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***FLIGHT AND OPERATIONAL MEDICINE
PROGRAM (FOMP)***

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This publication implements AFPDs 11-4, *Aviation Service* and 48-1, *Aerospace Medicine Enterprise (AME)*. It provides guidance, responsibilities and establishes procedures for the Flight and Operational Medicine Program (FOMP) in support of the overall AME. This publication applies to Air Force (AF) active component and Air Reserve Component (ARC) which includes the Air Force Reserve Command (AFRC) and Air National Guard (ANG) members and units. This publication may be supplemented at any level, but all supplements must be routed to the Office of Primary Responsibility (OPR) listed above for coordination prior to certification and approval. Refer recommended changes and questions about this publication to the OPR listed above using the AF Form 847, *Recommendation for Change of Publication*; route AF Forms 847 from the field through the appropriate chain of command. The authorities to waive wing/unit level requirements in this publication are identified with a Tier ("T-0, T-1, T-2, T-3") number following the compliance statement. See AFI 33-360, *Publications and Forms Management*, for a description of the authorities associated with the Tier numbers. Submit requests for waivers through the chain of command to the appropriate Tier waiver approval authority, or alternately, to the Publication OPR for non-tiered compliance items. This Instruction requires collecting and maintaining information protected by the *Privacy Act of 1974*, System of Records Notices (SORN) F033 AF B, *Privacy Act Request File*, and F036 AF PC Q, *Personnel Data Systems (PDS)*, apply. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with Air Force Manual (AFMAN) 33-363, *Management of Records*, and disposed of in accordance with the Air Force Records Disposition Schedule (RDS) located in the Air Force Records Information Management System (AFRIMS). The use of the name or mark of any specific manufacturer, commercial product, commodity, or service in this publication does not imply endorsement by the Air Force.

SUMMARY OF CHANGES

This document has been substantially revised and must be completely reviewed. Major changes include: removal of non-regulatory language from this instruction; introduction of an Operational Medical Element (3.6); inclusion of MAJCOM/SGP requirements for the Fatigue Countermeasure Medication Program (7.4); and guidance on medical functions embedded with line units (Ch 10).

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Chapter 1

INTRODUCTION AND OVERVIEW

1.1. Introduction and Overview. This Instruction highlights responsibilities at Wing-level and below and establishes procedures for the Flight and Operational Medicine Program (FOMP) in support of the overall Aerospace Medicine Enterprise (AME). It focuses specifically on elements that are required, delineated by directive language such as “will”, “shall”, and “must.” Supplemental (non-regulatory) information that focuses on best practices and “how to” processes related to the Flight and Operational Medicine Clinic (FOMC) can be found on the Kx at <https://kx2.afms.mil/kj/kx4/FlightMedicine/Pages/operationalmedhomeapril2012.aspx>.

Chapter 2

ROLES AND RESPONSIBILITIES

2.1. The Air Force Surgeon General (AF/SG). Provides strategic guidance, resources, policies and procedures to execute the FOMP.

2.2. Director, Medical Operations and Research (AF/SG3/5) shall:

2.2.1. Provide policy and regulatory guidance necessary to successfully execute the FOMP.

2.2.2. Oversee strategic planning and programming activities.

2.2.3. Maintain liaison with Department of Defense (DoD) agencies for aircrew and other special operational duty personnel's health, disease prevention, occupational health, environmental quality and crew performance issues.

2.2.4. Maintain liaison with AF/A3O on issues concerning SME utilization and Concept of Operations.

2.2.5. Set policy for implementation of Flight Surgeon (FS) and Squadron Medical Element (SME) utilization.

2.3. Chief, Aerospace Medicine Policy and Operations (AF/SG3P) shall:

2.3.1. Provide programming recommendations to support strategic guidance of AF/SG.

2.3.2. Maintain AFMS FOMP Mission Essential Tasks and Line Support (METALS) list.

2.4. Aerospace Medicine Division (AF/SG3PA) shall:

2.4.1. Develop plans and programs and provide consultative services to enable FOMP execution.

2.4.2. Ensure integration and coordination of FOMP initiatives and policy with Headquarters Air Force (HAF) agencies.

2.4.3. Provide consultation on all FOMP issues to MAJCOM, HAF, and other agencies.

2.4.4. Interface with all MAJCOM/SGPs to facilitate successful execution of the FOMP.

2.4.5. Maintain liaison with other Services and Federal agencies.

2.4.6. Develop objective metrics to measure the success of the FOMP.

2.4.7. Develop and maintain standardized medical training for all FOMC personnel.

2.5. MAJCOM/SG shall:

2.5.1. Organize, train and equip personnel to support FOMP execution within their command.

2.5.2. Assign a supporting medical treatment facility (MTF (RMU/GMU)) for FOMP components at Limited Scope Medical Treatment Facilities (LSMTF), Geographically Separated Units (GSU) and Medical Aid Stations (MAS).

2.5.3. The 25 AF ISR/SG will work with MAJCOM/SGs for planning, programming, budgeting and execution (PPBE) for medical support to ISR, Cyber and some RPA units,

including Operational Medical Units (OME) and work them into Business Case Analysis and Program Objective Memorandum (POM).

2.6. MAJCOM/SGP shall:

2.6.1. Develop guidance for subordinate installation medical units to properly execute the FOMP.

2.6.2. Execute MAJCOM/SG waiver authority for aeromedical waivers within delegated authority IAW AFI 48-123 *Medical Examinations and Standards* and delegate to base level SGPs as appropriate. (ARC/SGP and AFISRA/SGP function as MAJCOM-level authorities.)

2.6.3. Function as a liaison between the MTF(RMU/GMU), medical squadrons or medical groups, and Air Force Medical Support Agency (AFMSA).

2.6.4. Assign a supporting organization (MAJCOM or MTF) to serve as a “Hub” for units in support of the total force enterprise (TFE) and those Reserve Component units which are “MAJCOM-gained” when activated into Title 10 status. **Note:** *TFE includes both AF/A8 approved Total Force Integration (TFI) units and stand-alone ARC units executing a Title 10 mission.*

2.6.4.1. Identify locations requiring manpower support to operate as the “Spoke” in support of TFE Title 10 missions.

2.6.4.2. Identify TFE medical manpower requirements and incorporates them into Business Case Analysis (BCA) and Program Objective Memorandum (POM) processes or negotiate for Title 10 resources (MPA days) to meet the operational medicine support requirements.

2.6.5. Consult with their MAJCOM/A3 counterparts to develop fatigue countermeasure medication (Go Pill) program IAW the Fatigue Countermeasure Medication section of AFI 11-202 V3, *General Flight Rules*. The purpose of the SGP involvement is to provide appropriate risk/benefit information on each of the authorized Go Pills as the MAJCOM A3s determines which aircraft and missions sets could be authorized to use which medication under what circumstances.

2.6.5.1. Air Combat Command (ACC)/SGP shall be the medical lead for all MAJCOM/SGPs that support Combat Air Forces (CAF) aircraft.

2.6.5.2. Air Mobility Command (AMC)/SGP shall be the medical lead for all MAJCOM/SGPs that support Mobility Air Forces (MAF) aircraft.

2.6.6. Ensure FOMC personnel are appropriately trained and executing the Fatigue Countermeasure Medication Program.

2.7. Medical Group Commander (MDG/CC) shall: Note: *AFRC equivalent is a Reserve Medical Unit Commander (RMU/CC) and the ANG equivalent is a Guard Medical Unit Commander (GMU/CC).*

2.7.1. Provide resources, personnel, and guidance to ensure successful execution of the FOMP at their installation.

2.7.2. Ensure FOMP personnel are trained and resourced to successfully execute the FOMP at deployed locations.

2.7.3. Ensure FOMC, GMU and SME training (Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), Advanced Trauma Life Support (ATLS), national registry of emergency medical technicians (NREMT), on the job training (OJT)), supplies, and equipment are provided for home station medical care. This includes funding and preparing orders for Continuing Medical Education (CME) training equivalent to all other providers on the medical staff. (T-3) (Although Air Reserve Component units generally do not provide home station medical care, their medical providers and technicians still require AF Specialty Code (AFSC)-appropriate training for deployment purposes). CME funding is not applicable to ARC.

2.8. The MTF/SGP (Chief of Aerospace Medicine) shall:

2.8.1. Be appointed in writing by the MDG/CC IAW AFI 48-101, *Aerospace Medicine Operations*. This individual must be a credentialed active component Flight Surgeon (FS) (or ARC FS, for ARC units) and must have privileges for flight medicine at their MTF (RMU/GMU). **Note:** *ANG GMU/CC appoints the SGP in writing, and this individual must be a credentialed FS and must have ARC UTA privileges and request privileges in flight medicine (not supported unless approved by an MTF).*

2.8.2. Oversee the AME programs, coordinate aerospace medicine activities and maintain operational oversight for FOMC personnel. These programs directly support the Line of the Air Force (LAF) mission ensuring a healthy and fit force, preventing injury and illness, restoring health, and optimizing and enhancing human performance. See AFI 48-101 for specific roles and responsibilities.

2.8.3. Develop a local prioritized list of METALS and an annual execution and monitoring plan. See section 3.4.1 below for more detail on METALS.

2.8.4. Ensures assigned FSs (SME and MDG) complete and maintain required training and experience to the Fully Mission Capable (FMC) level. Non AD FSs must meet contract and/or job description requirements.

2.8.5. Ensures assigned FS, technicians, and SME personnel are trained on military physical exams and standards.

2.8.6. Assigns duties and monitors duty performance of FSs and Flight and Operational Medical technicians (4N0X1F) including SMEs when not deployed.

2.8.7. Facilitates and ensures the MTF(RMU/GMU) and SME 4N0X1F/C complete required tasks and knowledge items identified in the 4N0X1 Career Field Education and Training Plan (CFETP) and Master Task List (MTL) for SMEs.

2.8.8. Serves as the MDG's senior profile officer and chairs the Deployment Availability Working Group (DAWG). **Note:** *See AFI 10-203, Duty Limiting Conditions for further information regarding the DAWG.*

2.8.9. Serves as the local aeromedical certification and waiver authority when so designated by MAJCOM/SGP.

2.8.10. Serves as the installation subject matter expert on medical standards and physical qualifications. The SGP is the installation focal point in handling matters of medical standards application and resolving problems associated with conducting assessments,

documentation and required follow-up of complicated or sensitive cases, and other matters that may call for resolution.

2.8.11. Serves as the senior leader, maintaining operational oversight of the Medical Standards Medical Element (MSME) and appoints the MSME manager/lead.

2.8.12. Ensure quality and timeliness of medical examination process.

2.9. Aerospace Medicine SQ/CC or Equivalent. Manages the SME and MTF (RMU/GMU) FS activities in support of AME and will:

2.9.1. Establish clear objectives and goals for the FOMC.

2.9.2. Define tasks and responsibilities necessary to achieve the objectives of the FOMC.

2.9.3. Specify clear and reasonable timelines.

2.9.4. Ensure accountability.

2.9.5. Ensure effectiveness of reaching the objectives and desired effects.

2.9.6. Redirect local plans, policies, and practices as needed to better achieve desired effects.

2.9.7. Retain administrative and punitive authority (Uniform Code of Military Justice (UCMJ) or State equivalent) over MTF (RMU/GMU) assigned FOMC personnel.

2.9.8. Address conflicting requirements or priorities for SME/Operational Medical Element (OME), and AOPT personnel with the SGP, and/or flying/operational squadron commander (Sq/CC).

2.10. Flying or Operational SQ/CC.

2.10.1. Retains administrative (ADCON) and punitive authority (UCMJ or State equivalent) over SME/OME personnel, but day-to-day operational oversight (OPCON) is under the supervision of the SGP while in-garrison. SME rating chain will be through the flying or operational squadron. (T-3) While deployed, SME personnel will integrate with a fixed medical unit if available on the same base or in reasonably close proximity in order to provide seamless deployment health support to the population at risk (PAR). (Exceptions may include: AF Special Operations Command (AFSOC) assigned personnel and the Combat Search and Rescue Medical Element (CSARME)).

2.10.2. Reporting to Credentials Function and Medical Leadership: It is imperative that any concerns of inappropriate professional and/or medical conduct, noted by the Line Leadership, be reported to the chain of medical oversight. This is to ensure the quality of medical care and to ensure the integrity of the AFMS. The Operational Squadron/CC will immediately report any concerns of possible deficiencies in the provision of care and any concerns for conduct which could call into question the integrity of SME personnel. Any concern, to include the physician or IDMT receiving a letter of counseling or other administrative action, will immediately be reported to the SGP, SGH, credentialing body and be reported to anyone responsible for clinical oversight of SME personnel. For assigned 4N0X1F/C personnel, concerns and/or administrative action will be reported to the SGP, MTF 4N0 Functional Manager and SGN.

Chapter 3

FLYING, OPERATIONAL, AND SPECIAL OPERATIONAL DUTY PROGRAM

3.1. Objectives and Desired Effects. The flying and other Special Operational Duty (SOD) personnel program's purpose is to optimize the health and performance of aircrew, space, missile, Personnel Reliability Program (PRP), Presidential Support Directive (PSD), and other SOD personnel in support of the operational mission of the AF.

3.2. Organization and Functions of the FOMC.

3.2.1. Empanelment/population served.

3.2.1.1. The FOMC empanels personnel who require maintenance of AF Form 1042, *Medical Recommendation for Flying or Special Operational Duty* and their respective dependents. **Note:** *Even though 13Sx and 1C6xx AFSCs do not require an AF Form 1042, they will be empanelled to the FOMC along with their respective families.*

3.2.1.2. Empanelment additions/deletions must be approved/disapproved by the MAJCOM/SGP after request by the MTF (RMU/GMU)/CC. Deviations may include enrollment of other operational support groups or personnel with specific occupational exposures determined by the SGP, necessary for successful completion of local aeromedical or installation mission.

3.2.1.3. Members who are on PRP or PSD status will also be empanelled unless there is a stand-alone PRP/PSD clinic. (T-3) (See 3.3 PRP Element)

3.2.1.4. The FOMC will see, but not empanel the following categories: (T-3)

3.2.1.4.1. Active duty and civilian federal employees for occupational health exams, unless there is a stand-alone Occupational Medicine (OM) clinic.

3.2.1.4.2. Initial flying, special operational duty and incentive flight physical exams.

3.2.1.5. ARC RMU/GMU personnel only conduct the following exams and services: annual flying exams, initial flying or special operational duty physical exams, fitness for duty, occupational medical exams, Preventive Health Assessments (PHA) and incentive flight physicals. (T-0; US Code, Title-32)

3.2.1.6. For ARC, Aerospace Medicine will provide occupational examinations only for military flying and special operational duty personnel.

3.2.2. Staffing will be according to the Air Force Medical Service (AFMS) Flight Path and Unit Manning Documents. **Note:** *This is not applicable to ARC.*

3.2.2.1. If sufficient active component AF FSs are not available, contract and/or GS flight medicine physicians (FMPs) may be utilized in the FOMC. A description of expected qualifications and type of work can be found on the AFMS Knowledge Exchange (Kx) under Aerospace Medicine Signed Documents. Granting and maintenance of credentials will require approval and review IAW AFI 44-119. SGPs will be part of the review process if he/she is not the clinical supervisor. ARC FSs who are actively credentialed in FOMC may utilize their credentials in FS offices while functioning as a contractor. ARC FOMC credentials must be maintained to allow

continued function in FS contractor role as detailed IAW AFI 44-119, *Medical Quality Operations*.

3.2.2.2. At bases with stand-alone Occupational Medicine (OM) clinics, FSs will work with OM clinic staff to maintain clinical competency regarding occupational health exams and industrial shop visits. (Not applicable for the ARC)

3.2.3. Clinical Services Provided.

3.2.3.1. FSs and Physician Assistants (PAs) will provide active component (and civilian federal employees who choose the AF as their medical care for occupational health exams) initial, annual, termination or special purpose occupational evaluations to include fitness for duty (FFD) examinations (FSs only) and medical surveillance examinations (MSE), unless there is a stand-alone Occupational Medicine (OM) clinic. (Not applicable for the ARC)

3.2.3.2. FSs/PAs will provide preventive medicine services to mitigate travel-related health risks in empanelled populations and serve as MTF travel medicine consultants. ANG GMUs in Title-32 do not provide routine medical care, but ARC FSs provide appropriate medical prophylaxis and deployment counseling. They do not function as travel medicine consultants, except as related to deployments.

3.2.4. FOMC Grounding Management. FSs review medical care provided outside the FOMC no later than the next duty day to render timely aeromedical disposition. ARC FSs in-garrison, should render the disposition as soon as possible, but no later than their next duty/drill day. Signed and dated aeromedical dispositions must be documented in the Airmen's medical record and changes in status must be communicated to the member's SQ/CC and Squadron Aviation Resource Manager (SARM) via AF Form 1042.

3.2.5. Aircrew chemoprophylaxis ground testing. Rated and career enlisted aircrew will be offered ground testing with operationally required prophylactic medications (e.g. Ciprofloxacin) per the Official Air Force Aerospace Medicine Approved Medications list under supervision of a FS prior to completing initial aircrew training or as mission requires. Document results of testing (whether cleared for operational use or not) or members refusal to test IAW AFI 48-123.

3.2.6. Medical evaluation and disposition following suspected ocular directed energy exposure. **Note:** *Exposures to known directed energy sources previously deemed eye-safe by either AF or other competent United States (US) governmental authorities are exempt from these follow-up requirements.*

3.2.6.1. The Air Force Research Laboratory and School of Aerospace Medicine produce and maintain a Laser Injury Guidebook which has the most up to date recommendations for appropriate clinical work up and disposition. The most current version of the Laser Injury Guidebook located on the AFMS Kx at (<https://kx2.afms.mil/kj/kx4/FlightMedicine/Pages/operationalmedhomeapril2012.aspx>) and provides information for managing ocular directed energy exposure.

3.2.6.2. Aircrew with persistent visual complaints or symptoms without objective findings will be placed in Duties Not Involving Flying (DNIF) status and referred to an eye specialist. Non-aircrew with persistent visual complaints or symptoms without

objective findings will also be referred to an eye specialist. (T-2) Specific duty restrictions may be warranted based on personal and operational safety concerns.

3.2.6.3. Suspected ocular directed energy exposures must be reported to DoD Tri-Service Laser Injury Hotline; (800)-473-3549; (937) 938-3764; or DSN 798-3764. (T-1)

3.2.6.4. Confirmed ocular directed energy exposures must be reported as at least as a Class E Physiologic event, or if appropriate, at a higher class level IAW AFI 91-204, *Safety Investigations and Reports*. (T-1). Notify BE to ensure they are able to meet requirements from AFI 48-139, *Laser and Optical Radiation Protection Program*, section 3.6.

3.2.7. Aeromedical Evacuation (AE). FSs are the local clearance authority determining whether patients are clinically stable and physiologically ready for air transport. FSs will ensure proposed en-route treatment is appropriate and compatible with flight, IAW applicable guidance after consultation with the transporting/regulating authority.

3.3. Personnel Reliability Program/Presidential Support Duties Elements. Note: *A PRP element will be established to care for PRP certified members according to the current established AFMS manpower standard. (T-1) The primary reference for the PRP is DoD 5210.42R_AFMAN 13-501, Nuclear Weapons Personnel Reliability Program (PRP).*

3.3.1. PRP medical support staff should be assigned to the PRP stand-alone element or FOMC for a minimum period of 24 months to obtain the necessary proficiency. Rotations must be coordinated with the lead Competent Medical Authority (CMA), SQ/CC, and the respective functional manager. (T-2) Premature rotations (based on the needs of the AFMS and local mission) must be approved by the MDG/CC. (T-2)

3.3.2. PRP medical support staff will be designated with Special Experience Identifier (SEI) IAW AFI 36-2101, section 3.13, *Classifying Military Personnel (Officer and Enlisted)*. (T-3) **Note:** *ARC may award the SEI if the member meets the criteria, but it is not required as they do not PCS.*

3.3.3. The MTF (RMU/GMU) will ensure CMA contact information is provided to units with PRP personnel and to the Wing Command Post.

3.3.4. Training.

3.3.4.1. Assigned medical staff that directly supports PRP will accomplish AF Standardized PRP training IAW DoD 5210.42R_AFMAN 13-501. Additionally the Lead CMA will ensure all other medical personnel are trained to their appropriate level as directed within the MTF training slides.

3.3.4.2. Lead CMA, primary/alternate CMA (if designated), and lead MTF (RMU/GMU) PRP monitor will attend the one-time USAFSAM Medical PRP Course for certification within six months of assignment to duty supporting PRP. This training is required prior to PCS for members going to OCONUS locations. The requirement for training before PCS may be waived by the MAJCOM/SGP, but the member will still require this training within 6 months or assignment to duty supporting PRP. (T-2)

3.4. Mission Essential Tasks And Line Support (METALS) supporting Flying and SOD Personnel Program.

3.4.1. METALS Matrix: The SGP will develop a local prioritized list of METALS and an annual execution and monitoring plan which must be submitted annually to the MAJCOM/SGP for review. (T-2) This plan will ensure all FSs meet both clinical and non-clinical requirements to include METALS and squadron support activities, and carries the intent that approximately 50% of the FS's time is spent covering clinical workload and 50% accomplishing METALS and squadron operational support activities. Not all operational support activities exist or are of the same importance at each base due to different mission requirements. This should be reflected in the SGP's annual plan. A sample list of common METALS can be found on the KX Operational/Flight Medicine Page. It is recommended the METALS list be completed as a matrix based on manning levels, i.e. lists which METALS would be planned to be complete if manned at 100%, 75%, 50% or 25% of FS manning. This allows everyone from the MAJCOM/SGP to the base level flight surgeon to understand the priority of effort

3.4.2. Operational Inspections: All FSs (MTF (RMU/GMU)-based and SME) conduct operational inspections of agencies whose mission is support of aircrew such as: Aircrew Flight Equipment, control tower, alert facilities, radar approach control (RAPCON), parachute units, flying squadrons and space operations units. The frequency of visits is tailored to mission requirements. Each agency will be inspected at a minimum quarterly (annually for ARC) unless directed by regulation or other instruction. Minimum frequency may be waived by the MAJCOM/SGP.

3.4.3. Medical Support for Installation Safety Program: FSs and Aerospace & Operational Physiology Training (AOPT) personnel must have access to AF Safety Automated System (AFSAS). (T-2)

3.5. SME Operations.

3.5.1. Objectives: The SME is a line asset, which is integrated into normal FOMC operations while in-garrison, yet is available for deployment/exercise to the line commander as needed.

3.5.2. SME composition is determined by Unit Manning Documents (UMD), but generally consists of one FS and two technicians:

3.5.2.1. One FS, AFSC 48XX. Certified as medically qualified/acceptable for Flying Class II duties. FSs holding categorical waivers must be medically acceptable for their assigned Mission Designed Series (MDS) and must be medically qualified for worldwide duty. FSs with an Assignment Limitation Code (ALC) should not occupy an SME billet. (T-2)

3.5.2.2. Enlisted composition will be IAW the UMD, usually one IDMT (4N0X1C) and one 4N0X1F or two IDMTs. If no IDMTs are available, MAJCOM/SG (or ARC/SG) may waive the AFSC requirements and substitute a 4N0X1F for the IDMTs. If no 4N0X1F are available, then ARC/SG can substitute with 4N0X1.

3.5.2.2.1. There will be one 7-level and one 5-level technician assigned. ARC technicians should hold at least a 5-skill level to perform SME duties while deployed.

3.5.2.2.2. Technicians must be medically qualified for worldwide duty. Technicians with an ALC should not occupy an SME billet due to frequent deployment assignments. (T-2)

3.5.3. Performance Reporting.

3.5.3.1. Reporting official for the SME FS will be the operational squadron commander. SME FS's Officer Performance Reports (OPR) will flow up the line chain of command. If MTF (RMU/GMU) and line commanders concur, the rater can be the immediate MTF (RMU/GMU) supervisor. The OPR would return to the line chain for first and second level review/endorsement.

3.5.3.2. The reporting official of enlisted SMEs will be the senior SME technician and/or SME FS. SME technician's Enlisted Performance Report (EPR) flows up the line chain of command for review/endorsement. MDG 4N0 functional manager reviews draft EPRs for administrative correctness and provide comments on content. EPRs reflect the technician's duty performance supporting the line unit, AME, and duties within the MTF (RMU/GMU).

3.5.4. In-Garrison Operations. **Note:** *ARC/SME does not perform clinical care in-garrison. Occupational examinations will occur in the RMU/GMU or MTF while in-garrison.* These requirements apply to ARC providers and/or medical technicians assigned outside of the RMU/GMU.

3.5.4.1. SME personnel must be fully integrated with the MTF (RMU/GMU) and work under clinical supervision of the SGP. SGPs coordinate with line chain of command to assign and manage professional duties of SME personnel ensuring that approximately 50% of time is spent covering clinical workload and approximately 50% accomplishing METALS and squadron operational support activities. **Note:** *MAJCOM/SGPs can modify this requirement for specific subsets (i.e. CSARME) to meet operational needs.*

3.5.4.2. SME providers will maintain credentials with the MTF (RMU/GMU) and perform duties within the MTF (RMU/GMU) sufficient to warrant award and maintenance of privileges. (T-2)

3.5.4.3. Enlisted SME personnel will maintain required skills noted in the Career Field Enlisted Training Plan (CFETP).

3.5.4.4. SMEs with Independent Duty Medical Technician (IDMT) certification will meet rotational and medical skills maintenance training required for continued IDMT certification IAW AFI 44-103, *The Air Force Independent Duty Medical Technician Program*, for the duration of assignment as a SME.

3.5.5. Deployed SME Operations. SMEs deployed to locations with a fixed MTF must identify themselves to the MTF commander or SGP. Clear lines of communication must be established and support requirements for SMEs identified. SMEs using fixed MTF services (pharmacy, lab, or other services) may be required to submit a credentials transfer brief and complete other administrative procedures IAW AFI 44-119.

3.6. Operational Medical Element (OME).

3.6.1. Background: New and emerging technologies create work domains with unique human performance challenges. The communities of Remotely Piloted Aircraft (RPA), Intelligence, Surveillance and Reconnaissance (ISR), and other Operators experience a high workload demand with continuous compartmentalized operations, a high cognitive demand, shift work fatigue and occupational stressors.

3.6.2. The OME consists of medical personnel providing augmented medical, mental and occupational health support to unit personnel in addition to the regular medical service provided by their primary care teams. The support may include aeromedical dispositions and other medical support needed for accomplishment of unit operational missions. The concept of an OME is similar, but distinct from that of an SME. The goal is to improve access to care for “operators” that have challenges obtaining care from a traditional clinic-based system because of operationally based issues. One example is the ISR community where operations run on a 24/7 basis from a secured facility. Missing a shift may cause mission cancellation. **Note:** *OME is different than AFSOC Ambulatory Care Units (ACU). See Chapter 10 for further guidance on medical functions embedded with line units and specific guidance on AFSOC ACUs.*

3.6.3. Objectives: Providers/extenders/technicians identify medical concerns early and either intervene at a level before patients symptom’s become clinically significant or facilitate patient entry into the traditional clinic-based health care when needing more advanced care.

3.6.4. OME composition is currently determined on a case-by-case basis. Requests for an OME need to document the mission requirements that are currently not being met and whether the MTF/CC and the Operational Unit/CC are willing to allocate positions from their UMD to the OME concept. This request must be routed through the 25 AF ISR/SG or MAJCOM/SGP to Air Force Medical Support Agency (AFMSA)/SG3P.

3.6.5. OME at Sister Services Locations: Some AF ISR assets are located on non-Air Force installations or data-masked environments. At these locations the 25 AF-ISR/SG, ISR Wing/SG, Service Director of Medical Services, or MAJCOM/SG(P) will work with the facility medical installation to establish a memorandum of understanding (MOU). This MOU will establish the working relationship and clinical oversight responsibilities for the OME and the MTF.

3.6.6. In-Garrison Operations: OME personnel are not expected to deploy in support of their operators. All of their support will be “in-garrison.” Similar to Aviation Squadron Medical Elements, providers should operate at a reduced Full Time Equivalent (FTE) standard with the expectation that the provider team spends up to 50% of their work time outside of the standard clinical setting. The out of office time will be spent interacting with Line personnel, advising the line commander and performing shop visits to better understand and support the occupational/operational stressors in these unique work areas. **Note:** *ARC/OME must be in an active Title-10 status to perform OME duties for members in Title-10 status.*

3.6.6.1. OME personnel are only authorized to practice medicine IAW their local MTF (RMU/GMU) privileges as directed by AFI 44-119, *Medical Quality Operations*. Establishment of satellite clinics at the operational site must be coordinated with the host MTF commander and if established will meet all applicable requirements for a health care area (infection control, disposal of medical waste, etc.) and will be inspected with the MTF for compliance depending upon their scope of care. While the focus is primary and secondary prevention, when brief counseling occurs the patient care must be documented using the AF electronic health record (AHLTA) (T-2).

3.6.6.2. OME personnel must be fully integrated with the MTF (RMU/GMU) and work under clinical supervision of the MTF. SGPs coordinate with line chain of command to

assign and manage professional duties of OME personnel to ensure they have the appropriate balance of clinical workload and direct support of operational activities. (T-2)

3.6.6.3. OME providers will maintain credentials with the MTF (RMU/GMU) and perform duties within the MTF (RMU/GMU) sufficient to warrant award and maintenance of clinical privileges. (T-2) Privileged providers are responsible for all applicable Medical Staff Bylaws.

3.6.6.4. Enlisted OME personnel will maintain required skills noted in CFETP.

3.6.6.5. OMEs with IDMT certification will meet rotational and medical skills maintenance training required for continued IDMT certification IAW AFI 44-103, *The Air Force Independent Duty Medical Technician Program*.

3.7. Meetings: Where there is a separate AFI that details the expectations for a meeting, that AFI must be referenced for details.

3.7.1. Flight and Operational Medicine Working Group (FOMWG). The FOMWG will:

3.7.1.1. Review weekly (monthly for ARC) the AF Form 1041, *Medical Recommendation for Flying or Special Operational Duty Log* and recommend action on cases as needed. (T-3) AF Form 1041s are kept on file for five years then destroyed. Reference: AF Records Disposition Schedule (RDS).

3.7.1.2. Review Aeromedical Information Management Waiver Tracking System (AIMWTS) workflow data including new aircrew/SOD waivers, waiver renewals, and interim follow-up studies. (T-3)

3.7.1.3. Review all open initial flying/SOD physical examinations. (T-3)

3.7.1.4. Review/follow-up on all open referrals for flying/SOD personnel to local network (both waiver and non-waiver related). (T-3)

3.7.1.5. Review and track aeromedical data from other clinics, (i.e. dental, optometry, mental health and any others deemed necessary by the SGP). (T-3)

3.7.1.6. Plan and schedule operational site visits (shop, food facility, Aircrew Flight Equipment, etc) to meet METALS operational requirements. (T-3)

3.7.2. Deployment Availability Working Group (DAWG). The DAWG will be conducted IAW AFI 10-203, *Duty Limiting Conditions*.

3.7.3. Occupational and Environmental Health Working Group (OEHWG). The OEHWG will be conducted IAW AFI 48-145, *Occupational and Environmental Health Program*.

3.7.4. Population Health Working Group (PHWG). The SGP is a member of the PHWG which must be conducted IAW AFI 40-101, *Health Promotion* and AFI 44-173, *Population Health Management*. **Note:** *This is not applicable for the ARC.*

3.7.5. Installation Environment, Safety and Occupational Health Council (ESOHC). The ESOHC will be conducted IAW AFI 90-801, *Environmental, Safety, and Occupational Health Councils* and AFI 48-145, *Occupational and Environmental Health Program*.

3.7.6. Public Health Emergency Working Group (PHEWG). The Public Health Emergency Officer (PHEO) chairs the PHEWG, which is conducted IAW AFI 10-2603, *Emergency*

Health Powers on Air Force Installations (or AFI 10-2519, *Public Health Emergencies and Incidents of Public Health Concern*, when published). **Note:** *This is not applicable to AFRC RMUs at co-located bases.*

Chapter 4

OCCUPATIONAL AND ENVIRONMENTAL HEALTH (OEH) OPERATIONS

4.1. Objectives and desired effects: OEH operations protect AF personnel (both active, reserve components and civilian employees) from inherent health hazards associated with AF industrial activities and the environment, and promote a healthy, fit work force to enhance performance of mission essential functions. OEH Operations must comply with Federal, State and Local laws and requirements (including the Rehabilitation Act of 1983, 29 USC 794, and the Genetic Information Non-Discrimination Act, 42 USC 2000ff et seq.).

4.2. Organization and Functions: OEH is executed IAW AFI 48-145, *Occupational and Environmental Health Program*, AFOSHSTD 48-20, *Hearing Conservation Program*, and AFMAN 48-146, *Occupational and Environmental Health Program Management*. Flight Surgeons/Occupational Medicine Specialists will brief the MTF Professional Staff annually on the installation industrial health hazards. **Note:** *This is not applicable to the ARC.* (T-3)

Chapter 5

MEDICAL FORCE PROTECTION PROGRAM (MFPP)

5.1. Objectives and desired effects: The purpose of the MFPP is for the protection and promotion of Airmen's health in-garrison and when deployed. Integral to the MFPP is accurate identification and characterization of duty limiting conditions, medical clearances, and medical engagement throughout the deployment process.

5.2. Organization and Functions. PHAs and Flight Physical Exams: Flying and SOD personnel will follow existing guidance in AFI 44-170, *Preventive Health Assessment*. Required examinations for personnel requiring AF Form 1042 will be in sync with current PHA and Individual Medical Readiness (IMR) reporting business rules. Fly PHAs will be managed in the FOMC (RMU/GMU for ARC).

5.3. AIMWTS Management.

5.3.1. The FOMC (GMU/RMU) must perform monthly AIMWTS workflow reviews at a minimum, but it is recommended to accomplish with the weekly (monthly for ARC) AF 1041 log review. Expired/expiring waivers, pending interim evaluations, and open aeromedical summaries (AMS) must be reviewed. (T-3)

5.3.2. Delays in waiver processing beyond the Airman's control must have a waiver expiration extension requested through the MAJCOM/SGP.

5.3.3. The Medical Standards Management Element (MSME) will ensure Airmen are notified of waiver dispositions, and AF Form 1042s are processed appropriately when examinations are returned from the waiver authority. (T-3) **Note:** *SSNs are being phased out as ID numbers. Use CAC ID number for Joint 1042-equivalent form.*

5.4. Record Reviews: will be accomplished IAW source regulations and instructions.

5.4.1. PHAs will be accomplished IAW AFI 44-170.

5.4.2. Profiling Actions, to include PCS reviews, clearances, cross training, and acceptance for schools, will be accomplished IAW AFI 10-203.

Chapter 6

COMMUNITY HEALTH PROGRAM (CHP)

6.1. COMMUNITY HEALTH PROGRAM (CHP). This program is managed by Public Health (PH) and may be clinically executed by all PCM teams, but primarily the FOMC. Unless otherwise directed in Department of Defense Instructions (DoDIs) or AFIs, follow methods for controlling and preventing disease described in the Centers for Disease Control and Prevention (CDC) publication, *Morbidity and Mortality Weekly Report* (MMWR), and supplements. CHP activities are regulated IAW: AFJI 48-110, *Immunizations and Chemoprophylaxis*; AFI 48-117, *Public Facility Sanitation*; AFI 48-116, *Food Safety Program*; AFI 48-105, *Surveillance, Prevention, and Control of Diseases and Conditions of Public Health or Military Significance* which outlines, communicable disease surveillance/ prevention/control, Sexually Transmitted Infection (STI) surveillance/ prevention/control, latent tuberculosis infection (LTBI) management, and the Animal Bite Program; and AFI 44-178, *Human Immunodeficiency Virus Program* which guides the AF HIV program. **Note:** *For ARC: Referrals for treatment of conditions identified in Reservists/Guardsmen will be based on duty status and line of duty determination.*

Chapter 7

HUMAN PERFORMANCE OPERATIONS

7.1. Night Vision Devices (NVD) Program Support.

7.1.1. AFI 11-202V1, *Aircrew Training*, defines AF-wide training requirements for use of NVDs. AOP officers may become certified NVD instructors as part of the training team and assist in initial and refresher training. FSs, AOP technicians and optometrists/ophthalmologists may become certified NVD instructors. Weapons-specific training and operational requirements are IAW applicable AFI 11-2-MDS series.

7.1.2. The FS and/or AOPT personnel must be knowledgeable on basic visual issues: e.g. contrast, ambient lighting, color vision, etc., and work with local aircrew flight equipment technicians and aircrew on Laser eye protection, high contrast visor, ballistic eye protection, and aircrew spectacle equipment optimizing performance of war fighters. (T-2)

7.2. G-Awareness Continuation Training. FSs and AOP officers must have adequate training (to include centrifuge qualification IAW AFI 11-404, *Centrifuge Training for High-G Aircrew*) and be familiar with G-awareness continuation training requirements outlined in the respective AFI 11-2-MDS series and AFPAM 11-419, *G-Awareness for Aircrew*. AFI 11-404 describes the initial qualification, refresher centrifuge training requirements, and guidance and procedures for handling aircrew that do not satisfactorily complete this training program.

7.3. Fatigue Countermeasures Program.

7.3.1. A primary aim for FS, SMEs, and AOPT personnel is sleep hygiene, education and mitigation of effects of fatigue on successful mission completion. This is accomplished through advocacy, consultation with leadership, evaluation/analysis of threats, education, training, and use of approved fatigue countermeasure tools. FSs and AOPT personnel must be knowledgeable on AF guidance pertinent to mission and warfighters support. A mandatory starting point for supporting fatigue management in flying operations is AFI 11-202V3, *General Flight Rules*, Chapter 9, *Crew Rest, Fatigue Management and Flight Duty Limitations*. In addition, several platforms have guidance in Volume 3 of their respective AFI 11-2-MDS series. The publication, *Warfighter Endurance Management During Continuous Flight and Ground Operations: An Air Force Counter-Fatigue Guide*, is an excellent resource on fatigue management and can be found under Fatigue Management Information on the AFMS Kx: <https://kx2.afms.mil/kj/kx4/FlightMedicine/Pages/operationalmedhomeapril2012.aspx>.

7.3.2. The FS and/or AOPT personnel must be involved in mission planning on missions and operations where fatigue is likely to be a factor. They compare mission profile with operator circadian rhythm identifying phases of flight/operation where fatigue may be a factor. They plan ways to prevent or mitigate effects of fatigue ensuring mission/operation success. For aerial missions, focus is specifically on the critical phases of flight: take off, refueling, operational engagements, and landing.

7.4. Fatigue Countermeasure Medications. Pharmacologic interventions are intended to be a last resort when all other measures have been exhausted. The Aerospace Medicine community has conducted a tremendous amount of research to find the safest medication to use, but they are

NOT without risk, and should NOT be used in place of non-pharmacological interventions. However, there are situations where the use of these medications is warranted by mission needs and inability to sufficiently mitigate the risk with other measures.

7.4.1. Approved Fatigue Countermeasure Medications (Go/No-Go Pills). AFMSA/SG3P will publish the list of authorized stimulants (Go pills) and sedatives (No-Go pills) that have proven to be effective and have the least risk with their use to mitigate fatigue in the Official Air Force Aerospace Medicine Approved Medications list. This does not constitute approval to use these medications without prior authorization from the MAJCOM (or higher) AND approval from the local SGP and Wing/CC (or equivalent).

7.4.2. MAJCOM Specific Policy. Per AFI 11-202V3, *Flying Operations*, MAJCOMs will develop guidance on the use of fatigue countermeasure medications, specifically situations, exercises and contingencies where the use of Go Pills” could be authorized. This policy will list situations where Go Pills” could be authorized for use, but will still need local approval.

7.4.3. Local Approval. If AF and MAJCOM policy allow the use of Go Pills” for a given situation, then the local Wing/CC or equivalent can make an Operational Risk Management decision about whether to authorize their use. The local authority should consult with the SGP to ensure other risk mitigation strategies have been considered.

7.4.4. Flight Medicine establishes a program to ground test, dispense, and control pharmacological agents for fatigue management IAW AFI 48-123, AFI 11-202V3, and current AF policy. (T-2) **Note:** *For ARC: Written plans must address the security, storage and distribution of controlled substances IAW AFI 41-209, Medical Logistics Support. (T-2)*

7.4.5. The SGP counsels, with the Go Pill approval authority (wing or deployed commander), the medical utility of using Go Pills for a particular mission or mission set. The SGP will ensure appropriate non-pharmacological fatigue prevention strategies and operational countermeasures are utilized prior to concurring with operational Go-Pill use. (T-2)

7.4.6. Go/No-Go pill ground testing and operational use is voluntary. The FS offers ground testing for Go/No-Go pills to select eligible aircrew prior to use in an operational setting. Documentation of successful ground testing or deferral is entered in the medical record of eligible aircrew. All aircrew are “Duties not to include flying” (DNIF) while ground testing both Go and No-Go pills.

7.4.7. Operational use of stimulants (Go Pills) and sedatives (No-Go Pills) are IAW MAJCOM supplements to this instruction: (ACC for Combat Air Forces (CAF), AMC for Mobility Air Forces (MAF), and AFSOC/CV policy letter for Battlefield Airmen), and the Official AF Aerospace Medicine Approved Aircrew Medications list. The designated MAJCOMs will coordinate supplement development/revisions with AF/SG3P. **Caution:** *There is potential for Airmen using Go/No-Go Pills to become dependent on their use to the exclusion of all other non-pharmacological interventions. FSs must clinically supervise the use of any Go/No-Go medications and exercise careful judgment before dispensing. They are not intended to be a solution to manning shortages or to support a lifestyle of poor sleep habits or inappropriate prioritization of work and play activities.*

7.4.8. FSs provide eligible aircrew counseling regarding off label use of Go Pills as an operational countermeasure, and obtain informed consent as required prior to prescribing

them IAW 10 USC 1107(f), *Notice of Use of an Investigational New Drug or a Drug Unapproved for Its Applied Use*. Informed consent is required only once for each Go Pill medication and dosage and must be documented in the Airman's medical record. (T-2)

Note: *References and tools to provide this counseling can be found at the "Go Pills" link on the KX under Operational & Flight Medicine.*

7.4.9. FSs report operational use of Go Pills including adverse reactions during operational use to MAJCOM/SGP. A sample format to accomplish this can be found on the "Go Pills" link at the KX. The MAJCOM/SGP will maintain record of Go Pill use and provide annual summary to AFMSA/SG3PF.

7.4.10. Eligibility for the operational use of pharmacologic sedatives (No-Go) requires appropriate ground testing and approval of the local FS. Aircrew will declare themselves DNIF after use of sedative for the specified time as annotated in the Official AF Aerospace Medicine Approved Medications list and as instructed by the FS. (T-1)

7.5. Custom Hearing Protection. Standard Ear Impression Technique (SEIT) for Attenuating Custom Communication Earpiece System (ACCES) and similar devices. **Note:** All logistic support, ordering/receipt, routine maintenance and associated costs for training and materials remain the responsibility of the requesting flying squadron / group / wing.

7.5.1. Flight & Operational Medicine is the OPR for oversight of SEIT procedures for the ACCES and similar programs and will appoint a program manager to oversee SEIT if the wing supports such a program. The program manager will either be a flight surgeon or audiologist. (T-3)

7.5.2. Only individuals who have completed appropriate SEIT training may create SEIT impressions and assess fit/comfort of ACCES or similar devices provided by the manufacturer. In order of preference, the following individuals should perform these duties: Audiologist, FS, IDMT (4N0X1C) or 4N0X1F, Nurse, or AOP personnel (43A3 or 4M0X1). All personnel except audiologists must complete the manufacturer's SEIT training before performing these duties. (T-3)

Chapter 8

EMERGENCY RESPONSE AND DISASTER MANAGEMENT OPERATIONS

8.1. Organization and Functions. The MTF (RMU/GMU) Medical Contingency Response Plan (MCRP) supports an Installation Emergency Management Plan (IEMP 10-2) IAW AFI 10-2501, and AFMAN 10-2502. FOMC personnel must be familiar with the MCRP and their roles within the plan. (T-2)

Note: *For ARC, refer to Installation Emergency Management Plan (10-2) and AFI 10-2605, AF Incident Management System, and the Mass Casualty Response Plan (MCRP).*

Note: *Not all ARC units will have their own MCRP, but must be familiar with their role to support their host MCRP.*

8.2. Essential Functions. Note: This is not applicable to the ARC.

8.2.1. First Responders: The FOMC will maintain emergency responder capability supporting installation flying operations and coordinate with other available first response capabilities.

8.2.2. First responders provide initial on-scene command. The first medical responder to an incident must co-locate with senior Fire and Police/Security commanders and/or Incident Commander (IC) as the Medical Advisor (MA) and be clearly recognizable. Further medical personnel arriving on scene must report to the MA for instructions if not previously communicated. The MA should be the most senior/experienced medical person on-scene. The role of the MA should be transferred upon the arrival of a more experienced medical responder depending on the circumstances of the incident and the expertise required. The MA is typically the most senior/experienced FS.

8.2.3. Transport: FOMCs support airfield operations responding to a variety of in-flight emergencies and airfield incidents. The type of vehicles required and the ability to respond adequately depends on the type of aircraft assigned and the spectrum of aircraft that visit the airfield. Installation location, mutual-aid response capability, and proximity to definitive care are factors that must be considered. These parameters form the basis of a risk assessment conducted by the SGP to determine level and adequacy of emergency medical response. Emergency Transport response time must meet the requirements in DoDI 6055.06, *DoD Fire Emergency Service Program*, Table E3. T1, minimum level of service objectives-operations section under *Emergency Medical*. (T-0)

8.2.4. A transport vehicle must be able to transport a minimum of two first responders, one FS, and medical equipment/supply packs to any crash site within a 10 mile radius of the airfield over rough terrain. (T-2)

8.2.5. Medical vehicle drivers responding to in-flight emergencies and airfield incidents must have a valid flight line drivers permit and be proficient with flight line driving during both day and night operations.

8.2.6. First Receivers: Some locations require the FOMC to have first receiver capability. This must be staffed with medical personnel with ATLS or pre hospital trauma life support

(PHTLS) qualifications and knowledge of the Hospital Incident Command System (HICS). (T-2)

8.3. Specialized Response. Note: *There are no full-time providers at most ARC RMU/GMUs. Injured ARC members are transported to facilities as clinically appropriate. In no circumstance should an injured member bypass a civilian Emergency Room/Trauma Center in favor of an AD MTF unless the member is clinically stable and the delay is not expected to impact patient outcome.*

8.3.1. FSs provide medical oversight and emergency response to physiological and/or medical incidents resulting from hypoxia (i.e. altitude chamber or Reduced Oxygen Breathing Device (ROBD)), and/or centrifuge training as applicable for units with this training mission. During all scheduled training events, a designated flight surgeon must be able to continuously respond by telephone and get to the training facility in the timeliest manner possible. (T-1)

8.3.2. Chemical, Biological, Radiological, Nuclear, Explosive (CBRNE) / HAZMAT Response: FOMC personnel must have correctly fitting personal protective equipment/individual protective equipment (PPE/IPE) appropriate for their specific team responsibility and have exercised using the equipment while performing their duties prior to responding. (T-2)

8.3.3. Disaster Response. FOMCs must develop relationships and demonstrate familiarity with plans that include coordination with local emergency services and an understanding of integration with these agencies to support their missions under the IEMP/MCRP. (T-2)

8.3.4. Aircraft Mishap Response: FOMCs must review AFI 91-204, *Safety Investigation and Reports*, and the Aircraft Mishap portion of the MCRP and ensure they are able to execute their responsibilities per IEMP/MCRP. Critical elements include:

8.3.4.1. Initial Response: site safety, treatment of injured, initial collection and preservation of evidence. **Note:** Strong consideration should be given to sending any aircrew member that has undergone an ejection seat sequence to local Emergency Room/Trauma Center even if they report no or only minor injuries.

8.3.4.2. Evidence preservation/collection as directed by the interim Safety Board (ISB) President, usually a member of Wing Safety (SE).

8.3.4.3. Identify a local FS for the ISB, per base plan. The FS's primary duty is based on ISB requirements until released.

8.3.4.4. Sequester associated healthcare records (medical, dental, MH) until requested by the ISB or follow on Safety Investigation Board (SIB).

8.3.4.5. Obtain 72-hour and 14-day histories.

8.3.4.6. Obtain required toxicology and other relevant tests IAW AFI 91-204, section 2.7.4. Extent of testing depends on the nature of the mishap. Consult SGPs, Armed Forces Medical Examiner System (AFMES), and the AF Safety Center FSs as needed.

8.3.4.7. The FOMC ensures proper aeromedical dispositions are accomplished for mishap personnel on flying/SOD.

8.3.4.8. Notification of medical leadership (SGP, SQ/CC, MDG/CC) and MAJCOM/SGP.

8.3.4.9. Mishap kits must be developed, maintained, and appropriately resourced. FOMC personnel must train and be familiar with the kit. FOMC personnel must review mishap response plans and inventory the mishap kit every six months at a minimum. (T-2)

8.3.4.10. FOMCs will ensure and be familiar with written agreements with local coroner/medical examiner which governs possession of remains after aircraft mishap. This agreement should include authority to have a FS present at autopsies, and detail requirements for collection of AF mishap related specimens. (T-2) **Note:** *OCONUS sites will coordinate with MAJCOM ensuring this requirement is met under applicable Status of Forces Agreement.*

8.3.5. In-Flight Emergencies (IFEs): FSs must be familiar with the management of routine in-flight emergencies, especially physiologic incidents. FSs must meet aircraft after in-flight emergencies with a physiologic incident to identify causes of symptoms and assess and document the need for aircrew examination and/or treatment. **Note:** *This does not apply to ARC while in-garrison.*

8.3.5.1. A FS must be available (On-Call) for in-flight emergency coverage during scheduled flying hours. **Note:** *This is not applicable for ARC.*

8.3.5.2. FSs must respond to IFEs when requested by Fire Chief/Wing Safety/Supervisor of Flying (SOF) and where there is a risk for physiologic incident including G induced loss of consciousness (G-LOC), hypoxia, aircrew disorientation, altered mental status, loss of cabin pressure at >20,000 ft., rapid decompression, smoke and fumes, or other physical symptoms or injuries reported by the aircrew. ARC units without local full time flight surgeon support may need to send the patient for civilian evaluation if there is no flight surgeon available to evaluate the member.

8.4. Training: First responders must be trained and equipped for immediate response to expected hazards and environmental conditions. (T-2)

Chapter 9

FLIGHT AND OPERATIONAL MEDICINE CLINIC TRAINING AND DEVELOPMENT

9.1. Objectives and desired effects. FOMC personnel are required to deliver the best aeromedical and operational support in-garrison and while deployed. It is critical that FOMC personnel are skilled and proficient in their roles. MTF (RMU/GMU) leadership must allocate time and resources to ensure FOMC personnel are adequately trained.

9.2. Individual FOMC AFSCs.

9.2.1. FS (48R/G).

9.2.1.1. Initial Qualification Training (IQT). Physicians must successfully complete all required modules of the FS IQT course which collectively is the Aerospace Medicine Primary Course (AMP) provided by USAFSAM. Currently, this consists of three modules: AMP 101- Fundamentals of Aerospace Medicine, AMP 201- Clinical/Practical Flight Medicine, and AMP 202- Operational Medicine Workshops. (T-2)

9.2.1.2. Mission Qualification Training (MQT). After assignment to a FS billet and prior to deployment, the 48R1/G1 FS must complete MQT to become Fully Mission Capable (FMC) and receive the 48R3/G3 AFSC upgrade IAW Air Force Officer Classification Directory. MQT may be initiated immediately upon completion of the AMP courses or at a later date if not immediately assigned to work in a flight medicine clinic.

9.2.1.3. FS requirements for MQT and minimums for SGP to sign off as complete:

Table 9.1. MQT Requirements.

Requirements	Minimum Number for SGP Certification
Replacement Training Unit (RTU)	Once
Advanced Trauma Life Support Certification	Maintain
Advanced Cardiac Life Support Certification	Maintain
Occupational exams	Five (5) ¹
Annual flight physical examinations	Five (5) ¹
Initial Flying Physicals	Five (5) ¹
Aircrew waiver package completion	Four (4) ¹
Flight Medicine Working Group (1041 log meeting)	Four (4) ¹
Occupational health shop visits	Two (2) ¹
Public Health sanitation/food inspections	Two (2) ¹
Aeromedical Council meetings	Two (2) ¹
Deployment Availability Working Group	Once (1) ¹
Occupational Environmental Health Working Group	Once (1) ¹
Profile review as Profile Officer	Twenty Five (25) ¹
Flight Surgeon sorties/flying hours	Sorties (4) & Hours (6) ¹
Unrestricted flight surgeon privileges ²	Obtain/Maintain

Table 9.1 Notes:

1. MTF (RMU/GMU) SGP may certify with less than minimum observed if the individual demonstrates the requisite knowledge and skills to perform the function. MAJCOM/SGP must still approve the certification upgrade.
2. ARC flight surgeons must obtain/maintain the flight surgeon portion of their UTA privilege list.

9.2.2. Physician Assistants (PA; 42G3)

9.2.2.1. PAs assigned to the FOMC must complete AMP 201 at USAFSAM. (T-2) This should be completed before being assigned to FOMC, but if not, will be accomplished within six months of assignment to FOMC. Aerospace medicine privileges for PAs are dependent on completion of this training.

9.2.2.2. PAs assigned to FOMC will practice within the scope of their training and privileges and seek physician consultation when appropriate.

9.2.2.3. PAs will be privileged utilizing the Physician Assistant Flight Medicine master privilege list and IAW AFI 44-119. **Note:** *ARC PAs will be privileged per ARC requirements listed in AFI 44-119.*

9.2.2.4. PAs may evaluate and treat flyers and special duty personnel. Aeromedical dispositions, flying physical exam certifications and MTF profiles must be reviewed and approved by a FS on the day of the encounter, at the time determined by the supervising Flight Surgeon. *Exception: HQ AF/SG delegates to the Medical Treatment Facility (MTF) Commander the authority to grant AFSOC PAs working independently in support of Special Operations Command missions, aeromedical disposition privileges when deployed and without reasonable access to a FS preceptor. (T-1)

9.2.3. FOMC Nurse Manager (46NX). Nurses must maintain their AFSC specific training/certification and Readiness Skills Verification Program (RSVP) training.

9.2.4. Flight and Operational Medical Technician (4N0X1F). 4N0X1F must maintain AFSC specific (upgrade, training and certification) and RSVP training.

9.2.5. IDMT (4N0X1C). 4N0X1C assigned to FOMC must complete the IDMT Flight and Operational Medicine Workshop (IDMT FOMW) to obtain the 470 SEI and gain the knowledge base of aerospace medical programs and procedures. (T-3) IDMTs already holding the 470 SEI will complete the computer based Flight and Operational Medicine Technician bridge course. Both courses are developed and maintained by USAFSAM.

9.2.6. Health Services Management (4A0X1). 4A0X1 must maintain AFSC specific and RSVP training for career-field proficiency.

9.3. Squadron Medical Element (SME)-Specific Qualification Training.

9.3.1. SME FS-Specific:

9.3.1.1. SME and other line assigned FS that are expected to deploy with their unit must be fully credentialed, maintain unsupervised clinical privileges in the FOMC and meet FS MQT and currency requirements. (T-2) (See [Table 9.1](#)) FS should recertify ACLS and

ATLS IAW applicable standards. **Note:** *ARC flight surgeons must be privileged for ARC flight medicine in addition to their ARC UTA privileges.*

9.3.1.2. Will maintain unit specific training requirements.

9.3.1.3. Will maintain currency in other required medical and operational training, e.g. RSVP and Disaster Team Training.

9.3.1.4. AFSOC line FSs and Rescue assigned FSs must have Level-C Survival, Evasion, Resistance and Escape (SERE) training. It should be accomplished as soon as possible after arriving on-station, but must be completed prior to deployment in the SME role. (T-3)

9.3.2. SME Technician-Specific.

9.3.2.1. Should meet training requirements for SEI 470 prior to SME assignment. At a minimum, must attend the in-residence IDMT Flight and Operational Medicine Workshop (IDMT FOMW) or Flight and Operational Medicine Technician (FOMT) Course. IDMTs/4N0X1Fs already holding the 470 SEI must complete the computer based Flight and Operational Medicine Technician bridge course. All 3 courses are developed and maintained by USAFSAM. **Note:** *SEI 470 is not allowed for Physician Assistants filling an ARC SME billet.*

9.3.2.2. ARC personnel will maintain current NREMT certification prior to performing SME technician duties in a deployed environment. (T-2)

9.3.2.3. Initial qualification training (IQT) for SME technicians must include:

9.3.2.3.1. Certification/currency as 4N0X1F/C. **Note:** *This is not applicable for ANG Physician Assistants filling an SME billet.*

9.3.2.3.2. Intravenous (I.V.) therapy and certification.

9.3.2.3.3. Oxygen therapy.

9.3.2.3.4. Four-wheel-drive modular ambulance and flight line driving. **Note:** *This does not apply to ARC.*

9.3.2.3.5. Satisfactory experience performing occupational health and safety assessments of industrial shops, flight line facilities, and other base/site support operations.

9.3.2.3.6. Assessing proper waste disposal techniques.

9.3.2.3.7. Water sampling, analysis, and purification to establish proper water quality (IDMT).

9.3.2.3.8. Food safety and quality inspections to evaluate food handling and storage procedures (IDMT).

9.3.2.3.9. Site selection criteria for bare-base medical facility.

9.3.2.3.10. Operating mobile and base station radios.

9.3.2.3.11. Administration and tracking of immunizations.

9.3.2.3.12. Disease and Injury Surveillance, including use of current deployment-medicine Disease Non-Battle Injury (DNBI) software such as AHLTA-T or future iterations of similar software mechanisms of DNBI study.

Chapter 10

LINE EMBEDDED MEDICAL CARE UNITS

10.1. Purpose: This instruction provides guidance for the establishment and function of in-garrison operational Ambulatory Care Units (ACUs) associated with Special Operations Forces (SOF) and other embedded health providers. ACUs are associated with Operational Support Medical (OSM)/Special Operations Forces Medical Element (SOFME) and Special Tactics Squadrons (STS). OSM/SOFME support Special Operations Squadrons (SOS) flying squadrons, while the STS are the supported ground forces. ACUs are medical assets embedded within AFSOC line units. This guidance is intended to define the relationship and interactions between Military Treatment Facilities (MTFs) and line unit medical elements with regard to in-garrison embedded medical operations.

Note: This chapter is specifically applicable to AFSOC Ambulatory Care Units, but the concepts and requirements are applicable to other health care providers embedded with line units.

10.2. Background: For several years, Special Operations Forces (SOF) have utilized embedded medical assets to work in close proximity to the warriors. These embedded medical assets have historically included flight surgeons, physician assistants, IDMTs, physical therapists and operational psychologists. Due to high operations tempo and unique physical and emotional stressors, Special Operations Command (SOCOM) established an initiative called Preservation of the Force and Family (POTFF). The POTFF initiative is an attempt to overcome SOF reluctance to seek medical care and an even greater reluctance to seek mental health care by these warriors. The course of action guided by the POTFF initiative is an expansion of the embedded medical assets as well as the creation of several new non-privileged, non-medical positions to assist the SOF in managing the stressors particular to their profession. These actions can be applied to other operational communities that have similar stresses and needs.

10.3. Concepts: While any type of privileged or non-privileged provider could be embedded with a line unit, there are some restrictions for POTFF providers. All POTFF assets are contract personnel. Privileged POTFF providers may include: licensed clinical social worker; clinical psychologist; operational psychologist; sports dietitian; and physical therapist. Non-privileged POTFF may include: psychiatric technician; nurse case manager family life assistant; family support coordinator; athletic trainer; human performance advisor; strength & conditioning specialist and sports psychologist (unless they possess the credentials to be privileged as clinical psychologists IAW 44-119) (T-2); and data analyst. All or some of these may further be incorporated into other embedded healthcare units (OSM/SOFME, SME, OME) making the ACU/embedded unit a combination of DHP-funded active component, and Line-funded personnel. All privileged providers must be appropriately privileged through their host MTF prior to performing any medical duties. All non-privileged providers must meet credentialing, education, and training requirements commensurate with their specialty standard of care prior to performing their function. (T-2) The advantages of this care model include improved access to care, enhanced understanding by the providers for the unique nature of SOF/operational mission and operations tempo, and increased trust resulting in an improved patient-provider therapeutic relationship. The fundamental concept is that services by these medical and non-medical assets are provided in-garrison but outside the MTF. These units are designated areas within Line unit

spaces where care is provided to active component personnel ONLY. Although ACUs are not considered a component of the MTF, they rely on support from the local MTF.

10.3.1. This instruction is not intended to preclude embedded medical assets from caring for patients in the MTF. This policy is intended to establish the framework under which care may be provided outside of the MTF. All reference to the ACUs refer to care provided outside of the MTF. Care inside the MTF, and MTF operated locations, will be managed under guidance in place for the MTF.

10.3.2. Each base should review assigned medical assets and work between the Line and medical organizations to determine utilization of Defense Health Program (DHP)-funded and line-funded medical assets.

10.3.3. ACU policy at sister-services locations: Some AFSOC assets are located on non-AF installations. At these locations, the SOW/SG or GROUP /SG will work with the facility medical installation to establish a memorandum of understanding (MOU). This MOU will establish the working relationship and clinical oversight responsibilities for the ACU and the MTF.

10.3.4. POTFF privileged providers will typically provide care in ACUs but may occasionally provide care in the MTF. Any care, counseling, or interaction provided to dependents by POTFF providers will take place in the MTF only, in which case they will adhere to all AF MTF oversight, privileging and standard of care guidance. (T-2)

10.3.5. Accreditation: In accordance with DoDI 6025.13, *Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)*, all fixed MTFs shall meet or exceed the standards of appropriate external accrediting bodies. However, Operational Healthcare Units (not a component of an accredited MTF and treating active component personnel only), such as line-embedded medical assets described here, are exempt from the accreditation requirement. This guidance establishes a template for comparable quality-of-care oversight mechanisms for AFSOC ACUs. At a minimum, the functions of credentialing, risk management, patient safety and clinical performance improvement shall be included in the quality-of-care oversight mechanisms. ACUs will be inspected concurrently with compliance inspections for the MTF, and may be a separate graded area on the MTF report. (T-0)

10.4. Structure of SOF Embedded Medical Assets:

10.4.1. Ambulatory Care Unit (ACU): ACUs are located in (SOSs) and Special Tactics Squadrons (STSs). The types of providers assigned to each ACU vary based on need. The intent of the ACU is to provide resiliency resources in the form of medical and mental healthcare to SOF where the operators are located. POTFF medical assets will primarily be assigned to STS. However some POTFF assets will be placed at SOS units, as well as the Special Operations Wing (SOW) and Special Tactics Group (STG).

10.4.2. Special Operations Forces Medical Element (SOFME): SOFME is an element of the Operational Support Medical (OSM) and functions in a Special Operations Squadron (SOS). The SOFME typically refers to the flight surgeon and other members, that might include a physician assistant (PA), operational mental health provider, physical therapist and an IDMT. The primary responsibility of SOFME personnel is to provide aerospace medicine, primary care, and preventive medicine for AFSOC aircrew and special duty personnel in deployed

and in-garrison environments. SOFME medics may also provide care in ACUs while in-garrison. The SOS ACUs may be made up of OSM assets and POTFF assets. POTFF assets in this situation are part of the ACUs and are members of the SOS but are not part of the OSM. Therefore the OSM providers, functioning in the SOS ACU, will have operational control over the POTFF ACU providers but not administrative control.

10.4.3. Special Tactics Ambulatory Care Units (ST ACU): ST ACUs are designed to provide embedded medical care to SOF ST units. ST ACU assets are funded from DHP sources (for a minority of the active component assets) and non-DHP sources (through POTFF/MPF-11). The STS has administrative and operational control for all ST ACU providers. (T-2)

10.4.4. Clinical leadership in the STS and the SOS is provided by the senior physician overseeing the STS ACUs or SOS ACUs. In ST ACUs, the senior physician is the SOW/SG or the GROUP /SG. For SOS ACUs, the physicians are assigned to the SOSS and their senior physician is the OSM flight commander (OSMFC). If the ST ACU is located at a base with a collocated SOW, the senior physician is assigned to the Wing, identified as the SOW/SG. If there is no SOW collocated with the ST ACU, the senior physician for that ACU is the GROUP/SG. The senior clinician for an ST ACU in this document will be referred to as the SOW/STG SG. The SOW/STG SG and the OSM FC have the same responsibility for clinical oversight for the ACU assigned under their purview. ST ACU providers will provide clinical oversight of the POTFF ACU providers and fall administratively under the STS as noted above. (T-2)

10.5. Funding: Embedded ACU POTFF providers are funded through Special Operations Line sources as part of the Preservation of the Force and Family (POTFF) initiative. Funding needed for embedded active component medical staff will be provided primarily through Major Force Program-11 (MFP-11) sources. Non-disposable ACU medical supplies and equipment are funded using Line sources, and day-to-day disposable medical supplies are funded through DHP sources. The MTF should assist with ordering and procuring of medical equipment/supplies as needed so they can retain visibility on orders and determine capability of Biomedical Equipment Technicians (BMTS) to provide maintenance. ACUs are required to maintain both property and supply custodians appointed in writing for tracking of supplies & equipment and are responsible for pickup of equipment/supplies ordered for their ACU from the MTF. (T-3) Funding for ACU staff for TDY, to include any Continuing Medical Education (CME), will be line funded. AFIT funding for CME TDYs may be available for active component providers. The local MTFs' Education and Training Flight will assist ACU providers with processing AFIT funding requests if slots come available.

10.6. MAJCOM-level Guidance: AFSOC/SG develops policy guidance in support of AFSOC-specific embedded medical assets with the coordination of AF/SG3.

10.6.1. Contract Oversight: All contracts for embedded ACU POTFF assets will be managed by Line contracting office representatives (COR). Local MTFs will not be responsible for any aspect of non-medical ACU contracts.

10.6.2. The local AFSOC Line Commander will supply space suitable for ACU patient care.

10.7. MTF Responsibilities:

10.7.1. Clinical Oversight: The Medical Group Commander (MDG/CC) or equivalent ultimately has responsibility for, and authority over, professional supervision of medical care provided by all medical providers for that base as well as all embedded medical providers including but not limited to the 48Xs, 46Xs, 42Xs, 4Xs, and 2Xs. The work provided by the non-medical POTFF ACU consultants is overseen by the line squadron chain of command and detailed in AFSOC policy guidance. The MTF/CC, SGH, SGP, or other MTF personnel have neither oversight authority nor responsibility for the actions or results of these non-medical consultants. Day-to-day SOF ACU clinical oversight is delegated to the SOW/STG SG, OSM FC, or the senior active component, line-owned, flight surgeon in the chain of command, in coordination with the local MTF SGH and SGP. If no local, line, active component, group-level or OSM flight surgeon is available, the squadron level line flight surgeon will assume oversight responsibilities in coordination with the MTF. (T-3)

10.7.2. Credentialing and Privileging: The local Military Treatment Facility Commander (MTF/CC) will assume all credentialing and privileging responsibilities for ACU privileged providers. Eligible ACU providers will be privileged as affiliate staff members. Medical care will only be accomplished by appropriately credentialed and privileged providers. (T-3) ACU contract positions should include review through the Credentials Office early in the hiring process to avoid delays.

10.7.2.1. Education and Training (E&T): ACU providers will be tracked by the MTF Education & Training function in the same manner as similar providers assigned to the MTF. Education & Training will assist ACU providers with training requirements, but it is ultimately the responsibility of the provider to maintain currency with required training. Failure of any embedded provider to remain current in all required training activities and to provide E&T with proof of training currency will result in E&T making contact with the MTF SGH, SGP and the owning line commander who will assist with obtaining compliance. (T-3) MTF coding experts, if available, should provide guidance as requested by embedded providers or should reach out to embedded providers when coding education is deemed necessary.

10.7.2.2. Readiness Training: Readiness Skills Verification Program (RSVP) is described in AFI 41-106. ACU providers' RSV tasks will be monitored by their line unit. Each ACU provider is responsible for ensuring their own RSV currency. The responsible G-series commander is ultimately responsible to ensure readiness requirements are completed.

10.7.2.3. Electronic Health Record/Medical Information Systems (AHLTA, CHCS, ASIMS, etc.) Support: MTFs will support ACUs in obtaining access to appropriate medical information systems, to include working with base communications. This includes assistance with obtaining access at line unit ACUs remote to the MTF. The MTF Medical Information Systems Flight will act on letters of request from line units for access to medical information systems.

10.7.2.4. Medical Equipment Maintenance: Maintenance of ACU medical equipment will be accomplished by MTF Biomedical Equipment Technicians (BMETs). BMETs will prioritize line medical equipment as they would similar MTF equipment.

10.7.3. Chief of Medical Staff (SGH):

10.7.3.1. Has oversight of the professional staff management program, professional practice review, patient safety, health risk management and performance improvement activities that occur at the ACU. (T-3)

10.7.3.2. Clinical Performance Improvement: Clinical Performance Improvement activities are via peer review and clinical oversight by the SGH (or SGH designee) and SOG/STG SG or OSM FC, and Line group or squadron senior flight surgeon. Other clinical Performance Improvement initiatives may be directed by the MTF or senior ACU flight surgeon. These will be tracked to completion by the senior ACU flight surgeon and reported to the MTF Quality Office.

10.7.3.3. Peer Review:

10.7.3.3.1. MTF/SGH and SOW/STG SG or OSM FC are jointly responsible to ensure peer review activities are being completed on ACU providers. (T-3) Failure of the ACUs to ensure completion of quality assurance activities, such as peer review, is elevated to the SOW/STG SG, OSM FC or above. The SOW/STG SG or OSM FC (senior active component line flight surgeon or PA for locations without a collocated SOW/STG SG or OSM FC), will forward monthly peer review results to the local MTF/SGH or SGH designee. If there is no local AF SGH at an ACU location, the SOW/STG SG or OSM FC will forward the peer reviews to the person most closely filling the role at that location.

10.7.3.3.2. Mental Health Peer Review. Peer reviews will be accomplished IAW the AF Primary Behavioral Health Care Services practice manual (for providers seeing patients in ACUs) and established MTF policy. (T-3)

10.7.3.4. Self-Assessments: ACUs will undertake self-inspections as directed by AF Inspection Agency (AFIA) guidance and instructions and enter their findings into the approved AFMS Self-Assessment Tool (i.e. MICT). Entries will be reviewed and approved by the SOW/STG SG or OSM FC as applicable. Line medical element, (and above), leaders will perform a self-inspection within 60 days of assuming the leadership role. This self-inspection will consist of all applicable self-assessment checklist elements as well as any other associated self-inspection items. (T-3)

10.7.3.5. The SGH ensures Patient Safety Reporting (PSR) is available to providers in each ACU. MTF Patient Safety assists with PSR training, reporting, and tracking, and may also assist with other Patient Safety initiatives in the ACUs.

10.7.3.6. SGH works with the MTF Medical Information Systems staff, in coordination with MTF Quality staff, to provide data to ACU clinical leadership, SOW/STG SG or OSM FC, regarding unsigned orders, incomplete encounters, results pending review, and other quality items consistent with similar reports on MTF providers.

10.7.3.7. Risk Management: The local Healthcare Risk Manager (RM), with oversight from the SGH, provides a review of clinical activities of ACUs and submits a report of findings to the senior ACU flight surgeon and the MTF/SGH. The RM reviews take place within three months of the initiation of provision of care at the ACU and annually thereafter. RM reviews and ACU senior flight surgeon responses to findings are forwarded to the SGH, the SOW/STG SG or OSM FC, and the AFSOC/SGP. (T-3)

10.7.4. Chief of Aerospace Medicine (SGP):

10.7.4.1. Acts as liaison between ACUs and the local MTF.

10.7.4.2. Provides expert advice and training as needed to ACU providers on all aspects of aerospace medicine, and consults on quality control for all aspects of care provided to aircrew and special duty personnel.

10.7.4.3. Facilitates coordination between the MTF PHA Cell and ACU to ensure that ACU providers have the information necessary to complete PHA activities IAW AFI 44-170.

10.8. SOW/STG SG or OSM Flight Commander:

10.8.1. Develops ACU supplemental policy for day-to-day management of ACU clinical staff. Policy will be implemented by SOW/STG SG and OSM FC. At locations where the SOW/STG SG or OSM FC is not collocated with the ACU, policy will be implemented by the senior SO physician or PA under the guidance of the SOW/STG SG or OSM FC.

10.8.2. Determines optimal process for utilization of ACU clinical resources.

10.8.3. Monitors clinical performance of ACU clinical staff and coordinates with local MTF/SGH to enhance quality of care and ensures appropriate remediation if there is concern regarding quality of care (as per AFI44-119).

10.8.4. Monitors and addresses privileged providers' response to applicable MTF directives and medical staff bylaws. The local MTF will work with the senior line flight surgeon to ensure compliance with the intent for ACU providers to attend Prostaff and other assigned MTF functions. The MTF will maintain an active list of ACU providers and ensure they are invited to MTF activities. (T-3)

10.8.5. Ensures AHLTA/CHCS/ASIMS access for ACU providers. The SOW/STG SG or OSM FC, or the senior line flight surgeon, when the SOW/STG SG or OSM FC is not located at the same installation, will work with ACUs to determine a list of computers and the primary users of these computers, which will require AHLTA/CHCS/ASIMS. The intent is to balance access for users against the expense and risk inherent with excessive installation of AHLTA/CHCS/ASIMS. The SOW/STG SG or OSM FC, or senior flight surgeon will forward the request to the person designated by the local MTF for action regarding AHLTA/CHCS/ASIMS access requests.

10.8.6. Ensures ACU representation at the MTF grounding management activities.

10.8.7. Coordinates with the MTF PHA Cell to ensure ACU providers have the information necessary to complete PHA activities IAW AFI 44-170.

10.9. ACU Providers:

10.9.1. ACU privileged providers are designated as affiliate staff, but should attend Prostaff, AF Form 1041 log review meetings, and other MTF Aerospace Medicine meetings to the maximum extent practical. Although ACU providers' line taskings are separate from MTF taskings, ACU providers are still responsible for all applicable Prostaff content. (T-3)

10.9.2. ACU providers will adhere to all guidance applicable to AF providers to include local Medical Staff Bylaws.

10.10. Staffing and Empanelment:

10.10.1. Empanelment: ACU patients will remain empanelled to MTF providers and will not be empanelled to ACU providers. The ACU providers will, whenever possible, perform most functions of the PCM, to include Preventive Health Assessments (PHA), profiles, Medical Evaluation Boards (MEBs), Deployment Health Assessments (DHA), aircrew waivers, aircrew grounding management, and other tasks typically performed by the PCM.

10.10.2. Staffing: Staffing for ACUs is requested by AFSOC/SG and line leadership with input from the host MTF Commander. Exact composition of the AFSOC ACUs will vary based on unit and mission.

10.10.2.1. Physical Therapists (PTs): Patient treatment modalities may include: ice, heat, ultrasound, myofascial manipulation, range of motion and weight training. Other clinical activities may be provided as per the individual PT's privilege list. PTs may function within an ACU and/or within an MTF. Location of care provided will be determined by the provider's unit medical leadership, and with the consent of the MTF leadership when MTF facilities are used.

10.10.2.2. Mental Health Professionals: ACU mental health providers may include: Clinical Psychologists, Operational Psychologists, and Licensed Clinical Social Workers (LCSWs).

10.10.2.2.1. Clinical Psychologists: Clinical psychologists providing services in the ACU will receive Behavior Health Optimization Program (BHOP) training and function IAW the Primary Behavioral Health Care Services Practice Manual. When providing services within an MTF specialty clinic, clinical psychologists may provide full-spectrum mental health care IAW AFI44-119, AFI44-172, and other applicable policies.

10.10.2.2.2. Operational Psychologists: Although much of what Operational Psychologists do falls outside of medical channels, they may also provide traditional mental health care. In addition to functions as an operational psychologist, operational psychologists are privileged to practice IAW requirements for licensed clinical psychologists (outlined in AFI44-119). Other activities of an operational psychologist are not within the scope of clinical psychology and will consequently not require privileging or medical documentation. These activities may include assessment and selection, performance enhancement, SERE training/interventions, aircraft mishap investigation, and Military Information Support Operations (MISO).

10.10.2.2.3. Licensed Clinical Social Workers (LCSW): LCSWs providing services in the ACU will receive BHOP training and function IAW the Primary Behavioral Health Care Services Practice Manual. When providing services within an MTF specialty clinic, LCSWs may provide full-spectrum mental health care IAW AFI44-119, AFI44-172, and other applicable AF policies. Other functions which can be accomplished by the LCSW include (but are not limited to) case management and family program development, as well as consultations with medical personnel, legal authorities, military commanders, and school districts as required.

10.11. Scope of Care: ACUs provide office-based, medical and limited scope mental health care, as well as spiritual and life skills support within designated squadrons, groups, and wings.

10.11.1. Medical care provided at the ACU (outside of an MTF) will be provided to active component members ONLY. Any care, counseling, or interaction provided by ACU providers to dependents will not occur at the ACU. Care of the active component member may in some circumstances include input by an active component member's dependent(s), but dependents will not be seen at the ACU. (T-0) POTFF contract healthcare providers that are properly credentialed and privileged by the local MTF Commander may provide limited short-term care to dependents within the MTF on a space-available basis when local MTF providers are not reasonably available.

10.11.2. ACU providers shall provide care consistent with privileges awarded by the local MTF. Minimally invasive procedures may be performed in the ACU (e.g. dry needling, acupuncture, immunizations, etc.). More invasive procedures will not be performed in the ACU. This includes (but is not limited to) suturing, local anesthetics, lesion removal or destruction, pap smears, closed reduction of fractures and nail removal.

10.11.3. Immunizations: May be performed at ACUs but must be in compliance with all policies including local guidance regarding training, storage, quality assurance, documentation, and emergency procedures related to providing immunizations.

10.11.4. Procedures: ACU providers should, to the maximum extent possible, perform procedures, for which they are being trained and supervised or for which they are privileged, as part of care provided to patients in their unit. ACU providers must hold privileges for procedures they perform. These privileges will be exercised within the MTF. The MTF will support the providers performing these procedures.

10.11.5. Mental Health:

10.11.5.1. Mental health-related interventions provided in the ACU, or by ACU providers within the MTF, will be in accordance with the AF Primary Behavioral Health Care Services practice manual. Mental health providers delivering BHOP services will be appropriately trained in that particular modality. POTFF assets must be privileged by the local MTF to be able to provide mental health care within the MTF Mental Health Clinic and will be in accordance with applicable local MTF, AF and DoD guidance.

10.11.5.2. Any care provided will be provided to active component members only; no care, counseling, or interaction with dependents will occur at the ACU. Clinical and non-clinical interventions by privileged POTFF contractors in the MTF Mental Health Clinic will be provided to dependents in accordance with DoD policy and as detailed in SOCOM memo "*Preservation of the Force and Families – Family Readiness Resources*", dated 19 Dec 2012.

10.11.5.3. The following services are excluded at the ACU, but may be provided by properly trained and privileged POTFF mental health assets when working in an MTF mental health specialty clinic: forensic evaluations; command directed evaluations; sanity boards; Medical Evaluation Boards (MEBs); and independent treatment of patients who should be referred to mandated DoD/AF programs (e.g., ADAPT, Family Advocacy). (T-3)

10.12. Provision of Care:

10.12.1. Guidance. All guidance applicable to the provision of care as noted in AFI44-119, *Medical Quality Operations* and AFI44-102, *Medical Care Management*, as well as patient privacy rules will be adhered to by all ACU providers, regardless of the site at which care is provided. All embedded providers will adhere to local Medical Staff Bylaws.

10.12.2. Pharmacy: ACU providers will preferentially use the local MTF pharmacy when open or an AF-approved medication dispensing device (MDD), when available.

10.12.2.1. Only when these sources cannot reasonably meet the needs for an individual prescription will a prescription be written and filled at a civilian pharmacy. These off-base prescriptions will not include refills. Ensure any prescriptions written to be filled off base are appropriately documented in AHLTA. This does not preclude the use of the Tricare Mail Order Pharmacy.

10.12.2.2. MDD use: AF-approved MDDs are acceptable for use in the ACUs. MDDs would preferentially be able to communicate with CHCS/AHLTA if/when the MDDs have this capability. Medication dispensed from the MDD must be ordered in the A/P section of AHLTA then dispensed. Any medication dispensed from the MDD will be accompanied by complete documentation in AHLTA and a current patient education monograph for the medication being dispensed will be provided to the patient. No controlled substances will be dispensed from, or placed in, any of the ACU MDDs. (T-2)

10.12.2.3. Operational use of stimulants, sedatives, and nutritional supplements are to be IAW MAJCOM supplements to Air Force Instruction (ACC for CAF, AMC for MAF, and AFSOC/CV policy letter for Battlefield Airmen) and the Official Air Force Aerospace Medicine Approved Medications list document on the Kx under Flight Medicine. The designated MAJCOMs will coordinate supplement development/revisions with AF/SG3P. Guidance on Kx remains the primary program resource until MAJCOM supplements are approved.

10.12.3. Ancillary services: All lab and radiology services needed, as a result of care provided in the ACUs, will be provided at the local MTF.

10.12.4. Clinical Documentation: All clinical care provided will be documented electronically to include AF Form 1042, AF Form 469, medical quarters reporting, and ASIMS requirements.

10.12.4.1. Prescription of any medication, to include Over-the-Counter medicine (OTCs) and supplements, will be performed in the Assessment/Plan module in AHLTA. Medication reconciliation must be accomplished at every encounter. ACUs will follow local MTF procedures for medication reconciliation.

10.12.4.2. Administering treatment modalities to include (but not limited to) physical therapy, psychotherapy, diet prescription, or care which results in a medical diagnosis, requires documentation in AHLTA. (T-3)

10.12.4.2.1. Medical documentation (IAW AFI 44-172, *Mental Health*) is required when POTFF MHPs conduct any of the following:

10.12.4.2.1.1. Screening for mental disorders.

10.12.4.2.1.2. Assessments in which Protected Health Information (PHI) is used to guide interventions or referral recommendations.

10.12.4.2.1.3. Individualized treatment.

10.12.4.3. Medical management activities, to include care coordination, require documentation in AHLTA.

10.12.4.4. Medical Expense and Performance Reporting System (MEPRS) and Defense Medical Information System (DMIS):

10.12.4.4.1. A new DMIS will be created for each base on which an ACU is located. This single DMIS will be used for all ACUs on a given base. At locations where the AF is not the lead for the base, the ACU should work with the local MTF to have a new DMIS generated. As it may take 2 or more months to have a new DMIS generated, each location should use the DMIS for the host MTF until the new DMIS is generated.

10.12.4.4.2. ACU MEPRS codes for care will be:

10.12.4.4.2.1. BJAA for primary care (any care performed by a physician or a physician assistant)

10.12.4.4.2.2. BJAA for mental health care. (This code is used as all mental health care in the ACU will be performed using the BHOP (see below) model. BHOP care is coded the same as primary care for the clinic in which the care is performed.)

10.12.4.4.2.3. BLAA for physical therapy care.

10.12.5. Infection Control: Infection Control activities will meet or exceed the Centers for Disease Control (CDC) guidance in *Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care*, available on the CDC website: search “*Minimum Expectations for Safe Care*” on the CDC website.

10.12.6. Emergencies:

10.12.6.1. ACU privileged providers will be trained to the Basic Life Support (BLS) level. ACU facilities will provide BLS (or higher level care when available) for patient emergencies, while seeking patient transport as needed through the 9-1-1 system. All buildings in which an ACU is located will have an Automated External Defibrillator (AED) present. This AED will be part of the base Public Access Defibrillation (PAD) Program. This level of response may be different than the level of response typically at the local MTF.

10.12.6.2. Suicidal/Homicidal Patients. As per the AF Primary Behavioral Health Care Services practice manual, POTFF providers can manage patients within the ACU who are determined to be at low risk for suicide. Patients at a higher risk level will be referred to Mental Health Clinics and managed IAW high interest procedures.

10.12.6.3. Management of Patients in Crisis (during duty and after-duty hours). Per AFI 44-172, if emergency evaluations cannot be delivered by close of business, arrangements should be made for the patient to be seen at an emergency medical facility. In an outpatient setting, MH assessments should be performed during regular duty hours, when both security and privileged medical support is available. The MTF emergency department is the safest and most appropriate venue for conducting after-hours

emergency mental health assessments, including suicide risk assessments. In MTFs without an Emergency Department, these emergencies should be handled in a similar fashion to other acute medical emergencies, using community medical resources.

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Surgeon General

Attachment 1**GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION*****References***

- AFI 10-2501, *Air Force Emergency Management (EM) Program Planning and Operations*, 24 January 2007
- AFI 10-203, *Duty Limiting Conditions*, 15 Jan 2013
- AFI 10-2603, *Emergency Health Powers on Air Force Installations*, 13 October 2010
- AFI 11-202 V1, *Aircrew Training*, 22 Nov 2010
- AFI 11-202 V3, *General Flight Rules*, 22 October 2010
- AFI 11-404, *Centrifuge Training for High-G Aircrew*, 28 Oct 2005
- AFI 33-360, *Publications and Forms Management*, 25 Sep 2013
- AFI 40-101, *Health Promotions*, 29 Feb 2012
- AFI 41-106, *Unit Level Management of Medical Readiness Programs*, 1 Jul 2011
- AFI 44-102, *Medical Care Management*, 20 Jan 2012
- AFI 44-103, *The Air Force Independent Duty Medical Technician Program*, 6 Dec 2013
- AFI 44-119, *Medical Quality Operations*, 16 Aug 2011
- AFI 44-170, *Preventive Health Assessment*, 30 Jan 2014
- AFI 44-172, *Mental Health*, 14 Mar 11
- AFI 44-178, *Human Immunodeficiency Virus Program*, 4 Mar 14
- AFI 48-101, *Aerospace Medicine Operations*, 19 Oct 2011
- AFI 48-105, *Surveillance, Prevention, and Control of Diseases and Conditions of Public Health or Military Significance*, 1 March 2005
- AFI 48-116, *Food Safety Program*, 22 March 2004
- AFI 48-117, *Public Facility Sanitation*, 6 May 1994
- AFI 48-123, *Medical Examinations and Standards*, 5 November 2013
- AFI 48-139, *Laser and Optical Radiation Protection Program*, 25 Jul 2012
- AFI 48-145, *Occupational and Environmental Health Program*, 15 Sep 2011
- AFI 91-204, *Safety Investigations and Reports*, 12 Feb 2014
- AFMAN 10-2502, *Air Force Incident Management Systems (AFIMS) Standards and Procedures*, 25 September 2009
- AFMAN 48-146, *Occupational and Environmental Health Program Management*, 9 Oct 12
- AFOSHSTD 48-20, *Hearing Conservation Program*, (May 2013)
- AFPD 48-1, *Aerospace Medicine Enterprise*, 23 August 2011

AFPD 90-8, Environment, Safety & Occupational Health Management and Risk Management, 2 Feb 2012

AFSOCI 48-101, *Aeromedical Special Operations*, 23 November 2012

DoDI 6025.13, *Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)*, 2 Oct 13

DoDI 6490.03 para 2.2 *Deployment Health*, 11 Aug 2006

DoD-R 5210.42_AFMAN 13-501, *Nuclear Weapons Personnel Reliability Program (PRP)*, 26 Feb 14

Laser Injury Guidebook (AFRL-SA-WP-SR-2012-0005), USAF School of Aerospace Medicine, Apr 2012

Official Air Force Aerospace Medicine Approved Aircrew Medications list located at the Knowledge Exchange (<https://kx2.afms.mil/kj/kx4/FlightMedicine/Pages/standards.aspx>)

Title 10, United States Code, Subtitle A, Part II, Chapter 55 §1107 (f), 1 February 2010

Adopted Forms

AF Form 190, *Occupational Illness/Injury Report*, 1 August 2003

AF Form 422, *Notification of Air Force Member's Qualification Status*, 25 October 2007

AF Form 469, *Duty Limiting Condition Report*, 25 October 2007

AF Form 847, *Recommendation for Change of Publication*, 22 September 2009

AF Form 1041, *Medical Recommendation for Flying or Special Operational Duty Log*, 1 September 1994

AF Form 1042, *Medical Recommendation for Flying or Special Operational Duty*, 1 February 1992 (or Joint 1042-equivalent per updated AFI 48-123 to reflect use of CAC ID vice SSN)

Abbreviations and Acronyms

ACU—Ambulatory Care Unit

ACC—Air Combat Command

ACLS—Advanced Cardiac Life Support

AF—Air Force

AFIA—AF Inspection Agency

AFIMS—Air Force Incident Management System

AFMS—Air Force Medical Service

AF/A3O—Director of Operations

AFPD—Air Force Policy Directive

AFRC—Air Force Reserve Command

AFSAS—Air Force Safety Automated System

AF/SG—Surgeon General
AF/SG3—Assistant Surgeon General, Health Care Operations
AF/SG3P—Chief, Aerospace Medicine Policy and Operations
AF/SG3PF—Aerospace Medicine Branch
AFSOC—Air Force Special Operations Command
AFOSH—Air Force Occupational Safety and Health
AIMWTS—Aeromedical Information Management Waiver Tracking System
ALC—Assignment Limitation Code
AMC—Air Mobility Command
AME—Aerospace Medicine Enterprise
ANG—Air National Guard
AOPT—Aerospace and Operational Physiology Training
ARC—Air Force Reserve Component (AFRC, ANG)
ASIMS—Aeromedical Services Information Management System
ATLS—Advanced Trauma life Support
BLS—Basic Life Support
CAF—Combat Air Forces
CBRNE—Chemical, Biological, Radiation, Nuclear, High Explosive
CDC—Centers for Disease Control and Prevention
CFETP—Career Field Education and Training Plan
CHP—Community Health Program
CMA—Competent Medical Authority
CME—Continuing Medical Education
CSARME—Combat Search and Rescue Medical Element
DAWG—Deployment Availability Working Group
DMIS—Defense Medical Information System
DNIF—Duties Not Involving Flying
DoD—Department of Defense
DoDI—Department of Defense Instruction
EPR—Enlisted Performance Report
ESOHC—Environmental Safety and Occupational Health Council
FMC—Fully Mission Capable

FMP—Flight Medicine Physicians (contract)
FOMWG—Flight & Operational Medicine Working Group
FOMC—Flight and Operational Medicine Clinic
FOMP—Flight and Operational Medicine Program
FS—Flight Surgeon
FTE—Full Time Equivalent
G-LOC—G induced loss of consciousness
GMU—Guard Medical Unit
GS—General Service Employee
HAF—Headquarters Air Force
HICS—Hospital Incident Command System
HIV—Human Immunodeficiency Virus
IC—Incident Commander
IDMT—Independent Duty Medical Technician
IEMP—Installation Emergency Management Plan
IPE—Individual Protective Equipment
IQT—Initial Qualification Training
LTBI—Latent Tuberculosis Infection
MAF—Mobility Air Forces
MAJCOM—Major Command
MCRP—Medical Treatment Facility Medical Contingency Response Plan
MDD—Medication Dispensing Device
MDG—Medical Group
MDG/CC—Medical Group Commander
MDS—Mission Design Series
MEPRS—Medical Expense and Performance Reporting System
METALS—Mission Essential Task/Activities for Line Support
MMWR—Morbidity and Mortality Weekly Report
MOU—Memorandum of Understanding
MQT—Mission Qualification Training
MSME—Medical Standards Management Element
MTF—Medical Treatment Facility

NATO—North Atlantic Treaty Organization

NGB—National Guard Bureau

NREMT—National Registry of Emergency Medical Technicians

OEH—Occupational and Environmental Health

OEHWG—Occupational and Environmental Health Working Group

OJT—On the Job Training

OM—Occupational Medicine

OME—Operational Medical Element

OPR—Officer Performance Report; Office of Primary Responsibility

OSHA—Occupational Safety and Health Administration

OSM—Operational Support Medical

PAR—Population at Risk

PCM—Primary Care Manager

PH—Public Health

POTFF—Preservation of the Force and Family

PPE—Personal Protective Equipment

PRP—Personnel Reliability Program

PSD—Presidential Support Directive

PULHESX—Physical Condition, Upper Extremities, Lower Extremities, Hearing, Eyes, Psychiatric, Strength Aptitude

RAPCON—Radar Approach Control

RDS—Records Disposition Schedule

RMU—Reserve Medical Unit

ROBD—Reduced Oxygen Breathing Device

RPA—Remotely Piloted Aircraft

RSVP—Readiness Skills Verification Program

SEI—Special Experience Identifier

SGP—Chief, Aerospace Medicine

SIB—Safety Investigation Board

SME—Squadron medical Element

SOD—Special Operational Duty

SOF—Special Operations Forces

SOFME—Special Operations Forces Medical Element

SOG—Special Operations Group
SOS—Special Operations Squadron
SOSS—Special Operations Support Squadron
SOW—Special Operations Wing
SrART—Senior Air Reserve Technician
ST ACU—Special Tactics ACU
STG—Special Tactics Group
STI—Sexually Transmitted Infections
STS—Special Tactics Squadron
TAOS—Team Aerospace Operational Symposium
TB—Tuberculosis
TDY—Temporary Duty
TFE—Total Force Enterprise
TFI—Total Force Integration
UCMJ—Uniform Code of Military Justice
UTC—Unit Type Code
US—United States