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SGP-earls

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SGP OVERVIEW

What does the Surgeon General of Preventive Medicine (SGP) do, anyway? That's not a quick answer. The SGP is a full time executive position who chairs a number of committees, is responsible for approx. 2/3 of the HSI criteria (or at least was back in the HSI days) and manages nearly 50 programs. To make things more difficult, your job is to lay a foundation that prevents negative events from happening. If you do your job well, no one will know because nothing will happen.

It's also a position that relies more on informal authority than formal authority. An SGP has formal authority based on rank and 3-letter position, but little, if any, direct supervision over the individuals and programs they're managing, unless they also happen to be the AMDS/CC. (I'm assuming for the sake of thoroughness that the SGP is a stand-alone, and that they have to coordinate with the MDOS or AMDS/CC.)

Every base has unique challenges requiring a unique approach, so there may be advice in this manual that doesn't work everywhere. I also realize that much of the material will already be familiar to an experienced SGP. Such sections may be useful as teaching material for young flight surgeons or ProStaff meetings.

DISCLAIMER: *This manual is a collection of "what I wish I knew when I took this job". It is not policy, it is not directive, and it may not reflect the opinions of those people who make policies and directives. In other words, it's my personal style, not instruction.*

THE OFFICIAL USAF JOB DESCRIPTION FOR THE CHIEF OF AEROSPACE MEDICINE (SGP)

The Chief of Aerospace Medicine is the Medical Group's functional expert in aerospace and operational medicine. This individual has the following roles and responsibilities:

- *Serves on the Medical Group Executive Committee and works directly for the MDG/CC*
- *Advises the Medical Group Commander, line Commanders, Aerospace Medicine Squadron Commander, MAJCOM aerospace medicine staff, and the facility medical staff on all operational medicine matters relating to the wing's missions*
- *Coordinates on all flight surgeon evaluations and decorations, including Squadron Medical Elements (SMEs)*
- *Provides medical oversight for group occupational medicine functions as well as the PHA Programs*
- *Directs aircrew support through physical standards, participation in the wing safety program, and optimization of warfighter performance*
- *Supports other special operational duty personnel*
- *Provides epidemiological expertise for population-based health services*
- *Participates in the wing's flying mission to maintain knowledge of human factors issues in the wing's mission and to monitor the balance of risk and effectiveness*
- *Provides guidance on performance aspects of nutrition, food and water sanitation, immunizations, and other community health issues.*
- *The Chief of Aerospace Medicine serves on the Executive Committee and may be a member of other advisory committees that require an operational medicine perspective*
- *Ensures mentoring and professional development of assigned Aerospace Medicine physicians and specialties*

DUTIES AND RESPONSIBILITIES

The responsibilities are defined in AFI 48-101 (1.4.15.) and AFI 48-149 (2.8), so I won't attempt to list them all here. The following are groundwork references to establish the basic authority of the SGP.

1: The SGP is a stand-alone 3 letter, aligned directly under the MDG/CC and rated by them.

Sadly, some MDG's still look at the SGP as little more than the senior flight doc. There are even a few who may not have the SGP as a stand-alone-3-letter directly under the MDG/CC. Fortunately, in recent years, there has been better understanding of the SGP role and improved integration into the medical exec council, so these hurdles are fast becoming a thing of the past.

> *AFI 48-101 1.4.13. The MDG/CC shall,*
>
> *1.4.13.3. Appoint the most qualified FS as the SGP. If he/she is not the Aerospace Medicine Squadron Commander, will be a stand-alone 3-digit functional manager aligned directly subordinate to and rated by the MDG/CC. The SGP must be a FS with sufficient experience and formal training, optimally a graduate of the AF Residency in Aerospace Medicine (RAM) program, to be knowledgeable in all aspects of clinical and operational Aerospace Medicine. If there is a RAM assigned as Sq/CC or below, he/she should normally be designated as the SGP. Dual duty as SGP and Sq/CC is not ideal but is allowable. When no RAM is assigned, the SGP will be the most qualified FS in terms of training, experience, and aptitude. If not a RAM, then attendance at the SGP course is required within 12 months of assignment as SGP.*

2: The SGP answers the mail on medical standards questions.

There may be people (i.e.: MDOS/CC or SGH) who promote themselves as the sole focal point for all questions on medical issues. While they are the touchstone for the business of medicine, the SGP has the stick on medical standards and their application.

> *AFI 48-123. 2.6. Chief of Aerospace Medicine (SGP),*
>
> *2.6.6. 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.*

3: The SGP chairs quite a few meetings.

AFI 48-101 1.4.15. The MTF/SGP shall,

1.4.15.4.2. Chair the AMC, the Occupational and Environmental Health Working Group (OEHWG) (the SGP may delegate this to an experienced Occupational Medicine Physician if available), the Deployment Availability Working Group (DAWG), the Wing Public Health Emergency Working Group (PHEWG) (if designated as Public Health Emergency Officer (PHEO)), and the Flight and Operational Medicine Working Group (FOMWG) (may delegate to Flight Medicine Flight Commander or most senior FS). (T-1)

AFI 10-203 2.7. The MTF SGP shall:

2.7.3. Serve as chairman of the DAWG. (T-2) Alternatively, the SGH may serve as the DAWG chairman if the MTF/CC determines that the SGP is not available or capable of overseeing the DAWG. In these instances, the MTF/CC will advise the MAJCOM/SGP or ARC/SGP of the change in DAWG Chair. Any other DAWG Chair waivers for this requirement will be approved by AFMOA/SGP.

4: The SGP needs to be sharp on public health emergencies.

In case you're wondering why the SGP has to take all of the FEMA management courses, it's a little known fact that the PHEO can be appointed as IC during biologic disease outbreaks. It used to be required that the SGP be appointed as the PHEO (AFI 48-101 1.4.15), but the new AFI 10-2519 changes the requirements; if you don't have an MPH or equivalent, you can no longer be the PHEO. So, be aware that if you are a non-RAM, you might be the Alt PHEO instead. Regardless, you need to know the duties.

AFI 10-2519 para 2.3.6.1.2. The primary PHEO must be a senior AFMS officer with a clinical degree (e.g., MD, DO, or DVM) and a Master of Public Health (or equivalent) degree, with at least four years of experience in public health or preventive medicine. For Reserve, the primary PHEO must be a senior AFMS officer with a clinical degree (e.g. MD, DO, or DVM) and with some experience in public health or preventive medicine. This section does not apply to an ANG GMU. For the ANG guidance, refer to Chapter 6 of this instruction. ***(T-1)****.*

AFI 10-2501 2.4.2.5.2. Since federal certification standards for IC's do not currently exist for biological disease outbreaks, the Installation CC could appoint the PHEO as Incident Commander for a biological incident.

5. The "profile buck" stops with the SGP.

All profile officers work with MSME and the DAWG to track and act on profiling matters. Ultimately, though, it's the SGP who makes the call on controversial cases.

AFI 48-101 The MTF/SGP shall,

1.4.15.4.3. Serve as both the senior profile officer and the Lead Competent Medical Authority (CMA) for the PRP. (T-1)

AFI 10-203 2.8. MTF SPO shall:

2.8.1. Be the MTF/SGP IAW AFI 48-101. In rare instances where no credentialed Flight Surgeon (FS) is assigned to the MTF, the senior credentialed physician may serve as the SPO. (T-2)

2.8.3. Serve as the installation's final medical authority on DR and/or MR and the application of medical standards as it applies to AF Forms 422 and AF Form 469. (T-1)

6. The SGP needs to know occupational medicine (Hint: OSHA is not a small town in Wisconsin.)

It used to be required for the SGP to be appointed as Installation Occupational and Environmental Medicine Consultant (IOEMC) and to chair the OEHWG. While they aren't specifically required to do so anymore, the SGP is still responsible for the installation occ health and should count on being the IOEMC and OEHWG chair.

AFI 48-145 2.8. Military Treatment Facility Commander (MTF/CC) (or local equivalent).

2.8.4. Assigns a physician in writing to serve as the Installation Occupational and Environmental Medicine Consultant (IOEMC) as well as the Chair, Occupational and Environmental Health Working Group (OEHWG). An occupational medicine physician (48EX) or an aerospace medicine specialist (48AX) is most appropriate; a flight surgeon or family practice physician with occupational health experience may substitute for a 48EX or 48AX.

AFI 48-145 2.9. Chief of Aerospace Medicine (SGP).

2.9.5. Ensures integration of OEHWG activities with other installation ESOH professionals, including but not limited to Safety, Civil Engineering, Fire and Emergency Services, Physical Therapy, and the Injury Compensation Program Administrator.

7. The SGP is a mentor and 48XX functional.

The SGP shares responsibility with the SGH for training providers on medical standards as well as providing career mentorship. Also, if a provider has a primary or secondary 48XX AFSC, they are supposed to maintain Aerospace Medicine proficiency. This is often overlooked when providers attend the AMP and return to their AFSC without working in a flight med clinic.

AFI 48-101 1.4.15. The MTF/SGP shall,

1.4.15.7. Provide Aerospace Medicine career guidance for all physicians with primary or secondary 48XX designations as appropriate. (T-2) The SGP will coordinate with the MTF/CC or ARC (RMU or GMU)/CC and appropriate Squadron Commander (Sq/CC) to involve FSs not currently assigned to the Flight Medicine Clinic in the base AME to assist in maintenance of proficiency in Aerospace Medicine. (T-2)

AFI 10-203 2.9 MTF SGH shall:

2.9.1. Share responsibility with the SGP for training all providers (see 2.7.4 and Supplemental Guidance). (T-2) This may include results of RILO reviews and quality reviews of DLC determinations (see 2.9.2. and 2.9.4.)

8. The "PRP buck" also stops with the SGP.

AFMAN 13-501 allows the MTC CC, with MAJCOM SGP approval, to appoint someone apart from the SGP as Lead CMA. However, that contradicts AFI 48-101 1.4.15.43 which specifically states that the SGP will be appointed. Both are T-1 requirements, so the most conservative (AFI 48-101 applies).

AFMAN 13-501Enc 2. 15. Medical Treatment Commander (MTF/CC).

Enc 2. 15. c. (Added)(AF) Appoints the MTF/SGP (or, subject to MAJCOM SGP approval, other qualified provider) as Lead CMA to act as the primary MTF liaison to the CO for all health related PRP notifications (T-1) The MTF/CC may also appoint an Alternate Lead CMA and additional providers qualified to serve as functional CMAs for area responsibilities (T-1).

AFI 48-101 The MTF/SGP shall,

1.4.15.4.3. Serve as both the senior profile officer and the Lead Competent Medical Authority (CMA) for the PRP. (T-1)

9. The SGP is the driving force behind METALS.

It falls on the SGP (in concert with the MDG CC) to develop the METALS priorities for Team Aerospace. This should address priorities of what can be accomplished at different manning levels. For example, Priority 1 will be accomplished always, Priority 2 if manning is above 75%, and Priority 3 if manning is above 50%. At the end of this manual, there is a sample METALS list that gives priorities, recurrences, and even MEPRS codes for common Team Aerospace activities.

> *AFI 48-101 1.4.15. The MTF/SGP shall,*
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> *1.4.15.5. Serve as the wing Aerospace and Operational Medicine Consultant:*
>
> *1.4.15.5.1. Serve as the MTF and installation authority, consultant, and subject matter expert in the medical specialty of Aerospace Medicine and in all Aerospace Medicine programs to include: aerospace, operational, occupational, deployment, disaster, and preventive medicine, human factors, human performance enhancement and sustainment, disease surveillance and prevention, occupational, operational, and environmental health risk assessment and risk communication, PRP, and the application of medical standards. (T-1)*
>
> *AFI 48-149*
>
> *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*

10. The SGP is a physician, and that means being a physician.

Looking back over the previous items, there is a recurring theme. The SGP has to be a credentialed flight surgeon. That means they have to maintain their credentials, and that means they have to be seeing patients regularly. The AF/SG recently required that for non-clinical positions, providers must see at least 32 hours of patients per year. Shoot to double or triple that as a minimum.

> *AFI 48-101 1.4.15. The MTF/SGP or ARC/SGP shall:*
>
> *1.4.15.8. Maintain clinical currency in the practice of Aerospace Medicine. (T-1)*

HINT: *There is a list of AFI's and a "where do I find it" list at the end of this manual for commonly referenced items. Download important AFI's as .pdf's and put them on your iPad if you have one. Also, burn them to CD and pay a visit to your local print shop or office supply store to have them printed and bound. Then, spend a few quality evenings with a highlighter and some page markers.*

Meetings, Meetings, and more meetings…

A wise person once said that meetings take minutes and waste hours. I realize that when they are well managed, meetings can be effective, but too many are poorly run and drain productivity. There are many management books offering advice, but here are my thoughts:

1. Establish ground rules: Treat it like a flight brief. If people aren't on time, the doors close and they will be marked absent.

2. Set a firm agenda. Consider having a visible timer or countdown running.

3. Make sure people know the purpose of the meeting and what they contribute. This ties in to the section on 'working groups', since few attendees actually understand how a working group differs from a committee.

4. Brief at each local meeting as if you are briefing the 3-Star. Consider it a rehearsal for when you brief the wing.

5. If the discussion doesn't concern everyone present, take it offline. As Chair, it's your role to keep people on task and stop the pontificating.

6. Meetings aren't for brainstorming – that should be done in focus groups ahead of time. Brief the plan that resulted from brainstorming.

7. If one person is holding everything up and you can't get anything done, call for a recess so they can talk to the OPR while everyone else takes a restroom break.

8. People can read faster than you can talk. Don't read data slides aloud. Present them, give a pause, note any trends, mention how you will maintain / fix the trend, then ask for questions.

9. NTSR = Nothing Significant To Report. It's a good acronym. Use it.

10. Consider a "stand up meeting". No chairs. It speeds up the meeting and people pay more attention.

CORE AEROSPACE MEETINGS AND WORKING GROUPS

The following is a listing of the various meetings and working groups that make up the core of the AME. They will be addressed in more detail later in this manual.

HINT: *Because most meetings recur, build a robust outlook template to automatically populate the calendar. This also makes it easy to invite others, move meeting times, and manage the schedule.*

WORKING GROUPS:

At some point, nearly every SGP inherits a "working group" that does little except gather and report metrics. It's what they've always done and members are shocked when told they aren't doing what they need to do. A working group doesn't just gather metrics, but interprets them, analyzes trends, determines if they meet standards, and then works on plans to improve or sustain them.

It's not enough to simply gather metrics. It's not enough to simply build slides. To be a working group, they must look at what's being done and what needs to be done that isn't being done. That's a working group.

AMC – Aeromedical Council:
The AMC is the AME's voice on the executive council. The aligned working groups report to the AMC and the MDG CC directly reviews the minutes. Make sure to invite a representative from the OG to sit in on the meeting. They may not attend, but it's good to offer.

It is not a FOMC flight meeting, nor should it be used for admin oversight of OPR's, etc. However, it's appropriate to document NOTAM's, policy letters, and other items that you want to ensure are on "on the record" for inspection time.

> AFI 48-101, 1.6.1.1 The AMC is a collaborative decision making body chaired by the SGP responsible for the functional oversight of the AME and is directly accountable to the MDG/CC. The AMC is the reviewing/approval authority for the OEHWG, the FOMWG, and the DAWG minutes.

OEHWG – Occ. & Environ. Health Working Group:
Like in the AMC, you should extend an invitation outside of the MDG – in this case, to Wing Safety and the FECA working group. They can speak to reported accidents and incidents on the base.

> AFI 48-101 1.6.2. The OEHWG is a collaborative decision making body chaired by the SGP or Occupational Medicine Physician and is responsible for providing guidance and establishing medical surveillance requirements for the installation Occupational and Environmental Health Program. It is directly accountable to the MDG/CC through the AMC. Key functions of the OEHWG are detailed in AFI 48-145, *Occupational and Environmental Health Program* and in AFI 48-149, *Flight and Operational Medicine Program*.

DAWG – Deployment Availability Working Group:
The DAWG is one of the most labor intensive working groups in AME. Because of the amount of data and the number of recommendations to make, it's best to have a pre-DAWG with a core group of members. Their findings can be submitted to the DAWG for endorsement.

> AFI 48-101 1.6.3. 1.6.3. The DAWG is a cross-functional tracking and decision making body chaired by the SGP with the purpose of administratively managing the medical cases of all personnel identified as having a deployment-limiting medical condition. It is directly accountable to the MDG/CC through the AMC. Key functions of the DAWG are detailed in AFI 10-203, *Duty Limiting Conditions.*

> AFI 10-203 4.1.1. Purpose. The DAWG will be established at each wing/base level and will meet at least monthly to review personnel with a DLC that affects mobility, retention, or long-term physical fitness. (T-1) The DAWG will identify personnel not deployment eligible (Not Mission Capable, NMC) and track progress of the medical condition through resolution or definitive disposition. (T-1) They will further identify cases exceeding prescribed time limits, review a representative sample of DLCs, and provide feedback to PCM teams, including providers, via the SGH. (T-1) The DAWG will produce and provide a report to the MTF executive committee via the Aerospace Medicine Council (AMC). (T-1) The DAWG will also review cases referred for potentially unfitting medical conditions. (T-1)

FOMWG – Flight Medicine Working Group
(AKA GM or 1041 Review):

FOMWG is often run informally and attendees sign 1041 logs, but consider using a minute template instead. This makes it easier to submit minutes to AMC, track attendance, and review grounding logs. Most of the material reviewed at FOMWG can simply be included as attachments to the minutes, so there is little time spent writing and signing various forms.

> AFI 48-101 1.6.4. 1.6.4. The FOMWG is a forum chaired by the SGP or delegate for administratively managing and tracking all flying and special duty personnel medical actions. It is directly accountable to the MDG/CC through the AMC. Key functions of the FOMWG are detailed in AFI 48-149, *Flight and Operational Medicine Program*.

OPTIONAL: POWG – PRP Operational Working Group:

The POWG is the PRP equivalent of the FOMWG, and acts in the same manner to track folks with removal actions and review the program integrity. You have to dig for old guidance, but the (now rescinded) AFGSC Supp to the (now rescinded) AFMAN 10-3902 defined the POWG in DL.62. and referred the reader to the AFGSC/A3IR SharePoint site. Ultimately, the trail ended with the POWG meeting at least monthly to review medical PRP processes, chaired by the SGP (Lead CMA) with the Alt. Lead CMA as alternate chair. There is <u>no requirement</u> for a POWG, but it's a good idea for the PRP team to meet regularly and review updates, case management, training, etc. Depending on the size of your PRP, consider rolling it into FOMWG instead of having it as a stand-alone meeting.

ADDITIONAL MEETINGS THE SGP MAY (OR SHALL) ATTEND

Executive Committee:
The SGP is the executive voice for the installation Aeromedical Program (AMP), and that means having a voice on the executive committee.

> AFI 48-101
> 1.6.6.1. Medical Group Executive Committee or ARC equivalent. (T-1)
> 1.6.6.1.2. The SGP will attend as the 3-letter functional. (T-1)

ESOH Council:

Although the BEE's play the largest role at the ESOH council, it's good for the SGP to attend as well.

> AFI 48-101 1.6.6.2.1. [Environment, Safety, and Occupational Health (ESOH) Council The OEHWG Chair will attend or ensure representation to provide professional expertise regarding occupational and environmental health issues. (T-2) This includes an annual OEH Program Management Review brief to the ESOCH leadership (T-2)
>
> Assuming that the SGP is the IOEMC, they also:
>
> 2.13.6.1. Represents the MTF or ARC medical unit at the installation's workers compensation working group, the Installation ESOHC Council and or other AF forum where OEH illness data are discussed and used to approve or disapprove compensation.

FECA WG – Federal Employee's Compensation Act Working Group:
The FECA WG tracks claims if they meet a certain threshold. It may be that your installation doesn't meet that threshold and the FECA WG doesn't actually meet. If the WG exists, a FECA rep is supposed to be at OEHWG, so ensure you document in the OEHWG minutes if you don't have such a WG at your base.

> AFI 91-202 [The Chief of Aerospace Medicine (SGP) or Occupational Medicine physician:] 1.5.17.5.5. Attends the Federal Employees' Compensation Act (FECA) Working Group. Medical participation in FECA program will be IAW DoD 1400.25-M, *DoD Civilian Personnel Manual,* Subchapter 810, *Injury Compensation.* Participates in military and civilian lost work/duty time initiatives.

PHWG – Population Health Working Group:
The PHWG is intended to integrate population health management strategies with the CAIB / IDS and advise the Executive Committee on relevant community needs. Too often, the PHWG turns into little more than a reporting forum for HEDIS metrics and it loses sight of its mandate to assess community needs and focus on areas for community based interventions. While public health and health promotion could attend in lieu of the SGP, the SGP is typically the only preventative medicine clinician with public health training, and even if they don't attend, they are still required to work with the SGH to keep the PHWG on task. So, it's simpler just to be there.

> AFI 44-173 [MTF Chief of Aerospace Medicine (SGP) will:] 2.12.1. "Serve as OPR for FHP and collaborates with SGH on PHWG efforts."

> AFI 48-101 1.6.6.7. Population Health Working Group (N/A for ARC).
> 1.6.6.7.1. SGP and/or PH will attend as the epidemiology consultant to help formulate questions regarding population health issues and provide meaningful analysis of resulting data. (T-2)
> 1.6.6.7.2. SGP and/or Health Promotion will attend as human performance sustainment and enhancement consultants to aid in identification and targeting of at risk individuals and subpopulations. (T-2)

HINT: *The Community Guide for Preventative Services http://www.thecommunityguide.org is a phenomenal resource that evaluates studies to determine what works to promote public health. It gives solid evidence you can use to justify ending high effort/low yield programs within the PHWG and help you focus efforts on interventions proven to work.*

TWG - Threat Working Group and Force Protection Working Group:
The medics typically provide a medical intelligence brief at the TWG. The discussion varies from base to base, and throughout the year as new threat emerge. The TWG is not medic-centric, but it's important to know what hot spots are emerging that require medical force protection measures, especially for the PHEO.

> AFI 10-2519 2.3.6.1.3. The primary PHEO must be a member of the installation Threat Working Group (TWG). In addition, it is recommended that he/she be a member of the EMWG. (T-3).

> 1.6.6.4. Force Protection Working Group. BE and/or PH should attend regularly. (T-2) The PHEO or alternate will attend as needed. See AFI 10-245, *Antiterrorism* and 10-2501, *Air Force Emergency Management Program Planning and Operations* for specific responsibilities.

Medical Readiness Committee

In addition to managing the flightline response that falls on the FOMC, the SGP is likely also the PHEO. As such, they need to be working closely with Medical Readiness to ensure the MCRP is consistent with the base plans and mishap responses. It's very common for the MCRP to be inconsistent with mishap response guidance. As SGP and PHEO, it's your role to represent the AME to prevent such problems.

> AFI 48-101 1.6.6.5.2. The SGP (or designee if unavailable) will attend as the appointed consultant for professional oversight issues related to the AME. (T-2)

Wing/Squadron Flight Safety Meetings:

Don't be the kind of person who only shows up at the squadron to fly, and don't delegate all of the teaching to AOPT. If you have inexperienced flight surgeons, consider pairing them with an experienced AOPT briefer at first, but place an expectation that FS's (and the SGP) will take the podium as well.

> AFI 48-101 1.6.6.6. Wing/Squadron Flight Safety Meetings. FSs and AOP will attend and each will periodically brief topics of aeromedical relevance for the flying community. (T-2) Involvement in ground safety issues is also encouraged in order to help mitigate locally unique safety concerns.

Misc. Wing executive forums:

As the face of operational medicine, the SGP needs to build strong bridges with the Ops group. One way is to be a regular at the Ops Group Exec meeting, the Hanger Fly meetings, the staff break out meetings, or another forum. It may take a few tries to find the best forum, but don't be discouraged. Being present at a regular forum is a chance to keep abreast of upcoming ops challenges and be proactive on medical support. This is important not only for the information sharing, but for them to see the SGP as a reliable and familiar ally. I can't emphasize enough the importance of being seen as an authority by the line and this goes a long way toward that. Just make sure to be on time, look sharp, and have an elevator speech prepared if they ask you for medical updates.

> AFI 48-101 1.6.6.9. Operations Group Executive Staff Meeting. The SGP should request permission to attend in order to interface with the wing flying leadership regarding medical support to the flying and operational mission.

Installation Restoration Program-Restoration Advisory Board

> AFI 48-101 1.6.6.8. Installation Restoration Program Advisory Board. The SGP and BE personnel should attend as needed to address community concerns associated with installation restoration and clean-up programs. BE may represent ANG where no SGP is assigned.

Medical Professional Staff Meeting

Briefing topics used to be pulled directly from HSI criteria. Now that the HSI is gone, there is more latitude, but I suggest a schedule submitted to AMC and ProStaff annually. Set up a rotating schedule to give all the flight docs experience and hang onto briefs to use with next year's schedule. Remember that Occupational Hazards must be briefed annually, but be careful not to stray into the classified portion of TIC/TIMS.

> AFI 48-149 3.2.1.14. Providers must be briefed on installation industrial health hazards annually. This can be accomplished during their Professional Staff meetings.

Sample ProStaff briefing schedule.

Month	Aeromedical Topic	PRP Topic
January	Profiles (AF 469 / 422)	Profiles and PRP
February	MEB Program	Perm Decertifications
March	TB Program	PRP medications
April	Travel medicine / Malaria Prophylaxis	After hours care for PRP
May	Deployment Preparation	Deployment PRP
June	Aerovac (emphasis on commercial)	Suspensions
July	Animal Bite Program	Inspections
August	Fetal Health Program	Record management
September	Care for Flyers (DNIF)	Notifications
October	Decompression Sickness / Hypoxia	Suitability Factors
November	Fatigue Countermeasures	Certifications
December	Aircraft Mishap / Occupational Hazards	Dull Swords, Broken Arrows, and PRP impacts

SUMMARY TABLE OF SGP MEETINGS:

Meeting	Frequency	Role	Authority	Reference
Flight/Op Med Working Group (AKA GM)	Weekly	Chair	SGP	AFI 48-149 3.7.1
PRP Susp Review	Weekly - Monthly	Chair	Lead CMA	Not required, but a good management option as a 1041-style PRP overview.
AMC	Monthly	Chair	SGP	AFI 48-101 1.6.1.
OEHWG	Monthly (recommended)	Chair	SGP	AFI 48-145 2.14.
DAWG	Monthly	Chair	SPO	AFI 10-203 2.7.3.
POWG	Monthly	Chair	Lead CMA	Not required but a good management option. It could also be rolled into AMC.
ProStaff	Monthly	SME – Aerospace Medicine Program	Provider	
Exec Staff	Monthly	SME – Aerospace Medicine Program	SGP	AFI 48-101 1.6.6.1.2.
PHWG (Pop Health)	Monthly	SME – Preventative Medicine	SGP	AFI 48-101 1.6.6.7.
Wing / Squadron Safety Meetings	PRN	SME – Human Factors / Operational Medicine	Flight Surgeon	AFI 48-101 1.6.6.6.
Ops Group Staff Meeting	Monthly	SME – Aerospace Medicine Program	SGP	AFI 48-101 1.6.6.9.
TSR-WG (threat response WG)	Monthly-Quarterly	SME – Operational Medicine	SGP	
ESOH Council	Quarterly	SME – Occupational medicine	IOEMC	AFI 48-101 1.6.6.2.1
Nuclear Surety Council	Quarterly	SME – medical PRP	Lead CMA	
TWG	Varies	Member	PHEO	AFI 10-2519 2.3.6.1.3.
EMWG	Varies	Member	PHEO	AFI 10-2519 2.3.6.1.3. (recommended)
MRC (Medical Readiness Committee)	Varies	SME – Aerospace Medicine Enterprise	SGP (or surrogate)	AFI 48-101 1.6.6.5.2.

COMMON SGP PITFALLS:

Some SGP's fail only a few months after assuming duties. How does that happen? Usually it's a matter of balance; a good SGP has to juggle time between being a physician, an industrial hygienist, an instructor, a health inspector, an aircrew member, and a half dozen other roles. While there are functional experts in each area, a good SGP has to be knowledgeable in all those different lanes, and this is a foreign concept for the highly specialized nature of most medical positions.

This goes beyond just the MDG. You need to be seen as a "good doc" by the line side. This is a combination of factors, including being a regular attendee at their meetings, appearing professional, being knowledgeable about mission requirements, and being seen as a good clinician. If you look, you'll see just about every one of those items are listed on this "common pitfalls" list:

1. **Not establishing clear priorities.**

   Fact: You won't have time to do everything.

   While it's essential to establish individual priorities, it's just as important to know the boss's priorities. One of the first stops for a new SGP should be the MDG CC's office. Be ready for questions about priorities, and be ready to give an answer. If asked about goals, don't give a general answer like "Supporting operations", but give specific goals such as "maintaining DNIF rates below 10% and having all waivers up to date".

   If you need a place to start, take a look at the AMC minutes. If Occ Health stats are flagging, then OH should be a priority. At an active PRP base, PRP will top the list.

   If the SGP and MDG/CC's priorities match, the job is much easier. If they don't, take some time to look at the differences. Chances are, the CC's goals still fit within the METALS. For example, they may say that clinic access is a top priority, while you feel that keeping a low DNIF rate and up-to-date waivers are more important. When you step back, you both have the same goal (good patient care) but a different way of tracking it. Start from that common ground and work out a reasonable means of measuring success.

2. **Not being, or appearing to be, a team player.**

Fact: An SGP can't do their job without buy-in from the other execs.

It's difficult being responsible for programs, but not the assets to run those programs. For this, an SGP needs to work closely with the MDOS CC and the SGH. But before they can, they need to have passed Pitfall #1. If the SGP's goals align with the MDG CC's goals, it's much easier to get others on board. To build bridges, look for common programs and be proactive with ProStaff briefings, MEB's, and other areas of shared responsibility with the SGH. Also, consider a weekly, informal, meeting with the SGH and MDOS CC. Lunch at the club is a low threat way to meet and network.

3. Not appearing professional.

Fact: Appearances matter.

Like it or not, how someone looks in uniform influences how people view them professionally. If patches are dirty, flight suits are pilled, or zippers are unzipped, they look sloppy. And if people look sloppy, others assume their work is sloppy. Toss the patches in a pocket when washing the flight suit. Turn it inside out when washing and line dry it to avoid pilling. Simple things make a difference.

To avoid being pigeonholed, wear ABU's regularly. The OG CC and the Wing CC probably wear ABU's more often than flight suits. It's not because they aren't proud to be aviators, it's that they know they'll alienate the non-fliers if they always dress like aircrew.

Off duty appearances are just as important. Jeans and a T-shirt are fine at the mall, but at the going-away for the FOMC NCOIC, break out the khakis and a polo shirt, or skirt and nice blouse. It's always better to be overdressed than underdressed and it builds the professional image.

The same applies to writing; the first impression that a CC has of the SGP might come from a memo, so their opinion will be shaped by the grammar, punctuation, and format. If PRP letters, MEB's, minutes, etc, are poorly written, it reflects poorly on the writer. When junior troops write letters and minutes, read them closely before signing. Once signed, it's the same as if the signer wrote them.

4. Trying to fly solo.

Fact: The SGP network is there to help you. It's not a sign of weakness to forward questions or share resources.

Even when it feels like you're facing a unique problem, chances are another SGP has faced it before. Create an email list of your classmates from AMP, the SGP course, or RAM, and use it often. Need a new presentation for ProStaff? Ask the network and see if someone has one to share. Struggling with a way to track your DAWG metrics? See if a colleague has already broken the code.

Don't be afraid to contact the MAJCOM SGP as well. They've been through the trenches and have a collection of resources to share. If you have a waiver that needs to be pushed, channel that to ACS or MAJCOM. Most of the time, they're willing to shuffle your work to the top if they know it's important. However, if you need a rush job because you dropped the ball on waiver management, expect some wrist slapping. Don't let that stop you, but don't be surprised.

Lastly, don't forget about mentoring young flight docs. Time spent will pay off as they become more self-sufficient and assume responsibility for more programs.

5. Failing to keep coworkers informed.

Fact: Many SGP's fail not because of their time management, but because of the perception of their time management.

Many duties pull the SGP out of the MDG, and the rest of the MDG doesn't have visibility on what the SGP does when they're gone. It also means that the SGP will often be out of office when people are looking for them. Just like in risk communication, if there are holes, people will make up stories to fill in the blanks.

There are a few easy ways to fix that. First, use Outlook and populate the calendar, then share it with the MDG CC, SGH, MDOS CC, and the rest of the FOMC. Not only will this show everyone where you are, it will also make MEPRS much easier. Post a copy of the schedule by the door, so when people drop by, they know if you're at a shop visit, flying, or otherwise gainfully employed.

Lastly, consider sending a weekly activity report (WAR) to the MDG CC. Not only will this provide SA on what you were doing, but it also makes building your OPR much simpler. For bonus points, focus on how you are working to fulfill the previously agreed upon priorities, (Pitfall #1) and how you're working with the team (Pitfall #2). Is it necessary? Nope. Is it helpful? Yep.

SAMPLE WAR:

AOPT

- Briefed the OG on fatigue management as part of the Fly Safe Program
- Worked with SGH and AOPT to refine MDG safety event investigations. We're trying to adapt the SIB model to improve the MDG PCE program.

BEE

- Worked with BEE and PH to develop new tracking spreadsheet for Cat 1 shops

PH

- Signed off 2 rabies board reviews. Mentored Capt Snuffy (GMO) on AF rabies program
- Conducted food service inspection of the DFAC with PH.

PRP

- Met with POWG Tiger Team (myself, MDOS CC, monitor, alt lead CMA) to review programs. Identified training deficit and we are developing an improved program with timelines, tests, and clearer expectations
- Briefed Wing command staff at quarterly nuclear surety council.

FOMC

- Conducted in-service with SGH on profiling process. Had FS's meet with FHMI providers for 1:1 reviews
- Working with MDOS CC and SGH to build template for IDMT's to see scheduled patients in FOMC and FHMI

Other

- Did not fly this week, but am scheduled for sortie next Wednesday. I expect to be out most of Tuesday mission planning. Capt Snuffy is the FSOC.

6. Communication skills. Or lack thereof.

Fact: Grammar is like personal hygiene. You can ignore it, but sooner or later, people will draw their own conclusions.

Proofreading: Take a moment before hitting "send" on the email to re-read it. When you edited it, did you accidently leave orphaned punctuation? There is an old editing trick to read from the last sentence backwards. That keeps you from subconsciously filling in blanks and makes spotting mistakes easier.

Speaking: There is no substitute for practice. If you struggle at briefings, practice at home and consider joining the local Toastmaster's organization. They offer tips, support, and opportunities to practice.

Briefings: There are a multitude of books with advice on building and giving presentations. I'm not going to list them, but I will repeat my favorite advice. If you build your presentation with these rules, you'll be protected from falling into the "Let me read you this slide" trap.

Rule of 10, 20, 30:

- No more than 10 slides.
- No more than 20 minutes.
- No smaller than 30 point font.

Rule of 6's:

- No more than 6 bullets per slide
- No more than 6 words per bullet
- No more than 6 text slides in a row without a graphical slide

If all else fails, then take Abraham Lincoln's advice, "Better to remain silent and be thought a fool than to speak out and remove all doubt."

7. Failing to sing praises of their staff.

Fact: Award nominations can be painful to write. But it sends a strong message to the MDG CC and MAJCOM if you don't.

There will be multiple calls for awards throughout the SGP's tenure. Some will be local awards from the MDG, while others will be AF wide, such as the Malcom-Grow award. Failing to submit a nomination sends a strong message to the MDG and MAJCOM that team aerospace isn't performing well, and that directly reflects on the SGP's leadership. As promotions, especially among NCO's, become more competitive, being an award winner can make the difference in making rank, and that may make the difference in staying in the military.

If you aren't a good writer, delegate to someone who is. Engage with the FOMC Flt CC for nominations and packages and review names and packages with the MDOS CC / AMDS CC and the squadron superintendent. This ensures that names will go forward with the leadership's blessing, but also that the packages will be written at a level that won't embarrass the team. However, do not submit poorly written nominations just to have a name in the hat. There is nothing worse than submitting a package to MAJCOM for an award and to have them opt not to choose a winner since none of the nominations had acceptable narratives.

Don't feel limited to group level awards, either. Consider developing a 'Top Knife' award, given to an outstanding performer in Team Aerospace and award it at AMC monthly. Not only does this give a chance for people to shine outside of the normal award cycle, it encourages them to create a log of bullets that can be used for the more formal awards.

8. Forgetting that the SGP is still a clinical physician.

Fact: It's easy to let admin duties take over your schedule. But you cannot be effective as an SGP if you aren't respected as a clinician.

The SGP is one of only two executive positions that must be filled by a physician, with the SGH being the other. As such, the rest of the medical staff looks to the SGP and SGH as examples of military medicine. To keep active credentials, you need at least 32 hours of patient care per year. If you want to keep current, at least double that. If you want to be respected, at least quadruple it.

When you first arrive, pick a day or a ½ day every week for clinic and load it as a recurring commitment in your outlook calendar. Schedule your meetings around it. Make it well known that you will be there. And actually be there. If this means you have to miss meetings, then have a delegate attend or reschedule the meetings. If the other docs don't see you making clinical proficiency a priority, you can't expect them to make it a priority. This makes a huge difference, not only in the eyes of the other docs, but in the line side as well. Remember that part about being respected by the line as a "good doc"? An essential part of that is actually being a good doc.

Keep an eye on the clinic flow and offer to help out as needed. If it's Sick Call after a 3 day weekend, spend an hour in the morning helping out. When you aren't in clinic, take responsibility for patients that you've seen. This means following up on labs, answering T-cons, writing RILO's, writing waivers, etc - especially if they are particularly thorny cases.

If you find yourself struggling in primary care, focus your CME's, swallow your pride, seek out one of the stronger docs, and spend time with them. In addition, consider what it will take to maintain currency. Are you an FP? If so, you probably aren't seeing enough pediatrics in flight medicine to remain current. Give a call to the pediatric clinic and volunteer for a few hours every month. This goes a long way toward building bridges with the SGH, MDOS CC, and keeps you current in your practice. It also lets you meet and recruit potential flight docs that you might otherwise not have close contact with. Lastly, if you've built up a strong relationship with the line, they probably want you to see their children who may not be empaneled in flight med. You can build relationships, hone your skills, and help out in MDOS, all at once. It's a Win-Win-Win.

9. Failing to delegate

Fact: You can't be everywhere at once. And you can't do everything at once. Learn to delegate.

It's been said that if someone else can do a job at least 80% as well as you can, you should delegate the duties to them. This can be one of the hardest things that an SGP learns to do. But you don't have the time to micromanage, and you need people to feel empowered to work.

This means that sometimes, things don't get done in your time frame, or they may not be done exactly how you'd do them. Accept that, offer advice on how to improve in the future, and move on. This leads us directly to #10…

10. Not mentoring the younger docs.

Fact: Like it or not, some of the newest officers in the MDG will be GMO's in flight med. For many, this is their first military experience. It's up to you to turn them into successful AF officers and respected physicians.

So.

No pressure there.

As I'm sure you've noticed by now, the SGP doesn't operate in a vacuum. (Unless they work with NASA. And even then, they probably don't spend much time there.) Fact is, you can't do your job alone, and most of the work in flight med is performed by junior officers and junior physicians. As much as AMP has improved in recent years, and continues to evolve and improve, it is never going to fully prepare a young flight doc for the myriad duties they'll be expected to perform. That's where you come in.

Sit down with your docs regularly and discuss common flight med concerns, perhaps in a mentoring session after FOMWG. Not every SGP is an expert in all things military, and that's OK. You don't need to know everything; you just need to know where to look. Pull in other resources in the MDG. I've never met an enlisted functional, 1st Sergeant, or Chief who wasn't happy to sit down and discuss EPR's, enlisted training programs, and what NCO's look for in good officers. Remember, the more you mentor the docs now, the more independent they will be in the future.

If you don't already have a copy of the Air Force Officer's Manual, swing by the clothing sales shop. It's filled with insights and advice that you may not find elsewhere. Hit on the areas that you wish you knew when you started in flight med. Use this manual if you need a place to get started.

OEHWG AND OCCUPATIONAL HEALTH

The SGP, in most cases, is the Installation Occupational and Environmental Health Consultant (IOEHC) and chairs the OEHWG. The OEHWG brings together the BEE's, PH, and flight medicine clinic under the umbrella of worksite safety. It's the forum to identify safety trends, develop plans to reverse or sustain the trends, and to review the surveillance exams for each shop. If you have another occ med doc at the base, you have some flexibility for IOEHC, but such luxuries are few and far between.

SURVEILLANCE PROGRAMS

The Public Health flight CC is the go-to person for surveillance. They ensure the Clinical Occupational Health Exam Requirements (COHER), AKA the AF 2766, is updated with your inputs. It is based on the Occupational and Environmental Health Exposure Data (OEHED) sheet, the BEE's summary of work processes and exposure data. Having an accurate COHER is essential, as it drives ASIMS to flag who is coming due or overdue, and it lists the exam requirements for the clinic.

It falls on the IOEHC to crosscheck the OEHED and the COHER to ensure that every exposure on the OEHED is either below threshold, or that it has an appropriate corresponding exam on the COHER. Likewise, every exam on the COHER needs to be linked to an appropriate exposure on the OEHED. Having a set of reliable COHER's and OEHED's is the best way to maintain good metrics, as it allows you to focus on exams that need to be accomplished and stop doing unnecessary work.

Consider a meeting the week before the OEHWG to review COHER's with the BEE's and PH staff. For an added bonus, bring in a representative from the shop whose OEHED is being reviewed. They can discuss workplace processes to help make the OEHED clearer, and you can explain to them any changes in the COHER. This is especially important if dealing with union employees that are used to having certain exams every year. Be mindful that some employees, such as firefighters, may have union clauses that require specific annual exams - another good reason to have a shop supervisor at this pre-OEHWG meeting. At the OEHWG, present the reviewed sheets for approval by the working group. This is also the time to review which shops still need to be listed as Cat I and which can be moved to a lower category. Pay particular attention to noise survey levels, as it's not unusual for processes to change and levels to drop. You may find that there are people on the HCP that do not exceed threshold levels and who can be dropped from the HCP.

OCCUPATIONAL INJURIES AND ILLNESSES

The definition of an occupational illness, per OSHA, is "any abnormal condition or disorder, other than one resulting from an occupational injury, caused by exposure to factors associated with employment." It's important to remember this since an occupational injury and an occupational illness are tracked and reported differently, so don't fall into the trap of calling an injury an illness.

To paraphrase AFI 91-202 1.6.3., the Installation Safety Office will record occupational injuries and Public Health will record occupational illnesses within seven calendar days of notification using AFSAS. The host ground safety staff is the office of record for maintaining occupational illness and injury data, while the IOEHC is responsible for making the determination of occupational relatedness of illnesses in AFSAS. Wing Safety maintains the consolidated OSHA logs, so it's important to have a safety rep on OEHWG to report status and take information back. If you don't already have a good working relationship with the Wing Safety office, build one.

Per AFI 48-145, suspected occupational illnesses or worksite injuries must be documented, tracked, and followed. There are a number of ways to do it, but they all rely on reporting from the primary care clinics or BOMC. The only way to get this done reliably is to make it as easy as possible. For better or worse, the ICD-10 coding system requires a lot more detail on injuries than the ICD-9 system did. This makes more work on the provider end, but makes it much easier for public health to pull injury codes for you.

Before an illness can be confirmed as occupational, it requires an investigation and final determination by a provider, typically the IOEHC. When making the determination, an IOEHC will rarely be able to prove 100% that an illness is due to occupational factors. But, if there is a well-established correlation between exposure to a worksite factor and the development of a disease, and the patient has both the occupational exposure and the disease, the assumption is that it 'more likely than not represents an occupational illness'. This assumption includes temporality – a worksite asbestos exposure with mesothelioma 2 months later? Perhaps from an earlier exposure, but not the one 2 months ago.

The most common occupational illness is hearing loss. Fortunately, by the time it reaches AFSAS, there will be audiology reports and it becomes a matter of confirming that there is an STS consistent with NIHL and that the member was in a hazardous noise environment. At that point, the assumption is that the hearing loss 'more likely than not represents an occupational illness'.

There will be other diagnoses that aren't quite so clear cut. In such cases, look to see if the disease developed suddenly (injury) or over time (illness). Here are a few common ones:

> **Back injuries:** *Because so many instances of back pain can be traced to a single event (injury), OSHA classifies these as injuries vs illnesses, even if you can't pinpoint a single precipitating event.*
> **Dermatitis:** *If the dermatitis results from a splash or other sudden exposure, it's most likely an injury. If it developed over time, it's more likely an illness.*
> **Heart attacks:** *If they occur on-the-job, they may be considered an occ illness. Even though the event is sudden, there is presumed to be a 'lead up' to it.*
> **Temperature related injury:** *Frostbite or burns are most likely an injury vs. illness, but hypothermia or heat stress is more likely to be an illness vs. injury.*

HINT: *For further guidance on illness vs. Injury, refer to National Institute for Occupational Safety and Health (NIOSH) publication 79-116, A Guide to the Work-Relatedness of Disease. It can be found at several links, but I like the indexed one at:* http://www.cdc.gov/niosh/docs/1970/79-116.html

HEARING CONSERVATION PROGRAM (HCP)

Exposure to 88 dB for an 8 hour time-weighted-average is known to cause NIHL. Based on that, OSHA set the action level at 50%, or 85 dB (remember the rule of doubling every 3 dB). If an individual is exposed to 85 dB as an 8 hour time-weighted-average, they must be in the HCP.

The OEHWG determines, based on the COHER, who needs to be enrolled. The BEE's may not be able to conduct a standard 3-person-full-shift dosimetry, so they may use published estimates for known processes, or point-source measurements.

NIHL is very common, but isn't always occupationally related, so it's very important to review all shops in the HCP and ensure their dosimetry is up to date. If it's been more than 5 years or if there are known changes to the shop processes, consider having the BEE's retest them. You may be able to drop entire shops from the HCP.

LASER WORKERS

The only lasers requiring medical surveillance are Class 3b and 4 lasers and laser systems. Although ANSI 136.1-2000 leaves decision of laser worker termination exams to the employer, AFOSHSTD 48-139 (10 Dec 99) requires them in the USAF. There are a number of not-quite-so-obvious laser shops throughout the base. EOD and NDI may have them for measurements. The Arts and Crafts shop may have one for engraving. The morale of the story is to work closely with the BEE's and ask questions during your shop visits. You may find some surprises.

HINT: *The issue of laser workers sometimes arises with SFS laser sights which can be 3a or 3b, depending on their settings. The setting is specifically set by an armorer and is not field adjustable. Double check to ensure that they are using the lower setting unless you want to be monitoring every SFS troop as a laser worker.*

SHOP VISITS

For an Occ doc to make recommendations on fitness for duty and to detect diagnostic clues of occupational illness, they need to know what happens within the shop. Not only does a visit to the shop foster better medicine, it builds credibility with the workers. There are many thoughts on how to perform a shop visit, but this is one approach. It's broken down into 3 phases: The preparation, the visit, and the recommendations.

CHOOSING A SHOP:

The BEE's maintain a shop list as well as required frequency of visits. First, consider a visit to any worksite with an injury trend; there may be biomechanical risks that aren't noted on the OEHED. If there aren't any current trends, look for a Cat 1 shop coming due for its annual visit or a Cat 2 shop due for its 2 year visit.

Once you've chosen a shop, call the supervisor – the BEE's have a list of members and supervisors in their files. Set a time and date, and make sure that they will be actively working at that time. It doesn't help if you go on a down day, where you can't see the actual work processes. Start with a review of the OEHED and COHER. These give the dates of prior visits as well as hazards and countermeasures.

NOTE: FOR CHOOSING / TRACKING SHOPS: *Build an Excel spreadsheet with a list of shops, categories, date last visited, and the visiting doc's name. Use conditional formatting to flag the shops green, yellow, or red, depending on how close they are to breaking the due date.*

THE VISIT:

During the introduction to the shop supervisor, ask them to treat you like a new troop. Have them walk you through the shop and describe the processes as if you were going to be starting there.

Common Areas of Concern:

- **Personnel Roster:** Ensure the BEE roster is up to date (it usually isn't) and get corrections. When you return to the MDG, have a tech enroll the missing personnel in proper screening programs and remove those who have left.

- **Changes in Processes:** Review the OEHED with the supervisor to check if they have changed processes, bought chemicals from a different supplier, or have concerns. This is one of the key issues that build credibility – it's their chance to talk with a doc on their turf instead of yours.

- **Fall Protection:** Look for slip / trip hazards, especially with wet worksites and winter weather.

- **Hazard Communication:** All hazardous chemicals must be clearly labeled and their MSDS be readily available. Members must be trained on shop hazards and how to handle them correctly. This training is performed by the shops (not medics) and documented on an AF 55 or locally devised form. Failure to maintain a HAZCOM program is one of the most common inspection findings.

- **PPE**: Ensure that PPE is available and is being used. Double check the actual respirators they have in stock with the ones on their OEHED – there is often a mismatch. Are eye wash stations and first aid kits readily available?

- **Administrative Protections**: Are there clearly marked 'safe zones' around equipment? When you talk with workers, are they aware of what processes are going on elsewhere in the shop?

- **Noise:** Have there been any changes to the machinery or protocols? It's not unusual for old equipment to be replaced with newer, quieter, equipment that no longer requires hearing protection. You may be able to remove shops from the HCP.

THE RECOMMENDATIONS:

After the visit, write a memo documenting what you did and what you recommend. Copies of the letter go to OEHWG, and I recommend sending a copy to the supervisor as well. It lets them know that their time wasn't wasted, and they can use it when they face their next inspection. Make a simple template that covers the basics, something like this:

1. *On _____, I conducted a shop visit of ___ , located in Building ___ at Base ____. I was accompanied by ____. MSgt ____, the shop supervisor, accompanied the medical team on the visit.*

2. *Major processes of occupational medicine interest involve ___, ___, and the use of ___. The OEHED was reviewed with the shop supervisor who verified that the processes and hazards described on the OEHED have not changed.*

3. *Effectiveness of worker protection programs*

    A. *There are ____ individuals assigned to the shop, ___ of whom have presented with occupational illness over the past year.*

    B. *PPE was observed to be readily available and properly used.*

    C. *Random interviews with workers showed them to be well aware of the hazards in the shop and the necessary precautions to avoid injury / illness.*

4. *Based on this shop visit, I recommend no change in our current monitoring process. If the shop processes change or if new illnesses or injuries are identified, we will re-evaluate the shop. Otherwise, the next visit is scheduled NLT _____.*

See? Easy ☺

HINT: ***Go with the BEE's or go solo?*** *Some people like to go with the BEE team, others prefer to go solo. Either way is fine, but consider going separate from the BEE's occasionally. When they visit, they focus on sampling, analyzing, and engineering factors. Although docs look at all of this, we focus on the human factor. Going solo is more informal and lets you see people in their natural working environment, which gives you better information on human factors.*

PUBLIC HEALTH (FOOD SERVICE) VISITS

The Public Health Flt CC manages the inspection program, but the SGP is operationally responsible for food service visits as the chair of the AMC. While the SGP doesn't need to be informed of the results of every inspection, they should be notified whenever there is a failure. Public Health has a set schedule of which establishments to visit and when, but there are many opportunities to accompany them. Work with the community health NCOIC to find a good time and location.

PUBLIC HEALTH (PHEO) VISITS

As PHEO, you may also be pulled into focused site visits to homes or workplaces where there is a suspected public health hazard. Common scenarios are lead paint in base housing or mold growth in a worksite or home. Being able to project confidence to base leadership as well as the affected parties is an important part of being the PHEO, and these are excellent opportunities to practice your risk communication.

Here is an example letter of how you might address a typical call to assess a worksite for mold – in this case, at the base veterinarian's office. Make sure to have the letter entered into the appropriate minutes for documentation. (Exec Council, PHEWG, AMC, etc.).

Sample PHEO inspection letter:

1. *On 5 August 2014 at 0830, I conducted a site visit to the _____ AFB Veterinary Services Clinic (Building 123) due to concerns over mold growth in the waiting room. The inspection team consisted of myself,1LT ___, MSgt _____, and TSgt _____ of the _____ MDG Public Health Flight. CPT _____ and SSG _____ of the veterinary clinic accompanied the medical team on the visit. Photographs of the findings will be uploaded separately.*
2. *FINDINGS:*
    a. *We identified two patches of active mold growth, approximately 5x10 cm and 12x8 cm in size, affecting a single ceiling tile in the waiting room. The affected areas were water saturated. After moving the tile, we discovered that the copper outflow pipe from the nearby wall AC unit was sweating heavily and dripping onto the tile.*
    b. *We inspected the rest of the facility and found no other evidence of active or inactive mold growth on ceilings, walls, or floors. There was no evidence of previous or current water damage to other areas of the facility.*
    c. *We made incidental note of improperly stored cleaning supplies in the storage room and significant floor staining around the latrine. The clinic has a contracted cleaning service which is responsible for reconciling these two findings.*
3. *RECOMMENDATIONS / RESOLUTIONS:*
    a. *The current health impact of the mold to workers or visitors is minimal, although it should be remediated to prevent further damage to the building and continued growth.*
    b. *MSgt _____ contacted CE and placed a work order (L4678) for replacement of the tile and insulation of the copper outflow tubing. In the meantime, we moved the tile out of the way to allow accumulated water to evaporate.*
    C. *The clinic is negotiating a new contract for cleaning but will contact their current cleaners for resolution of the latrine and storage issues*

FITNESS AND RISK EVALUATIONS

Fitness and risk evaluations look intimidating at first; however, the process is actually fairly straightforward. AFOSH 48-20 para 7 gives step by step instructions for conducting the exam for hearing loss, but the process is nearly the same regardless of the medical diagnosis that affects the patient's ability to do their job.

The process begins by identifying the patient. This may come from a screening program or it may come from the shop supervisor. In the event of a civilian employee, it may be requested by the union as a means to receive accommodations for their worksite.

Once the patient is identified, the member needs a clinical examination to focus on any conditions that affect their ability to perform their job safely and capably. For civilians, you may need to have them bring a copy of their core job requirements from the civilian personnel office. This document breaks down exactly what they are expected to do, and the percentage of their job that each task requires.

The next step is to visit the worksite with the member, their supervisor, and a rep from wing safety. The focus is whether they can safely perform their tasks, but also whether the limitations are truly from a medical condition or are artificial from workplace habits. In other words, does the patient with chronic lung disease really need to make multiple trips a day to the 5th floor (no elevator) to deliver documents, or can documents be emailed or carried with other existing deliveries?

If the member is active duty, then restrictions or accommodations are listed on the AF 422. You may have to submit an IRILO if their medical condition prevents them from fulfilling their primary purpose of employment. If the member is civilian, you may have a final meeting with civilian personnel, their supervisor, and a union rep. You can't discuss specifics of the medical condition, but you can address medical limitations (no climbing stairs, no overhead lifting, etc.). The other people at the table will decide if they can accommodate those restrictions at the worksite or if the person needs to be offered a different job.

Sample Fitness and Risk Assessment for NIHL

The hearing conservation program manager (HCPM) in Public Health is the lead and should identify members at-risk, but there may be times that the member comes directly to the occupational medicine (flight med) clinic.

Triggers for a Fitness and Risk Evaluation for NIHL (from AFOSH 48-20):

Personnel who cannot perform essential job functions or who pose a safety risk. Or if they:

- *Experience a second PTS in either ear.*
- *Exceed the H-1 profile and work in a hazardous noise area.*
- *Complain of not hearing/understanding spoken communications, auditory cues or signals.*
- *Exhibit behavior resulting in invalid or unreliable audiograms (Failure to obtain accurate audiometric test data should result in a worker being removed from all hazardous noise environments due to an inability to accurately monitor hearing).*
- *Exhibit behaviors that call into direct question the ability to work in the assigned job.*
- *Cannot be fit with HPDs.*

Once the individual is identified, the HCPM will arrange for an audiology examination and prepare an AF Form 1753. The provider completes Section II (clinical exam). Once that's done, the HCPM generates an AF Form 1754 and contacts the member's supervisor and Wing Safety, then schedules a time to meet at the worksite to complete the form.

The three of you complete the 1754. The supervisor (or base personnel) completes the section on responsibilities, you write the assessment of safety impacts due to the medical condition, and wing safety writes the assessment of the overall safety of this individual.

Once the 1754 is completed, a copy is filed by the HCPM and a copy is sent to the unit for their records. The medical recommendation for placement or continuation in a noise-hazardous job will include the following statement on the AF form 422 or locally derived return to duty memo,

"This worker meets medical standards to work as a [insert job title and occupation code] in [insert shop name and number]."

HINT: *This program only applies to non-fliers. The fitness and risk evaluation process for fliers is integrated into the waiver process.*

MEDICAL REVIEW OFFICER (MRO) DUTIES

There is no requirement to appoint the SGP as an MRO, but it's a common duty since MRO training is an occupational medicine program on the civilian side and the SGP is typically the IOEMC. MRO responsibilities are defined in AFI 44-120, para 4.6.7. It's important to note that MRO's must be either MD's or DO's. PA's, NP's or even a Pharm D cannot serve as an MRO.

MRO's must complete training within 4 months of appointment IAW AFI 44-120. This used to require an in-person course, but web based MRO training is now available from the Air Force Drug Testing Laboratory (AFMOA/SGBD). The course is restricted but access can be requested through Dr Mark Bruins at 210-292-3101 or Dr Aaron Jacobs at 210-292-3089.

PROCESS:

The DDR Program Manager will receive positive screening notifications and should forward an MRO review letter along with the lab notification. They'll probably redact the SSN's from the non-positives on the notification. However, make sure to double check the SSN on the lab notification and ensure that it matches the SSN on the MRO letter. It has happened that the wrong SSN gets transcribed. You aren't allowed to contact the patient. Simply review the records and answer whether or not the member had a valid script.

Once the request is sent, use the same review process each time, even when it is apparent that there is no medical reason for a positive. You may get called to testify and you need to be able to state that you checked X, Y, and Z because you always, without exception, check X, Y, and Z. If there is a valid script identified, the process can stop, but until it's found, cycle through the following steps.

- ✓ Start with an AHLTA check. If there is no entry in AHLTA encounters, double check for t-cons referring the member off base or scanned clinical notes from a specialist. Then run a query in CHCS to look for meds filled off base that were billed to Tricare. CHCS differs base to base, so engage the pharmacist if you need assistance. If there is still no record of a valid prescription, pull the paper-record and look for downtown notes. Lastly, check dental records.
- ✓ If you live in a state that requires mandatory logging of controlled scripts in a central database, ask the pharmacist to query at this point. However, even with mandatory reporting, this tends to be hit-or-miss.

- ✓ At this point, there is either a valid script or there isn't. If there is a valid script, indicate this on the form letter, but check if it was filled more than 6 months before the test. The 6 month time limit stems from the 17 April 13 MEDCOM Reg 40-51 8.e. It's an Army reg, but it's hard to find guidance that discusses the time that a script is considered legitimate, so it's a good guide.

AFI 44-120 para 4.6.7.5. requires that if a the positive is due to lawful drug use, the MRO needs to include the name of the drug, amount prescribed, directions for use, and date of prescription in their report to the program manager.

If there is no valid script, indicate that on the form and state there was "no evidence of a valid script found in pharmacy, outpatient, or dental records." There is no requirement for this wording, but it reduces the calls from OSI to ask if you checked specific records.

Common Pitfalls:

- Script filled after the urine test
- Script filled more than 6 months before the urine test.
- SSN's not matching between the lab, the memorandum, and AHLTA
- Missing a script filled off-base

HINT: *I highly recommend downloading a copy of "Urine Drug Screening: Practical Guide for Clinicians", Moeller, Karen E, et al. Mayo Clin Proc. 2008;83(1)66-76. It includes tables of duration of time drugs of abuse can be detected in the urine, agents that can cause false positives, and discussions of common drugs of abuse.*

PHEO

The PHEO position is intended to be a full time position. However, in reality, it's an extra duty, so this makes it important to lay the groundwork ahead of time. The new requirements for a PHEO mean that it has to be a doctorate level officer (MD/DO/DVM) with an MPH (or equivalent). This means that the base SGP is most likely to be the PHEO, but there may be times when they are not. If the primary PHEO is a DVM, then the alternate must be a physician. (AFI 10-2519 2.4.6.1.4.)

So, what does the PHEO do in an emergency? That's summed up in Table A4.31 of AFI 10-2501 and AFI 10-2519 2.3.7. I combined the two to form this very basic checklist:

	Upon initial declaration of a public health emergency by the Commander, the PHEO ensures notification of the MTF/CC, MAJCOM/SGP, and installation Public Health.
	Coordinate with Public Health to ensure information is relayed to the United States Air Force School of Aerospace Medicine (USAFSAM) and the local civilian health department. (USAFSAM will become the clearinghouse of epidemiological information to the MAJCOMs and AFMOA, and will provide information to AFMSA during on-going public health emergencies.)
	Direct the response to the emergency, to include the diagnosis, treatment, and isolation/quarantine measures.
	Recommend diagnosis, treatment, and prophylaxis of affected individuals or groups and populations in consultation with appropriate clinical staff.
	Establish rules and orders for commander-directed quarantine or isolation. • Establish quarantine or isolation premises. • Provide guidelines regarding contact with any person not subject to quarantine or isolation. • Establish criteria to terminate quarantine or isolation.
	Notify the installation Antiterrorism Officer (ATO) and appropriate law enforcement authorities through military channels of information indicating a possible terrorist incident or other crime.
	Maintain close contact and close coordination with the local and State health departments and the CDC concerning actions taken, to include seeking mutual aid agreements (MAA). In foreign locations, coordinate with appropriate host nation and, if applicable, other allied forces' public health officials.

The good news is that the PHEO only directs traffic for a short time before the MAJCOM and / or local authorities take the lead. Don't worry about the marathon, just the sprint.

PHEO – KOW YOUR ALLIES

The Medical Emergency Manager (MEM) is your right-hand. They are the keeper of the phone numbers, AFI's, etc, and they get things done once you decide what needs to happen. Some MDG CC's name a provider as the MEM - do NOT let them. The MEM needs to be well versed in logistics, preferably an MSC officer, but a civilian with corporate knowledge and continuity is even better.

The alternate PHEO is very important since an emergency requires 24/7 operations and you need someone who can work independently. Although the alt. PHEO can be a Public Health Officer, I recommend a senior flight surgeon or the SGH. This is NOT a slam on PHO's, but if everything hits the fan, the PHO will be insanely busy with the PH flight and response. I'd rather my PHO is running PH instead of attending meetings, press conferences, etc. Also, the public trusts physicians, so it's beneficial to have a physician trained in risk communication as the medical face with the Wing/CC and public affairs.

Update MAJCOM with the name of your PHEO, your alternate, and your MEM. Include good contact numbers and when your training was accomplished. Not only is it required, it ensures you receive updates, memos, and other essential information.

Keep the base senior leadership well informed. It's required to provide public health and disease outbreak emergency response training every 24 months (AFI 10-2519 para 2.3.7.15. & 4.4.), but you may need to do it more frequently if there is high staff turnover.

HINT: *The Kx has a resource page for PHEO's at https://kx2.afms.mil/kj/kx10/SGP/Pages/AFMS_PHEO.aspx*

Public Health Emergency Definition and Determination

Public Health Emergencies (PHE's) are defined in DoDI 6200.03 as a biologic incident (man-made or natural), chemical attack / release, radiologic attack / accident, or high yield explosive event that poses any of the following:

- High probability of significant number of deaths
- Significant number of serious / long term disabilities
- Widespread exposure to a toxic or infectious agent
- Healthcare needs which exceed available resources

Only the installation commander (Wg CC) can declare an event to be a PHE, and they do so on the advice of the PHEO. This means that as soon as event is suspected, the PHEO needs to collaborate with Public Health to determine the event and develop recommendations for the Wg CC.

HINT: *DoDI 6200.03 lists specific diseases that trigger a PHE as one or more cases of smallpox, anthrax, pneumonic plague, poliomyelitis (wild type), novel influenza, SARS, viral hemorrhagic fevers.*

or

One or more cases of any disease that requires use of quarantine to control.

or

Other disease which is unusual/unexpected, or has significant risk of spread. i.e.: Dengue fever, yellow fever, West Nile fever, Rift Valley fever, meningococcal disease, cholera.

Typically, public health emergencies affecting bases are either environmental (e.g. flood with displaced personnel) or disease (e.g. novel outbreak). The first case is simpler since the environment mimics a deployment, and most military personnel are comfortable with the food, water, hygiene, and disease challenges of the deployed environment. Also, although the workload ramps up quickly, things fall into routine quickly once recovery efforts begin. The second, that of an outbreak, is more difficult as the media creates crises that don't exist, and much of your time will be spent in risk communication and stopping rumors. You will also have to contend with evolving guidance from HAF and MAJCOM as the epidemic defines itself and CDC/WHO recommendations unfold.

Every situation is different, so it's essential to play a proactive role. Anticipate questions and communicate answers before the question is asked. The MDG ProStaff is on the front lines of patient communication, so educate them on risk communication points and ensure they pass your message. It does no good to reassure a town hall meeting that all is well, only to have the MDG pediatrician tell a child's parents something else. As part of the risk communication, consider how your recommendations play to the public eye. For example, walking down the MTF hall in a Tyvek suit and PAPR is sure to incite panic. Do all you can to avoid such visuals, especially if such levels of PPE aren't required.

Engage with the BEE's and MEM to get an annual brief on Water Vulnerability and Toxic Industrial Chemicals / Toxic Environmental Materials (TIC-TEM). After the brief, draft a memo stating you were briefed and have it entered into the minutes at Exec Council as evidence the PHEO is properly engaged.

- TIC-TEM: The MEM will (or should) have engaged with the local PH department and know what hazards are local to the area. If something goes bad, it's most likely to be a known industrial hazard, so if you know ahead of time what's likely to go bad, you're already one step ahead.
- Water vulnerability assessment – Same rationale as above. This brief should come from the BEE's.

AFI 10-2501 has a table of PHEO duties during a CBRNE response in Table A3.6, copied below. It's a good way to organize your approach when you are notified of an event.

1.	Incident Command (IC)	May assume IC for pandemic, epidemic, or public health emergencies.
2.	Detection	Ascertain the existence of cases suggesting a public health emergency.
3.	Identification	Collaborate with Public Health to develop a case definition of the outbreak.
4.	Quantify (Hazard Concentrations)	Investigate all public health emergency cases for sources of infection.
5.	Monitoring	Define the distribution of the illness or health condition.
6.	Decontamination	Direct the decontamination of any facility or material contributing to a public health emergency.
7.	Sampling	No specified role in sampling.
8.	Hazardous Waste Collection and Removal	Coordinate to ensure the safe disposal of remains to prevent the spread of disease.
9.	PPE Determination	No specified role in PPE determination.
10.	IPE Determination	No specified role in IPE determination.
11.	Downwind Hazard Areas Determination	No specified role in downwind hazard areas determination.
12.	Evacuation Plans Development	No specified role in evacuation plans development

DCP

As PHEO, the SGP assists Wing XP with the Disease Containment Plan, working through the EMWG. It can be part of the existing emergency management plan (IEMP 10-2), but often it's a stand-alone document that can run 200 pages and is quite involved.

Firstly, make sure to have a strong relationship with Wing XP. They are the OPR for the DCP and it's a wing plan, not a medical one. There will be a concerted effort to push this off to the PHEO, so be prepared. You'll need to review the materials base agencies provide, but it should be XP assembling, tracking, and routing the DCP for signature.

THE DISABILITY PROCESS AND THE DAWG

As chair of the DAWG, the Senior Profile Officer, and the president of the MEB, the SGP has an enormous role within the disability process. The medical evaluation process is a frightening one for many patients and we can avoid complaints if we use the proper terms and communicate the purpose of the process.

Although the SGH is responsible for the admin process of the Integrated Disability Evaluation System (IDES), it falls on the SGP to educate providers and run quality control. Bear in mind while in flight medicine's empanelment is primarily active duty, that isn't the case in the rest of the MTF. As such, most providers don't manage as many IDES cases and aren't as familiar with the process.

There are two main reasons for the disability process. The first is to determine if an individual requires reasonable accommodations to perform their duty. Think of it as the military equivalent of a civilian fitness-for-duty evaluation. If the AF can accommodate someone with a disability, they will via permanent profile or C-code. The other purpose of the process is to determine compensation for the shortened career of a member who develops an issue that is not able to be accommodated. In this case, they will receive either a lump sum payment (separation with severance pay) or a monthly payment (medical retirement). The money is not meant to be a complete welfare program, but rather to compensate for a shortened military career. That's an important distinction and it's vital to understand.

The first step is to determine whether a condition is "unfitting" or instead "unsuitable" for military duty. This is key since an unfitting condition may result in medical separation but an unsuitable condition results in administrative separation. For a complete list, see DoDI 1332.38 E5.1.3.

HINT: *Regarding reimbursement, consider the mutual expectation when the member joined the AF they could serve 20 years to retire. If, through no fault of their own, they are unable to, the AF reimburses them; think of it like 'buying out the contract'. The IDES makes more sense from that perspective, especially as it relates to presumption of fitness, misconduct, or EPTS cases.*

DEPLOYMENT AVAILABILITY WORKING GROUP: THE DAWG

The DAWG is tasked with a number of duties related to the IDES. It has to track the timelines and outcomes related to IRILO's and MEB's, review cases for potential action, approve AC exemptions from fit testing, and oversee review of common diagnosis resulting in IRILO. This can be daunting, and the MSME is essential to making it work.

MSME is required to review any Code 31 profiles in effect for 90 days or more, as well as any in effect for 300 days or more. You'll have some providers try to game the system by writing for 89 and 299 day profiles, so address that in ProStaff early. Also remember that although the DAWG is mandated to meet monthly, you'll quickly find that your IRILO processing metrics suffer if you wait to present everything at the DAWG before taking action. An effective technique is to review cases weekly in a smaller group (SGP, rotating PO, MSME) and report the findings to the DAWG for approval. That allows you to keep up with the flow while still maintaining DAWG oversight and record keeping. It also keeps the DAWG meeting from bogging down in case review. (I called mine the "PUPPY", since it was a "Pre-DAWG").

Another duty of the DAWG is to provide quality control on DLC determinations and fitness exemptions (AFI 10-203 4.1.3.8.). The easiest way to do this is to incorporate it into the existing peer review process. If for some reason, you can't do that, you can have your PO's do the review when they sign off profiles in ASIMS.

The supplemental guidance to AFI 10-203 has information on other DAWG tasks. One of the traditional ones is to put together a list of the top 10 diagnosis requiring RILO's at the installation and to institute a regular process of reviewing files for those conditions and their associated medications. The review is accomplished by MSME and reported to the DAWG. This list is going to vary based on the demographics of the base, but it may look something like this:

Diagnosis	Topic	Month	Comment
Reactive Airway Disease	Inhaled steroids	Jan	Advair, Symbicort, etc
Sleeping Disorders	Provigil, Sleep Study Consults	Feb	Any Rx in 12 months
General Medical Conditions	UM/High Utilizer	Mar	-----
Severe Mental Health Disorders *	Lithium/Seroquel/Abilify	Apr	Any Rx in 12 months
Anxiety Disorders, PTSD	Benzo list	May	3 month sample
Chronic Pain (unspecified)	Narcotic list	Jun	3 month sample
Chronic Back Pain	PT Consults	Jul	3 month sample
Illnesses / Injuries requiring hospitalization	Admission review	Aug	----
Anaphylactic Reactions*	Epipen	Sep	Any Rx in 12 months
Severe Depression	Antidepressant	Oct	SSRI, others, 3 mo sample
DT / A Fibb / PE / Coagulopathies	Warfarin	Nov	Any Rx in 12 months
Diabetes	Metformin/Januvia	Dec	Any Rx in 12 months

*These may actually be unsuiting as opposed to unfitting conditions and should be addressed administratively as opposed to via the IDES process.

IRILO = INITIAL REVIEW IN-LIEU-OF (MEB)

The IRILO evolved from the fact that most members evaluated by the Informal Physical Evaluation Board (IPEB) returned to duty. The IPEB is a cumbersome process, made even longer by the addition of VA examinations, so cases first go to DPANM for an IRILO pre-review.

The IRILO is the DPANM program at AFPC on Randolph AFB, a few floors and hallways away from the IPEB office. They evaluate the DAWG's recommendations to either return-to-duty or refer-to-IPEB. Often, DPANM will concur that a member should be returned to work, and they assign an appropriate C code of 1, 2, or 3. However, they may determine that a case requires further investigation and send it back to the base for an MEB. When that happens, the package and the patient are sent to the VA for a disability evaluation. After the VA assessment, an MEB is performed locally and the package sent to the IPEB.

IRILO REFERRAL PROCESS

Each program is different, but you shouldn't wait until the next monthly DAWG to discuss cases and complete the IRILO worksheet. It's better to have the SPO and PO's review the cases ad hoc, then present their findings to the DAWG. Another technique is to have the MEB review these cases when they meet. It keeps the program moving, and doesn't bog down the DAWG with long discussions that only involve a few players.

There are a number of ways to run the IRILO process, but the key is that the packages should be able to stand alone. In the past, many bases sent an expanded AHLTA note to DPANM and expected the case to be adjudicated. Needless to say, they spent a great deal of time dealing with requests for more information, cases returned without action, etc.

SHOULD YOU RECOMMEND RTD OR IPEB?

The hardest part of the IRILO worksheet is determining whether to recommend RTD or referral to IPEB. Each case is managed separately, but there are a few DPANM trends that you can use to guide your decision.

HINTS THAT MAY TRIGGER AN IPEB REFERRAL VS. RTD

- < 4 year time on service (TOS) = likely to refer to IPEB vs. C code
- 8 years TOS = AF "buys" EPTS conditions
- 10-12 years TOS = more likely to RTD, even if a "high deployer"
- 15 years TOS = likely to C code vs. refer to IPEB
- Asthma with running or gas mask restrictions: controlled asthmatics should be able to run and wear gas masks. If they can't, it indicates poor control, and poor control will result in IPEB referral.
- GI disorders requiring special diets. Most of these will be referred to IPEB.
- Any condition requiring medications that need cold chain. If a med needs refrigeration, chances are the member will be referred to IPEB.

NARRATIVE SUMMARY

The most important piece that the medics contribute to the IDES is the narrative summary (NARSUM). It's also where some of the preventable reasons for "kick back" occur. The NARSUM contents are dictated in AFI 41-210 para 10.6. It's a straightforward summary, but include everything on the list. If items on the list don't apply, for example, "Hospital Course" for a non-hospitalized member, simply mark "Non-applicable" or "Non-contributory". Save headache by using the NARSUM template at the end of this manual.

If providers use the NARSUM template at the end of this manual, then they only have to write a one line addendum for the MEB affirming that there has been no significant change in the member's condition if there is referral to the IPEB.

BTW, if you copy and paste things from AHLTA, take a moment to adjust fonts / line breaks / etc. so that they all match. The patient's career may well rest upon the NARSUM, and it needs to look professional.

When writing the NARSUM, include an explanation for anything that's noted on the AF Form 469. For example, if patients have a limitation for "no repetitive bending / twisting", include their "low back pain controlled with yoga" in the medical history of the NARSUM. If the low back pain is severe enough to be unfitting, then it should be included on the AF 618. If the diagnosis is present but not unfitting, simply mention it in the medical history and move on.

Line of Duty (AFI 36-2910 A2.1) determinations are a very important, but often overlooked, piece of the NARSUM. In most cases, the LOD will be "Admin: Yes", indicating that the medical condition arose from the natural course of life. However, in the event of genetic diseases, pre-existing conditions, or potential misconduct, the process is tricky. (Please refer to the section in this manual for more information on LOD determinations.)

Lastly, ensure that the NARSUM has a clear prognosis. This is the most predictive piece of whether an individual is returned to duty or separated, yet is commonly omitted. You won't always have exact data, but give your best estimation and use resources such as the Aircrew Waiver Guide to help. Even a statement as simple as, "Member will likely remain non-world-wide qualified for the duration of her career," is helpful.

NOTE: *The Aircrew waiver guide is a great resource for determining occupational impacts and recommended studies when writing a NARSUM.*

Other areas DPANM manages:

Refer to AFI 41-210 chapter 10, DoDI 1332.38 E4.A1.1.3 for details on admin and processing for medical hold and elective surgery.

Medical Hold: AFI 41-210 10-7-11. DPANM is the only entity that can authorize Medical Hold. It's used for people pending separation secondary to regular time in service commitment ending.

Elective Surgery: Members are prohibited from elective surgery within 6 months of separation. The purpose of the 6 month window is to prevent surgery a few weeks / days before separation, when the patient will lose Tricare benefits before the post-surgical aftercare is completed. DPANM is the approval authority for this, and usually will approve it, BTW.

MEB = MEDICAL EVALUATION BOARD

If DPANM decides the case needs to go to the IPEB, then the MEB process starts. Although the term "MEB" is often used to refer to the IDES process, an "MEB" is the panel of physicians who evaluate a case at the local level. The term is commonly misused to refer to the process at AFPC or DPANM, but an MEB is the base-level board, not the IPEB or IRILO. It consists (or should consist) of the SGP, SGH, and a 3rd provider. In the event of a psychiatric MEB, the 3rd provider must be a psychiatrist (not psychologist).

Patients often misuse the term when they complain to the MDG, Congress, or on the web, and you should ferret out whether it's their "MEB" that's frustrating them, or the "IPEB" that's delayed. Otherwise, you may end up inheriting problems that aren't your responsibility.

IPEB = INFORMAL PHYSICAL EVALUATION BOARD

This is the board at Randolph AFB after the MEB is submitted to AFPC. The package is reviewed by a panel of physicians and personnelists who ensure the condition is properly documented as disqualifying. If not, they may send the package back to the base for more information. They may also determine that a condition is not disqualifying, and consult with DPANM to return-to-duty with "C-code".

If the IPEB determines separation is in order, then the package is sent to the VA for a disability percentage determination. Using the VA System of Rating Disability (VASRD), the VA makes the determination and sends the package back to the IPEB who then completes the process and returns the disposition to the local base.

It's good to note (and brief the patient) that the VA will rate all conditions, whether disqualifying or not. Because the IPEB focuses only on disqualifying diagnosis, it's not unusual for the VA to rate a member's disability higher than the IPEB. The patient will be covered by the VA for their other conditions, but only the disqualifying ones determine compensation. It sounds unfair at first, but remember that the money is meant to compensate for a career shortened by a medical issue; if the condition isn't disqualifying, then compensation is not appropriate.

FPEB = FORMAL PHYSICAL EVALUATION BOARD

This board meets at Lackland AFB to listen to appeals from members who disagree with the findings of the IPEB. If the member agrees with the findings, but disagrees with the disability rating, they are allowed a one- time appeal to the VA instead of the FPEB. The PEBLO will help direct the member to the proper venue for their appeal.

It consists of a medical member (physician) and two personnelists. If a member submits an appeal, they are given a hearing date and flown to Lackland to meet with a FPEB attorney. The attorney, civilian or JAG, reviews their case and helps them build their appeal, then the member and their counsel appear before the board to formally present it. Participants are under oath and the proceedings are recorded.

After hearing the case, the board may change the determination from the IPEB, returning the member to duty or separating/retiring them. In some cases, they may determine that a condition was pre-existing and rule for administrative separation. It's rare, but it does happen. Usually, the attorney picks up on the potential for EPTS before the board, and the member will drop their appeal.

OUTCOMES OF THE IPEB (OR FPEB)

RETURN-TO-DUTY: Self-explanatory. The member returns, either with a C code, or with no restrictions.

C-Coding is determined by DPANM who assigns a code of C-1, 2, or 3 to the person. The code is used by assignment personnel to determine limitations in future assignments or deployments.

- PCS with a C1 requires gaining SGH approval
- PCS with a C2 requires gaining MAJCOM approval
- PCS with a C3 requires AFMSA approval

Examples of typical ALC Codes for diabetes or asthma

- C1: Oral / Diet Controlled DM, or Mild RAD
- C2: Two Oral Rx Needed For DM, or Moderate RAD
- C3: Insulin Dependent DM, or Severe RAD

ADMINISTRATIVE SEPARATION – EPTS: If a condition is determined to pre-date service, for example, asthma as a teenager, then the member may be separated without pay. This isn't common, except in certain genetic diseases if a member has less than 8 years of service. Even if the member had the condition prior-to-service, they may still be eligible for IDES if the unique rigors of military service caused the disease to progress beyond what would normally be expected.

SEPARATION WITH SEVERANCE PAY: If a member has a medically disqualifying condition and they have less than 30% disability per the VASRD, and they are not otherwise eligible for retirement, then they will be separated with a lump sum payment of 10 x 2 month's pay

RETIREMENT: If a member has 30% or more disability or are eligible for retirement, they retire with a percent of their base pay. The percent is either their disability or their normal retirement, whichever is higher (max 75%).

NOTE: *Members will retire on higher of the percentage of disability or standard retirement. For example, a 16 year TSgt with 30% disability will retire at 40% as opposed to 30%. (2.5% x 16 years = 40%).*

TEMPORARY DUTY RETIREMENT LISTING (TDRL): If a condition is disqualifying but has potential to change, the individual may be placed on TDRL. A good example is PTSD. A patient with disqualifying PTSD will be placed on TDRL for 6 months, and then reevaluated after they have (presumably) had therapy and are separated from triggers in the military. After reevaluation they may be returned to duty, placed on permanent retirement, or the TDRL continued. If they remain retired, either permanently or in TDRL, a new disability percentage may be determined. The new percentage may be higher or lower than the TDRL rating, but is generally lower since the patient has had time to recover.

LIMITED ASSIGNMENT STATUS: The PEB may opt to keep an unfit member on duty to the 20 year mark if they are in a critical field or a wounded warrior. However, if the member's condition worsens, or if they desire, they can request a RILO to evaluate for medical retirement. This is a fairly rare event and the member needs to understand that they are still required to maintain all other active duty standards. They could, for example, still be administratively separated for failing the PT test (provided they have the proper FAE's).

LINE OF DUTY DETERMINATIONS (LOD)

Per AFI 36-2910 para 1.6, an illness, injury, disease, or death sustained by a member in an active duty status or in IDT is presumed to have occurred in the line of duty. However, this can be rebutted if a medical officer determines that the injury, illness, or disease existed prior to service, or if a formal LOD investigation finds that it occurred while the member was absent without authority or was proximately caused by the member's own misconduct.

An LOD determination may be "Administrative", which is made by the medical officer, or "informal" or "formal", which are made by a line-of-AF investigation. An AF 348 is required to be completed for informal and formal LOD's. But for Admin LOD's (the majority of the ones done by medics), there is no need to complete any forms or make specific comments about LOD in the medical record. The one exception is for IDES, where the board needs the LOD documented in the NARSUM, even if it's an Admin LOD, which most are.

HINT: *AFI 36-2910 para 2.3, Attach 2 & Attach 5 and AFI 41-210 section 4E are the governing documents for LOD's*

EXISTED PRIOR TO SERVICE

The first step is to determine whether the injury / illness / etc., existed prior to service. When considering whether something existed prior-to-service, "Any hereditary or genetic disease will be evaluated to determine whether clear and unmistakable evidence demonstrates the disability existed before the Service member's entrance on active duty and was not aggravated by their current period of military service. However, even if the disability is determined to have been incurred prior to entry on their current period of active duty, any aggravation of that disease, incurred during the Service member's current period of active duty, beyond that determined to be due to natural progression will be determined to be service-aggravated. " (DoDI 1332.18, 7.b (4). Hereditary and/or Genetic Diseases).

When a medical diagnosis is that the illness, injury, disease, or death occurred prior to entrance to military service, or between periods of service, and was not aggravated by the unique aspects of military service, then the medical officer documents "EPTS: LOD Not Applicable" in the medical records. You will have to consider whether the unique rigors or military service caused the problem to progress faster than it would naturally be expected in some cases. Also, remember that genetic diseases are always EPTS, but even so, military duties can cause a minor genetic quirk to manifest as a serious disease, so there is some judgment involved.

ADMINISTRATIVE LOD

You can classify most conditions with an administrative LOD if they don't fit the EPTS category. If the injury was characterized as a hostile casualty, it's addressed with an admin LOD. Likewise, if the patient was injured while a passenger in a commercial or military aircraft, it is an admin LOD. If it was a simple injury, such as a sprain, fracture, or the like, and it's not likely to result in permanent disability, then an administrative LOD is appropriate as well. Lastly, if it's an illness or disease that is not clearly due to misconduct or caused by abuse of alcohol or drugs, it is also addressed with an administrative LOD determination.

For an administrative LOD, there is no need to complete any specific forms or to document the LOD determination specifically in the medical records. Once you make your determination, the case is closed.

HINT: *AFI 36-2910 is inconsistent in paragraph 2.3.1.2 and 2.3.2, when it comes to performing an LOD in the event of death. Err on the side of caution and complete an informal LOD if an active duty member dies while on duty.*

INFORMAL LOD

If an LOD determination is required, but an administrative LOD is not appropriate, then a medical officer can complete an informal LOD. To do this, the medic fills out items 1 through 12 on an AF 348. Items 1-8 are merely demographics and background, 9-10 are summary of civilian / other MTF records, and item 12 is the signature block. So, if the incident occurred at the local MTF, the main concern is item 11, which is a complete description of the alleged circumstances based on the available information. The medic does not make a determination of whether the death, illness, or injury was in the line of duty; that's left for the commander to determine.

Once the AF 348 is complete, forward it to the Line of Duty Medical Focal Point (LOD MFP), who is nearly always going to be the SGH. The LOD MFP will send the original to the member's commander for processing, a copy for the medical record, and will retain a copy in their office.

FORMAL LOD

A formal LOD is done almost exactly the same as an informal LOD. The main difference is that a medic may originate an informal LOD by submitting an AF 348, but the CC originates the formal LOD. The CC may originate it based on the AF 348 that was submitted as part of an informal LOD, or they may initiate a formal LOD and send an AF 348 to the MTF for completion. Regardless, it is filled out exactly like an informal LOD, with a summary of events in item 11. Do not state whether you feel the event was line-of-duty or not. There will be an investigating officer who will work with the CO to make that determination.

SPECIAL SITUATIONS

There will times when you don't know if you should initiate an informal LOD or classify the condition with an Admin LOD. AFI 36-2910 attachment 5 discusses some common situations and is summarized below. In the cases when an admin LOD is not appropriate, you may find that the CC initiates the formal LOD process and sends an AF 348 to you, or you may initiate it with an informal LOD AF 348.

Alcohol Abuse The condition itself doesn't require an informal or formal LOD. Only initiate an informal LOD determination if a member suffers an illness, injury, or disease as a result of alcohol abuse. If the member has an injury as a result of use (i.e. – a fight) then an informal LOD is appropriate to let the CC determine if misconduct was the cause. If it's a medical condition like cirrhosis, you should still initiate the informal LOD, but the determination from the CC should be "in the line of duty".

Drug Abuse The condition itself doesn't require an informal or formal LOD, but the CC will consider it as strong evidence of misconduct. If the member has an illness, injury, or death from drug abuse or from the effect of the drug on the body, then an informal LOD is appropriate. The CC will likely pursue a formal LOD investigation and will likely find that the injury was due to misconduct.

Fights The CC will determine whether injuries were as the result of misconduct or self-defense. If it's a simple injury that isn't likely to result in permanent disability, then an admin LOD is OK. If the injuries are more than minor, simple, self-resolved injuries, then initial an informal LOD for the CC.

Motor Vehicle Accidents Often times, alcohol is involved, which complicates the procedure for the CC. However, the medical side is pretty straightforward. Similar to the case of fighting, if injuries are minor and not likely to result in permanent disability, an admin LOD is fine. If the injuries are more significant, then plan on completing an AF 348 for the CC for an informal LOD assessment.

Pregnancy There is no need for an LOD assessment for pregnancy or for any diagnosis related to it unless there is likelihood of permanent disability. There are some caveats if the member has an illegal abortion. If she is put on OB quarters, there is an LOD determination, but it's a simple admin one.

Refusal or Failure to Seek Treatment If someone has an unreasonable refusal to seek medical care or treatment, then it would be managed as misconduct by the CC, even if the original medical condition would have been managed as an Admin LOD. These cases will generally be identified during an IRILO for failure to seek treatment, and in those cases, you might have to submit an informal LOD AF 348 to the CC for them to make the determination before submitting the NARSUM.

Suicide Attempts or Gestures The CC will a determination on whether the member was acting out of misconduct or was mentally irresponsible at the time. They will need you to fill out an AF 348 to help with that decision, so this will either flow from you as an informal LOD, or more likely, from the unit as a formal LOD.

NOTE: ***LOD's (either Admin, Informal, or Formal) are required if:***

- *A member dies*
- *The member cannot perform military duties for more than 24 hours**
- *There is likelihood of permanent disability*
- *An ARC member is treated (regardless of ability to perform duties)*
- *An ARC member is likely to apply for incapacitation pay*

** I know…you're thinking, "Do I need to do an LOD if I put someone on 48 hour quarters for AGE since they can't perform military duties for more than 24 hours?" You do, but it is an admin LOD, and for an admin LOD, there is no need to complete any specific forms or to document the LOD determination specifically in the medical records. It's assumed to be "LOD: Admin Yes" for illnesses.*

COMMON MISTAKES IN THE IDES PROCESS:

1. ***"The AFI (SGH, PEBLO, etc.) says that the MEB has to be done within 30 days of diagnosis."***

   Actually, that's not what AFI 41-210 para 10.3 says. It states that the MEB must be submitted within 30 days of work-up and definitive diagnosis. The newly diagnosed diabetic will need an IRILO, but not 30 days later, while you're still struggling to bring sugars under control. It may take 3-4 months before that patient has a definitive diagnosis of "Type II Diabetes, requiring oral hypoglycemic agents".

   If you send the IRILO without a definitive diagnosis, one of two things will happen. Either it will be sent back for resubmission or the member will be adjudicated based on their unstable disease – generally resulting in a less than favorable outcome. The NARSUM must include a prognosis, and you can't do that if you don't have a definitive diagnosis.

NOTE: *Don't be pressured into pushing a NARSUM out the door if the patient is not stabilized and you lack a clear prognosis. Call DPANM at (210) 565-3580 if you need more time.*

2. ***"SMSgt Snuffy has been doing his job for 24 years and is retiring next summer. Isn't it unfair to deny retirement by doing an IRILO?***

   First, he won't be denied a retirement from an IRILO. Once he has been in long enough to qualify for retirement, the IDES will not result in a separation with severance pay. The real issue is "Presumption of Fitness for Duty", which is covered in DoDi 1332.18 para 5.a and b.

   The IDES process is used (among other things) to determine compensable disabilities if a medical condition contributes to an early end to a member's career. The ability to follow a career to the point of retirement creates a rebuttable presumption that the medical condition was not the reason for career termination. In a nutshell, what this means is that if a member has an approved date for retirement, or is within 12 months of mandated retirement due to age or length of service, they are presumed to be fit for duty and won't be separated / medically retired for medical reasons.

There are exceptions, though. Presumption of duty can be overcome if the condition is of acute onset and would prevent further duty if the member were not retiring (i.e. – an MI), if the condition was chronic but deteriorated to the point of preventing further duty if they were not retiring (i.e. – progressive kidney failure in a diabetic), or if the condition prevented the member from performing duties befitting their office, rank, or rating prior to the presumption period.

What does all this mean? Remember that an MEB may result in disability payments to offset loss of income from a physical condition. If SMSgt Snuffy's duty is limited by his condition, then it's appropriate to press with the IRILO. If the disability finding is lower than his retirement percentage, he'll get the higher of the two. However, there are certain tax breaks to disability payments that don't apply to retirements, so it's in his best interest financially to press if he has disqualifying limitations due to the condition.

At any rate, DPANM will make the presumption of fitness determination based on the IRILO. Make sure to include information on retirement and address the conditions that could overcome this presumption in the NARSUM.

3. "We need to list everything from the narrative summary medical history on the AF Form 618 as part of the MEB."

This is a common error, often caused by zealous PEBLO's, and causes no end of headaches to the MEB and IPEB. It's common to have a case where a patient has a disqualifying condition and a list of other medical conditions that are not disqualifying. For example, TSgt Snuffy may have asthma (DQ), but also well-controlled HTN (not DQ), high cholesterol (not DQ), and an ingrown toenail (not DQ). His AF Form 618 should only include conditions that the DAWG has determined to be "unfitting".

AFI 41-210 para 10.7.5.3.23 states that only conditions that "contribute or may contribute to disqualification for worldwide duty" should be listed on the 618. If TSgt Snuffy's HTN, cholesterol, and ingrown toenail are not disqualifying, do not list them on the AF Form 618. The VA will still rate all conditions, whether they're disqualifying or not.

NOTE: *The IPEB will categorize all conditions from the NARSUM into three categories:*

1. *Conditions that are disqualifying and compensable (included in the disability rating)*
2. *Conditions that might be disqualifying, but are not at this time. (not included in disability rating)*
3. *Conditions that are not disqualifying. (not included in the disability rating)*

4. The member insists that his painful back was "permanently aggravated by service" and the 618 should have a checkmark in that column.

The "Permanently aggravated by service" column is only used if the condition existed prior to service (EPTS). Normally, EPTS conditions aren't eligible for medical disability, but marking "EPTS with permanent aggravation" shows that although the condition pre-existed service, the unique rigors of military service exasperated it beyond normal progression, resulting in it becoming unfitting. For example, by definition, genetic conditions are always considered EPTS. However, the member may have symptoms that resulted from the unique aspects of military life that caused them to become unfit.

If you believe the condition did not exist prior to service, then it's assumed that the condition resulted from service. In that case, state "Admin LOD=yes", and leave this column unmarked. Patients (and PEBLO's) don't always know this, so it's good to explain. I've seen letters of exception written by patients, and they've followed with complaints that they weren't treated fairly since the 'exasperation column' wasn't marked in an "admin LOD=yes" condition. Save yourself the hassle with a quick explanation.

NOTE: *A common error in the 618 is an inaccurate LOD. Make sure the LOD on the 618 matches the LOD on the NARSUM*

- *If it is "Admin Yes", then write, "LOD: Admin Yes."*
- *If the condition EPTS, then mark "LOD: N/A EPTS" and mark the column indicating whether the condition was exasperated by military duty.*

5. ***"I did all that you said. Why did DPANM send the case back for more tests?"***

In certain cases, there are specific tests and consults mandated by AFI 41-210 para 10.6.10. If these aren't done, DPANM will bounce the case back, leaving you to reaccomplish it. Part of the problem is that the VA is rates the person according to the VA System of Rating Disability (VASRD). This handbook dates back to the 1950's, so it uses standards that are often outdated. As a result, they need specific terms and studies in order to determine disability percentage. The best bet is to know what special cases require and to include the information in the original narrative summary.

Here is the information copied from 41-210:

- ***Asthma:*** *Current pulmonary or allergy consult on complex cases (an experienced Family Practice Physician may accomplish the more routine asthma cases) to include steroid dependence or usage, level of control, exercise induced, or climate or locally induced symptoms, time lost from duty, frequency and severity of attacks, hospitalization, E.R./Acute Care visits, and functional impairment; also medications (including immunotherapy), dosages, and at least three (3) current pulmonary function tests (pre- and post-bronchodilator, if abnormal, with results within 5% of each other). If asthma diagnosis is in doubt, then a Methacholine or Histamine Challenge Test may be appropriate.*

- ***Burns:*** *Percent of body burned (by degree) and photographs for rating disfigurement. Include measurements of functional impairment, i.e., range of motion of extremities involved.*

- ***Collagen Vascular Disease/Rheumatoid Disease:*** *Rheumatology consult.*

- ***Coronary Artery Disease and other Cardiac Diseases:*** *Cardiology consult and New York or Canadian Heart Association classification.*

- ***Diabetes:*** *Include evaluation for end organ damage (Optometry or Ophthalmology evaluation required), therapeutic history and level of control (HgA1C). Endocrinology consult for insulin dependent conditions.*

- ***Hearing:*** *Ear, Nose and Throat (ENT) evaluation for hearing and inner ear disease with evaluation of pure tone decibel loss at 500, 1000, 2000, 3000, 4000, and percent of speech discrimination without hearing aids.*

- ***Eyes:*** *Ophthalmology consult to include visual acuity, degree of peripheral constriction, and perimeter charts.*

- ***Malignancies:*** *Dermatology consult for melanoma; neurosurgery and psychiatry consult for brain tumor; ENT on all head and neck cancer, urology for renal, bladder, and testicular cancer; oncology consult on all other cancers. Consider including an oncology consult if patient is receiving chemotherapy.*

- ***Multiple Sclerosis:*** *Neurology consult.*

- ***Seizure Disorder:*** *Neurology consult, EEG and CT Scan (or MRI) to include date of last known seizure. MEB should be accomplished after two months of trial medication.*

- ***Neuromuscular Injury:*** *Orthopedic consult with range of motion strength and functional impairment and EMG if appropriate; also note dominate extremity if applicable.*

- ***Renal Disease:*** *Nephrology consult to include appropriate laboratory studies, i.e., serum BUN, creatinine, and urine chemistries.*

- ***Gastrointestinal Diseases:*** *Gastroenterology consult on complex cases (an experienced family physician or internist may accomplish more routine cases). If endoscopy performed as part of the work-up, that specialist's consult will be included.*

- ***Psychiatric:*** *Psychiatric evaluation, to include degree of social and industrial impairment and impairment for civilian life, and degree of impairment for military service. If a "Return to Duty" determination is anticipated, consider a 45-day trial of medication.*

Special provisions for reporting psychiatric cases: Multi-axial DSM diagnosis reporting is required, all five Axis including personality assessment and global assessment of function (GAF). The degree of impairment for civilian social and industrial adaptability for all boardable axis I cases are required. "Total", "severe," "considerable","definite","mild", or "none"are the only terms used. For degree of impairment for military service, use the degree of the evaluee's current and projected impairment for military service:"no impairment", "minimal", "moderate", and "marked"

NOTE: *DPANM maintains an archive of field updates and advice on the Kx. Bookmark:*

https://kx2.afms.mil/kj/kx8/AFPCMedicalRetentionStandards/Pages/home.aspx

6. ***The commander's letter states that "Whatever decision the board makes, ongoing care for the individual's medical condition should be considered." But it doesn't make a recommendation for continued suitability for duty. What does that mean?***

   It means you either have a CC who is afraid to commit, or a PEBLO who hasn't taught them what a letter needs to contain. The CC letter needs to be brutally honest. This isn't a time for EPR/OPR fluff. In all reality, the CC's opinion on whether the member should be retained or separated carries more weight than the medical summary.

   The PEBLO can reassure this CC that regardless of whether the member is separated or retained, they VA will still offer them support for their medical condition.

FOMWG (AKA GROUNDING MANAGEMENT)

Grounding Management, or the 1041 Meeting, is officially termed FOMWG, but it's essentially the same meeting. The SGP may chair this themself or delegate it to the Flight Medicine Flt CC. There are arguments for and against, but the SGP must attend even if they aren't the chair. (AFI 48-149 2.6.1.2.)

Traditionally, 1041 meetings were informal, but I recommend making the FOMWG a more formal meeting with minutes. The Chair is accountable to show that everyone has reviewed the 1041 log, waivers, etc., and having an attendance roster is easier than signing loose papers. It also lets you attach such documents to the minutes and submit them to AMC, making documentation simpler.

AFI 48-149 para 2.6.1. gives a complete list of all the information that needs to be addressed during the FOMWG. The biggest stumbling blocks are in waivers and DNIF management, so here are some tips for both.

NOTE: *www.goflightmedicine.com is a website from Dr. Rocky Jedick which is a great resource on flight medicine. It's written for the layperson and is an excellent reference for your patients as well.*

1041 LOGS:

ASIMS generates a fairly robust 1041 log. Make sure to pay attention to the ratio of days predicted vs. days down. If there is someone that should be returned but hasn't, have the techs email them to come to the clinic for a RTFS visit and make a note in the notes section. The 2nd notification gets copied to their Flt CC and SGP, and the 3rd notification gets copied to their DO and SGP.

I recommend using the notes section to mark down the last t-con or appointment with long term DNIF's in order to show that you're meeting the requirement to touch base every 30 days. More importantly, though, it ensures that you ARE touching base with the patient.

Although the HSI used to look for a monthly report of DNIF rates to the line commanders, this was dropped when the HSI dropped. However, I recommend to send it anyway. An email with a summary DNIF rate give them SA, and you can follow with individual CC's that have unusually high rates within their squadrons. Don't forget to brief the DNIF rate at Exec Staff and put it in the AMC minutes' exec summary.

WAIVERS:

Waiver tracking and writing is a never-ending chore for the offices. The good news is that the workflow screen in AIMWTS does a decent job of tracking waivers. However, it does not track where a waiver is once it leaves your office. I.e.: You may submit a waiver to MAJCOM, but they send it to ACS where it expires before disposition. You need to be able to lead turn such waivers and realize it can take 4-8 weeks (easily) for ACS. If there are extenuating circumstances that prevent accomplishing required ACS studies, contact the MAJCOM SGP and request a waiver extension.

The goal is to make the approval for the waiver as simple as possible by anticipating questions that the approval authority may have and answering them in the AMS. You may be familiar with the case from FOMWG, but the approval authority isn't. The AMS needs to be able to stand alone, so include a solid history and exam to build the case that the individual deserves (or doesn't deserve) to continue to fly. Once the waiver arrives at the authority, they're going to review the waiver guide to ensure all the pieces are present before considering approving the waiver. When performing the Senior Reviewer evaluation, open a copy of the waiver guide, turn to the paragraph on required information, and run the checklist against the AMS. It's discouraging when a waiver sits for a time, only to bounce back for additional information.

Some MAJCOM's allow the local SGP to disposition renewals and new waivers. This can be a timesaver for your tracking logs if you can review, sign, and disposition all at once. However, the MAJCOM will review the case regardless of whether it's locally or MAJCOM approved. If they find that your AMS's are subpar or that Waiver Guide requirements aren't met, you might lose the local authority.

As P.A.'s continue to assist with the flight medicine clinic, the question sometimes arises whether they can write waivers. The August 2012 printing of AFI 48-149, para 8.2.2.7addressed how P.A.'s may be used and specifically states that they are not authorized to make continuation, DNIF, return to duty aeromedical dispositions, serve as profile officers, or perform flying physical exam certifications. Based on that, they may not sign an AMS in AIMWTS.

Lastly, if a member is separating or retiring, the waiver should be left to expire rather than retiring it. (AFI 48-123 6.6.4.)

NOTE: *Unless your docs are experienced at waiver writing, encourage them to write a draft of the waiver in a word processer so they can format and spell check it before copying / pasting into AIMWTS.*

SECTION I: IDENTIFICATION AND IDENTIFICATION REMARKS

AIMWTS will automatically generate a basic introduction, but it doesn't include some important information that the approval authority will need to have. In the identification remarks section, include the AFSC, job title, flying class, and purpose of the examination. Don't make the waiver authority try to guess whether you support a waiver or not. If you support a waiver, say so, but if you don't support waiver, then say that the purpose is to request disqualification. Also include any previous waivers, when they were granted and by whom, and when they expire. You can get the information, such as ASC, from their DD 2292 on ASIMS.

Sample introduction:

> Major Montgomery "Scotty" Scott, SSAN (123-45-6789), is a 43 year old (DOB: 3 March, 2222), male, active duty Air Force, Electronic Warfare Officer for the B-52H *(yeah….it's <u>still</u> flying…- TPH)* (AFSC: 12BX1, ASC: 1A) who has served for 12 years and 3 months. Maj Scott has flown a total of 7085 hours, none of which have been in the last 6 months. Maj Scott is currently assigned to the Starfleet Academy as an instructor.
>
> The purpose of this aeromedical summary is to request an initial Flying Class II waiver for Diabetes Mellitis, Type II, diet controlled. (Maj Scott underwent an MEB for this condition and was returned to duty with an ALC-2. See attachments) The condition is disqualifying IAW the USAF medical standards guide, section M6.

NOTE: *Create a demographics worksheet to collect information from the patients who are pending a waiver, and keep it on hand in a tracking folder until the waiver is complete. It works just as well for NARSUM's for IRILO's.*

SECTION II: MEDICAL HISTORY (SIGNIFICANT HISTORY)

The medical history may be known to the clinic and SGP, but not to the approving authority. The most important part of the history is to show timeframes so stability can be established and required time periods from the waiver guide are addressed. This is also where to include conditions that are not disqualifying, but that contribute to overall medical status.

Look at the Waiver Guide, especially Part III (Waiver Consideration). The waiver authority is going to use this list to see if the member is eligible for waiver. If the Guide says that a waiver for condition X may be granted if there is no recurrence, no associated neurologic dysfunction, and no use of prescription medication, then use those words specifically in the history and state, "There has been no recurrence, no associated neurologic dysfunction, and no use of prescription medication."

Sample medical history:

> In November of 2264, Maj Scott presented to the Academy flight medicine clinic and underwent routine laboratory testing to for his hypertension. He was noted to have elevated lipids at that time, and was started on simvastatin 20 mg daily. At his follow up for the simvastatin, his blood chemistry results showed an elevated fasting glucose of 246 mg / dl. He was diagnosed with diabetes mellitus, underwent optometry evaluation, and an MEB was submitted. His MEB returned as "return to duty" and Capt Scott was given diabetic education and referred to the HAWC for exercise and diabetic dietary counseling. He was started on metformin, and his hypertension medication changed to the current dose of lisinopril and hydrochlorthiazide. He began regular glucose monitoring, responding very well to the metformin, and his fasting glucose and HbA1C rapidly fell to normal ranges. He has never required emergency treatment, suffered a hypoglycemic episode, or complained of fatigue or visual changes.
>
> He was titrated off the metformin and his glucose and HbA1C remained controlled with diet alone over the next 10 weeks. He continued his exercise program of weight lifting, and has lost approximately 4 inches from his waist measurement over the past year.
>
> PMHx: Hypertension, Hyperlipidemia, Diabetes Mellitus (type II, diet controlled)
> FamHx: Hypertension in father, Premature (< age 50) CAD in mother.
> SocHx: No alcohol, no tobacco, no herbal medications, married.
> All: NKDA
> Meds: Simvastatin 40 mg daily, Zestoretic (lisinopril 20mg/hydrochlorthiazide 25mg) daily

SECTION III: VISION/HEIGHT/AUDIOGRAM

Unless the waiver is for vision, height, or hearing, this section can usually be blank. However, if it is for one of those categories, please include the data in the appropriate tab to have it included in this section automatically.

SECTION IV: PHYSICAL EXAM

The bulk of the physical exam can be copied / pasted from AHLTA, but take a few moments to clean up the fonts, even out the spacing, and remove the various other "AHLTA-isms." If labs are included, include a normal range for the value and whether there were interventions at the time. Make sure to include any required exams from the Waiver Guide. If there are a lot of labs or other data, attach a scanned copy and summarize the findings in the physical exams section.

Sample portion of the physical exam:

EKG: Normal sinus rhythm approx. 72 bpm, with no evidence of infarct or ST changes.

Dilated retinal exam by optometry showed no evidence of diabetic retinopathy or other disorder. (Complete exam is enclosed in attachments.)

LABS:
Due to the number of labs and propensity of formatting to be disrupted in AIMWTS, these labs are also found in a word document under attachments.

Hemoglobin	A1c Units	Ref Rng
20 Jul 2265	6.8 (H) %	(3.9-6.1) with diet control only
05 Apr 2265	6.2 (H) %	(3.9-6.1) on 500 mg metformin bid
15 Jan 2265	8.0 (H) %	(3.9-6.1) prior to treatment
17 Nov 2264	8.7 (H) %	(6) prior to treatment

Fasting Glucose		
20 Jul 2265	117 mg/dL	(70-110)
28 Jun 2265	120 mg/dL	(70-110) with diet control only
15 Jan 2265	152 mg/dL	(70-110) prior to treatment
17 Nov 2264	225 mg/dL	(70-110) prior to treatment

Lipoprotein Screen Panel

	28 Jun 65	5 Apr 65	15 Jan 65	15 Nov 64
Triglyceride	48	87	96	79
Cholesterol	152	169	174	236
HDL Cholesterol	34	33	31	31
LDL (Calculated)	109	118	124	189

SECTION V: DIAGNOSIS / TREATMENT

List all the aeromedically significant diagnosis along with the treatments and applicable dates. If the member has non-disqualifying conditions, don't include them here. This section will be copied by the approving authority when they disposition the waiver and will appear as part of the disposition.

Sample portion of the Diagnosis / Treatment:

[250] DIABETES MELLITUS. (Treated with diet control alone)

SECTION VI: RECOMMENDATION

The last section is the most important. Include the patient's name, their condition, make it clear what you recommend and explain why you recommend that course. Do you recommend an ACS review, FC II wavier, an FCIIC waiver, or disqualification? Make it clear; if you don't give a recommendation, it's assumed that you don't support a waiver. If the member's commander submitted a letter, reference it here and include it in the attachments.

If there was a requirement in the waiver guide that you did not follow, explain why. In most cases, the approving authority will be flexible on requirements such as allowing a family medicine doc to provide an evaluation in lieu of an internist evaluation, or they may approve a waiver at 5 ½ months instead of 6 months - if there is justification. If you don't explain why you deviated from the guide, they'll assume that you didn't know any better, and they'll send the waiver back for corrections.

Sample Recommendation:

> The patients laboratory values fall within the ranges for fasting glucose (<126) and HbA1c (<7%) as listed in the USAF Waiver Guide (pages 115-117) and his screening tests for retinopathy and his EKG have been negative for pathology. His LDL levels have responded extremely well to statin treatment and lifestyle changes, and he is well under the required levels of 130, and close to optimal levels of <100.
>
> Maj Scott has demonstrated a high motivation to change his lifestyle and has instituted a rigorous weight lifting program. Although his increase in muscle mass has offset weight loss, his successful body composition change is evident in his loss of 4 inches from his abdominal circumference. However, even prior to these lifestyle changes, his latest USAF PT test was performed in Nov 2263, and he passed with "good" scores.
>
> I request that Maj Scott be granted an FCII waiver for Diabetes Mellitus (Type II, diet controlled). I recommend that he have rechecks of his HbA1C, lipids, and fasting glucose every 6 months as interim evaluations. He is not at risk of hypoglycemia, and his lipids, blood pressure, and glucose are all controlled to within normal limits. Granting this waiver does not pose a safety hazard to Maj Scott, his fellow aircrew or mission completion.

NOTE: *Your recommendation is very important. For example, if you merely say, "Waiver is submitted for consideration," it sends a strong message to the waiver authority to deny the waiver and DQ the member. In some circles, that's actually taught as a 'coded' way to send a DQ request.*

QUATTRO'S TOP REASONS FOR WAIVER REJECTION

1. The AMS is missing required information from the waiver guide, without an explanation why it's not included.
2. Sent to the wrong approval authority – common with IFC's.
3. SSN was wrong or First/Last names were transposed
4. Missing attachments (see #1).
5. The history fails to give a narrative of the treatment course.
6. The member's condition hasn't stabilized yet.
7. The medications aren't waiverable and there is no discussion of alternate (allowable) medication use.
8. The condition requires an IRILO (MEB) and it hasn't been either completed or the results are not included in the AMS.
9. There was no clear recommendation to deny or grant the waiver from the local base.
10. The AMS discusses other potentially disqualifying conditions, but doesn't explain why they are not disqualifying. (i.e.: In a waiver for gout, the member is also noted to have HTN and hypercholesterolemia, but the AMS doesn't comment on the treatment or response.)
11. The member's AFSC isn't included. It is required to make the disposition in AIMWTS.
12. The request is for a DQ and there is no indication that the member and CO are aware of a medical DQ request.

EXTENDING WAIVERS, PHA'S & DD 2292'S

Occasionally, there are times when circumstances prevent a member from completing required exams on time. In such cases, there are avenues to offer extensions, but use them judiciously.

Some MAJCOM's require a specific form, while others accept an email explanation. Regardless, the explanation must focus on how circumstances beyond your control prevent renewal on time. Reasonable examples may be if the member has a deployment extended, emergency leave, PCS'd with a waiver immediately due for renewal, or ACS has to reschedule appointments. Typically 60-90 days is appropriate, though extensions up to 6 months may be considered on a case-by-case basis. However, it's best to be proactive and rehack a waiver early rather than asking for it to be extended because of deployment.

Waivers: AIMWTS will allow waivers to be extended by MAJCOM once, but only once. If the waiver is being extended due to deployment, the MAJCOM will typically extend it to be redeployment date + 90 days, to coincide with the DD 2292. Make sure to let them know when the member is returning. Technically speaking, a second extension could be created, but it would require creating a new waiver and having it approved for a short time (i.e. 90 days). This would only be an option under extraordinary circumstances and you'd need to work 1:1 with MAJCOM to discuss it. Lastly, pay attention to the waiver authority. If it's a conditional waiver, AFMSA is the waiver and extension authority, not MAJCOM.

NOTE: *Asking for an extension because you are too busy or you failed to be proactive with the 1041 meeting will result in:*

1. *Chastisement from the MAJCOM*
2. *Denial of your request.*

PHA's: PHA's can be extended by the AF/SG, but delegation authority is given to the MAJCOM/SGP or AFMSA/SG3PF. (AFI 48-123 para 3.1.11. and AFI 44-170 para 2.1.6.4.). If extending a PHA on a member, include a note on the DD 2292 that the extension was authorized by the MAJCOM SGP IAW the AFI 44-170 reference. Keep a copy of the memo or email from MAJCOM authorizing it, just in case. During deployments, members are exempt from PHA requirements, so there is no need to request a PHA extension merely to cover a deployment. (AFI 44-170 2.1.8.1.). However, they may still need their DD 2292 extended (see below.)

DD 2292's: If a flier has a DD 2292 expiring during deployment, the home station has authority to draft a new DD 2292 with an expiration date of redeployment + 90 days. (AFI 44-170 para 2.1.8.2.) No need to call MAJCOM on this one.

PEPP HINTS

IFC's can take over. Especially frustrating are the patients who no-show appointments. If you want to be draconian, you can build policy that a no-show for a required appointment will cacnel the IFC and they will only be allowed to reinitiate it with a note from their CC.

With that in mind, and assuming you are a fan of late night television, I offer the following "Stupid PEPP Tricks."

Common mistakes that result in delays or cases being returned for corrections:

- Forgetting to mark "DQ" on a member who requires a waiver
- Pushing the waiver via PEPP vs. AIMWTS. (The PEPP interface is buggy.)
- Forwarding a waiver to AETC in AIMWTS without also forwarding the PEPP exam. Remember – AETC won't disposition an initial waiver without the corresponding exam in PEPP.
- Marking 'normal' for GU exam on members who have been circumcised. (Basically, if the member wasn't born 'that way', mark it as 'abnormal.' Include an explanation in the comments section.)
- Not including all required ARMA's for members who need more than one.
- Omitting clearance statements for Army schools on special operators' PEPP exams. Below are some of the special operators with their required tests and statements.

Job Title:	AFSC	CLASS	ARMA:	Duties	Additional tests
SERE	1T0X1	III	ARMA	Military Aviation	IPPD, Hep C, CBC
			MDD	Parachute	"Rectal and prostate examination normal to digital exam"
				HALO/Freefall	"Chest x-ray (inspiratory and expiratory) negative"
				Marine Dive	no fear, breath holding x 60 seconds, RAT, serial 7's
					"(is) qualified for initial Flying Class III/Airborne/Combat
					Control/Pararescue/Maring Diving Duty/SERE specialist"
Pararescue (PJ)	1T2X1	III	ARMA	Military Aviation	IPPD, Hep C, CBC
			MDD	Parachute	"Rectal and prostate examination normal to digital exam"
				HALO/Freefall	"Chest x-ray (inspiratory and expiratory) negative"
				Marine Dive	no fear, breath holding x 60 seconds, RAT, serial 7's
					"(is) qualified for initial Flying Class III/Airborne/Combat
					Control/Pararescue/Maring Diving Duty/SERE specialist"
Combat Control	1C2X1	III	ARMA	Military Aviation	IPPD, Hep C, CBC
		GBC	MDD	GBC	"Rectal and prostate examination normal to digital exam"
			AR-GBC	Parachute	"Chest x-ray (inspiratory and expiratory) negative"
				HALO/Freefall	no fear, breath holding x 60 seconds, RAT, serial 7's
				Marine Dive	"(is) qualified for initial Flying Class III/Airborne/Combat
					Control/Pararescue/Maring Diving Duty/SERE specialist"
RPA Sensor Operator	1U0X1	GBC	AR-GBC	GBC	
Tactical Air Control Party (TACP)	1C4X1	GBC	AR-GBC	GBC	
Air Liasion Oficer (ALO)	13LX	GBC	AR-GBC	GBC	
Air Battle Manager (ABM)		III	ARMA	Military Aviation	
		GBC	AR-GBC	GBC	
Space and Missiler Operations (SMOD)	13C, 1C6XX	SMOD	AR-SMOD	SMOD	

CLINIC MANAGEMENT

It's a fact of life that the MDG lives and dies by its metrics. Even if FOMC is doing an exemplary job of supporting the mission, if it looks "bad" on paper, expect meddling from administrators and negative pressure from the MDG CC. A little preventative medicine applied to the clinic management can avert this problem and let you focus on mission support and operations.

Pitfall: Excessive open appointments. While that intuitively seems good, it actually works against FOMC.

How it happens: The FOMC schedule has 24HR's, but also a walk-in/sick call. You hit targets for access, but have open appointments since many patents are seen at sick-call and don't need the 24HR appt.

Impact: It makes it appear that FOMC isn't busy, and when that happens, you can expect demands from PCMH to pull staff or to cover their appointments for them.

Fix: There are two ways to fix it, but either way, the goal is to eliminate the hybrid clinic that uses both 24HR and walk-in approaches.

Option #1: Walk-in all acute issues and use only the FUT appointment type for scheduling. This approach eliminates all 24HR from the schedule, instead walking all acute issues in. There are some advantages to seeing patients as they need to be seen, and it eliminates the denominator from the metric measurement, meaning you cannot be held accountable for 24HR access. Non acute issues can be booked into the FUT appointments giving you follow up, and makes the schedule very easy to manage. If you have a small clinic, this is an easy approach that tends to be popular with patients. A large clinic can quickly overwhelm your staff, though, so consider Option #2 for that.

Option #2: Traditional schedule with FUT, 24HR, etc appointments and no walk-in or sick call. It takes some balancing to get the right mix, and you can always book a patient into an afternoon ACUT slot and see them in the morning. It works best with a population large enough to maintain a fairly predictable workflow and it requires monitoring of clinic demand and working closely with the GPM. That said, it makes it easier to manage a larger clinic, schedule out of clinic duties, and makes things more predictable.

Pitfall: SME's disengage from the clinic to spend time with their squadron and don't help with clinical duties.

How it happens: SME's are the stepchildren of flight med and it's easy to lose visibility on where they are at any given time. This is compounded if they have an office at the squadron. Some take advantage of the fog to tell the medics they are at the unit, tell the unit they are at the MDG, and then disappear entirely.

Impact: The MTF loses provider staff when the SME's aren't available. The unit loses out on having clinically proficient docs when they deploy.

Fix: Meet with the Sq/CC and break out AFI 48-149. Explain that the SME must maintain clinical proficiency to be able to provide deployed support. Even with a 50:50 split, there is more than enough time to cover squadron operational support.

> 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)

POWG AND PRP

Don't expect to be a PRP expert after reading this section. It provides tips and insights, but to become adept requires practice and networking with experienced CMA's at the IG, MAJCOM, and other bases.

There are a number of PRP manuals floating around, some better than others, and most based on one I wrote back in 2005. But PRP is simple. People make it hard, but it's simple if you approach it from an occupational medicine perspective and keep the focus on medical care. Where it becomes difficult is when providers let the program drive the medicine.

PRP OPERATIONAL WORKING GROUP (POWG) - OPTIONAL

The POWG is the PRP equivalent of the FOMWG. It gives you a chance to disseminate information, manage patient cases, ensure that patients are receiving appropriate care, and minimize operational impact. The POWG is <u>not</u> a required meeting, however, even though it's not required, it's still a good idea for the same reasons that you hold FOMWG. It's a simple matter to hold it in conjunction with FOMWG and avoid keeping two sets of minutes.

There are a number of metrics reported at the quarterly Nuclear Surety Council, and the POWG is a good forum to track them and report them to the AMC. That way, when the NRC occurs, there won't be any surprises. The easiest way is to use the ASIMS PRP Module, since it generates the data for any specific time frame.

Typical metrics reported to the NRC:

- Number of recommendations made for suspensions, temp decerts, and perm decerts
- Number of certifications received, number completed, and average time to completion
- Number of Suitability Factor letters sent (not including those included with suspensions, temps, perms, or certifications)

Like the FOMWG, the POWG minutes could be submitted to the AMC, so consider appointing the Alt Lead CMA as a member of the AMC and invite all CMA's to attend. Although the SGP could represent the program as the Lead CMA, the FOMC CC and flight docs are all expected to attend even though the SGP is there. The PRP CMA's should be involved in the same manner.

PROGRAM MANAGEMENT

Within the PRP, there is a tendency to react to inspection findings by creating more management rules. I challenge you to apply mishap training to look for the chain of events that led to the infraction. In many cases, the problem isn't solved by creating additional rules. As a matter of fact, the degree of program complexity resulting from an overabundance of rules may be what caused the finding.

One trap that SGP's fall into is to disengage from the program and turn management over to the Alt. Lead CMA. While the Alt Lead-CMA needs to be empowered to run day-to-day operations, the Lead CMA is the executive representative and is responsible for medical PRP to the MTF CC and the Wing Reviewing Official. It is a team approach, with the Alt Lead CMA managing day-to-day operations and the SGP making the managerial decisions and guiding the program. For comparison, the relationship is similar to that of a flying squadron CC and their DO.

NOTE: *Often, management problems can be solved by simplifying the program rather than making it more complicated. Consider: If techs struggle to follow a 5 step process, will it help to make it an 8 step process? Or would it be better to have 3 steps they can follow correctly every time?*

DAILY REVIEWS:

Daily reviews are an optional once-over with the primary purpose to make sure that the PRP determination is in accordance with care given – it's not an evaluation of the care, but of the PRP determination. These can be accomplished by another CMA, a 4N, or even a 4A before filing the record. There is no requirement to do this, but it can help catch minor trends before they evolve. Key issues to check are:

- Documentation appropriate for medication given.
- CMA signature and PRP determination present
- Do LSSC and the medical outpatient records' notes match up?

PERMANENT DECERTIFICATIONS

Permanent decertification is a bit of a misnomer. Few conditions are truly permanent, and under some circumstances, members can reacquire their status. There is considerable leeway within medical PRP, and perm decerts are only mandated for drug abuse or failed compliance following alcohol dependency. In most cases, a perm recommendation falls into the gray area of a prolonged suspension with a prognosis that isn't consistent with continued PRP duties.

There is no need, however, to exhaust the limit of suspension before recommending a perm. If you feel the member shouldn't be on PRP, make the call. To make it easier on the unit, have an informal discussion with the CO as soon as you make that decision. In most cases, they'll ask you to proceed, but this allows a chance to address concerns before an official recommendation is sent. For bonus points, when making the recommendation, do it early in the day to give the squadron time to process it.

Lastly, consider having the Lead CMA and/or Alt LCMA co-sign perm recommendations. A perm decertification is the same as a DQ waiver in AIMWTS; there should be a senior level review before it leaves the MDG. This keeps the heads of the medical PRP informed of major events and allows one last quality check before the letter goes out.

ANNUAL AUDIT

Audits need to be conducted annually but the depth is determined by the LCMA. In the old days, every record was reviewed, but that's not necessarily the case now. The goal is to review enough records to sufficiently gauge the program. This might be as small as 10%, or might be higher, depending on the size of the program and the trends identified.

The audit schedule depends on program size. Smaller programs may perform all audits in a designated month, while a large program may have audits spanning the entire year. Some bases audit by squadron, which is a throwback to the early 2000's when the AFI required the CO to co-sign them. While it's simpler for the unit to track, it's more difficult for medics to audit by squadron since it requires more time to identify and pull records, re-file them, and monitor for PCA moves into and out of squadrons.

Consider a simpler approach. Charts are filed by terminal digit; run the audit the same way. Begin in January with 00-09, February 10-19, and so on. This leaves November as a "catch-up" month and doesn't require an audit in December when staffing is tight. The other advantage is that there is no need to track PCA's. Members can move from squadron to squadron and it doesn't affect how their charts are identified.

NOTE: *The easiest way to create a list of PRP personnel by terminal digit is to place a copy of the ABC roster into an Excel Database. Use the formula "=RIGHT(cell reference, 2)" to separate the last two terminal digits and then arrange that list in ascending order.*

THE ROLE OF THE CMA

The CMA's is first and foremost a medical provider. Never lose sight of that. Programs that suffer tend to be ones that focus on the administrative aspects of PRP and let medical care slide. Very few CMA's intend to practice poor medicine, but it becomes a cycle. They get tied up with administrative duties, so appointments are curtailed. Without appointments, patients go off-base, creating more paperwork, more reviews, and more work. This drives lower availability, and the cycle continues. Break the cycle by focusing on solid medical care and much of the other work ceases to exist.

In addition to medicine, the CMA has two other roles. They are a funnel, collecting data from a variety of sources, and a filter, applying medical knowledge to sort what is important. Most CMA's, especially newer ones, excel at funneling. They report everything, from broken fingers at age 3 to URI's from months ago. Unfortunately, this creates additional work and buries the CO in layers of chaff.

The steepest learning curve for a CMA is applying medical knowledge and deciding what is important and what is not. Unlike flight medicine which has clear medical standards of what is allowable, PRP leaves much of the decision making to the CMA. This means they have to be willing to make consistent decisions, sometimes without a specific AFI reference.

SUITABILITY FACTORS (THE INFORMATION FORMERLY KNOWN AS PDI)

"PDI" as a term no longer exists. It's now "Suitability Factors". While there may not be a major difference in what you're looking for when you review records, it does have a difference in that suitability factors are more of a current vs. historical concern.

The explanation of why an item is not a factor should be in proportion to the significance of the item being explained. Documentation for a headache associated with an acute URI might be as simple as "HA from acute URI. No impact", while a severe tension HA might need more detail. Likewise, stress on a PHA could be explained with "Stress in proportion to job. Good coping. No impact."

Life Skills Support Center (LSSC) records are notorious for intake screenings. Make sure to screen them for issues such as of Letters of Reprimand (LORs), Art 15's, etc. If any of the actions had a medical impact (i.e.: underage alcohol (EtOH), suicidal ideation, etc.) make sure there is an evaluation. Other spots where Stealth issues can be found:

- Answering 'yes' to the PHA questions about stress or anxiety*
- Severe headache, severe fatigue or dizziness*
- Other areas to consider: Headaches on optometry survey, or temporo-mandibular joint disease (TMJ), dizziness, or tinnitus on the audiology survey*

*Use CMA judgment to determine if problems are, in fact, present. Document if the symptoms affect duty, and in the case of psychological issues (i.e.: stress), that the patient has good coping skills.

INSPECTIONS AND STAFF ASSISTANCE VISITS

There are several type of inspections, but the most common are Nuclear Surety Staff Assistance Visits (NSSAV's) from the MAJCOM and Nuclear Surety Inspections (NSI's) from the IG. They focus on the same items, but an NSSAV is a training opportunity and an NSI is a compliance inspection. There are other, less frequent, inspections, including Defense Threat Reduction Agency (DTRA) inspections, which are the DoD equivalent of an NSI and usually held concurrently with an NSI.

There are certain areas that consistently produce findings. While you should always be inspection ready, it's worthwhile to review these before the team arrives.

- Pull and check all perm files.
  - Were records deflagged with an SF600 with the reason and date?
  - Do dental / mental health dates deflagging dates match the OPR?
- Pull and check all Alcohol Treatment charts.
  - Were proper recommendations made?
  - Were mandatory timeframes followed?
- Pull and check all mental health files.
  - Were proper recommendations made?
  - Were mandatory timeframes followed?
  - Are notes in the MH record in the OPR chart and vice versa?
- Pull and check all CO's.
- Inspectors will ask about the training program. Be comfortable talking about commander's calls, briefings, squadron stand ups, MICT, and individualized training on identified issues.
- Verify that appointment letters for CMA's, technicians, and HIPAA letters for squadrons are all up-to-date.

NSSAV

If we imagine the NSI as a final exam, then the NSSAV is the TA's last minute study session. NSSAV's are generally held 3-6 months prior to an NSI, but sometimes held afterwards if there were severe deficiencies found by the IG. The key to a successful NSSAV is to remember the team is there to help. They evaluate the same items as the NSI, but rather than simply identifying problems, they offer training and advice on how to fix the areas that need work.

It's never easy when a 3rd party digs into your programs, but you need the NSSAV to give the most invasive evaluation possible. It doesn't matter how strong your program is, there will be errors identified. If it's done well, it's going to hurt. They won't issue you a score, so this is the time to be open about concerns, questions, and problems so you can get advice on how to polish your program before the IG arrives.

Typically, the team will set aside minor items for fixing on the spot. They may have questions that can be fixed with a simple explanation. Fix them, but don't spend much time worrying about these items. Unless there are an inordinate number of admin errors, or a consistent trend, these don't usually represent a core problem and therefore don't typically find their way to a write up. The charts that they hold back for further investigation are the ones that tend to have more serious problems.

NOTE: *Remember: The NSSAV is there to teach, so make them do it. Don't let them get away with identifying problems and then walking away. If they identify a problem, don't let them leave without discussing potential solutions.*

NSI

In contrast to the NSSAV, the NSI team isn't there to educate, but to evaluate for compliance. Don't be insulted if they seem brusque; there are specific rules to ensure that they remain objective, so they may be less social than the NSSAV.

Sometimes inspectors will find what looks like a major discrepancy in the medical records but which can be easily explained. Occasionally, they'll already know it's a non-issue but they'll present it to test the reaction of the PRP staff. If you are given such a chart, calmly review it. Look at the notes immediately before and after the one in question. Often what looks like a problem is actually a misfiled note from another patient's chart. Check AHLTA, since there may be a missing note that explains the issue or shows that a restricted medication was never picked up. Although these still show process breakdowns, they are of a far less serious degree.

There may be times when you disagree with their findings. Be firm but fair. Pick which battles you can win, and stand up for what you are doing differently, but correctly. That said, if you are wrong, own up and implement an immediate fix.

If there is a finding where you're certain you're correct, but they insist is a problem, don't argue. Use phrases like, "Help me understand the AFI…" or "What kind of impact are we discussing?" to understand their concerns. Don't waste time and good-will by arguing minor points. If they identify an issue you already corrected, agree that it was a problem, but then direct their attention to the solution you created to make the problem go away. NSI inspectors must validate any write ups through the MAJCOM, so if all else fails, politely request that disagreements be upchanneled to MAJCOM for clarification.

NOTE: *There are only 3 unacceptable answers during an IG interview:*

1- *I don't know.*
2- *We've always done it that way.*
3- *The inspectors told us to do it this way.*

PRP, HIPAA, AND OTHER 4 LETTER WORDS

Because PRP often involves passing medical information outside of the MDG, HIPAA is very important. Information sent from the MDG, such as a PDI letter, is protected by HIPAA. Once the information is in the CO's hands, it is no longer HIPAA protected and falls under the Privacy Act instead.

HIPAA

HIPAA allows for the CO to have some access to the medical information as part of their duties. However, the minimal disclosure rule applies, so they are only privy to the minimum information necessary to make their decisions. Why is this important? Well, as mentioned, a CMA needs to function as both a funnel and a filter. If you are passing along medical information that has no bearing on a member's PRP Status, technically, it could be a violation of the minimum disclosure rule. Providing information in a PDI letter that could not reasonably affect PRP status may be an example. Has anyone been cited for this? Not to my knowledge. But it's a good incentive to make sure your PDI disclosures are relevant and contain only information that is of value in determining the member's PRP status.

HIPAA disclosures are a painful issue. Some bases claim that by having the member sign a PRP authorization form, they are exempt from needing to log disclosures when they send a letter to the CO. Unfortunately, the Medical Legal read does not support that. When I ran it up the chain, here is what was said by Marcia L. Kurtz, the Legal Advisor on Procurement and HIPAA (AFMSA/SG5J),

> "The PRP question has been asked many times over the years. . . . Release [of this PHI] to the authorities mentioned in the PRP DoDI/AFI outside the MTF is considered required by law [("RBL")] since it is directed by a regulation that meets that definition. [See DoD 6025.18-R, C7.1.] While an argument could be made that release is to a CC authority or designee [under DoD 6025.18-R, C7.11], this one fits better as RBL. As such it is an accountable disclosure. My understanding is that most MTFs have adopted an electronic accounting (their own or the DHA PHIMT system), or use the 1 disclosure for the event (while in the PRP program) in C13.2.3. The idea of having the members sign an auth has surfaced to avoid the accounting but that really isn't appropriate. Asking for an auth implies the info cannot flow unless the auth is signed and that is not the case. Since this falls under RBL, the PHI can flow so it is a bit misleading to the member to ask for an auth simply to avoid the accounting. What if the member doesn't sign? The PHI may be disclosed anyway. It is not considered national security [which is the possible exception I discussed below], that is very rare, I think I've had one of those. When you think about it, anything could be argued as under national Security. It has to fall under the type of laws, EO, actually mentioned."

So, make sure to log HIPAA disclosures when sending PDI letters to the CO.

1. ***Should CMA's report everything that might possibly be a suitability factor?***

   If given the (false) choice between over-reporting and underreporting, over-reporting is more desirable. But it's still the lesser of two evils.

   If a CMA over-reports, it doesn't take long for the CO to notice. Soon, they take everything the CMA says with a large grain of salt. Then, when a serious issue is found, the CO either doesn't appreciate the severity (crying wolf) or doesn't notice (needle in a haystack). Neither option is acceptable.

   The proper role for the CMA is to apply medical knowledge and report only items that could significantly affect an individual's ability to perform PRP duties. Finding this balance takes some practice and a degree of confidence and assertiveness. CMA's need to explain (and document) decision making on judgment calls, and to be consistent throughout the clinic. If one CMA is overly or underly cautious, the Lead CMA needs to bring them back into balance.

   Suitability factors should be reported with its impact so the CO can appreciate the reason it's being reported. If the CMA can find no impact, then the item in question may not actually be an issue after all. Of course, any alcohol related incidents, drug related incidents, or suicidal concerns should always be reported.

2. ***Should we distribute off-base care sheets at the unit or the MDG?***

   Back in the early 2000's, it was common to require personnel to visit the MDG prior to going off base and to collect a summary sheet for the off-base provider to complete. The MDG contacted the unit to recommend suspension pending evaluation and the off-base care sheet was returned to the PRP clinic for CMA review. However, members commonly forgot to visit the MDG and no notification was made. Additionally, this shifted the onus of responsibility to the MDG. In response, it became standard for the sheets to be maintained at the unit instead.

   The new AFMAN put the onus back on the individual. Some MDG's still use a form to facilitate patient followup, but from a PRP perspective, there is no longer an expectation that patients are suspended or off-base care forms used.

3. ***Should we put our day-to-day instructions in an MDGI?***

   Years ago, it was commonplace to put all the step-by-step processes for daily work into an MDGI. It allowed for continuity and was a good training tool. Unfortunately, it was also an easy target during inspections. If a process in an MDGI wasn't followed exactly, the inspection team had grounds for a write-up.

   A compromise that keeps some degree of continuity but is less vulnerable to inspectors is to maintain a set of business rules. They allow for continuity, but they don't carry the weight of law and are easier to update and change. This allows for deviation from the business plan as mission dictates, but still provides a set of guidelines for training and continuity. Just make sure that the business rules are clearly labeled as a "guide" and that "deviation is permitted".

4. ***We've been struggling to follow our defined processes. Should we add another step to double check the work or should we require more training?***

   It's easy to add steps or blame failure on inexperience and make techs spend more time training. But what if the root cause is that they are already task saturated? Adding more steps to the process or taking time for more training will compound the problem rather than solve it. A better fix is to look at the reason that they haven't been following the existing process. This is a chance to apply mishap investigation training and examine how human factors play a role.

   One of the most effective ways to fix the process is to meet with the workers in the trenches and ask them how they could best accomplish the task. They may have insights that will streamline the process and allow them to accomplish it consistently with fewer steps. You may need to have a temporary cross-check to ensure that the fixes to the system are effective, but that's much more effective than adding a permanent cross-check to a broken system.

   NOTE: *"Any intelligent fool can make things bigger and more complex…It takes a touch of genius – and a lot of courage to move in the opposite direction." - Albert Einstein*

5. ***Base X always reports if the patient has a pain level 7/10 or higher. Should we do that?***

   Short answer: There are very few "always report" conditions in the DoDM. Pain is not one of them, and there is no number over which pain must be reported.

   The reflexive reporting of pain over a certain number is a classic example of doing the "what" (reporting pain) without understanding the "why" (how does it affect the member). The reason that people fixate on pain 7/10 or higher is that at that level, it is reasonable to expect that the provider is going to treat pain. They may prescribe narcotics, limited duty, or other PRP impacting action. At high levels, pain might also cause fatigue, inability to concentrate, or other effects. It's the treatment and effect, not the pain, which might affect PRP duties.

   If you say, "Pt reports no effect on concentration and pain does not impact daily activity or duty," you have made clear statements about the effects of the subjective pain. But your CMA's have probably already addressed the pain level in their note. Look under "objective". Does it say "In no acute distress"? If so, the CMA has evaluated the pain and found it to be a non-issue.

   What if the pain is severe enough to affect PRP duties? One common technique is to tell the CO that the member has "Distracting pain." ***Please <u>don't</u> do that.*** As a medical provider, why would you tell a CO that a patient has severe pain that impacts their daily life, without treating it?! If you alert the CO that a member is having severe pain, their first question is how you plan to treat the member. Put medical care first and address the underlying condition. Rather than, "distracting pain", explain that the patient, "Requires narcotic medications, physical limitations, frequent medical visits, and has fatigue." That gives the CO objective conditions to discuss with the member when determining if they are able to perform their duty. (and it shows you're actually treating the patient.)

   Lastly, data shows an individual rating on the pain scale isn't reliable. Published studies found that "A single rating of pain intensity is not adequately reliable or valid as a measurement of average pain," and that it took at least 3 assessments of pain per day for 4 days to achieve an adequate level of stability. ("Increasing the reliability and validity of pain intensity measurement in chronic pain patients", Jensen, Mark P, McFarland, Candace A. *Pain*. Vol 55, Issue 2, Nov 1993. Pages 195-203).

MISHAPS

The number one priority for all medics after a mishap is to provide medical care. It's easy to lose sight of this and let mishap crews sit in the cold at the site while the flight docs gather evidence. Never lose sight that patient care and safety comes first.

When a mishap occurs, the SGP will be working closing with Wing Safety to establish the ISB, and MAJCOM will be tasked with finding members for the SIB and AIB. On that note, remember to notify the MAJCOM SGP as soon as you are able. The AIB is a legal as opposed to a safety investigation and is headed by JG instead of SE. The results of the AIB are (eventually) releasable to the public.

The SGP must maintain a list of flight surgeons who are potential medical officers on ISB's or SIB's and track their annual AMIP training and previous SIB experience. The SGP must also track AOPT personnel who have mishap training and provide these lists to installation Chief of Safety and the MAJCOM SGP. (AFI 91-202 para 1.5.17.5.4.) The MAJCOM may also want to know your staff's experience in different airframes. For the sake of the report, broad categories such as 'heavy', 'bomber', 'fighter', or 'rotary wing' are sufficient.

Good resources are the SoUSAFFS Aircraft Mishap Investigation Handbook, AFPAM 91-211, and particularly, AFMAN 91-223.

NOTE: *The Naval Safety Center, Aeromedical Division publishes an excellent aircraft mishap handbook. The best part is that their Pocket Reference to Aircraft Mishap Investigation has been made available online. Check:*
http://www.public.navy.mil/navsafecen/Documents/aviation/aeromedical/duties/Pocket_Ref.pdf

INTERIM SAFETY BOARD: ISB

The goal of the ISB is to lay the groundwork for the SIB, so there is a focus on gathering and preservation of evidence. Medical evidence can be time sensitive, so it's essential to move quickly for lab testing and interviews. The ISB typically runs about 3 days until the SIB is formed and takes over. It's likely that Wing Safety will name the responding FS to be the ISB Medical Officer (MO), but that doesn't stop the other flight docs from supporting and assisting. If it's a large mishap, there may be dozens of involved parties, so it's expected that the entire flight med clinic will pitch in and assist with exams.

ISB MEDICAL OFFICER RESPONSIBILITIES

Duties are spelled out completely in AFMAN 91-223 and are summarized below. After the patients' medical needs are covered, the ISB MO will be responsible for the following:

- **Collection of 72 hour & 14 day histories.**
  - Keep blank copies of the forms in the mishap bag, and put copies in the Mishap MDGI as well.
  - Privilege can only be extended by the ISB BP or IO, but ideally, should not be used for histories. Notify the patients and document if privilege is extended or not.
  - Associated personnel (i.e.: aircrew & ground crew) should complete histories. The CC may test others per AFI 91-204 chapter 2. For an RPA mishap, "associated personnel" are defined as the last two crews to operate the RPA.
- **Toxicology testing:**
  - As soon as possible, collect from each of the involved parties: two 10 ml red top tubes, four 7 ml NaF (gray top) tubes, three 7 ml EDTA (lavender top) tubes, 50-70 ml of urine (no preservatives). Do not use SST, CORVAC or Tiger Top tubes, as the gel can cause false negatives for some drug testing.
    - Have local lab run serum glucose & blood alcohol (7ml gray top), CBC (7 ml lavender top), SMA-18 (7 ml red top), and UA with micro exam (20 ml urine.)
    - Send two NaF (gray top) tubes with at least 7 ml blood each, 1 EDTA tube (lavender top) with at least 7 ml blood, and 50-70 ml urine to AFMES with a DD Form 1323 (Toxicological Examination Request and Report).
    - The remaining red, gray, and lavender top tubes, and 10 ml of urine need to be held locally, frozen, for at least 90 days.
  - Skin should be cleansed with betadine or soap and water - no alcohol should be used for skin prep.
  - All toxicological specimens from fatalities will be collected by the medical examiner at the time of autopsy.

NOTE: The *AFMES Guidelines for the Collection and Shipment of Specimens for Toxicological Analysis*, April 2012, gives excellent details in what to collect, how to collect it, and how to ship it. Download a copy and ensure your lab has a copy as well. *http://www.afmes.mil/assets/docs/toxguidelines.pdf*

- **Medical / Dental record collection for involved personnel**. Keep the records in a locked cabinet or have them officially sequestered by your SGQ.
- **Coordinating medical care at the site and advising on environmental hazards on site**
  - Ensure food and water on site.
  - Consider having an IDMT on site for care to the recovery teams, especially in remote sites or with harsh weather.
- **Act as liaison between military and civilian health authorities.**
  - This may include working with the local coroner to process remains. Overseas, the SOFA will spell out who has jurisdiction and when remains must be released to the parent nation.
  - If there are toxic chemicals (hydrazine, fuels, etc.), the MO will need to work with base PA, but the SIB President will need to OK any information being released.
- **Ensure AFE is photographed.** If personal flight equipment or escape equipment is removed from the site, it must be carefully photographed.
- **In Class A mishaps, ensuring a complete physical exam is performed and documented in AHLTA.**
  - Physical examinations for other mishap and event classes may be focused physical exams appropriate for the mishap.
  - Although the extent of these examinations is at the discretion of the ISB medical officer, they should all be documented in AHTLA.
  - Do not enter any privileged information into AHLTA. AHLTA notes will be pulled for the AIB.
- **Post-mishap AF DD 2292 for involved aircrew.**

NOTE: *Why wouldn't the BP extend privilege to the 72 hour and 14 day histories? First, the information is factual vs. interpretive and factual information isn't protected. Also, if privileged is granted, the AIB will need to regenerate the forms and they will be less accurate at the later date. Based on these reasons, AFI 91-223 3.4.10.1 encourages NOT extending privilege for these histories.*

ISB MEDICAL OFFICER RESPONSIBILITIES FOR A FATALITY

If there is a fatality, little else changes, but everything is under higher scrutiny. Chain of custody of remains is essential and may require the MO to be present at the site prior to and during removal of remains. The remains may need to be moved to Dover for autopsy and collection of samples. If stationed overseas, be familiar with the SOFA, as some countries treat a mishap as a homicide and may not release remains unless the SOFA requires them to do so.

Notification of the family and survivor assistance is not an ISB function. Mortuary affairs is responsible, though the MO may be part of the team, especially if the dependents are their patients. However, the flow of information as it is uncovered is from the AIB president and Family Liaison officer, not from the ISB or SIB. AFI 34-1101 is the reference AFI for Survivor Care. It used to be mishap-centric, but has been broadened to address survivor care in all cases.

AFI 91-223 para 3.4.11 details the responsibilities of the MO if there is a fatality. The section is very proscriptive and is copied below:

> *3.4.11.1. The ISB medical officer and mortuary affairs officer (when assigned by the command) will collect and preserve life sciences evidence as required. The ISB medical officer should be present before human remains are removed from the mishap site when possible. Great care must be taken to ensure a positive chain of custody for all human remains. If any chain of custody issues arise, contact the CA immediately. The following steps will be conducted by or under the supervision of the ISB medical officer:*
> *3.4.11.2. Contact the Armed Forces Medical Examiner System (AFMES) to coordinate forensic pathology assistance. AFMES can be reached at* ***http://www.afmes.mil*** *or via telephone at DSN 366-8648 or (302) 346-8648. Contact HQ AFSEC/SEH (DSN 263-4868, Comm (505) 853-4868) if further assistance is needed.*
> *3.4.11.3. Before moving any human remains, determine jurisdiction (legal control) for those remains. In most cases, the local coroner or medical examiner will have jurisdiction over the remains. Jurisdiction issues for geographic areas surrounding military installations and ranges should be delineated ahead of time during incident response planning. Most FAA Regional Medical Examiners maintain a database delineating the areas of jurisdiction and may be of assistance in clarifying these issues.*
> *3.4.11.4. Complete detailed site diagramming before any human remains are moved. Use clearly labeled stakes and take sufficient photographs recording pertinent details.*
> *3.4.11.5. Remove human remains only after completely documenting and closely scrutinizing all surfaces of remains with on-scene photography. Ensure photographs include adjacent structures which could account for traumatic injuries or objects which show evidence of tissue transfer.*

Lastly, there are other biologic samples that are strongly recommended in the event of a fatality, typically collected the medical examiner at time of autopsy. The following is copied from the *AFMES Guidelines for the Colletion and Shipment of Specimens for Toxicological Analysis*, April 2012 on samples to submit in the event of a fatality. (see the web link in the previous note for the entire handbook).

Blood:	*All available up to 100 mL (indicate source)*
Urine:	*100 mL (no preservative)*
Bile:	*All available*
Vitrous:	*All available*
Liver:	*100 grams*
Brain:	*100-200 grams*
Kidney:	*50 grams*
Lung:	*50 grams*
Gastric:	*50 grams*

If no fluid or organs can be recovered, 100 grams of muscle (psoas, perispinal, or deep thigh preferred), and/or fat and red bone marrow can be submitted. In severe crush injuries, the gallbladder will often remain intact, permitting bile collection. Even in the most severely burned or fragmented cases, valuable information can often be obtained from only a few grams of dried blood or tissue (exp. spleen). If in doubt, submit as much tissue as is practical; ***do not submit fixed tissue for toxicological analysis.*** *All specimens must be labeled with the sample type, decedent's name, autopsy number and complete SSN. A properly completed AFMES Form 1323 (see Attachment 1)* ***must*** *be submitted with each fatality or Medical Examiner case.*

The qualifications for the SIB medical officer (MO) are established by the Board President and Investigating Officer. The MAJCOM will identify prospective members and then contact the base. This is why it's important to keep MAJCOM updated with local manning, training, and experience.

The SIB medical officer (MO) is less concerned about evidence collection and focuses on the investigation, but will need to watch for toxicology reports and labs or autopsy findings. In addition to investigation and writing of the report, the MO keeps the board from running afoul of HIPAA and protects information from inappropriate release.

The biggest task for the SIB MO is to write the Tab Y, discussing the medical and physiologic factors that played a role in the mishap. They also contribute to writing of Tab T. Tab Y is not a stand-alone document, and it needs to be consistent with the rest of the SIB. The most common cause for rejection of SIB findings is when Tab Y doesn't agree with the rest of the report. Ensure any HFAC's discussed in Tab T are included in Tab Y, and any discussed in Tab Y are also in Tab T.

Tabs T and Y should be written as an ongoing process throughout the SIB. There may be factors that are added, removed, and added again as the investigation continues. That's to be expected. The MO needs to be working on these tabs from day 1 and in constant communication with the board regarding opinions, reasoning, and theories. Never wait until the end of the board to begin writing and analyzing the HFAC's.

There may be a human factors (HF) consultant as a conditional member of the SIB, at the discretion of the board president (AFMAN 91-223 para 4.2.2.4) They can provide excellent HF insight and bring valuable experience to the table. However, if there is an aggressive physiologist and a young flight doc, it's easy for role reversal to occur. Remember that the HF consultant is there as an assistant to the MO; the MO is the lead expert for human factors discussions, even if there is an HF assistant on the board. (AFMAN 91-223 para 4.2.1.7.)

Note: *The summary statement in Tab T may be as simple as, "The MP's medical history, 14-day, and 72-hour histories were unremarkable. His flight physical was current with no waivers required. His physiological training was current."*

TAB Y1.1: SUMMARY OF INJURIES

Briefly describe the type and mechanism of injuries. Limit private information to the bare minimum needed; private and privileged information are included under Tab Y2.

If there are photos of human remains, they should be placed in Tab Y2. Discuss injury patterns instead of showing photos. If it is absolutely necessary to have them here instead, it requires HQ AFSEC approval.

NOTE: *No one truly wants to see autopsy pictures. Unless you absolutely need to show the board, don't. And if you do, use the minimum disclosure rule.*

TAB Y1.2: HFACS: INVESTIGATION AND ANALYSIS OF FACTORS

Although Y1.2 is titled 'analysis of factors', it only contains definitions; the specifics of how the HFAC contributed to the mishap are discussed in Tab T. Any HFACS in Tab T are listed and defined here as causal factors, factors, or non-factors worthy of discussion and are referenced to their counterparts in Tab T. For example, if a mishap cause was a pilot suffering an acute MI resulting in loss of consciousness, it would be listed as this:

> PC304 – Sudden Incapacitation/Unconsciousness (Causal – T4.3.1.): Sudden Incapacitation/Unconsciousness is a factor when the individual has an abrupt loss of functional capacity/conscious awareness (not GLOC). Capture medical causes for the incapacitation in the AFSAS medical module.

Causal factors are the last piece of the HFAC chain; if a significant factor causes another factor, then it isn't casual. Causal factors will be decided by the board through group discussion, but the MO (and HF consultant) will be major players in that discussion. If a factor contributed significantly to the mishap but resulted in another factor, it may be included as a factor, though not a causal factor, in this section. For instance, PC105 - Negative Transfer (Factor) may result in AE101 - Inadvertent Operation (Causal). Make sure these are labeled consistent with HFACS in Tab T.

Non-Factors Worthy of Discussion should not be listed unless they are also included in Tab T7 as a non-factor worthy of discussion. Make sure that HFAC's codes in Tab T, Tab Y, and AFSAS all match.

TAB Y1.3: HUMAN FACTORS CONSULTANT REPORTS

This section is summed up neatly in AFMAN 91-223, as listed below:

> Y1.3. Human factors consultant reports. If an HF member (i.e. aerospace and operational physiologist, psychologist) is on the SIB (either as a primary member or consultant), place the report here. The consultant report only speaks for the consultant's point of view.
>
> Y1.3.1. If the SIB disagrees or discounts a significant portion of a consultant report this should be annotated in this section.

TAB Y1.4: ADDITIONAL CONSULTANT REPORTS

This is self-explanatory from AFMAN 91-223:

> Y1.4. Additional Consultant Reports. Include other consultant reports here if applicable.

TAB Y2: PROTECTED MEDICAL DOCUMENTS

Any items that are non-privileged but protected by HIPAA, Privacy Act, etc., are put in this section. This section may be read by the AIB, so nothing that is privileged is placed here. Because the AIB may use this section, it cannot have any analysis. Highlighting, page references, or markups of records are considered analysis and would not be allowed to be given to an AIB.

AFOSH 91-223 Y2.1-2.2.1 lists the required documents:

> **Toxicology Reports.** Scan and paste in the reports from relevant toxicology tests.
> **Physical Examinations And Medical Condition**. Include scanned copies or AHLTA print-outs of all physical exams, the most recent PHA, the DD Form 2766, any active waivers, and the person's current serial profile.
> **Post Mishap Physical and/or Autopsy Report**. Factual post-mishap physicals and/or autopsy reports must be included here. Photos of human remains highlighting fatal injuries may be included as an attachment to the autopsy report. Also include factual radiology reports, statements of prognosis, and prescribed medications.

NOTE: *You may run a FAST analysis if fatigue is a factor. If there were significant continuous hours of wakefulness, it is sometimes useful to calibrate fatigue against blood alcohol level to express impact on the member. However, the effects of alcohol and fatigue are not the same, so this is only an analogy.*

Continuous hours of wakefulness	FAST Effectiveness	Blood Alcohol Concentration
18.5	77	0.05
21	70	0.08

(From the Naval Flight Surgeon's Pocket Reference to Aircraft Mishap Investigation, 6th ed. Naval Safety Center, Aeromedical Division.)

Arnedt, J.T., Wilde, G.J. Mint, P.W., MacLead, A.W. "How do prolonged wakefulness and alcohol compare in the decrements they produce on a simulated driving task?" *Accid Anal Prev.,* 2001 May: 33(3):337-44.

Dawson, D., Reid, K. 1997. "Fatigue, alcohol, and performance impairment." *Nature* 388, 23.

ACCIDENT INVESTIGATION BOARD: AIB

Although the AIB follows the same pattern as a safety investigation, it is a legal investigation led by JG instead of Safety. The SIB will turn-over to the AIB any non-privileged information. This includes coroner reports, labs, post-mishap exams, toxicology results, medical / dental records, 72 hour / 14 day histories (if privilege was not extended), and any factual results such as radiographs. If the AIB doesn't have a medical officer, they release all medical information back to the MTF, but they can request access to records and other HIPAA information if they need.

From there, the AIB proceeds like an SIB. There is no "Tab Y", but the medical officer writes sections 9 (Medical) and 11 (Human Factors).

The report must reference everything it includes; it can become very tedious reviewing and writing the report since every line must have a reference. There will be a legal advisor on the board who usually has experience, and will help keep everyone on track.

NOTE: *Unlike an SIB, the AIB's report is releasable. The JAG maintains a website of AIB Class A reports at http://usaf.aib.law.af.mil/ . It can be helpful to review previous reports involving similar aircraft.*

SECTION 9

The AIB legal advisor should have an AIB template that you can use. This is a fictional AIB medical report with the more-or-less standard language:

9. MEDICAL

a. Qualifications

At the time of the mishap, all members of the MC were medically qualified to perform flying duties without restriction. All annual Preventative Health Assessment's (PHA) and associated AF Form DD 2292's were current. The MP had a current and valid medical waiver. The MC displayed no physical or medical limitations prior to the mishap (Tab X-#).

b. Health

The AIB Medical Member reviewed all available MC medical and dental records. The MC were in good health with no evidence that medication or a medical condition contributed to the mishap (Tab X-#). The MC's post-mishap history and physical examinations revealed no injuries (Tab X-#).

c. Toxicology

Immediately following the mishap, toxicology testing was performed on the MC and MM. Blood and urine samples were submitted to the Armed Forces Medical Examiner System (AFMES), Dover AFB, Delaware, for toxicological analysis. Testing included carbon monoxide and ethanol levels in the blood and drug testing of the urine (Tab X-#). All samples were negative for elevated carbon monoxide levels or ethanol (Tab X-#). The MC and MM's urine was screened for amphetamine, barbiturates, benzodiazepines, cannabinoids, cocaine, opiates and phencyclidine. None of these substances were detected (Tab X-#).

d. Lifestyle

Based upon MC interviews and review of 72-hour/14-day histories, no lifestyle factors were found to be relevant to the mishap (Tabs X-# to X-#).

e. Crew Rest and Crew Duty Time

AFI 11-202, Volume 3, *General Flight Rules*, 22 October 2010, requires all air crew to have proper "crew rest" prior to performing in-flight duties. Crew rest is defined as a minimum of a 12-hour non-duty period before the designated flight duty period begins. During this time, an aircrew member may participate in meals, transportation, or rest as long as he or she has had opportunity for at least eight hours of uninterrupted sleep.

Based upon MC interviews and review of 72-hour/14-day histories, the MC met crew rest requirements (Tab X-#). There is no evidence that fatigue contributed to the mishap.

SECTION 11

This section splits HFACS as causal, contributory, and non-contributory. Unlike the Tab Y, the analysis of the HFAC is offered in this section. Although any HFACS may play a role, Acts are more often found as causal than other HFACS. A typical (fictional) section 11 might read:

11. Human Factors

a. Overview

The board evaluated human factors using the Department of Defense (DoD) Human Factors Analysis and Classification System (HFACS), implemented by Air Force Pamphlet (AFPAM) 91-204, *USAF Safety Investigations and Reports,* dated 24 September 2008 (Tab XX-#). The DoD framework to analyze and classify human factors and human error in mishap investigations classifies HFACS into four main tiers: Acts, Preconditions, Supervision, and Organizational Influences. Each category is divided into related subcategories. The relevant factors to this mishap are discussed below.

b. Causal

(1) AE 104 Overcontrol/Undercontrol

Overcontrol/Undercontrol is a factor when an individual responds inappropriately to conditions by either overcontrolling or undercontrolling the aircraft/vehicle/system. The error may be the result of preconditions or a temporary failure of coordination.

At 0500Z, the MA began its descent toward runway 45R. The MP stated that he was aware of an ice cream truck (MICT) parked on runway 45R. The MP attempted to abort the landing and go around for a second pass. However, the flight data recorder showed that stick input was insufficient to abort the landing. As a result, the aircraft struck the MICT, dislodging the ornament on its roof. The aircraft landed safely but Smiley the Ice Cream Clown was destroyed.

c. Contributory

(1) PC213 Get-Home-Itis/Get-There-Itis

Get-Home-Itis/Get-There-Itis is a factor when an individual or crew is motivated to complete a mission or reach a destination for personal reasons, thereby cutting necessary procedures or exercising poor judgment, leading to an unsafe situation.

The MP stated that he was aware of the MICT on the active runway, but that he wished to land and purchase a Smiley-bar before the MICT left.

d. Non-Contributory

There were no significant non-contributory human factors necessitating discussion.

RADIOFREQUENCY RADIATION EXPOSURE MISHAPS

This is one of the more common exposures. It often turns out to be a false alarm, but all suspected RFR exposures must be investigated and reported in AFSAS. AFOSH Std 48-139 and 48-9 detail the requirements for the investigation. Basically, the BEE's review the tech manuals to determine outputs, then measure or estimate the levels at the alleged exposure.

Unless there was more than 5 times the maximum permissible exposure (MPE), no medical effects are expected and no exam is required. It takes a significant amount of RFR to the eye to cause long-term effects (i.e. – cataracts). Those levels would be expected to cause noticeable burns and pain. However, meeting with a patient may defuse concerns, especially if the patients are complaining of symptoms, so evaluations may be prudent even in lower-level exposures.

Post exposure medical examinations should be performed within 72 hours of the exposure. Symptoms after 72 hours are not likely due to an exposure. The exam includes a basic H&P, focusing on evidence of facial burns and ocular (lens) damage. If there is suspicion, either from high levels of RFR, facial burns, or ocular symptoms, then the patient should have a slit lamp exam. If data is available, document exposure duration and level (or distance from source). Legitimate cases with > 5 times MPE should be followed for 2 weeks or until they are stabilized.

The biggest concern is risk communication and reassuring patients. AFOSH Std 48-9 requires that the patients be advised of the BEE's findings and a physician should be present to answer questions at that time. (A4.5.2.6.) I recommend meeting with them earlier rather than later; the last thing you want is for a group of frightened maintainers to present to the local ER complaining of "radiation exposure".

LASER EXPOSURE MISHAPS

If there is a suspected laser exposure, Attachment 2 of AFOSHSTD 48-139 outlines the exams and steps that must be taken. Additionally, AFI 48-149 discusses it in 2.2.7.

If results are normal, then an occupational injury did not occur, but you still want to document the investigation. A summary of Attachment 2 is below:

1. The member should immediately report to the Medical Treatment Facility whenever eye exposure to laser light is suspected.
    a. Contact the Base Laser Safety Office (BEE's) to begin an investigation.
    b. Notify the DoD Tri-Service Laser Injury Hotline; (800)-473-3549; (937) 938-3764; or DSN 798-3764.
    c. Confirmed ocular directed energy exposures must be reported as at least a Class E Physiologic event, or if appropriate, at a higher class level IAW AFI 91-204, *Safety Investigations and Reports*. (AFI 48-149 2.2.7.5.)
2. An examination should be done and include at minimum the following:
    a. Medical history
    b. External examination including skin
    c. Best corrected visual acuity (near and far)
    d. Amsler grid
    e. Stereopsis
    f. Color vision
    g. Nondilated funduscopy (dilated examination is recommended)
    h. If the results of the examination are normal and the patient does not have any persistent visual complaints, they can be returned to duty. (Normal is defined as normal for the individual.)
3. If the results of the initial examination performed are abnormal or questionable, additional examination will be conducted to include:
    a. Pupil examination
    b. Slit lamp bimicroscopy
    c. Dilated funduscopy
    d. Retinal photography
    e. If the additional examination does not find any questionable abnormalities, contact the Tri-Service hotline at (800) 473-3549.
4. If the additional examination is abnormal or questionable, the patient needs a thorough ocular examination which may include retinal photographs, visual fields, fluorescent angiography, and other tests. Contact the USAF School of Aerospace Medicine for further action. [DSN 240-3241]

AFOSH std 48-139

1.3.2.1.7. Laser strikes. Damaging laser strikes to both personnel and aircraft should be reported IAW this AFMAN according to the respective class of the mishap (i.e., Class A-D). Laser strikes involving exposure to personnel should be reported IAW AFI 48-139, Laser and Optical Radiation Protection Program, attachment 4. Additionally, aircrew should consider reporting laser strikes to the Federal Aviation Administration (FAA) laser incident reporting website at http://www.faa.gov/go/laserinfo.

NOTE: There is a guidebook located on the Kx. It was last seen at: ***https://kx.afms.mil/kxweb/dotmil/file/web/ctb_026112.pdf.***

GROUND MISHAPS

Ground mishaps may include any number of different situations, including an aircraft taxiing. Ground mishaps won't always involve a full investigation, but Wing Safety may convene an investigation board and require a medical member. These boards are generally much smaller than an SIB, and may have only a President, investigating officer, and medical member. Also, unlike an SIB, the ground safety board may be made of personnel from the affected base.

The flight med clinic may be pulled in to obtain 72 hour / 14 day histories, conduct medical exams, and order toxicology testing. There is no written requirement for any of the above, but it's generally best to treat the ground mishap like an aircraft mishap of the same classification. However, since toxicology testing is not mandated, patients will have to sign a voluntary order. Security Forces will provide the paperwork and follow up if there are refusals.

NUCLEAR MISHAPS

Hopefully, you'll never have a mishap in the nuclear enterprise, but there may be reference to a "Dull Sword" or "Bent Spear", during the quarterly nuclear surety meeting. They are discussed in AFMAN91-221 *Weapons Safety Investigations and Reports* and a summary is below.

All of the following are "Pinnacle" events, meaning that they are of interest to MAJCOM's, DoD, and National Command Authority (NCA).

- **"BENT SPEAR**" refers to incidents involving nuclear weapons, warheads, components, or vehicles transporting nuclear material. This category includes security or handling breaches. The (in)famous 2007 BUFF flight from Minot to Barksdale was a Bent Spear, but the term may refer to a mishap if a component is damaged in a storage bay.

- **"BROKEN ARROW"** refers to a mishap that does not create the risk of war, but may involve launching of a weapon, use of a nuclear capable weapons system, unplanned nuclear detonation, or non-nuclear detonation or burning of a weapon or component. The classic Broken Arrow is the crash of an aircraft which is carrying a weapon. Hollywood movies to the contrary, this does not refer to loss or theft of a weapon.

- **"DULL SWORD"** refers to a minor incident that could impair deployment of a nuclear device. An example might be damage to a transport vehicle that isn't carrying a weapon. If there is a significant unreported medical issue, it could result in a Dull Sword. This is the equivalent of a "near miss", so it's the most common flag word used.

- **"EMPTY QUIVER"** refers to the theft or loss of a functioning nuclear weapon. The movie, "Broken Arrow", should have been named Empty Quiver. The movie, "Sum of All Fears", involved an Empty Quiver, followed by (spoiler alert) a Broken Arrow.

- **"FADED GIANT"** doesn't refer to nuclear weapon incidents, but rather to nuclear reactors. An accidental radiation release from a power plant would be an example of a Faded Giant.

- **"NUCFLASH"** refers to the accidental or unauthorized detonation or launch of a nuclear device that creates the risk of war. It can also refer to the accidental or unauthorized flight of a nuclear capable aircraft if that aircraft could penetrate the airspace of a nuclear capable country.

- **"NIMBLE ELDER"** refers to nuclear / radiologic search operations.

OTHER SGP DUTIES

MICT

The MICT process is different from the old HSI (or Joint Commission) since the Wing CC owns the inspection process. Because of this, only s/he (via Wing IG) can tell you officially if you are in compliance or not. However, the MAJCOM SGP office will review the checklists regularly to monitor bases' status and offer suggestions on improvement plans as well as spot checks on "green" items.

But wait…if the MAJCOM SGP office doesn't have direct authority, why should you listen to their inputs? Well, the MAJCOM SG reports their findings to the MAJCOM IG, who reports it quarterly to the MAJCOM CC, who holds the Wing CC's accountable, who in turn will hold you accountable. If the SGP office is calling you out, saying that your justification for a "green" isn't sufficient, or that your "get well plan" is flawed, expect that eventually you'll be justifying yourself to your Wing CC if you don't fix it.

NOTE: *Morale of the story: the MAJCOM SGP office is there to help. Let them.*

AFIA's inspection focuses on 'unrecognized noncompliance'. In other words, if there is a 'yellow' or 'red' item on MICT, they aren't going to hold that against you. What they look at is the 'green' items to ensure that they are, in fact, green. When completing the MICT checklist, anticipate reviewers' questions. Don't write a book, but include enough information so the reviewer knows that it wasn't merely pencil whipped. It's a little extra work up front, but quarterly updates are simplified and it saves work answering inquiries from IG and MAJCOM. This also saves you time at the next review and gives your successor more SA on the programs. Examples:

Does X have an appointment letter?

Weak: *Yes.*

OK: *Yes. Signed on 15 Jun 2014.*

Best: *Yes. Signed on 15 Jun 2014. See attachments.*

Are occ health exam rates over 90%

Weak: *Yes*

Ok: *Yes. Rates are tracked monthly at AMC.*

Best: *Yes. Rates are tracked monthly at AMC. Quarterly average was 92.5%*

AEROVAC

One of the first topics to educate the MTF staff on Aeromedical Evacuation (AE) is the difference between Casualty evacuation (CASEVAC), Medical evacuation (MEDEVAC), and AE. The most important difference is that AE is specific to USAF regulated movement. The others can involve any service branch and are not formally regulated via a Patient Movement Center.

CASEVAC – unregulated movement by any Service, using any form of transportation

MEDEVAC – movement, typically by rotary wing, by USA, USN, USMC, or USCG

AE – USAF fixed wing movement of regulated casualties with dedicated airframes

NOTE: *For a more complete picture, read AFI 44-301 World Wide AE system and AFI 11-2 V3 Chapter 3 AE Operations Procedures.*

COMMERCIAL

Commercial AE may involve Lifeflight, ISOS, (or the like) or simply sending the member via a commercial airliner. The decision will depend on the patient's severity.

If flying on a commercial airliner, there is much less of a time constraint since the patient is by definition, stable. This can be coordinated via TPMRC, who will authorize civilian aerovac. If the patient is bringing any type of lab sample, including fixed microscope slides, they will need a letter explaining they are non-infectious, not biohazardous, and that they pose no risk to the crew/passengers.

Typically, Tricare will only pay for Lifeflight to pick up from an in-patient facility and travel to an in-patient facility. This may require sending the patient to a local civilian hospital for transport if your MTF is an outpatient clinic. In this event, the civilian hospital, *not the MTF*, is responsible for coordinating the aerovac flight.

If you are unable to transport the patient to the hospital or the hospital refuses to arrange transport for the patient, you can attempt to arrange the transport from your outpatient MTF. This requires high level red-tape cutting, so engage early with the MTF CC. (This happened twice to me; once when a child was discharged from the PICU with a bowel obstruction and the other was a child with an active intracranial hemorrhage from a newly diagnosed tumor. In both cases, the hospital discharged the children home and refused to coordinate the aerovac. Fortunately, both children were evaced to a Children's hospital, received immediate surgery, and recovered.)

If you plan to have the Lifeflight plane land at the Air Base vs. local airport, the ops desk will need to issue a transient aircraft authorization. They will need the landing time, type of plane, tail number, call sign, souls on board, and whether it will need fuel. The aircrew will need to know the frequencies, runway, and any cautions (lights out, taxiways, etc). This minimizes transport if you have a patient with serious problems, but it does require finesse and coordination to accomplish. That said, the ops desk tends to be eager to assist on this kind of mission, and your knowledge of the medical and aviation worlds makes you the perfect mediator.

MILTIARY

The USAF used to have a dedicated AE aircraft, the C-9A Nightengale, which retired back 2003. (Moment of silence please…) Since there is no longer a dedicated AE airframe, C-17's, C-130's, KC-135s, etc, are pressed into service as AE platforms. However, since this isn't their primary mission, there are a few hoops to jump through to have them hacked off for the AE mission.

ADMINISTRATIVE VALIDATION

Before a mission or patient manifest can be generated by the Joint (or Theatre) Patient Movement Requirements Center (JPMRC or TPMRC), the patients have to be validated in the TRANSCOM Regulating and Command and Control Evacuation System (TRAC2ES). You don't have to be an expert on this, and you probably don't even need an account. But you do need a Patient Movement Ops Officer (PMOO) who knows the system. Find out who this is at your MTF before the need arises.

You'll need to work with the PMOO to establish precedence, which is the urgency in how fast a patient needs to be moved. Remember that it can take up to 6 hours for a request to be validated, so if you have a truly urgent case, call ahead to give the PMRC a cranium's up that an urgent case has been submitted.

Urgent: Must be moved within 12 hours. Airlift missions will be canceled to re-route aircraft. Life, limb, or eyesight movements justify urgent precedence.

Priority: Must be moved within 24 hours. Airlift missions may be canceled to accommodate.

Routine: Can be moved within 72 hours. Psych patients and terminally ill patients are almost always routine.

MISC.

SOFT CONTACT LENS PROGRAM

The Aircrew Soft Contact Lens Program (ACSCL) seems prone to misunderstanding, but the intent is to encourage aircrew to use SCL's and ensure they are monitored. As part of the "reward" for doing so, they are eligible for unit funding for their lenses. The program is addressed in AFI 48-123 para 6.19-6.19.2.3. as well as via policy letters, which are in the KX2. These are summarized in four common questions that popup regularly:

Why do we want aircrew to wear SCLS?

It's actually quite simple. SCL's are more comfortable with helmet wear and are less likely to displace at high G's than spectacles. To keep people comfortable and to prevent loss of spectacles, we encourage SCL's.

Can aircrew just buy their own SCL's?

The ACSCL is mandatory for FC I/IA who want to wear SCL's, either on or off duty. And although FC II/IIU/III are allowed to wear personal SCL's off duty without joining the ACSCL program, they are required to follow the program if they want to wear SCL's during flight duties.

Why are only certain brands allowed?

There are literally hundreds of brands on the market, but due to the aviation environment, the AF wants lenses to have less than 60% water to prevent dehydration. To ensure aviators don't have to swap brands when they PCS, and to keep optometrists from needing to order hundreds of different brands, the AF made a list of easily available, dehydration-resistant ones to use.

What do we do if someone doesn't follow the program requirements?

If they don't follow the program requirements, then they aren't eligible for unit funding for their SCL's, and they aren't allowed to wear SCL's on duty (assuming they are FC II/IIU/III). If the member still doesn't get on board, then chat with the DO and let them know Capt Snuffy can't wear SCL's on duty anymore and that the unit can't pay for the SCL's. That'll usually fix it.

Go / No-Go Pills

Remember, the 26 Jul 01 memo states that only the immediate release Dex can be used, not the sustained release. Sometimes pharmacies ask which ones you want.

ABBREVIATIONS, STAFF POSITIONS, AND ACRONYMS

1 = Personnel
2 = Intelligence / Security
3 = Operations (often combined with #5 and termed Operations and Plans)
4 = Logistics
5 = Plans (often combined with #3 and termed Operations and Plans)
6 = Communications / IT
7 = Training or Engineering
8 = Finance / Resource Management
9 = Civil Affairs (This may be combined with #2 or #4, in which case #9 is JAG)
10 = Nuclear Operations (Often combined with 3)

A = USAF HQ
C = Combined HQ
E = Element
F = Forward deployed location
G = Army or USMC General Officer Staff positions
J = Joint
N = Navy
S = Army or USMC executive staff sections commanded by a field grade officer

In addition, there are special staffs such as the JAG, Chaplain, and Medical directorates. They don't have a numerical designation and are known respectively as JG, HC, and SG.

Using the above guide, you know that a call from J4 is from the Joint Logistics Cell, and when G9 is arranging a press conference, you can expect Army PA at the helm.

WHERE DO I FIND IT?

ALC table: AFI 41-210 Table 10.1
Convalescent Leave: AFI 41-210 para 4.36
DAWG responsibilities: AFI 10-203 Chapter 4
Death documentation / procedures: AFI 41-210 para 9.9
Email use for patient contact forbidden: AFI 41-210 para 2.7.2
Fitness program
- Pushups may be done on fists AFI 36-2905 AFGM 2 attach 1.11
- Environmental conditions: attach 1.19
- Test scoring attach 2
- Member must be given 42-90 days before retesting an unsat: 2.11.1.2
- Members must be given 42 days to inprocess/acclimate before testing: 4.2.4
- Member eligible for test 42 days after (30+ day) AF 469 expires: 4.2.2.3

Flight docs must spend 50% of time on METALS: AFI 48-149 para 2.4
Humanitarian request criteria: AFI 36-2110 A24.5
HIV testing and response to positive tests: AFI 48-135
LOD Determination: AFI 36-2910 A2.1
MEB 30 days after work up AND definitive dx: AFI 41-210 para 10.3
MEB admin and processing: AFI 41-210 chapter 10, DoDI 1332.38 E4.A1.1.3
MEB Combat relatedness: DoDI 1332.38 E3P5.2.2
MEB EPTS determination: DoDI 1332.38 E3.P4.5.4
MEB Presumption of fitness: DoDI 1332.38 E3.P3.5
MEB Special tests required: AFI 41-210 para 10.6.10
MEB Special cases
- GO's and medical officers not physically DQ: DoDI 1332.38 E3.P3.4.2
- no local MEB on MDG enlisted staff with discipline issues or MDG officers: AFI 41-210 para 10.1.4.6, also DoDI 1332.38 E3.P3.4.2

MEB (unsuitable vs unfitness): DoDI 1332.38 E5.1.3
Medical Hold processing: AFI 41-210 para 10.7.11
Mobility and deployment criteria (the big 19): AFI 48-213 Chapter 13
PHA's for PRP: web PHA must be accomplished within MTF: AFI 44-170 1.2.12.7
Physician special pays: AFI 41-109 5.3
Policy Letters: AFI 33-360 para 5.6.6.1.
PRP chart labeling in 2" red letters: AFI 41-210 para 6.2.6
Quarters
- PA or NP need cosign for > 48 hour: AFI 41-210 para 3.6.3

OB quarters: AFI 44-102

CC or supervisor can authorize 24 hours without medic: AFI 41-210 para 3.6.4

Refractive surgery program: AFI 48-123 Chapter 12

SIB: AFPAM 91-211 A4.7 and onward. Includes labs to order.

Soft Contact Lens Program: AFI 48-123 6.24

Wear of senior / master medic badge: AFI 36-2903 para 5.9.2 & 5.9.2.1

Wear of Flight Suit: AFI 36-2903 para 3.2

Removal of pen flap OK: 3.2.2.3

Zip jackets ½ way: 3.2.3

Leather jacket limited to those with aeronautical badge or SMOD: 3.2.3.1.1

Friday shirts OK if CC authorized: 3.2.6

Wear of scrubs: AFI 36-2903 table 3.10

CONTACT NUMBERS.

AFPC: 1-800-525-0102
Assignments: DSN 665-2641 (options: 44F=3, 48X=1)
Citibank (Gov. travel card): 1-877-784-1408
DPANM: 210-565-3580 (DSN 665-)
FAA CAMI – Military Region: (405) 954-6205
IPEB: DSN 665-5653 / 5654 / 5655
MAJCOM SGP's

AETC:	DSN 487-9203
AFMC:	DSN 986-3640
ACC:	DSN 574-1326
AFSPC:	DSN 692-9756
AFGSC:	DSN 781-0488
PACAF:	DSN 315-488-3423
USAFE:	DSN 314-480-6757
ANG:	DSN 612-8551
AFSOC:	DSN 579-1623 / 6575
AMC:	DSN 779-6305
USAFSAM:	DSN 798-2715

Nuclear Mishap / RDD "Radiation Assistance Program": 630-252-4800
Physician Special Pays: DSN 665-2377 (option 1)
USAA: 1-800-531-8722
SIB Support Hotline: DSN: 263-6175; Commercial Day: 505-853-6175
After Hours: 505-269-9583
Mobile 505-220-0183
AFMES can be reached at **http://www.afmes.mil** or via telephone at DSN 366-8648 or (302) 346-8648. Contact HQ AFSEC/SEH (DSN 263-4868, Comm (505) 853-4868) if further assistance is needed.

AFI'S WORTH HAVING ON HAND.

You don't need to print these out or necessarily download them. But you'll likely find yourself referring to them at one point or another, so it's good to know where to go.

- AFI 10-203, *Duty Limiting Conditions*, 25 Jun 2010
- AFI 10-250, *Individual Medical Readiness,* 9 Mar 2007
- AFI 11-403, *Aerospace Physiological Training*, 30 Nov 2012
- AFI 32-1053, *Integrated Pest Management Program*, 23 Jun 2009
- AFI 36-2905, *Fitness Program*, 1 Jul 2010
- AFI 36-2910, *Line Of Duty (Misconduct) Determination*, 4 Oct 2002
- AFI 36-3212, *Physical Evaluation For Retention, Retirement, And Separation*, 2 Feb 2006
- AFI 40-101, *Health Promotion*, 17 Dec 2009
- AFI 40-102, *Tobacco Use In The Air Force*, 26 Mar 2012
- AFI 40-104, *Nutrition Health Promotion*, 4 Oct 2011
- AFI 40-301, *Family Advocacy*, 30 Nov 2009
- AFI 40-701, *Medical Support To Family Member Relocation And Exceptional Family Member Program (EFMP)*, 15 Feb 2012
- AFI 41-101, *Obtaining Alternative Medical And Dental Care*, 01 Apr 1996
- AFI 41-126, *Department Of Defense/Veterans Affairs Healthcare Resource Sharing Program*, 11 May 2011
- AFI 41-210, *Tricare Operations And Patient Administration Functions*, 06 June 2012
- AFI 44-102, *Medical Care Management*, 20 Jan 2012
- AFI 44-107, *The Air Force Civilian Drug Demand Reduction Program*, 07 Apr 2010
- AFI 44-109, *Mental Health, Confidentiality, And Military Law*, 01 Mar 2000
- AFI 44-120, *Military Drug Demand Reduction Program*, 03 Jan 2011
- AFI 44-121, *Alcohol And Drug Abuse Prevention And Treatment (Adapt) Program*, 11 Apr 2011
- AFI 44-170, *Preventive Health Assessment*, 22 Feb 2012
- AFMAN 44-144, *Nutritional Medicine*, 29 Jun 2011
- AFI47-101, *Managing Air Force Dental Services*, 01 Jun 2009
- AFI 48-101, *Aerospace Medical Operations*, 19 Aug 2005
- AFI 48-102, *Medical Entomology Program*, 01 Jul 2004
- AFI 48-105, *Surveillance, Prevention, And Control Of Diseases And Conditions Of Public Health Or Military Significance*, 1 Mar 2005, IC 17 Oct 2011
- AFI 48-116, *Food Safety Program*, 22 Mar 2004
- AFI 48-117, *Public Facility Sanitation*, 06 May 1994
- AFI 48-120, *Deployment Resiliency Assessments*, 29 Dec 2010
- AFI 48-123, *Medical Examinations And Standards*, 24 Sep 2009
- AFI 48-135, *Human Immunodeficiency Virus Program*, 12 May 2004

- AFI 48-145, *Occupational And Environmental Health Program*, 05 Mar 2008
- AFI 48-149, *Flight And Operational Medicine Program (FOMP*), 29 Aug 2012
- AFJI 48-104, *Quarantine Regulations Of The Armed Forces*, 24 Jan 1992
- AFJI 48-110, *Immunizations And Chemoprophylaxis*, 29 Sep 2006
- AFJI 48-131, *Veterinary Health Services*, 29 Aug 2006
- AFMAN 48-125, *Personnel Ionizing Radiation Dosimetry*, 07 Aug 2006
- AFMAN 48-154, *Occupational And Environmental Health Site Assessment*, 28 Mar 2007
- AFMAN 48-155, *Occupational And Envirommental Health Exposure Controls*, 01 Oct 2008
- AFOSHSTD 48-137, *Respiratory Protection Program*, 10 Feb 2005
- AFOSHSTD 48-139, *Laser Radiation Protection Program*, 10 Dec 1999
- AFOSHSTD 48-20, *Occupational Noise And Hearing Conservation Program*, 30 Jun 2006
- AFOSHSTD 48-9, *Radio Frequency Radiation (RFR) Safety Program*, 01 Aug 1997
- AFPAM 48-151, *Thermal Injury*, 18 Nov 2002

MEDICAL EVALUATION BOARD NARRATIVE SUMMARY

13 November 2015

DEMOGRAPHICS

Patient Rank/Name: Rank / Name

SSAN : SSN

Total Years Service: # years in service (if part of the years in service are reserve/guard, delineate how many for ARC/Active)

AFSC/job title: AFSC / Official Duty Title

Job Description: brief (sentence or two) synopsis of primary duties

Squadron: Squadron or Unit

Member is currently: ADAF, Reserves, Air National Guard, TDRL, Basic Military Trainee, Air Force Academy Cadet, USAF Officer attending initial AFSC training, or USAF Enlisted attending initial technical training.

Does member have approved Retirement or Separation Date?
List whether or not member has approved retirement or separation date and give the date.

Is member pending administrative actions? Are there any administrative actions pending and, if so, what are they?

HISTORY

Pertinent Medical History: In "list" format: condition, year of onset, and state whether "resolved" or "active". Only list major diagnos(es) which would be a factor in determining overall health for a "fitness for duty" decision. (Most "resolved" conditions aren't appllicable).

Pertinent Surgical History: In "list" format, give name and year of procedure.

Pertinent Family History: List ONLY genetic, heritable disorders related to any condition for which the patient carries a related diagnos(es).

CURRENT MEDICATIONS

Current Medications: List both medications taken, and medications that have been prescribed and/or recommended that patient is not taking due to "noncompliance" or optional nature. Include dose/freq.

HPI – POTENTIALLY UNFITTING DIAGNOS(ES)

CC: What condition(s) are potentially unfitting?

History of Present Illness: Include onset, activities at time, deployment relatedness, related ER visits in last 24 months, meds, treatments, pertinent ROS, and if it existed prior-to-service

PHYSICAL EXAM

Vitals: Vital signs to include measured height and weight, with calculated BMI.

Physical Exam: Exam should not be lengthy—give a relevant exam that documents the pertinent positive and negative exam findings related to each potentially unfitting condition.

If the member is not a fully trained ADAF asset, (i.e. Basic Military Trainee), make sure that ortho exams include range of motion (in degrees), strength, and function. For active duty, these will be conducted by the VA if DPANM directs a full MEB.

Patient is Left or Right Handed. Left handed or Right handed

ANCILLARY STUDY SUMMARY

Pertinent Labs: List pertinent positive and negative labs ONLY. Provide values over a continuum of time if they pattern a picture of decline or improvement, or unpredictable nature of condition.

Pertinent Labs: Do not copy and paste the entire study. Give the name of study, the date, and a clear picture of the results (impression)..

Pertinent Other: If there are required ancillary studies, include them here. There is a copy of typical studies at the very end of this template.

CONSULT SUMMARY

Consultations: Provide a short, succinct summary of (a) pertinent findings, (b) diagnosis (c) prognosis and (d) recommended frequency of specialty follow-up

for each consult. The consults will be attached to this NARSUM, so only provide (a)-(d) for each consult.

CURRENT PROFILE RESTRICTIONS

Current AF 469: List specific duty restrictions, the diagnos(es) to which they are linked, and the release date of each restriction. Comment whether the date reflects the date the condition is expected to resolve, or if it is an admin date for a scheduled review.

LINE OF DUTY DETERMINATION

LOD: In most cases, it will be "Admin LOD: yes", but if it existed prior to service, put "EPTS" and explain if the condition was aggravated by military service. If AF Form 348 is required (see AFI 36-2910), include a copy

OCCUPATIONAL IMPACT

For each potentially unfitting condition, succinctly summarize: (a) whether or not condition limits the ability to perform duties and/or deploy, and (b) the extent of the limitation(s).

PROGNOSIS

For each potentially unfitting condition, state the prognosis for: (a) full or partial (if partial, state to what degree) recovery, or stabilized maintenance of chronic condition

(b) timeline for recovery or stabilized maintenance of chronic condition

(c) future treatments (surgeries, procedures, studies, etc.) and duration of expected requirements.

(d) list the anticipated annual frequency for each specialty requirement, and expected duration required.

_____

[CLICK HERE AND TYPE YOUR NAME / RANK / ETC]

[CLICK HERE AND TYPE YOUR TITLE]

TABLE OF SPECIAL STUDIES THAT MUST BE INCLUDED FOR SPECIFIC DIAGNOSIS

Diagnosis	*Required Consults*	*Required Studies/Info*
Asthma	*Pulmonology (ONLY if Complicated)*	*Spirometry (MCT or HC if diagnosis in doubt)*
Burns		*% BSA, ROM, Photographs of affected areas*
Collagen Vascular Disease	*Rheumatology*	
Arthritis	*Rheumatology*	
Fibromyalgia	*Rheumatology*	*Trigger point summary*
Coronary Artery Disease	*Cardiology*	*ETT, Echo or Cath, NYHA class*
Diabetes	*Endocrinology if Insulin Dependent*	*FBS, A1C, Optometry or Ophthalmology*
Hearing	*ENT*	*Audiogram*
Eyes	*Ophthalmology*	*Visual Acuity and Visual Field exam*
Neuromuscular	*Orthopedics (PT if available)*	*ROM (percent), Strength, Function, EMG if appropriate*
Musculoskeletal	*Orthopedics (PT if available)*	*ROM (percent), Strength, Function*
Cancer (Brain)	*Oncology, neurosurgery, & psych*	*5 year prognosis*
Cancer (Skin)	*Dermatology*	*5 year prognosis*
Cancer (Head and Neck)	*ENT*	*5 year prognosis*
Cancer (renal or GU)	*Urology*	*5 year prognosis*
Cancer (other)	*Oncology*	*5 year prognosis*
Multiple Sclerosis	*Neurology*	*MRI, spinal tap*
Headache	*Neurology*	*MRI, Log with # prostrating HA's last 12 months*
Seizure	*Neurology*	*EEG, MRI, Log of seizure frequency*
Renal	*Nephrology*	*Lab progression over time*
Crohn's/Ulcerative Colitis	*GI*	*Scope/Biopsy, Log of flare freq & severity*
Psych	*MD/DO Psych review and cosign*	*Military & Social-Industrial Impairment*
TBI	*Neuropsychiatry*	*MRI, Military & Social-Industrial Impairment*

PSYCH TEMPLATE FROM DR TROUT AT DPANM

MEDICAL EVALUATION BOARD NARRATIVE SUMMARY

IDENTIFYING DATA:

Name: Doe, John J. SSN: 123-45-6789
Age: 39 Marital Status: Married Race: Caucasian
Military Status/Branch: ADAF Rank: E-7 Years of Service: 20

Note: List whether or not member has approved retirement/separation date and give the date.

"Prior to interviewing the service member (SM), Provider discussed the purpose of the evaluation as a fitness for duty assessment, the limits of confidentiality, that they WOULD/WOULD NOT be his treating physician, and that a written report would be submitted to the MEB/PEB to determine fitness for military duty. SM expressed understanding of these issues and agreed to proceed. Sources of information include:_____, that were deemed sufficient to make conclusions with reasonable clinical certainty".

ADVISEMENT AND WARNING

(*Usual non-confidentiality warning*)

REFERRAL SOURCE AND CHIEF COMPLAINT:

HISTORY OF PRESENT ILLNESS:

(Concise and relevant. Summarize symptoms and behavior, especially work-related)

PSYCHIATRIC PAST HISTORY:

(*Prior symptoms, behavior, treatment and response; careful history of EPTS conditions)*

FAMILY HISTORY OF PSYCHIATRIC ILLNESS:

(First and second degree relatives, esp. history of suicide, substance abuse, legal problems)

PAST MEDICAL HISTORY:

(Relevant to mental symptoms: TBI, seizures, trauma; as well as unfitting medical diagnoses)

CURRENT MEDICATIONS:

(For medical and mental diagnoses—Reviewed and entered by prescribing provider)

SUBSTANCE USE/ADAPT:

PSYCHOSOCIAL HISTORY:

(No novel please; summarize relevant background for context)

MILITARY HISTORY:

(AFSC and Job title/description, call CC for input re: work function and risk to SM and misson)

PHYSICAL EXAM:

(*Summarize relevant PCM examination: entry by privileged medical provider)*

MENTAL STATUS EXAMINATION:

(Current MSE, and contrast w/ presentation across time and other examiners)

PSYCHOLOGICAL TESTING:

(Neuro-psych consult required for all TBI MEBs) *(Brief summary of relevant conclusions)*

CONSULTATIONS:

(Summarize findings of neuro, other medical consults related to duty fitness)

LABORATORY/RADIOLOGICAL DATA:

(Brain MRI required for all TBI MEBs)

HOSPITAL/OUTPATIENT TREATMENT COURSE:

(Summarize hospitalizations, locations, dates, outcome in bullet form)

DIAGNOSES:

Axis I – *(Axis I diagnoses can be either 'unfitting' (reason to discharge) or 'not-unfitting' (retain). State clearly which are/are not unfitting, and why; state specific duty impairments.*

Axis II – *(Personality Disorders are PEB 'Category III Unsuiting' conditions, for admin separation)*

Axis III – (*MC or NC writer determine from PCM notes or discussion)*

Axis IV – *(Military Social Stressors, ie PTSD triggers, deployment, family separation)*

Axis V – *GAF: Now and HIPY*

PREMORBID PREDISPOSITION:

(Genetic and psychological resilience/adaptation to military life prior to and after illness)

IMPAIRMENT FOR MILITARY SERVICE:

(C*omment specifically on worldwide duty and deployment/combat impairment—for impairment, –no impairment, -- minimal, --moderate, and –marked are the only terms used)*

SOCIAL AND INDUSTRIAL IMPAIRMENT:

(Comment on adaptation to ***non-military*** *work, school, family, social relationships—for degree of impairment, use the evaluee's current impairment, and state the projected impairment as --Total, --Severe, --Considerable,--Definite,--Mild or –None are the only terms used) .*

LINE OF DUTY DETERMINATION

Reference AFI 36-2910 for (a) whether or not this is an Administrative LOD determination or (b) if this requires an AF Form 348 LOD determination. If AF Form 348 is required, ensure it is included with Initial RILO package.

DUTY RESTRICTION REPORT (AF Form 469)

(All MEBs are no-Deploy/no-PCS. State other specific military duty limits: Driving? Arming? Security Clearance? Special Duty? Fly/PRP? Complete a 469 and keep current during MEB)

PROGNOSIS AND RECOMMENDATIONS:

(State ' competent for pay and records', danger to self or others, intensity/duration treatment required to maintain (XXX) level of function. Function is/is not compatible with rigors of military service.

(SIGNED)

PAT C. SMITH, Capt, USAF, MC *******DATE SIGNED********

Chief, Psychiatry Services

SAMPLE METALS LOG

FLYING AND AIRCREW QUALIFICATION TRAINING									
			Frequency						
Metal	MEPRS	Priority	Daily	Weekly	Monthly	Quarterly	Annually	PRN	Rationale
Flying (including brief and debrief)	FCGA	1		X	X				All flight surgeon positions are coded API-5, flying required.
Aircrew Life Support / Survival Training	FCGA	1					X		This training is directed by the flying squadron as a condition for flight.
Other Aircrew Training (CRM, ORM, NVG, StanEval, etc)	FCGA	1				X			This training is directed by the flying squadron as a condition for flight.

OPERATIONAL SUPPORT OF AIRCREW AND MISSIONS									
			Frequency						
Metal	MEPRS	Priority	Daily	Weekly	Monthly	Quarterly	Annually	PRN	Rationale
Non-pharmaceutical Counter-Fatigue Mgt	FCGA	1			X				
Line Consultant (medical, physiology, human factors)	FCGA	1	X						FS should be in daily comm with the line
Aeromedical Capability Gap Analysis	FCGA	3						X	Requirement rescinded, but PI's useful
Repatriation of POW's and Detainee Escort Missions	FCGA	3						X	Not a routine tasking

FLIGHT SURGEON AEROMEDICAL VISITS									
			Frequency						
Metal	MEPRS	Priority	Daily	Weekly	Monthly	Quarterly	Annually	PRN	Rationale
Flying Squadron Visits	FCGA	1		X					Between flying, scheduling, CC call, etc, a weekly visit to the squadron is necessary
Air Traffic Control Facility Visits	FCGA	1				X			ATC requires regular visits
Life Support Shop Inspection	FCGA	1				X			AFE requires quarterly visits
BEE Shop Visit	FCGA	2				X			minimum of quarterly visit per FS
PH Facility Inspection or Field Activity	FCGA	2				X			minimum of quarterly visit per FS
Other Base Facility Visit (Sim, Fire, Parachute shop, etc)	FCGA	2						X	If not covered by the quarterly visits, then other visits are done time permitting

FLIGHT SURGEION AEROMEDICAL BRIEFINGS									
			Frequency						
Metal	MEPRS	Priority	Daily	Weekly	Monthly	Quarterly	Annually	PRN	Rationale
Safety Briefings to the Wing or subordinate units	FCGA	1			X				RSV requirement for quarterly briefs, but goal is monthly
IRC Briefings	FCGA	2				X			AOPT typically briefs these, but FS can as well
NVG Briefings	FCGA	2						X	
ORM/CRM Briefings	FCGA	3						X	Such briefs are contractd out and not accomplished by FS or AOPT on a regular basis
Other Performance Enhancement Brief (Nutrition, fatigue, exercise, etc)	FCGA	1			X				Due to the number of long duration sorties, counterfatigue briefs are common.
Aeromedical Briefings to the Medical Professional Staff	FCGA	1			X				Required to be briefed monthly
Pre/Post Deployment Briefings	FCGA	2						X	Typically performed by PH vs FS.
Other Base Operational Support / Prevention Briefings	FCGA	2						X	Typically performed by PH vs FS.
Written Articles / Aeromedical NOTAMS, etc	FCGA	3				X		X	Not a focus of our mission, though contributions are encourged time permitting
Commander's Call – Wing / Base attendee	FCGA	1				X			mandatory military formations.

CLINICAL MEDICINE									
			Frequency						
Metal	MEPRS	Priority	Daily	Weekly	Monthly	Quarterly	Annually	PRN	Rationale
All Acute, Routine, Wellness Patient Care	BJAA	1	X						Daily clinical ops
Family Notifications / Support Following Death or Casualty	BJAA	3						X	(hopefully) rare event managed on case by case basis
Pharmaceutical Counter-Fatigue Management (counseling, dispensing, tracking)	BJAA	1			X				on average, a mission per month requires go-pills
Hyperbaric Treatment and Observation	BJAA	3						X	no local chamber. Managed case-by-case
Travel Medicine: interviews and medications	BJAA	2			X				PH manages the program, but occasionally sends individuals for clinical evaluation and medications
Aerovac Consultation / Review / Clearance	BJAA	1				X			Although not a frequent occurance, it is not uncommon for a patient to require aerovac to a civilian institution (usually pediatrics). On average 3-4x per year, there is such a need
Aeromedical Staging Facility (ASF) Support	FEFA	3						X	
Aerovac Missions: Provision of Enroute Care	FECA	3						X	No intrinsic aerovac support, so this would be on a case-by-case basis
Combat Stress Management	BJAA	3						X	(hopefully) rare event managed on case by case basis
Profiles, Duty Restrictions, DAWG	BJAA	1	X						Daily clinical and profile officer operations
AEROMEDICAL DISPOSITION ACTIVITIES									
			Frequency						
Metal	MEPRS	Priority	Daily	Weekly	Monthly	Quarterly	Annually	PRN	Rationale
Dispositions for Out of Clinic Consultations	BJAA	1	X						AMD's should be completed within 24 hours after the appointment (or at least discussed before the appt if going off base)
Review of Local Flying Mgt / Aircrew SCL Programs	BJAA	1		X					Weekly in the FOMWG meeting
Waiver Work-Up, Summary Writing, and AIMWTS entry	BJAA	1		X					Number of waivers makes this a weekly occurance
AMS Review and Certification as Local Waiver Authority	BJAA	1		X					Number of waivers makes this a weekly occurance
In-flight Medical Evaluations of Aviators	FCGA	3						X	I take this to be a formal medical flight evaluation as opposed to the typical observance during normal flight duties
Aeromedical Advice to other PCM's and Specialists	FCGA	1	X						between aeromedical advice, profile advice, and PRP advice this is a daily occurance

OCCUPATIONAL MEDICINE									
			Frequency						
Metal	MEPRS	Priority	Daily	Weekly	Monthly	Quarterly	Annually	PRN	Rationale
Pre-Placement Examination Certification	FBEA	1	x						Occ Health exams are part of the daily clinical mix
Pregnancy Evals for Workplace Exposures	FBEA	2				X			Most pregnancies don't require specific visit as the shop risks are well defined already.
Fitness for Duty and Disability Evaluations	FBEA	1						X	Formal fit for duty exams are relatively rare but are a high priority when they are required
Hearing Conservation Program / Fitness and Risk Evals	FBNA	1		X					HCP evaluations are common, though few reach the threshold of requiring a fitness for duty eval
Evaluate and Prescribe Personal Protective Equipment	FCGA	2			X				This is rolled into the review of AF 2766's and AF 2755's at the OEHWG
Occupational Health Working Group	FBEA	1			X				This is a monthly meeting
Safety Hazard Mitigation and Workplace Safety	FBEA	1		X					In addition to disussion at the OEHWG, this is also addressed during occ health exams and via our weekly training topic with FOMWG
Epidemiological Investigation of Occupational Health Conditions	FBEA	2			X				PH and BEE's conduct the bulk of the investigation, but the IOEMC or equivalent must sign AFSAS
Occ Med Advice to other providers / base leadership	FCGA	1		X	X				Between occ health exams, advice to other providers, and advisement to leadership, this is a weekly occurance.

MEB, PROFILING, and SPECIAL PROGRAM DISPOSITIONS									
			Frequency						
Metal	MEPRS	Priority	Daily	Weekly	Monthly	Quarterly	Annually	PRN	Rationale
MTF Profiling Officer: application of standards to individual defects	BJAA	1	X						Daily profile reviews and signatures with monthly reports for the DAWG on peer review
MEB Case work-up and summary writing	BJAA	1			X				Each provider probably writes about 1 per month
MEB Review and Approval	BJAA	1		X					The MEB has the SGP and SGH as regular members but the 3rd rotates to give all providers experience in the process. It meets weekly given our volume and the timeframes to turn the cases around
Clearances (Security, Overseas, etc)	BJAA	2			X				Mostly managed through MSME, but overseas clearances rotate throughout the medical staff
PRP/PSP Program Management and Chart Reviews	BJAB	1	X						PRP is a high priority mission
Medical Reporting Officer for Drug Screening Program	BJAA	2		X					On average, there is a MRO case every week, some are much busier.

TEAM AEROSPACE ACTIVITIES

Metal	MEPRS	Priority	Frequency						Rationale
			Daily	Weekly	Monthly	Quarterly	Annually	PRN	
Initial Standardization of Aeromedical Programs / issues	FCGA	1						X	Although a priority, initial standardization only occurs by definition with a new SGP
Aerospace Physiology Support (Chambers, etc)	FCGA	2			X				We have no chamber, but AOPT conducts regular training for incentive fliers. FS co-teach
Medical Vulnerability Assessments	FCGA	3			X				PH and BEE conduct these routinely, but a quarterly visit is required for FS
Food / Water Vulnerability Assessments	FCGA	2			X				PH and BEE conduct these routinely, but a quarterly visit is required for FS
Epidemiological Outbreak Investigation	GGAA	3						X	Primarily conductred by PH but FS may be a consultant
Disease / Vector Control and other Force Protection Issues	GGAA	3						X	Primarily conductred by PH but FS may be a consultant

EMERGENCY PREPAREDNESS and RESPONSE									
Metal	MEPRS	Priority	Frequency						Rationale
			Daily	Weekly	Monthly	Quarterly	Annually	PRN	
CBRNE Exercises and Responses	GGAA	1				X			Quarterly excercises by the Wing with FMM as Field response team
HAZMAT Exercises and Responses	GGAA	1				X			Quarterly excercises by the Wing with FMM as Field response team
Mass Casualty / MARE Exercises and Responses	GGAA	1							Quarterly excercises by the Wing with FMM as Field response team
In-flight Emergency and Physiological Incident Responses	GGAA	1		X					All airframes here are older and IFE's are common
Aircraft Mishap Exercises and Responses	GGAA	1				X			In addition to excercises with the Wing we have occasional mishaps requiring investigation both on ground and AC
Mishap Investigation: Medical member of ISB/SIB/AIB	GGAA	1					X		On average, we are tagged annually to provide medical consulting for a SIB
Search and Rescue (SAR) support	GGAA	2					X		Though not a primary mission, we have participated in SAR in the past.
Critical Incident Stress Debriefs	GGAA	3						X	Mostly managed via Mental Health
Develop / Refine Emergency Response Plans (all types)	GGAA	2							The SGP as the PHEO has this as a major responsibility with Wing XP. However, the other FS do not develop plans to that extent.
First Responder Training (all types)	GGAA	1			X				Between quarterly meetings, CPR refreshers, etc, it becomes a monthly requirement
Inspection / Inventory or Emergency Response Equipment	GGAA	2				X			Mishap kits are inspected regularly

READINESS ACTIVITIES									
			Frequency						
Metal	MEPRS	Priority	Daily	Weekly	Monthly	Quarterly	Annually	PRN	Rationale
Deployment	GDAA	2				X			
Pre/Post Deployment Screening / Clearances	GAAA	2			X				Although the bulk of the PDHRA's are done by PH, Fliers need care reviewed by a FS
Deployment Planning and Logistics	GAAA	3						X	Managed by PH with little direct involvement by FS
Med Intell: Research, Analysis, Briefing	GAAA	2					X		SME's brief their squadrons
Site Survey or Advon Team Member	GAAA	3						X	Will be managed on a case-by-case basis if called upon to do so
Operational Readiness Exercises / Inspections	GBAA	1				X			These are quarterly excercises
Deployed / Field Communication System Familiarization	GBAA	3				X			As part of the quarterly shop visits
Air Transportable Clinic: Inventory, Setup, Exercise	GBAA	3						X	Will be managed on a case-by-case basis if called upon to do so

PERSONNEL, LEADERSHIP, ADMIN ACTIVITIES									
			Frequency						
Metal	MEPRS	Priority	Daily	Weekly	Monthly	Quarterly	Annually	PRN	Rationale
Aerospace Medicine Sq ./ CC duties	EBCF	3						X	Do not currently have an AMDS
Supervision of Subordinates (EPR's, OPR's, awards, admin, etc)	EBCL	1	X						Primarily first tour GMO staffing requires more precepting than otherwise expected
Committee Meetings	EBCC	2	X						Various committees compile to a daily occurance for SGP and weekly for FS
Downtown Care (Seeing patients in downtown facility)	FCCD	3						X	Currently no one is privileged for downtown care
PT Time (during duty hours)	GFAA	2						X	Ideally, there would be time to support this, but in reality, it does not occur
All CME (HIPAA, coding, medical legal, etc) TDY or not.	FALA	1				X			Required to maintain licensure
Other TDY	FALA	2					X		Minimizing due to funding cuts
Leave		2				X			Capability for leave varies by manning level
Mil Other (MPF, finance, formation, permissive TYD, etc)		2				X			Certain of these will be essential to maintain as mandatory military formations. PTDY and others may be prioritized lower on the list to ensure continuity of operations.

CMA QUALIFICATION TRAINING AND INITIALIZATION OF PROGRAM									
			Frequency						
Metal	MEPRS	Priority	Daily	Weekly	Monthly	Quarterly	Annually	PRN	Rationale
Initial CMA training: Clinical	BJAB	1					X		Training is initial, but also required for annual recurrance training
Initial CMA training: Reviews / Audits / Certifications	BJAB	1					X		Training is initial, but also required for annual recurrance training
Initial CMA training: Attendance to PRP course at USAFSAM	BJAB	1						X	Required for the SGP, but other FS will be taught from the training guide / USAFSAM test
Initial Standardization of PRP Programs / issues	BJAB	1						X	Initial standarization by deifnition only occurs once
Review of Local PRP suspension logs and tracking of returns	BJAB	1			X				Reviewed at the POWG
Certification Reviews, Summary Writing, and notification	BJAB	1	X						Daily cert reviews to maintain program
Annual Audit consultation and CMA review	BJAB	1		X					CMA's do not do the bulk of the audit, but consult with the techs that do