, ancillary services, medical logistics, and administration personnel. The nurse administrator (046A3) must be a Lieutenant Colonel or above. At least one nurse (046N) must be a Major or above.

Sterile processing department in the deployed environment

Of course, another important job we do as surgical technicians is to work in SPD. EMEDS HRT has no dedicated SPD to receive, clean, and sterilize instruments and other medical items. The OR is equipped with a tabletop steam sterilizer. EMEDS+10 and EMEDS+25 have a separate area adjacent to the operating room. The EMEDS+10 equipment package provides a large sterilizer and water reclaimer unit, which should be placed in or near the operating room. The EMEDS+25 equipment package adds an ultrasonic cleaner and an additional sink. Both sterilizers need to be located near the OR, but you may want to think about setting up a separate covered area outside the main tent to place your sterilizers. When operating, the sterilizers produce a tremendous amount of heat and steam that is released into the atmosphere making it difficult to work in an enclosed area like a tent. The heat and steam also make a perfect environment for breeding bacteria.

SPD is responsible for issuing and storing small instrument sets for use in the intensive care unit (ICU), emergency medicine, dental, ward, and flight medicine areas. The possibility of being short manned is highly likely; therefore, you may have to train non-OR personnel to do part of your job. For instance, you can’t scrub and circulate a surgical case at the same time can you? What if something needs to be sterilized while you are scrubbed in? Who is going to do it? In addition, SPD and the surgical suite are to be operational 24 hours a day. How will you accomplish this? If you are the only surgical technician assigned and you don’t have a surgical nurse in your deployed unit, you will end up training nurses and 4N0s to do some of the things we are trained to do as surgical technicians. Similarly, if there are no surgeries on a given day, you may end up being trained to perform some tasks you would not normally do as a surgical technician. You may be tasked to do patient care, work in the emergency room, pull guard duty or be an escort for local workers on your facility. When you are deployed, everyone must work as a team to get the job done. Above all, remember and practice our core values: Integrity First, Service before Self, and Excellence in All We Do.

By understanding your role in the AEF concept, and completing the training you must have for the RSV program, you will be prepared to do your job in a contingency environment as a part of an EMEDS. When everyone practices core values and works together as a team, you can go through your deployment confident the job will be done well and you can be proud of your accomplishments.

Self-Test Questions

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

621. Readiness Skills Verification Program

1. What is the concept behind the RSV program?

2. RSVP training is designed to work directly with what other type of training?

3. What is the name of a team with which surgical technicians could possibly deploy?

622. Expeditionary Medical Support

1. What is the primary mission of an EMEDS or AFTH?

2. The EMEDS HRT includes which specialty care services?

3. An EMEDS+25 can reach full operational capability within how many hours of arrival?

4. Name the database in which EMEDS UTCs are postured against.

5. What deployment package contains a tabletop sterilizer?

6. If you are the only surgical technician assigned to a deployed location, who could be trained to perform surgical technicians duties?

Answers to Self-Test Questions

616

1. Central Services, Central Supply, Central Materiel, and Materiel Management.
2. SPD is a *service* organization. The mission is threefold:
   (1) Improve patient care by releasing the nursing staff from certain non-nursing functions.
   (2) Create a system whereby sterile supplies are properly controlled, distributed, maintained, and utilized.
   (3) Assure bacteriologically safe sterilization procedures.
3. Service.
4. (1) Maintaining an adequate stock of sterile and nonsterile supplies.
   (2) Providing a distribution and collection service.
   (3) Maintaining and updating a list of sterile and nonsterile supplies.
   (4) Maintaining a current list of the contents of sets.
   (5) Providing a continuous service on a 24-hour basis.

617

1. Receiving, processing, distribution, storage, housekeeping/sanitation, and administration.
2. To keep microbes and other potentially infectious “bugs” contained within the decontamination area.
3. Sterile items are stored separately from nonsterile ones, and proper storage and handling methods are strictly followed.

618

1. They are generally seen by a provider in the Primary Care/Family Practice clinic, and the provider then recommends the specialty clinic by completing a consultation request.
2. CHCS.
3. (1) Centralized—the appointment desk schedules all appointments for the MTF.
   (2) Decentralized—each clinic schedules its own appointments and coordinates with the appointment desk.
   (3) Combination—some appointments are scheduled by the appointment desk and some by specialty clinics.
4. The end-of-day CHCS option allows you to correct patient appointment history and review the status of daily appointments. It also provides the means by which the computer database is updated to reflect what as really happened in the clinic and which data is reported in numerous statistical reports, such as patient counts.
5. First, the patient presents a valid ID card. The second step in verifying a person’s eligibility status is the DEERS check.

619

1. Answer the phone and ask the individual if he/she will hold or if you could call him or her back. Don’t let the phone just keep ringing.
2. It usually leads to inaccurate self-treatment by patients and is legally risky.
3. Take a message and indicate to the doctor on the message the caller urgently wants to speak to them. Only disturb the doctor in cases of true emergency.

620

1. Numerically using the sponsor’s social security number.
2. To ensure all information on the care of an individual is available and accessible to medical personnel.
3. The health record is the property of the Air Force.
4. A list is generally sent from the appointment desk to the outpatient records section the day before the scheduled appointment, and the records are pulled and delivered to the appropriate clinic either the afternoon before or the morning of the appointment.

5. The patient reports to the outpatient records section to retrieve his/her record.
6. From your facility's *inpatient record library*, sometimes called simply *clinical records.*
7. Their potential for abuse.
8. Properly credentialed active duty and civilian doctors, dentists, veterinarians, and podiatrists are authorized to write prescriptions for medications. Nurse practitioners and physician assistants are also authorized to prescribe certain medications.
9. The drugs are stored in a double-locked cabinet of substantial construction.

621

1. To ensure you are trained in the tasks needed to perform your job in wartime or contingency environments
2. QTPs.
3. EMEDS.

622

1. To provide forward stabilization, resuscitative care, primary care, dental services, and force health protection and prepare casualties for evacuation to the next level of care individual sections.
2. Internal medicine, OB/GYN, and pediatrics.
3. 60 hours.
4. The UTA database.
5. EMEDS HRT.
6. Nurses and 4N0s.

Unit Review Exercises

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

Do not return your answer sheet to AFCDA.

36. (616) Where in the medical treatment facility (MTF) organization does Sterile Processing Department (SPD) usually fall?
    a. Under Medical Logistics in the Medical Support flight.
    b. Above Medical Logistics in the Medical Support flight.
    c. Under Surgical Services in the Medical or Surgical Services flight.
    d. Above Surgical Services in the Medical or Surgical Services flight.

37. (616) The Sterile Processing Department (SPD) *does not*
    a. provide a distribution and collection service.
    b. maintain an adequate stock of sterile and nonsterile supplies.
    c. develop, maintain, and update a list of sterile and nonsterile supplies.
    d. store and dispense medications for elements of the MTF and satellite activities.

38. (617) Disassembly, cleaning, decontamination, assembly, and packaging are all activities associated with the Sterile Processing Department (SPD)
    a. storage.
    b. receiving.
    c. processing.
    d. distribution.

39. (617) Which option *best* describes the workflow for reprocessing soiled instruments in Sterile Processing Department (SPD)?
    a. Receiving, decontamination, processing, and storage.
    b. Decontamination, processing, storage, and receiving.
    c. Processing, storage, receiving, and decontamination.
    d. Storage, receiving, decontamination, and processing.

40. (618) To determine if a patient under the age of 10 years is eligible to receive care, you should check the
    a. Defense Enrollment Eligibility Reporting System (DEERS).
    b. Medical Expense and Performance Reporting System (MEPRS).
    c. ID card and the DEERS.
    d. ID card and the MEPRS.

41. (618) Who oversees the accomplishment of all documentation that must be complete before surgery?
    a. Patient.
    b. Transport technician.
    c. Pre-admission clinic.
    d. Officer in charge (OIC) Surgical Services.

42. (619) Why are good telephone techniques important for clinic personnel?
    a. Can eliminate all patient complaints.
    b. Patients will be at ease and convinced you have an outstanding clinic.
    c. Air Force policy directs good telephone techniques in all medical facilities.
    d. Patients are influenced by the presence (or absence) of good telephone technique.

43. (619) How should you handle a telephone call for the doctor if he or she is with a patient and the caller does not want to hold?
    a. Take a message and hand it to the doctor at the earliest opportunity.
    b. Knock on the door and tell the doctor that he or she has a telephone call.
    c. Inform the caller the doctor is busy and ask them to try to call back later.
    d. Inform the caller the doctor is not taking calls during appointment hours.

44. (620) For a *same day appointment*, how does the provider or medical technician receive the patient's records?
    a. Patient reports to the outpatient records section and retrieves his or her record.
    b. Technician uses the patient's ID card to retrieve the record from the outpatient records section.
    c. Patient requests records from the outpatient records section via telephone and clinic personnel retrieve the record.
    d. Clinic personnel send list of same day appointments to the outpatient records section to pull and deliver the records to the clinic.

45. (620) Who is primarily responsible for correctly coding the patient's visit to see a provider?
    a. Technician.
    b. Team nurse.
    c. Patient's provider.
    d. Resource management office.

46. (620) The *main* purpose behind the coding of a patient's visit is to
    a. ensure your clinic is properly manned.
    b. ensure proper credit for the patient visit.
    c. provide a chronological record of patient care.
    d. get the maximum dollar amount from third-party collections.

47. (621) The Readiness Skills Verification (RSV) Program is designed to train which type of skills?
    a. Normal.
    b. Wartime.
    c. Advanced.
    d. Peacetime.

48. (621) What is the *maximum number of months* between each cycle of evaluations under the Readiness Skills Verification (RSV) Program?
    a. 5.
    b. 10.
    c. 15.
    d. 20.

49. (622) What is the *maximum number of personnel* organized within a Expeditionary Medical Support Health Response Team (EMEDS HRT)?
    a. 20.
    b. 30.
    c. 40.
    d. 50.

50. (622) What pieces of equipment are added to an Expeditionary Medical Support (EMEDS) + 25 to accommodate increased instrumentation and processing of sterile supplies?
    a. Ultrasonic cleaner and an additional sink.
    b. Ultrasonic and a large steam sterilizer.
    c. Peracetic acid sterilizer and an additional sink.
    d. Hydrogen peroxide plasma sterilizer and a large steam sterilizer.

Glossary of Abbreviations and Acronyms

AAMI	Association for the Advancement of Medical Instrumentation
ACLS	advanced cardiac life support
ACN	authorization change notice
ACR	authorization change request
AEF	Air Expeditionary Forces
AFH	Air Force Handbook
AFI	Air Force Instruction
AFMAN	Air Force Manual
AFML	Air Force Medical Logistics
AFPAM	Air Force Pamphlet
AFSC	Air Force specialty code
AFTH	Air Force theater hospital
AMH	Accreditation Manual for Hospitals
AORN	Association of Operating Room Nurses, Inc.
APO	Air Force Post Office
AS	allowance standard
AST	Association of Surgical Technologists
ATLS	advanced trama life support
BCA	business case analysis
BCO	base contracting office
BTZ	below-the-zone
BPA	blanket purchase agreements
C2	command and control
CA	cost account
CAC	common access card
CAIM	customer area inventory management
CAL	custodial actions list
CC	cost center
CCDR	combatant commander
CCM	cost center manager
CDC	career development course
CFETP	career field training plan
CFM	career field manager

CHCS	Composite Health Care System
CJR	Career Job Reservation
CMA	centrally managed allotment
COB	close of business
COMAFFOR	Commander, Air Force Forces
CONUS	Continental United States
CRL	custody receipt/locator listing
CS	customer support
CSS	Central Sterile Supply
DBMS	director of base medical services
DD	Department of Defense (forms)
DEA	Drug Enforcement Administration
DEERS	Defense Enrollment Eligibility Reporting System
DLA	Defense Logistics Agency
DMHRSi	Defense Medical Human Resources System internet
DMLSS	Defense Medical Logistics Standard Support
DMM	Directorate of Medical Materiel
DOD	Department of Defense
DR	disaster relief
DSCA	defense support of civil authorities
EAID	equipment authorization inventory data
ECAT	electronic catalog
ECG	electrocardiogram
EMEDS	expeditionary medical support
ENT	ear, nose, and throat
EPR	enlisted performance report
ER	emergency room
ERAA	Equipment Review Authorization Activity
FDA	Food and Drug Administration
FEQ	field evaluation questionnaire
FIFO	first in first out
FOC	full operational capability
FPO	Fleet Post Office
FWA	fraud, waste, and abuse

FY	fiscal year
GAS	graduate assessment survey
GPC	government purchase card program
GSA	General Services Administration
HA	humanitarian assistance
HEAR	Health Enrollment Assessment Review
HEAR-PCM	Health Enrollment Assessment Review for Primary Care Managers
HRT	health response team
ICU	intensive care unit
JC	Joint Commission
LP	local purchase
LWOBS	left without being seen
MAJCOM	major command
MDG	medical group
MEDLOG	Medical Logistics
MEMO	Medical Equipment Management Office
MEPRS	Medical Expense and Performance Rating System
mg	milligrams
mL	milliliter
MPS	Military Personnel Section
MRI	magnetic resonance imaging
MRL	medical resource letter
MSA	medical service account
MTF	medical reatment facility
NCOIC	noncommissioned officer in charge
NF	National Formulary
NLT	no later than
NSN	national stock number
OB/GYN	obstetrics/gynecology
OCC-SVC	occasion of service
OI	operating instruction
OIC	officer in charge
OJT	on-the-job training
O&M	operations and maintenance

OPR	office of primary responsibility
OR	operating room
OSR	occupational survey report
OTC	over-the-counter
PA	physician assistant
PACU	post anesthesia care unit
PCS	permanent change of station
PDG	professional development guide
PI	performance improvement
PME	professional military education
PRP	Personnel Reliability Program
PSP	Presidential Support Program
PV	prime vendor
QTP	quality training packages
RC	responsibility center
RM	risk management
RMO	Resource Management Office
RSVP	Readiness Skills Verification Program
SF	standard form
SPD	sterile processing department
SSN	Social Security Number
STEP	stripes for exceptional performance
STS	specialty training standards
TAMP	Transitional Assistance Management Program
TDY	temporary duty
TIGERS	The Integrated Global Equipment Request System
TPC	third party collection
UMD	unit manpower document
UPMR	unit personnel manpower roster
USP	United States pharmacopoeia
USPHS	United States Public Health Service
UTA	unit type code availability
UTC	unit type code

Student Notes

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