Updated on:

7.19

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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, their job is to lay a foundation that prevents negative events from happening. If they do their 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 ORMS/CC. (I'm assuming for the sake of thoroughness that the SGP is a stand-alone, and must coordinate with the HCMS or ORMS/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,*
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> *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.: HCMS/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 AFMRA/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, its 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 the SGP doesn't have an MPH or equivalent, they can no longer be the PHEO. So, be aware that if the SGP is a non-RAM, they might be the Alt PHEO instead.

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.

Further, AFI 44-102 1.3.3.1. states that the SGP is the "most qualified flight surgeon". Not necessarily the highest ranking. Not necessarily the most experienced. But the most qualified. This means that the SGP must strive to be not only the best physician, but also the best officer that they can be.

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 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.

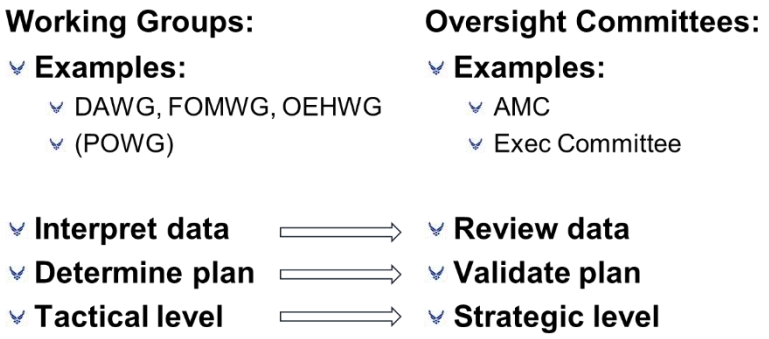
> *AFI 48-101 1.4.15. The MTF/SGP or ARC/SGP shall:*
>
> *1.4.15.8. Maintain clinical currency in the practice of Aerospace Medicine. (T-1)*

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 an iPad. Also, burn them to CD and pay a visit to the 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. Various studies have found a typical professional loses 31 hours per month in meetings[1], over 50% of time in meetings is wasted[1], 39% of people doze off[2], and 73% work on unrelated work during the meeting[2]. While there are entire business books devoted to meeting management, this is what I teach at the USAFSAM AOME course:

Step one is identifying what the meeting is designed to accomplish. For example, a working group has a very different purpose than an executive oversight committee.



In practice, this means that information flow might look like this:

MSME

- Pulls Code 81 metrics from MPF and Women's Health.
- Notes negative trend in timely Code 81 profiling.
- Brainstorms COA's to address the trend.
- Presents data, trends, and COA's to DAWG.

DAWG

- Analyzes data, trends, and selects a COA.
- Reports trend and the chosen COA to AMC.

AMC summarizes trend and COA to **ExComm.**

[1] A network MCI Conferencing White Paper. *Meetings in America: A study of trends, costs and attitudes toward business travel, teleconferencing, and their impact on productivity* (Greenwich, CT: INFOCOMM, 1998

[2] https://www.wolfmotivation.com/articles/the-expense-of-ineffective-meetings

Step Two is identifying the "how" the meeting accomplishes its purpose. This often requires tracking metrics – "If you don't inspect it, you can't expect it." This is also where many meetings fail, by simply reporting metrics, but not using them as tools to improve operations.

Think of metrics as "vital signs" for programs. It's not enough to document a blood pressure of 155/95…you need to determine what's causing it and what needs to be done. Likewise, it's not enough to simply document a DNIF rate of 12%...you need to determine what's causing it and what needs to be done.

Once the purpose of the meeting and the means by which it achieves that purpose are clear, **Step Three** addresses actually running the meeting effectively. There are many management books offering advice, but here are some thoughts on managing an effective meeting:

1. Make sure people know the purpose of the meeting and what they contribute.

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

3. Establish ground rules: Treat it like a flight brief. If people show late, the doors close and they are marked "absent" or "tardy" in the minutes.

4. Set a firm agenda. Consider having a visible timer or countdown running and end promptly – preferably in less than an hour.

5. If the discussion doesn't concern everyone present, take it offline. As Chair, don't be afraid to interrupt and redirect the group's focus.

6. 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.

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

8. Close the meeting by reviewing "Who is doing what, and by when." Quickly summarize open items and what needs to be done, who is doing it, and when they are expected to have it done. This clear communication of expectations is what often separates an effective meeting from a non-effective one.

9. Keep good minutes to provide historical context, continuity, and accountability.

KEEPING EFFECTIVE MINUTES

Well-kept minutes allow continuity when the SGP isn't available to run a meeting and maintain accountability by clearly identifying who is doing what and when.

Good minutes need to identify what the meeting accomplished, as well as who is responsible and what is being done in the future. The good news is that it isn't hard. Once the agenda is formalized, it can be used as a skeleton to build the minutes, and the latest set of minutes can quickly be updated to reflect current status.

An example of a typical OEHWG entry may look like this:

Poor example: *Fetal Protection Completion Rates: Compliant. See attachments.*

Better Example: *Fetal Protection Completion Rates: 4 positive tests. One member exceeded 5-day limit. OEHWG Atch 2 Fetal Protection.ppt Program COMPLIANT*

Best Example: *Fetal Protection Completion Rates: 4 positive HCG for December. One member exceeded the 5-day limit. Zero cases concerning for fetal risks. Year to date trend shows appropriate, timely profiling. See attach: OEHWG Atch 2 Fetal Protection.ppt Program COMPLIANT with Air Force Standard for Pregnancy Profiles. (INFO: OPR: SGPM)*

Hint: *Occasionally, a well-intentioned SGP decides to simply use their slide deck as 'minutes'. Unfortunately, these 'minutes' invariably omit important information and exist primarily to check a box for inspections. This is a perfect example of losing sight of the purpose of minutes and putting efficiency ahead of effectiveness.*

It's much more effective (and arguably faster) to create a good set of minutes as a word document and update it with the latest proceedings.

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.*

AMC – Aeromedical Council:
The AMC is an executive oversight committee and its mission is much different than a working group. The AMC is the AOME's voice on the executive council, and the execs don't need to know what went into the "sausage making" at the working group level. This is a good place to use stoplight charts to display a data with compliance / non-compliance. The key is to provide the execs the necessary data without bogging down in the details that the working groups used. 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.

The aligned working groups report to the AMC and the MDG CC directly reviews the minutes. 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 to be placed "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.

HINT: *Although the AMC is only directed to meet quarterly, remember that MDG/CC's place importance on items they see more often. If they receive weekly access-to-care reports and quarterly AMC reports, it indicates that METALS are not important in the grand scheme. Additionally, most of the metrics that are reported to AMC are tracked monthly at the exec level, so it makes sense to hold a monthly AMC.*

OEHWG – Occ. & Environ. Health Working Group:

The OEHWG should extend an invitation 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 actions to AMC, track attendance, and review grounding logs. Most of the material reviewed at FOMWG can be included as attachments to the minutes, so there is considerable time saved from 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 removal actions and review program integrity. It's based on old guidance, starting with the (now rescinded) AFGSC Supp to the (now rescinded) AFMAN 10-3902 DL.62. which 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 good 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. Not all installations meet that threshold, so the FECA WG may not need to meet. If the WG exists, a FECA rep should be at OEHWG, so ensure OEHWG minutes document whether there is a local FECA WG.

> 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, it turns into little more than a reporting forum for HEDIS metrics and 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).
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> 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 to justify ending high effort/low yield programs within the PHWG and help focus efforts on interventions proven to work.*

TWG - Threat Working Group and Force Protection Working Group:

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.

> 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 "That Guy" who only shows up at the squadron to fly, and don't delegate all of the teaching to AOPT. Grow the flight surgeon talent pool by pairing young flight surgeons with an experienced AOPT briefer, 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. Being present at regular forums is a chance to keep abreast of upcoming ops challenges and be proactive on medical support. 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. This is important not only for information sharing, but for SGP visibility as a reliable ally. I can't emphasize enough the importance of being seen as an authority by the line. Make sure to be on time, look sharp, and have an elevator speech prepared if asked 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 flight docs experience and save 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 (recommended)	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.

Reportable Metrics

There is an intimidating list of metrics that are reported in the above listed forums. Given the sheer volume of information, it's easy to bury it in minutes and meet the letter-of-the-law for reporting data, but not the spirit. In other words…

What's your Why?

Why are so many AOME items reported at exec council?

> Without the AOME, there is no need for a MDG. We could send everyone and everything off base. It's the AOME that earns the MDG real estate on base. If the MDG CC only hears about access and patient satisfaction, they lose sight of the mission. You're there to keep them honest.

Isn't it good enough to drop off a copy of the AMC minutes?

> Be honest…when was the last time <u>you</u> sat and read every line of the AMC minutes? Can you really expect someone else, someone without an AOME background, to learn the nuances and lessons from the meeting?

The simplest way to clearly report the AMC data is to build a stoplight chart. With only a few slides, all the AMC data, with trends, can be shown. For example:

MTF	DNIF/DNIA/DNIC rate (30 day ave.)	Percentage of members DNIF/DNIA/DNIC over 30 days	METALS plan completion	Code 37's over 30 days	Flight Surgeon manning	PRP Initial Cert. (ave. days of completion)	PRP initial certs completed
January	9.8%	6.1%	100%	0%	80%	11	17
February	4.0%	2.1%	100%	0%	66.7%	11	12
March	11%	1.2%	70%	3.7%	83.3%	5	5
April	4.5%	3.2%	100%	27.7%	100%	11	7
May	9.8%	5.8%	85%	33%	50%	5	4
June	4.0%	4.3%	66.7%	0%	66.7%	9	10
	AFI 48-101 2.4.1.	AFI 48-101 2.4.1	AFI 48-101 2.4.2.	AFI 48-101 2.6.3	N/A	N/A	N/A
	< 5 %	< 2%	> 90 %	0%	> 80%	< 30 days	N/A
	< 10%	< 5%	> 80%	< 5%	> 70%	<35 days	N/A

Locally determined or "other" frequency					
Metric	**Goal or metric**	**OPR**	**Reported to**	**AFI Reference**	**Notes**
Prioritized list of local human performance sustainment threats	locally determined	FOMWG	AMC, OG Staff (at SGP discretion, with OG coordination)	AFI 48-101 6.5.1	I recommend an annual plan to coincide with METALS
Annual METALS list	>90% completion	FOMWG	MAJCOM/SGP	AFI 48-101 2.4.2.1.	
Emergency Response and Disaster Management program review	Review every six months	FOMWG	N/A	AFI 48-101 7.6.1	
Review of Mishap Kits	Review every six months	FOMWG	N/A	AFI 48-149 8.3.4.9.	
Food and facility inspections	locally determined	AMC	MDG Exec Council	AFI 48-101 5.4.3.	
Surveillance programs for conditions of public health significance	locally determined	PHEWG	MDG Exec Council	AFI 48-101 5.4.4.	
Consolidated conceptual site model discussing updated surveillance activities IRT exposure pathways	Annually	OEHWG	N/A	AFI 48-145 2.12.3.2.	
PH Shop visit schedule	Annually	OEHWG	N/A	AFI 48-145 2.12.1.2.	Approved annually via OEHWG minutes
MTF employees exposed to BBP for appropriate management and tracking	locally determined	Infection control	MDG Exec Council	AFI 48-101 5.4.6.	
Surveillance of tobacco use, obesity, physical activity and nutrition	locally determined	(PHWG)	MDG Exec Council	AFI 48-101 5.4.7.	For efficiency, these may be tracked in the PHWG.
Review of Airmen with non mobility limiting DLC's > 365 days (eg: Fitness restrictions)	Annually in conjunction with PHA	MSME	N/A	AFI 10-203 3.1.3.1.	Review does not necessarily drive need for IRILO
IOEMC brief on occupational medicine	Locally determined	N/A	ProStaff	AFI 48-145 2.13.7	IOEMC or qualified flight surgeon
Flight surgeon brief on installation industrial health hazards	annually	N/A	ProStaff	AFI 48-149 4.2.	Be careful not to stray into the classified TIC/TIM items

Monthly Reports					
Metric	**Goal or metric**	**OPR**	**Reported to**	**AFI Reference**	**Notes**
AIMWTS Waiver reviews	Not established	FOMWG	N/A	AFI 48-149 5.3.1.	Recommended to accomplish the weekly, in conjunction with the weekly 1041 log review
DNIF	Not established	FOMWG	Operational squadron and Group CC's	AFI 48-101 2.4.1.	Reviewed by FOMWG weekly (AFI 48-149 3.7.1.1.) Also briefed at least quarterly to the MDG Exec
IMR (includes FMC, PMC, NMC)	80%	DAWG	MDG Exec Council, Squadron, Group, and Wing Leadership	AFI 48-101 4.6.3., 4.4.1., AFI 10-203 4.3.1.	
Duration from potential IRILO until DAWG determination	<45 days	DAWG	MDG Exec Council	AFI 10-203 4.3.3.1.1	AMC may meet quarterly, but metric is due monthly
Duration from DAWG determination for IRILO until case transmitted to DP2NP	<30 days	DAWG	MDG Exec Council	AFI 10-203 4.3.3.1.2.	AMC may meet quarterly, but metric is due monthly
Duration from DP2NP notification to the MTF to conduct MEB until referral into IDES	<7 days	DAWG	MDG Exec Council	AFI 10-203 4.3.3.1.3	AMC may meet quarterly, but metric is due monthly. The AFI says 10 days, but it was altered to 7 days via memorandum in Sept 2018.
Overdue rate for Annual RILO	%	DAWG	MDG Exec Council	AFI 48-101 4.3.3.2.	AMC may meet quarterly, but metric is due
DLC Quality review	Locally determined	DAWG	ProStaff	AFI 10-203 4.1.3.8	Sample may be included in peer review
90 Day Code 31 reviews	Not established	MSME	AMC	AFI 10-203 4.1.3.2.1.	Once a 90 day review is complete, the AF 469 does not need to be reviewed again unless it hits 300 days
300 day (cumulative) Code 31 reviews	Not established	MSME	AMC	AFI 10-203 4.1.3.2.2.	
Code 81 confirmation / reconciliation	Not established	MSME	AMC	AFI 10-203 4.1.3.4.	Confirm Code 81's with clinic (ie: Women's Health). Related to OEHWG fetal protection tracking driven by AFI 48-101 3.4.7.
Diagnosis and Medication Surveillance	Not established		Brief ProStaff at least annually	AFI 10-203 4.3.2	Technically, due 10 times per year, not monthly.

Quarterly – at minimum					
Metric	**Goal or metric**	**OPR**	**Reported to**	**AFI Reference**	**Notes**
DNIF	Not established	FOMWG	MDG Exec Council	AFI 48-101 2.4.1.	Also briefed monthly to operational squadron and grkoup CC's
METALS	90%	FOMWG	MDG Exec Council	AFI 48-101 2.4.2	Briefed at least quarterly
Flight Surgeon MQT status	100% within 6 months of assignment	FOMWG	MDG Exec Council	AFI 48-101 2.4.3.	The 6 month timeframe is generally accepted, but no longer AFI 48-101.
4NOX1F Training	100% within 6 months of assignment	FOMWG	MDG Exec Council	AFI 48-101 2.4.4	
Epidemiologic analysis of OEH related illnesses, to include STS and PTS.	Not established	OEHWG	N/A	AFI 48-145 2.12.1.1.	Although this is done "as deemed necessary and appropriate by the OEHWG", I recommend reporting STS at each OEHWG
MSE currency Rates	Not established	OEHWG	ESOHC	AFI 48-145 2.12.5.6.	MSE completion and show/cancellation rates are reported to OEHWG by the PH CC
OEHME completion for individuals on the Medical Surveillance Exam program	> 90%	OEHWG	MDG Exec Council and Wing Leadership via ESOHC	AFI 48-101 3.4.1, AFI 48-145 2.13.5.8.	
OEH Site Assessments (OEHSA) and QA approved annually	Annually	OEHWG	MDG Exec Council	AFI 48-101 3.4.2.	Although its an annual requirement, AFI 48-101 3.6.2. requires at least quarterly updates
Cat-1 and Cat-2 health risk assessments	>90%	OEHWG	MDG Exec Council	AFI 48-101 3.4.3.	
Percentage of Defense Occupational Enviornmental and Health Readiness System (DOEHRS) High priority special assessments closed within 60 days	Not established	OEHWG	MDG Exec Council	AFI 48-101 3.4.4.	
Cat 1 Annual workplace shop visits	>90%	OEHWG	MDG Exec Council	AFI 48-101 3.4.5.	Although its an annual requirement, AFI 48-101 3.4.5. requires at least quarterly updates
Cat 1-2 OEH Risk Assessment Codes (RAC's)	Not established	OEHWG	MDG Exec Council	AFI 48-101 3.4.6	If RAC's are assigned, they require at least quarterly updates

Quarterly – at minimum					
Metric	**Goal or metric**	**OPR**	**Reported to**	**AFI Reference**	**Notes**
IFC Access rate	Not established	MSME	MDG Exec Council	AFI 48-101 2.4.5	
Workplace assessment completion rate for Fetal Protection Program within 5 days of referral with workplace specific guidance within 15 days	> 90%	OEHWG (DAWG)	MDG Exec Council	AFI 48-101 3.4.7	Although not tracked by the DAWG, it relates to their monthly report on Code 81 reconciliation
Active MEB, RILO, and/or TDRL cases under review or "open" for each category	Not established	DAWG	AMFOA/SGAT	AFI 41-210 4.70.1.1.	
Number of MEB, RILO, and/or TDRL cases per PEBLO	Not established	DAWG	AFMRA/SGAT	AFI 41-210 4.70.1.1.1.	
Number of PEBLO's assigned and training	Not established	DAWG	AFMRA/SGAT	AFI 41-210 4.70.1.1.2	
Average number of days for active MEB cases that it takes the MTF to process a typical MEB	Not established	DAWG	AFMRA/SGAT	AFI 41-210 4.70.1.1.3.	

THE SGP AS A LEADER

As an executive, and often as the senior medical corp officer, the SGP is expected to be familiar with more than just aerospace medicine operations. They need to be able to fluently converse with the SGH, SGN, and SGA and find ways to balance operational and non-operational needs.

COMMON SGP PITFALLS:

Some SGP's fail shortly after assuming duties. Others fail after years of complacency. Often it's a matter of balance; an SGP has to juggle between being a physician, an industrial hygienist, an instructor, a health inspector, an aircrew member, and many other roles. While there are functional experts in each area, a good SGP has to be knowledgeable in all those lanes, and this is a foreign concept for the highly specialized nature of most medical positions.

This goes beyond just the MDG; it's a combination of officership factors, including being a regular attendee at Ops meetings, appearing professional, being knowledgeable about mission requirements, and being seen as a good clinician.

1. **Not establishing clear priorities.**

   Fact: There isn't 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, measurable, goals such as "maintaining DNIF rates below 10% and having all waivers up to date".

   If the SGP and MDG/CC's priorities match, the job is much easier. But even if they don't appear to synch, chances are they are closer than they appear. For example, the CC may state that clinic access is a top priority, while the SGP feels that keeping a low DNIF rate and up-to-date waivers are more important. Actually, they both have the same goal (good patient care) but a different way of measuring 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 assets to run those programs, so a wise SGP works closely with the HCMS CC and the SGH. To build bridges, look for common programs and be proactive with ProStaff briefings, MEB's, and other areas of shared responsibility. Also, consider a weekly, informal, meeting; 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 OCP's regularly. The OG CC and the Wing CC probably wear OCP'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. It's always better to be overdressed than underdressed.

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.

Create an email list of 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. And don't be afraid to contact the MAJCOM SGP. They've been through the trenches and have a collection of resources to share.

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 clear visibility on what the SGP does. Just like in risk communication, if there are holes, people 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 exec staff, 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 and MAJCOM SGP. Not only will this provide SA on what you were doing, but it makes building an OPR much simpler. For bonus points, focus on meeting 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, HCMS 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 OMRS 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.

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.

Proofreading: Take a moment before hitting "send" on the email to re-read it. 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 on building and giving presentations. I'm not going to list them, but 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 are MDG awards, while others are 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 HCMS CC / ORMS CC and the squadron superintendent. This ensures that names go forward with leadership's blessing, and also that packages will be written at a level that won't embarrass the team. However, don't 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. 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.

If the other docs don't see you making clinical proficiency a priority, you can't expect them to make it a priority. 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. This makes a huge difference, not only in the eyes of the other docs, but in the eyes of the line as well.

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.

Are you an FP or pediatrician? 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, ORMS/HCMS 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 HCMS, 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.

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.

Fact is, the SGP doesn't operate in a vacuum. (Ok, I did have patients working in a vacuum while at NASA. But that's not the point.) 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, and continues to evolve and improve, it is never going to fully prepare a young flight doc for their myriad duties.

Sit down with your docs regularly and discuss common flight med concerns, perhaps in a mentoring session after FOMWG. Hit on the areas that you wish you knew when you started in flight med. Remember: the more you mentor the docs now, the more independent they will be in the future.

Not every SGP is an expert in all things military, and that's OK. Pull in other resources in the MDG. Enlisted functionals, 1st Sergeants, or Chief s are always happy to discuss EPR's, enlisted training programs, and what NCO's look for in good officers. 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.

11. Running efficient meetings.

Fact: Hold on….Wait…how is running an EFFICIENT meeting a bad thing?!

There is a fundamental difference between running an *efficient* meeting and an *effective* meeting. Many unsuccessful SGP's run meetings very efficiently. They cover the required agenda items in a timely fashion, they report their required metrics, and they have very nicely typed minutes. But they don't actually accomplish the purpose of the meeting. Effective meetings may do all the things that efficient meetings do, but more importantly, they accomplish their purpose and effect change.

Consider this analogy.

An *efficient* physician will see patients on time, have their charting completed promptly, and log patient labs and vitals neatly in AHLTA. But are they using that information to improve the patient's health? An *effective* physician isn't only interested in logging the patient's vital signs and labs, they use that information to actively improve the patient's health. Meetings are very similar. Approach metrics with the mindset that they aren't just numbers, but they are the "vital signs" for AOME programs.

By looking at metrics as vital signs and approaching programs with a physician's mindset, it's much easier to run an effective meeting.

- What does the DNIF trend signify? Is it a symptom of an underlying problem?
- Are IRILO metrics responding to "treatment"? If not, what is the next COA?
- Based on OEHWG stats, what preventative measures can be taken to prevent problems from developing later?

MENTORING

It can be difficult to mentor younger officers (or sometimes peers) when the SGP isn't in a command position. But there are some simple things which have a major effect on a career and being aware of them is helpful.

AIRMAN DEVELOPMENT PLAN

The ADP is a chance for people to list career goals and assignment preferences. It's reviewed as part of the vectoring process and is be a major driver for assignments.

When an Airman is identified as a Future Leadership Potential Officer (FLPO) by the Medical Corp Developmental Team, their basic information, including ADP, is sent to the MAJCOM senior medical corp member for 1:1 mentoring. The ADP is the basis for this mentoring and the senior member can help advocate on their behalf to achieve the goals on the ADP. Yet, the most common comment on mentoring sessions is that the ADP is blank. Nothing. Nada. No indication of the member's intent or desire. The second most common comment is the ADP hasn't been updated in several years and the member is pursuing a goal they've already met.

OUTREACH

One way for the SGP to lead despite not being in command is to champion outreach to the line. This can come in a variety of ways, from squadron briefs, to representing the medical team at wing meetings. Look for opportunities to use the SGP line connections to forge new outreach efforts. For example, the SGP is uniquely positioned to conduct a Line Commander Immersion Brief.

Consider: Once a year, after PCS season, offer a line commander medical immersion briefing and cover common topics of interest to new CC's:

- Quarters: No need to send the Airman to the MDG.
- Profiles: How does the system work? Recommend they forward a copy of profiles to their airmen with read receipts and then keep those in a mailbox. It will save major headache if MEB's or actions are required.
- MEB's: Emphasis the importance of the CC's letter and show them the MDG is a small wheel in the process – most delays are outside of your control.
- Discus Who's Who in the MDG: Help them understand that topics of command go to the Sq/CC but the business of medicine (ie: quality of care) is managed by the SGH and military standards are managed by the SGP.

SURF

The combined career brief, AKA the SURF, is a summary of duty and personnel information. Since the SURF is a summary, it is useful for spotting errors, but it may take a while to reflect corrections. It's typically required for any military training opportunity, but it's not easy to find. First find a copy of the SURF by doing the following:

1. *Navigate to the MyPers site, then click the 'View My SURF" link.*
2. *On the next page, click the "AMS" link to go to the Assignment Management System.*
3. *At the AMS page, click the dropdown for "personnel information" and select "my career brief".*
4. *From there, you can click the "consolidated SURF" tab for a pop-up printable copy of the SURF.*

Common errors on a SURF:

- Missing PME. It can take some time to update the SURF, so if a member is facing a promotion board, it's essential that the SURF show completion of PME. Contact the CSS immediately – PME is one of the biggest discriminators for "definite promote" vs. "promote" recommendations.
- Missing the "M" prefix on a medical AFSC. For instance, a board certified family doc should be M-44F3 to show they are board certified. While not a major issue, this can be a discriminator for scholarships and below-the-zone promotions. It's easy to fix: Simply send an AF 2096 to CSS requesting the correction.
- Missing SEI's. Special Experience Indicators are included near academic information and show that the Airman has a special skill set. There are a few common ones that flight surgeons pick up along the way. The AF 2096 is used to request SEI's.
    - HHP: PRP (medical) support. While some people avoid this out of fear of being pigeonholed, it's actually looked for as a plus for some choice billets in USAFE and MAJCOM staff.
    - HUO: medical mishap board member. If a surgeon has served on a mishap board, they can request this SEI. It is helpful in RAM applications to show knowledge depth.
    - HY4: while not a common SEI, this shows that the surgeon has trained with NASA in space medicine. As of this writing, there are only two surgeons in the ADAF with it. In the meantime, it's a major discriminator for positions at AFSPC and soon-to-be USSPACECOM.

THE EXEC TEAM: COORDINATING WITH THE SGH

As the only other physician executive, the SGP may be called upon when the SGH is on leave or short-term TDY. Even if another physician is acting as deputy SGH, the SGP is often the most experienced physician and can expect to be asked for advice.

This section isn't intended to cover the full scope of SGH duties. Many routine items can wait until the SGH returns, however, there are some fires that have to be put out immediately. It's important to remember that the MAJCOM and AFMRA staff are there to answer questions, so don't hesitate to ask for advice.

CREDENTIALING ACTIONS

CLINICAL ABEYANCE

One of the items that may require immediate action is to restrict a provider from patient care if there is reason to question patient safety but there isn't sufficient information to justify a summary suspension of privileges. AFI 48-119 para 9.16 discusses this scenario in its section on abeyances. It is very important to remember that abeyance is <u>not</u> an adverse action and does not need to be disclosed by the MTF or provider. Also, self-identifying as an impaired provider and voluntarily restricting privileges does not drive an abeyance.

An abeyance is invoked to place a provider "on notice" that there is an investigation into their practice. It's used when there is reason to suspect a risk to patient safety and it's prudent to limit the provider from providing patient care until a quality investigation is complete. Any or all of the provider's privileges may be affected, and during the abeyance, the provider is not allowed to practice their affected privileges, even under supervision.

An abeyance is normally imposed by the Credentials Function Chair under the direction of the MTF/CC. It can only last up to 30 days, which is why this is such a hot item. When placing an abeyance, the Credentials Function Chair must notify the provider, in writing, that their privileges are in abeyance and which privileges are affected. The notice must also state that a QA investigation is being performed and will be reviewed by the Credentials Function, and that if the investigation isn't completed in 30 days, the abeyance automatically turns into a (reportable) summary suspension. Because of the short time frame, it may require an Ad Hoc meeting rather than waiting for the next formal function. AFI 44-119 attach 10 has a sample format for the notification letter.

SUMMARY SUSPENSION

A significant step up from abeyance is a summary suspension, discussed in AFI 44-119 para 9.20. This is a reportable action to both the MAJCOM SG, using a DD Form 2499, and by the provider on all future privileging applications. Because it's such a significant impact on present and future licensing, it should be decided upon at the credentials function meeting. However, since it's typically driven by significant misconduct, incompetence, or clear-cut negligence, it usually cannot wait for an official meeting and its best to hold an ad hoc credentials function meeting to address the suspension immediately. Self-identifying as an impaired provider and voluntarily restricting privileges does not drive a summary suspension.

A suspension shouldn't exceed six months, though AFMRA/SGHQ can issue a waiver if more time for investigation is needed. Due to the significance of these cases, in addition to the standard written notification from AFI 48-119 Attachment 11, the provider must be notified that they have the right to legal counsel.

Similarly to an abeyance, the provider cannot practice their suspended privileges, even while supervised, during this time. Additionally, they cannot engage in off-duty employment during that time and must inform other medical facilities where they practice that their privileges were suspended. If a summary suspension action needs to be taken, it will drive a QA investigation.

IMPAIRED PROVIDERS

Since the Air Force wants to encourage impaired providers to self-identify rather than conceal impairments, there are certain protections granted by AFI 44-119 section 9E to providers who self-identify. If the provider voluntarily requests restriction, then adverse action is not required. If a provider fails to self-identify as impaired, then there may be need for a QA investigation, with abeyance or summary suspension.

The requested restrictions must be reported to the MTF/CC for concurrence, then to the AFMRA/SGHQ. In addition, SGHQ may be required to report the voluntary restriction to the state board, but not as an adverse action. It's important to note that self-identifying and requesting a voluntary restriction must be done before an abeyance or adverse action has been initiated.

If a provider self-discloses alcohol or drug impairment and requests treatment, they can voluntarily restrict their privileges. This is not an adverse action and isn't normally reportable. Once notified, the SGH must conduct an inquiry to determine the extent and impact on patient care. For instance, if the provider was found to have been under the influence of alcohol or drugs while rendering patient care, it may drive adverse actions due to patient safety. The SGH will need to work with the MLC to review the facts of the case and determine their recommendation to the MTF CC. However, if the impaired provider does not self-refer, if they fail to complete their rehabilitation program, or if they relapse, DoD 6025.13-R requires adverse actions and reporting.

Assuming the provider self-identified, voluntarily restricted their privileges, and sought appropriate treatment, there are time limits to consider. Substance dependence (substance use disorder – severe) drives a minimum of six months stability following treatment before returning to clinical duties. Substance abuse (substance use disorder – moderate) drives a three month stability period following treatment. This period begins after the treatment program is completed.

Providers may also self-identify with a temporary or permanent medical condition that limits their ability to perform their clinical privileges, for example, performing surgical procedures with a broken arm. If the condition is temporary, it can be managed with an AF 469, with the profile placed in their file. This isn't considered an adverse action and it is not reportable. A more permanent condition would need to be reviewed by the credentials function and the AFMRA/SGHQ who will determine if reporting is required.

An IRILO or MEB doesn't mean a provider is unable to safely provide medical care and doesn't drive an automatic limitation in clinical practice. If the medical condition is serious enough to drive concerns about the provider's ability to safely provide medical care, then it would be considered under the impaired provider considerations in AFI 44-119 para 9.65.

GS and contractor employees are managed similarly to the above. For GS employees, the supervisor of Federal civil service employees must contact the CPO, employee relations branch, before questioning the employee. For contractors, the contract staff supervisor will contact QA personnel assigned to the contract and the base contracting officer to ensure the contract agency is informed. In neither case can the employee be fired in lieu of taking adverse action.

NOTE: *The SGH consultant maintains helpful checklists on the Kx.*
https://kx2.afms.mil/AFMOA/ClinicalQuality/SGHConsultant/Documents/Forms/ShowFolders.aspx?RootFolder=%2fAFMOA%2fClinicalQuality%2fSGHConsultant%2fDocuments%2fMentoring%2fAdverse%20Actions%20%2d%20SGH%20information&FolderCTID=0x0120000F042B85C54C8445AB848F5FD5FF8E00

SUICIDES, DEATHS, AND MALTREATMENT CASES

Another item (that hopefully doesn't happen often) involves the patient who suffers maltreatment, a serious illness, or death. In the past, there were specific criteria and reports for serious illness (SI), very serious illness (VSI), or imminent death (ID). While there are still notifications, it's no longer quite as formal. The immediate goal is to ensure there wasn't medical mismanagement and the secondary is to ensure that the MDG and Wg CC are informed to the level they need to be.

DEATHS, SUICIDE ATTEMPTS, AND COMPLETED SUICIDES

For suicide attempts, suicides, or deaths, notify the AFMRA SGH cell within 24 hours, and cc: MAJCOM SGO. There is a PDF form to complete for these notifications of an active duty event. It can be found at:

https://kx2.afms.mil/AFMOA/ClinicalQuality/SGHConsultant/Documents/SGH%20AD%20Death%20and%20Disability%20Event/Active%20Duty%20Event%20Notification%20Form%2027%20May%2019.pdf

- The AFMRA cell will make a determination for PCE, SOC, or MII and provide input to SGH usually w/in 72 hours of event.
- Proofread your report well; the info you provide to the MDG/CC will be forwarded to WG/CC and used in WG/CC communication with MAJCOM/CC.
- For suicides and attempts, the MDG MH clinic is required to provide an Individual Suicide Event Report (ISER) to MAJCOM/MH and AFMRA. Ask MDG MH to cc: the local SGH (AKA: you) so details are easily available for AD event reporting.
- AJOCM/SGO requires that all patients added to High Interest Log (Suicide attempt or high interest patients) are required to be briefed and staffed to SGH by MH.

There are a number of other tasks to accomplish in the event of death, so use this handy SGH checklist posted on the Kx to ensure they're all completed:

https://kx2.afms.mil/AFMOA/ClinicalQuality/SGHConsultant/Documents/Forms/ShowFolders.aspx?RootFolder=%2fAFMOA%2fClinicalQuality%2fSGHConsultant%2fDocuments%2fSGH%20AD%20Death%20and%20Disability%20Event&FolderCTID=0x0120000F042B85C54C8445AB848F5FD5FF8E00

CHILD SEXUAL MALTREATMENT CASES

The Family advocacy officer (FAO) has the stick on these cases, and will coordinate with OSI, JA, and local medical facilities to ensure the proper chain-of-custody medical exams are performed. Normally, FAO will draft the statement for the MDG/CC, but they should copy the SGH. The SGP may also be pulled in if there is need for aerovac, for instance, to bring the child to a facility able to perform a SAFE exam. Be aware that evac for SAFE exams is considered a priority movement.

SEVERE MALTREATMENT CASES

The FAO also has the stick on these cases, and will coordinate with OSI, JA, SFS, Sq/CC, and/or the Shirt. They will work with these personnel to determine the need for the high risk for violence response teams (HRVRT). Normally, FAO will draft the statement for the MDG/CC, but they should copy the SGH. The SGP may also be pulled in if there is need for aerovac, but in most cases, the in-patient facility will be the one coordinating an evec (see chapter on aerovac). Any severe trauma to an infant (ex- shaking baby ect.) requires AFMOA-FAP notifications by FAO, normally with a copy to the local SGH for SA.

FOMWG (AKA GROUNDING MANAGEMENT OR 1041)

Grounding Management, AKA the 1041 Meeting, AKA FOMWG, is a weekly meeting to monitor the status of DNIF aviators and manage FOMC business. The SGP may chair or delegate it to the FOMC Flt CC, but the SGP must attend regardless. (AFI 48-149 2.6.1.2.). AFI 48-149 para 2.6.1. provides a complete list of the information to address, but the biggest rocks are waiver tracking and DNIF management.

At many bases, the FOMWG is held at the end of the week, but the weekend makes it difficult to follow up on DNIF fliers and upcoming waivers. For that reason, it's better to hold it early in the week to allow time to work issues identified during the meeting and bring DNIF fliers into the clinic.

Traditionally, FOMWG were informal, but consider making it more formal and use 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 simplifies documentation by attaching documents to the minutes and simply submitting them to AMC.

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: DNIF AVIATORS

ASIMS generates a fairly robust 1041 log. Make sure to pay attention to the ratio of days predicted vs. days down. If someone should have returned but hasn't, have a tech email them to return to the clinic for RTFS and annotate that in the 1041 notes section. The 2nd notification gets copied to their Flt CC and SGP, and the 3rd notification gets copied to their DO and SGP. A monthly email with summary DNIF rates gives the Flying Sq/CC's good SA, and you can follow with CC's who have higher rates within their squadrons.

I recommend using the notes section of the DD2992 to document the last t-con or appointment with long term DNIF's to show compliance with the requirement to contact them every 30 days. Don't forget to brief the DNIF rate at Exec Staff and put it in the AMC minutes' exec summary.

WAIVER WRITING

The AMS needs to be able to stand alone, with a solid history and exam to build the case that the individual deserves (or doesn't deserve) to continue to fly. The goal is to make the approval for the waiver as simple as possible by anticipating questions the approval authority may have and answering them in the AMS. A few other tidbits:

- Once the waiver arrives at the approval authority, they review the AFWG. When writing the waiver, turn to the appropriate section and run the checklist. Do the same before signing as senior reviewer.

- Attachments don't appear in the PDF version of the AMS and automatically delete from AIMWTS after a time. Unless attachments are summarized, their content will be lost forever, so write a short summary rather than just "see attachments".

- Occasionally, there's good reason why AFWG checklist information isn't included. As long as the omission is explained and the impact is negligible, it's not usually a problem. However, if a required item is missing and there's no explanation, the assumption is that it was forgotten, and the waiver will be sent back.

- AIMWTS attachments sometimes don't attach properly, so double-check before sending it to MAJCOM to save addendum requests.

- Always send the wavier to the MAJCOM first, even if AFMRA is the authority. Before AFMRA approves a waiver, they want endorsement by the MAJCOM.

- It can take weeks for ACS reviews, so a 90-day check is wise to identify potential ACS cases. If there are extenuating circumstances that prevent accomplishing ACS studies in time, contact the MAJCOM SGP and request a waiver extension.

- If you're asking for something unusual, such as a non-approved medication, contact the MAJCOM ahead of time. You may be able to grease the wheels with a journal article, consultant, or other evidence. The MAJCOM SGP can even use that to request the standard be updated at the next medical standards working group.

- Lastly, if a member is separating or retiring, the waiver should be left to expire rather than retiring it. (AFI 48-123 6.4.4.3.)

SECTION I: IDENTIFICATION AND IDENTIFICATION REMARKS

AIMWTS automatically generates a basic introduction, but it doesn't include all the information the approval authority needs. 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 don't support waiver, say right up front the purpose is to request disqualification. Include any previous waivers, when they were granted and by whom, and when they expire. Information, such as ASC, is on the DD 2292 on ASIMS.

Sample introduction:

> Major Montgomery "Scotty" Scott, SSAN (xxx-yy-zzz), is a 43 year old (DOB: stardate 2222.03), male, active duty Air Force, Electronic Warfare Officer for the B-52H (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 IRILO 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 appropriate section in the Waiver Guide, especially Part III (Waiver Consideration). The waiver authority uses this list to check waiver eligibility. 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 IRILO was submitted. His IRILO returned with an ALC-2 and Capt Scott was given diabetic education and referred 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, include the data in the appropriate tab and it will populate in this section automatically.

SECTION IV: PHYSICAL EXAM

The bulk of the physical exam can be copied / pasted from AHLTA, but 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 extensive labs or studies, attach a scanned copy and summarize the findings in the physical exams section –- and double-check to ensure it uploaded.

NOTE: *Write a draft of the waiver in a word processer, to format and spell check it before copying / pasting into AIMWTS. It's also good for young docs to do this and have the SGP edit it before uploading and signing in AIMWTS.*

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 aeromedically significant diagnosis along with the treatments and applicable dates. But 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 the recommendation clear, 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 a waiver isn't supported. If the member's commander submitted a letter, reference it here and include it in the attachments. If the wavier is to request a DQ, state that the member and CC are aware and in agreement with the recommendation. That will stave off potential ETP's and disgruntled aviators.

If there was a requirement in the waiver guide that was not followed, 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, or they may approve a waiver at 4 months instead of 6 months - if there is justification. If you don't explain why you deviated from the guide, they'll assume 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. If a waiver is not possible or not recommended, then come out and say so. Don't just say, "Waiver is submitted for consideration." It's OK to couch the statement with, "Member remains highly motivated to fly, but per the AFWG, waiver is not permitted." But make sure to manage expectations and tell your patient that you'll hope for the best, but to understand that odds are against them.*

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 – IFC's go to AETC and MOD to AFGSC.
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 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.
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.
13. The AMS doesn't stand on its own. For instance, instead of briefly summarizing attached consultant notes, the AMS merely says, "see attachments."

EXTENDING AND RETIRING WAIVERS, PHA'S & DD 2292'S

Occasionally, there are times when a member is unable to complete exams on time. Other times, members no longer require a waiver and it can be retired. Both are fairly simple processes, but there are some unique cases that require finesse.

EXTENDING WAIVERS, PHA'S, AND DD 2992'S

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 an extended deployment, emergency leave, PCS'ing with a waiver due for renewal, or ACS rescheduling 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 always best to be proactive and rehack a waiver early rather than asking for it to be extended.

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, AFMRA is the waiver and extension authority, not MAJCOM.

When contacting the MAJCOM for waiver extension, verify that the member remains stable and that their condition(s) and medications(s) do not impact their ability to continue to safely perform their duties. Typically, an emailed statement will suffice.

NOTE: *Asking for an extension because you are too busy or you failed to be proactive with the 1041 meeting will likely 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 AFMRA/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.

WAIVER RETIREMENT

If a member's condition resolves, or if the MSD is updated, and a waiver is no longer required, it can be retired with concurrence of the MAJCOM SGP. AFI 48-123 6.3.1.4. provides the proper verbiage to use in AIMWTS2 when retiring the waiver. Most MAJCOM SGP's will accept an emailed explanation of why the waiver is ready for retirement, but occasionally, they'll ask for it to be made indefinite rather than being retired. That case is simple, but there are times where things get more complicated.

What if the member has multiple diagnosis, but one is retirement eligible and the other is a time limited waiver?

> At the time of renewal, address the DQ conditions as normal, and explain why the other diagnosis should be retired. At that point, the waiver authority can include the to-be-retired diagnosis in the disposition, but annotate it as *retired* so it's clear on future renewals that those conditions were retired, not merely forgotten, and no longer need to be carried forward.

What if the member has multiple diagnosis but one is retirement eligible and the other is approved indefinitely?

> When the retirement-eligible section becomes due for renewal, renew the waiver and request retirement of the eligible condition (see above question). The "indefinite portion" of the AMS can simply be a copy-paste from the previously approved waiver along with a comment that the member's condition remains stable and unchanged from the time it was approved indefinitely.

EXCEPTIONS TO POLICY

I hesitated including this, since it's a means to circumvent a medical disqualification, and it's not something to encourage. But as SGP, it's important to know the process. Think of this section as "Defense Against the Dark Arts."

The most common case involving flight medicine is the ETP to allow an Airman to be trained or retained for flying duties despite having been medically disqualified. First and foremost, this is NOT a medical process. It is requested by the line, processed through the line, and does not involve medics until a review is requested at the CSAF level. It should never be suggested or processed by the MDG or FOMC.

AFI's are hesitant to give step-by-step instructions how to circumvent AF standards, so there is little solid documentation; the Airman Retraining Program, AFI 36-2626, merely directs HQ USAF/A1P to coordinate with career field managers to process ETP's. If an ETP is started, the only one who can stop it is the MAJCOM/CC, so even if the Wg/CC disagrees, the package still has to route to MAJCOM.

The basic process for IFC's is this:

1. Once the Sq/CC has identified a member that they want to process for ETP, they create a package with the member's UPT application, IFC I, and the corresponding medical waivers. This package is routed to the Wg/CC, NAF/CC and then to MAJCOM/CC.
2. With MAJCOM/CC endorsement, the package is then sent to HAF/ES and copied to AFPC/DP2OR. HAF/ES reviews it and coordinates with AF/CV.
3. HAF/ES (AF/CV) then requests AF/SG (AFMRA/SGPA) to conduct a risk assessment (RA).
4. AFMRA forwards the case to ACS for the RA, and upon its return, provides the ETP+RA package to AF/A3/5 and AF/SE for their concurrence.
5. Once this coordination is complete, it's forwarded back to HAF/CV for determination, and the result is provided via AFMRA channels.

Notice that the base MDG has nothing to do with the process. As SGP, you may be asked for a letter endorsing the ETP. Remember, the DQ was done at the headquarters level, so don't rise to the bait of endorsing a dissenting position. The proper response is, "The member failed to meet documented medical standards and MAJCOM SGP (or AFMRA/SGPA) determined, through the waiver process, that they exceeded the risk threshold for a waiver, resulting in the medical DQ."

IFC's can take over. Especially frustrating are the patients who no-show appointments. If this becomes a problem, advertise that no-showing for a required appointment will cancel the IFC and the member will only be allowed to reinitiate it with a note from their supervisor. Second offenses require a note from the CC.

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	

FLIGHT MED OPERATIONS

While anything in this manual could be considered 'operations', this section focuses on the business of flight med and tasks associated with running Team Aerospace.

SELF INSPECTIONS

The MICT self-inspection 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 officially determine compliance. However, the MAJCOM SGP office reviews MICT 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 bother listening 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 hold the MDG/CC and SGP accountable. If the MACJOM office is saying that justification for a "green" isn't sufficient, or that the "get well plan" is flawed, expect that eventually the Wing CC will say the same thing.

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 and 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, as well as time at the next review, and gives the next SGP 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. (link to appt. letter on shared drive).*

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%*

HINT: *Include a link to an "appointment letter" folder on your shared drive. Then, you only have to update the letters, not the MICT attachments..*

EXAMPLE SELF-INSPECTION CHECKLISTS

A good way to conduct self-inspections is to review the relevant AFI's and look for the phrases "The (MTF/CC, SGP, FOMC, etc) shall…". Then generate a checklist for the FOMC staff to review. Maj Alicia Florence at AFGSC developed the following example checklists:

Note Taker for AFI 48-101

1. Does the SGP provide programmatic oversight of the AME, to include chairing the AMC, OEHWG, DAWG, PHEWG, possible PHEO, and FOMWG (unless delegated). 1.4.15.4
2. Is the SGP the Senior Profile office and lead CMA? .4.15.4.3.
3. Is the SGP part of the Executive committee functions?
4. Does the AMC remove/approve the OEHWG, DAWG and FOMWG minutes? 1.6.
5. Does the AMC meet monthly (no less than quarterly) and are notes signed by the Exec committee?
6. Do the following attend the AMC: SGP, OICs and NCOICs of AOP, BE, FOM, Optometry, PH, Medical Standards Management Element (MSME), Health Promotion, and all assigned FS (SMEs included). (T-3) Dental is also a member where part of the Aeromedical Dental Squadron (ORMS). (T-3)?
7. Do the AMC minutes demonstrate a review and plan for any deficiencies or concerns?
8. Does the SGP attend the Medical Readiness Committee meetings? 1.6.6.5.3.
9. Is the DNIF rate reported monthly to the operational Sq and Group/CC? 2.4.1.
10. Have the METALS been approved and are they >90%? 2.4.2.2.
11. Are all assigned FS MQT qualified? 2.4.3.
12. Have the 4NF's attend the FOM training within 6 months of assignment? 2.4.4.
13. Is IFC completion rate tracked? 2.4.5.
14. Are the indicators (DNIF rate, METALS, MQT and 4NF training) reported quarterly to the Exec committee? 2.6.2.

Note Taker for AFI 48-149

1. Is the SGP appointed in writing? 2.8.
2. Are patients empaneled appropriately? 3.2.1.
3. Is all medical care provided outside of the MTF reviewed NLT the next duty day? 3.2.4.
4. Do all notes contain an aeromedical disposition?
5. Has the Lead CMA received the one time USAFSAM training? (6 months) 3.3.4.2.
6. Are the METALS completed appropriately? (50% time) 3.4.1.
7. Are SME personnel ensuring that approximately 50% of time is spent covering clinical workload and approximately 50% accomplishing METALS and squadron operational support activities? 3.5.4.1.
8. Are SME's credentialed within the MTF? 3.5.4.2.
9. Does the FOMWG meet weekly? 3.7.1.
10. How/when is AIMWTS reviewed? (Minimum monthly, usually at the FOMWG) 5.3.1.

OPERATIONAL INSPECTIONS

Among the occupational site visits there are several operational shop visits as well. The expectation is that each shop be visited quarterly, unless waived by the MAJCOM/SGP. The FOMWG provides a good opportunity to track and schedule these visits. (AFI 48-149 3.7.1.6.)

These operational shop requirements are defined in AFI 48-149 3.4.2. and include:

- flight equipment
- control tower
- alert facilities
- radar approach control (RAPCON)
- parachute units
- flying units
- space operations units.

BALANCING CLINICAL AND OPERATIONAL DUTIES

Much has been said about the intent that flight surgeons spend 50% of time covering clinical workload and 50% accomplishing METALS (AFI 48-149 3.4.1.). This is one of the factors that drove the flight surgeon maximum empanelment of 550-650, since that's 50% of the empanelment of a PCMH provider. But the number of patients isn't the sole indicator of clinical workload for flight medicine. Between providing BOMC support, occupational exams for non-empaneled patients (ie: fire fighters, HCP members, etc), and other oversight duties, the clinical workload of a flight surgeon extends well beyond a simple empanelment number. That said, it's more important to accomplish METALS than it is to have a specific ratio.

MAKING MEPRS WORK FOR YOU

MEPRS data is used to determine the amount of full time equivalent (FTE) hours that individuals spend, which in turn drives manpower decisions. Correctly logging MEPRS is especially important in FOMC since it directly relates to the 50:50 clinical to operational split.

In flight medicine, the "BJAA" code is used to designate acute/routine/wellness patient care and is also used for profiles, pharmacologic fatigue management (including tracking), aeromedical dispositions, waivers, MEB's, MRO duties, and other non-direct patient care duties. (per AFMOA FY 18 METALS Guidance, the most current posted on the Kx). In other words, the USAF considers the time flight surgeons spend on many non-patient care duties to be *clinical* workload. Because this is different than PCMH coding, many flight docs are (wrongly) told to use admin codes for these clinical duties. Additionally, BJAA doesn't differentiate between codable and non-codable time. Other clinics, including the PRAP clinic, BJAC, splits codable-clinical and non-codable clinical time. Sometimes GPM's wrongly believe that only codable clinic time is BJAA; refer them to the AFMOA guidance above.

Applying this to a typical FOMC, suppose Capt Smith sees patients 2.5 days of the week and spends another 1.5 days on aeromedical reviews, waivers, and profile officer duties. She spends her last day working on MRO, AMRO, and DAWG cases, then doing fatigue analysis for her unit and tracking go-pill usage. On the surface, she appears to have a 50% split between clinical and operational time, since she only saw patients for 2.5 days. But since all of those duties are coded BJAA, she actually spent 100% of her time on clinical workload. (!)

When recorded properly, MEPRS coding often shows an overemphasis of clinical workload. Having this data is invaluable when questions arise and the SGP needs to show that flight docs are overly utilized for clinical workload at the expense of operational support.

NOTE: *DoD 6010.13-M is the MEPRS manual and describes flight medicine (BJ) functions in the C2.2.18. section. The codes are built, similarly to an AFSC, by having each letter assigned as a designator. For example, in flight medicine clinic ("BJAA"), the first letter (B) designates ambulatory care, the second (BJ) flight medicine, the third (BJA) is the particular work center, and the fourth (BJAA) designates the particular team. This is why a PRP clinic is designated as BJAC, to designate is as a flight med ambulatory care program, but as a separate team.*

FOMC EMPANELMENTS AND WAIVERS

Per AFI 48-149 3.2.1.1, FOMC empanels personnel who require an AF 1042 (DD 2292) and their dependents. They also empanel PRP members unless there is a standalone PRP clinic. Additionally, FOMC performs occupational exams for active duty and civilian federal employees, although they do not empanel those patients. There is a wavier process to allow the MTF/CC to request that the MAJCOM/SGP authorize empaneling other personnel as necessary for successful completion of the local aeromedical or installation mission (3.2.1.2.).

Some MTF's push to enroll non-fliers and non-fly dependents as a means to reduce PCMH empanelments, or they argue that occupational exams (e.g. firefighter) are too complicated for PCMH. But as AFI 48-149 3.2.1.4.1. clearly states, firefighters already get their exams from FOMC, and changing enrollment to reduce an empanelment in PCMH is not "necessary for successful completion of the local aeromedical or installation mission." In fact, more times than not, its detrimental to the successful completion of the aeromedical mission.

If there is a desire to increase empanelments, begin by looking at METALS. Do the flight surgeons routinely complete all of the METALS? Are they accomplishing a 50:50 time split between clinical and operational workload? (See above for how to define clinical workload). If the answer is yes, then feel free to enroll more patients. But begin by enrolling FLY dependents rather than asking the MAJCOM/SGP for a waiver.

Why enroll dependents first? Assume that Base X's FOMC can support enrolling 100 more patients without negatively impacting mission support. The MTF/CC requests a waiver to do so, and it's approved. But at any point, they can decide to also move all the FLY dependents into FOMC, overwhelming the clinic's ability to effectively support operations. No new waiver is needed since FLY dependents are authorized enrollees per AFI 48-149. It may be that having both a waivered enrollment and dependents is overwhelming, so to protect from that, the MAJCOM/SGP will want to see dependents enrolled and verify METALS are met before they consider a waiver to further increase FOMC empanelments.

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 pressure from administrators and the MDG CC. Some preventative medicine applied to clinic management can avert this problem and renew focus on mission support and operations.

PITFALL: EXCESSIVE OPEN APPOINTMENTS.

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

Impact: While this intuitively seems good, it actually works against FOMC. It makes it appear that FOMC isn't busy, and when that happens, PCMH may pull staff to cover their appointments or look to increase flight surgeon empanelments.

Fix: There are two ways to fix it, but the goal is to eliminate the hybrid schedule that uses both 24HR and walk-ins.

Option #1: Walk-in all acute issues and use only FTR appointments for scheduling. This approach eliminates all 24HR's 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 FTR appointments giving follow up, and it makes the schedule very simple to manage. In a small clinic, this is an easy approach that tends to be popular with patients. A large clinic can quickly overwhelm its staff, though, so consider Option #2 for that.

Option #2: Traditional schedule with FTR, 24HR, etc appointments and no walk-in or sick call. It takes some balancing to get the right mix, but remember you can book a patient into an afternoon 24HR slot and still 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 and schedule out-of-clinic duties.

PITFALL: CLINIC SCHEDULES ARE CHAOTIC, WITH DOUBLE-BOOKING AND BACKLOGS

How it happens: In an effort to make scheduling easier, daily schedules are identical and "clean" but may not provide the right mix of appointments at the right time of the week.

Impact: Clinical care is fragmented and double booking becomes common. Admin time is lost as other providers have to assist to reduce backlogs. Techs are burnt out trying to keep up with the chaotic flow.

Fix: Meet with the GPM and review the clinic needs. Look at the flow of appointments throughout the week and have the daily clinic schedule reflect the daily demand. Is there demand for acute appts on Monday? If so, build a Monday schedule that is weighted toward 24HR appts and have the mid-week focus on PHA's. But be aware that if Monday is a holiday, the first duty day has to manage a 24HR demand, perhaps with a 2nd provider seeing acute patients. Plan for surges as well; if there is a need for 800 PHA's per year, build a schedule to accommodate 900 PHA's so the occasional surges don't disrupt the schedule.

PITFALL: SME'S DISENGAGE FROM THE CLINIC

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 when the SME's aren't available and the unit loses 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, and that while in garrison, SME's are fully integrated into MTF ops. 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)

PITFALL: DESPITE OPEN APPOINTMENTS, "3RD DAY ACCESS" IS POOR

How it happens: The 3rd Day Open metric doesn't look at the total number of appointments on the schedule. It looks at the appointments available at a specific time. For example, if there are three providers with open 0800 appointments, the metric will count a single open appointment, since there is only one time (0800) when there is an appointment available.

Impact: The FOMC appears to have poor access to care, when in fact, it may have excellent access and open appointments sitting on the books.

Fix: The simplest fix is to stagger the appointments to allow the algorithm to note them as separate entities. Instead of having two clinicians, with two appointments at 0800 and 0830 (counted as two total open appointments), schedule appointments at 0800, 0815, 0830, and 0845 to let the algorithm count four open appointments on the calendar.

PITFALL: PRAP APPOINTMENTS ARE DESIGNATED AS 20 MINUTES, BUT THAT'S NOT EVNOUGH TIME FOR THE ASSOCIATED ADMIN

How it happens: Under DHA and new rules, PRAP appointments are mandated as 20 minute, not 30 minute appointments.

Impact: MTF's either create double appointments, seeing a patient every 40 minutes and having to work multiple providers to meet demand, or have 20 minute appointments and fall behind on the admin tail of PRAP.

Fix: Simply schedule 20 minute appointments every 30 minutes. Have an appointment from 0800-0820 and another from 0830-0850, 0900-0920, 0930-0950, etc. That way, providers have enough time to keep on top of the admin, but still have enough appointments in the day to meet demand.

GO AND NO GO PILLS

Fatigue countermeasures are discussed in AFI 11-202 V3 (and MAJCOM supplements) as well as AFI 48-149. There is a tendency to use pharmacologic countermeasures as the "easy button" and neglect crew rest, planning, scheduling, sleep cycle shifting, crew augmentation, strategic napping, diet, caffeine, etc. But in reality, pharmacologic countermeasures are intended to be a "break glass" option. It's up to the SGP to keep perspective and ensure the other options are all utilized to the fullest extent possible.

GO PILLS

Go Pills are not authorized for training or simulator missions, and are typically restricted to fighter missions (dual or single seat) over 8 hours, dual piloted bomber missions over 12 hours, or pilots with crew days over 16 hours. But this may vary by MAJCOM, so engage early with the MAJCOM SGP for any CONOPS or supplements. Aircrew can use choose to use either Dex or Modafinil, but not both during the same mission.

Drug name	Dose	Notes
Modafinil (Provigil)	200 mg q 8 hours	Max dose 400 mg in 24 hours, do not use more than 72 continuous hours. May be approved case-by-case for other airborne combatants by HQ USAF/A3 and SG. May be used by AFSOC Special Tactics teams. (31 Aug 06 SG memo)
Dextroamphetamine (Dexedrine)	5-10 mg q 4 hours	Max dose 60 mg in 24 hours, do not use longer than 72 continuous hours. Sustained release capsules are not authorized (26 Jul 01 AFMOA Policy letter.) May not be used by AFSOC Special Tactics teams. (31 Aug 06 SG memo)

NO GO PILLS

While these don't tend to be quite as highly controlled as Go's, it's important to reserve them for justified circumstances. Typical examples include flights occurring within the first few days after crossing multiple time zones or short-notice operational requirements which require a major sleep/wake cycle shift. No-go guidance can be found in the 20 March 03 AFMOA memo from BG Murray and is summarized below

Drug name	Dose	Minimum Verbal DNIF	Restrictions
Zaleplon (Sonata)	10 mg	4 hours	Max 10 consecutive days and no more than 28 days in 60 day period
Zolpidem (Ambien)	5-10 mg	6 hours	Max 7 consecutive days and no more than 20 days in a 60 day period
Temazepam (Restoril)	15-30 mg	12 hours	Max 7 consecutive days and no more than 20 days in a 60 day period

AEROVAC

Many Airmen believe that Aerovac is only used in distant theatres to bring casualties to deployed MTF's. But the fact is, smaller CONUS MTF's must rely on it regularly when their acute patients exceed local capabilities.

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 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, it's possible to arrange transport from an outpatient MTF. This requires high level red-tape cutting, so engage early with the MDG CC.

It's possible, and sometimes desirable, to land a Lifeflight plane at the AFB flightline vs. the local airport, but the ops desk will need to issue a transient aircraft authorization. They need the landing time, type of plane, tail number, call sign, souls on board, and whether it will need fuel. The aircrew need to know the frequencies, runway, and any cautions (lights out, taxiways, etc). This minimizes transport for patients with serious problems, but it requires coordination. That said, the ops desk tends to be eager to assist on this kind of mission, and the SGP's knowledge of the medical and aviation worlds makes them the perfect mediator.

MILTIARY

The USAF used to have a dedicated AE aircraft, the C-9A Nightingale, which retired back 2003. Without 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 it is a truly urgent case, call ahead to give the PMRC a cranium's up that an urgent case has been submitted.

There are patient prep checklists in AFI 48-301 V1, attachments 6,7,8, and 9 that will guide you through the stages of preparing your patient for transport.

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.

OPTOMETRY: SOFT CONTACT LENSES AND LASER EYE PROTECTION

Optometry plays a large role as an adjunct to flight medicine. Paths cross specifically for soft contact lenses and laser eye protection. Both programs generate some questions, but the answers are pretty straightforward.

AIRCREW SOFT CONTACT LENS PROGRAM (ACSCL)

The ACSCL is 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 encourage aircrew to wear SCLS?

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 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.

AIRCREW LASER EYE PROTECTION (ALEP)

The requirements for ALEP are spelled out in a policy message as opposed to an AFI - specifically, the HAF-AFECM037 HQ USAF/A3TF Policy Message on 25 June 2018.

The message puts the responsibility for the program on Stan/Eval and AFE, but the ALEP is sized based on interpupillary distance (IPD). Para 2.2.1. specifically puts the responsibility on Flight Medicine to approve use of ALEP, NVG's, and high contrast visors, but then directs use of a memo in Attachment 1 that is signed, not by Flight Medicine, but by optometry. This leads to some questions on who is ultimately responsible for approval.

My suggestion is to have optometry perform the IPD measurement since they are most precise and experienced. After that, they can complete the memo by providing the IPD and approving the member to use ALEP, NVG's, and high contrast visors. If the member requires visual correction, they "approve with prescriptive insert / outsert". If the member has visual problems that cannot be corrected within aeromedical standards, then optometry would "not approve" and send the member to Flight Med since they probably need to be DNIF and obtain a waiver.

If optometry still doesn't feel comfortable, then the alternative plan is to have them perform the measurements and have flight med sign the memo as above. However, that requires the member to visit several offices and coordinate different signatures. I prefer to keep things simple and offer a one stop-shop.

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 there is another occ med doc at the base, there is 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 IOEHC's inputs. It's 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 the team to focus on exams that need to be accomplished and stop 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. It's very common to find shops on the HCP which no longer exceed threshold levels and can be dropped from the HCP.

OFF BASE EVALUATIONS FOR CIVILIAN FEDERAL EMPLOYEES (CFE)

Occasionally, a CFE requires an off-base referral, often to audiology, as part of their occupational visit. When that happens, the question arises: Who pays for it?

Short answer: The AF, through the eligible member's unit, is responsible for the cost of such off-base evaluations, with payment made from the same appropriation that funds the employee's salary (AFI 41-210 2.33.6.2.1.).

The details lie in AFMAN 48-146 7.2.3.1:

7.2.3.1. CFEs receive AF required medical examinations and assessments from AF designated HCP at no cost to the CFE (5 CFR 339.303; 29 CFR 1910). When an MTF lacks the resources to perform a required examination, specialty consult, study or lab, IOEMC may arrange to send the patient to the civilian community (within 25 miles of the base when possible) upon approval of funding from the unit or organization to whom the CFE belongs (see AFI 41-210 for details on process). The IOEMC is responsible for ensuring results are of adequate quality to protect the CFE and the interests of the USAF.

AFMAN48-146 goes on to discuss how to obtain the funding verification:

7.3.2. Obtaining Funding for Outside Examinations and Assessments. Consults, studies and tests that will be done outside the MTF for a CFE must be approved for full payment before they are ordered following procedures in AFI 41-210 (T-2). Bases with pre-existing agreement between the Line and the MTF that already support execution of required non-DHP consults, studies, laboratory tests and medical examinations for CFEs are not required to replace their agreed to practices in order to comply with this policy (T-1).

AFI 41-210 2.33.6.2 provides step by step instructions for RMO to arrange verification of payment after the IOEHMC requests the exam. Once RMO has verified payment, then the RMC can assist in scheduling the visit. As with any occ health exam, PH will have to track to completion, which may be a little more complicated due to the off-base referral.

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.*

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.

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.

DETERMINING A PTS AND ESTABLISHING A NEW BASELINE

At first glance at AFI 48-127, it appears that a PTS would automatically drive a referral off-base with an HCDC overread. But that's not necessarily true. AFI 48-127 para 2.23 and A6.4 both allow for an occupational health consultant (AKA a flight surgeon) to review problem audiograms. If they determine it is a PTS, they can re-establish the baseline without performing an audiologist referral.

This is where clinical judgement comes into play. It may be appropriate to send the patient to ENT or to an audiologist if there are clinical indications that indicate an underlying disease process. The reviewer needs to consider risks, patient demographics, and any other symptoms as they make that determination.

Once the flight surgeon determines there is a PTS, the case can be sent to AFSAS for OSHA reporting *if* it meets the criteria for on OSHA reportable hearing loss. But not every PTS requires AFSAS reporting. (see below)

AUDIOGRAMS AND OFF-BASE REFERRALS

AFI 48-127 offers guidance on how to manage hearing conservation programs, but it's rather unclear and circular in its direction about what to do when referring off-base. There are some important pieces when working with an off-base audiologist:

1. If the base doesn't have a DoD associated audiologist, the report will need to be sent to a regional Hearing Conservation Diagnostic Center (HCDC) for an over read. (para 2.20.14.6.3)

2. AFI 48-127 gives a complete list of tests that need to be done by an off-base audiologist in section 2.20.14.6.1.1. As intimidating as the list is, it's really just a standard-of-care audiologic evaluation that most audiologists can complete in about 25 minutes.

3. The off-base audiologist also needs to provide proof of current audiometer calibration (para 2.20.14.6.1.5.2.) and serial number of their machine (OSHA). Again, this seems odd, but is standard of practice in the audiology world. Chances are, the information is pre-printed on the audiogram reports since it's also an OSHA requirement.

***Hint*:** If you're having problems getting all of the above information from the off-base audiologist, draft a memo detailing the required information above. Then, rather than giving it to the patient, visit the audiologist and give them a copy. Explain the purpose of the referrals and thank them for supporting the Air Force.

OSHA REPORTABLE PTS AND AFSAS

Bases often run into problems meeting the 7 day timeline to document OSHA reportable PTS in AFSAS. This is compounded by waiting for an HCDC overread before entering the information and updating the file. The good news is that it doesn't have to be that difficult.

First, not all hearing changes are OSHA reportable. There are three criteria that have to be met per OSHA Std 1904.10(a).

1. **It must be work related.** *Assume 'yes' if there is change consistent with NIHL and the patient is on the HCP.*
2. **It must be a confirmed STS.** *The loss of average of 10 dB in 2,3, and 4k Hz.*
3. **It must be an overall loss of 25 dB or more in 2,3, and 4k Hz above audiometric zero.** *This is an important criteria. It isn't uncommon for someone to meet the definition for a confirmed PTS, but not meet OSHA criteria of losing 25 dB if they started with better-than-audiometric- zero hearing.*

Second, remember that the 7 day clock doesn't begin until the PTS is confirmed. If the reviewing flight surgeon feels that the case requires an ENT or audiologist referral, then the clock doesn't begin until the ENT or audiologist referral is completed and the PTS is confirmed.

Lastly, be aware that there may be a case when a flight surgeon determines a PTS and the case is completed in AFSAS, despite a pending audiologist referral. That's OK. And it may turn out the case is later deemed not to require reporting. That's OK, too. To my knowledge, no one has ever gotten into trouble by *over* reporting.

***Hint*:** For questions on difficult cases, contact the USAFSAM Hearing Conservation Org Box at USAFSAM.PHR.HC.WPAFB@us.af.mil

There is also a wealth of information on the interwebs:

OSHA: https://www.osha.gov/laws-regs/regulations/standardnumber/1904/1904.10

Hearing Conservation KX:
https://kx.afms.mil/kj/kx7/PublicHealth/Pages/content.aspx#/FH/OccHealth/HCP

DOEHRS-HC Data Repository: https://doehrswww.apgea.army.mil/doehrsdr/

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, or a Cat 3 coming due for its 48 month check.

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.*

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

5. *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.*

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. For the most part, it is similar to a DAWG review, in that a trigger may warrant a look, but doesn't necessarily require a fitness and risk evaluation. Each case is evaluated independently.

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 90-507, para 2.6.4.4. It's important to note that active duty MRO's must be either MD's or DO's; PA's, NP's or even a Pharm D cannot serve as an MRO for ADAF. In April 18, AFMOA signed a waiver allowing PA's and NP's to work as MRO's, but ONLY for the ANG.

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. The course is restricted but access can be requested through Dr Michael Hubek or Dr Rhonda Hamby-Mason via the main Air Force Drug Testing Lab (AFDRL) number at DSN 554-8648.

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: *Download "Urine Drug Screening: Practical Guide for Clinicians", Moeller, Karen E, et al. Mayo Clin Proc. 2008;83(1)66-76. It includes tables of detection durations for drugs of abuse in urine, agents that cause false positives, and discussions of common drugs of abuse.*

There is a full text version at:
https://www.mayoclinicproceedings.org/article/S0025-6196(11)61120-8/fulltext

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. <u>You aren't allowed to contact the patient.</u> Simply review the records and answer whether or not the member had a valid script. The way to review records and document it isn't prescribed, but I recommend the following:

- ✓ Once the request is sent, use the same process each time, even when there is no reasonable medical reason for a positive. You may get called to testify and need to state that you checked X, Y, and Z because you always, without exception, check X, Y, and Z.

- ✓ 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.

- ✓ Occasionally there is a script, but it's old. There is no specific time limit mandated, but 6 months is the default recommendation. The 6 month time limit stems from the 17 April 13 MEDCOM Reg 40-51 8.e. It's an Army reg, but there is limited guidance regarding how long a filled script is considered legitimate, so it's a good guide.

- ✓ At this point, there is either evidence of a valid script or there isn't. If there is a valid script, indicate so on the form letter. AFI 90-507 2.6.6.4.4.3.2. requires that if the positive is medically justified, the MRO needs to write a memo which include the name of the drug, date prescribed, expiration date, amount prescribed, and directions/circumstances for use.

- ✓ If it's a difficult case, contact the toxicologist at the AFDTL at DSN 366-8648.

  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 protects from falling into the legal trap of definitively saying that there was 'no valid script' when in fact, all that can be said is that you found no evidence of one. It also prevents calls from OSI asking if you checked specific records.

PUBLIC HEALTH

ANIMAL BITES

The SGP is typically the preventative medicine physician consulted on animal bite cases, which can range from the simple (household pet) to the complicated (bats found in the open BMT sleeping bays). In all cases of bites, scratches, or other animal based injury, the animal bite form (DD 2341) must be completed and given to the base vet. Scan it and place it in AHLTA, attached to the bite visit.

RABIES

The CDC recommendations for rabies PEP are based off of type of exposure, epidemiology of the animal, and circumstances of the exposure. Because of that, there is no universal recommendation, but there are some common themes:

- Domestic animal bites: While dogs pose a higher risk outside the US, rabid cats are reported more often within the US. A healthy dog, cat, or ferret should be observed for 10 days, usually in the house if it was a pet. If healthy after 10 days, they wouldn't have been shedding virus at the time of the bite. If they do fall ill, they need immediate vet evaluation and PEP should be started if they have signs or symptoms or rabies. If the animal was a stray, they should either be observed for 10 days or euthanized and tested.
- Wild terrestrial bites: Raccoons, skunks, and foxes are the most commonly infected wild terrestrial animals in the US and any bites should be considered possible rabies exposure. Typically, there won't be an opportunity to observe the animal or promptly test it, so PEP is indicated.
- Non-bite exposure: Saliva or other potentially infectious material applied to an open wound mucus membrane (ie: by licking from an infected animal) might warrant PEP. Otherwise, scratches or other non-bite exposures almost never cause rabies. The only high risk non-bite exposure is associated with organ transplants from infected donors.
- Bat exposures: These are the most common cause of human rabies cases in the US. Merely being in a room with a bat or observing bats does not warrant PEP. However, if a person cannot attest to lack of a bite, PEP may be warranted. Typically, this involves someone sleeping a room with a bat, or a witness verifies a bat in a room with an unattended child, mentally challenged person, or intoxicated person. If possible, bats involved in human exposures should be collected and tested, since approx. 94% of collected bats are negative, which can greatly reduce the need for PEP.

Rabies can infect any mammal, but small rodents, mice, and rats are almost never infected. It makes sense – the wound from a rabid predator is likely to be fatal to a small mammal before infection and viral shedding begins. Also, the rabies virus is sensitive to drying and UV radiation, so it doesn't persist well in the environment. In general, if suspected material is dry, it is non-infectious.

OTHER BITES

With individuals deployed worldwide, there is a risk of exotic animal bites and one of the most serious is the monkey. Macaque monkeys are common in SE Asia and eastern Afghanistan and can transmit Simian Herpes B Virus (SHBV), a highly fatal encephalomyelitis. If a bite case presents, ensure the following are done:

SHBV checklist:

- Immediate wound cleansing for 15 minutes
- Antivirals: Valacylovir 1 gm q 8 hours for 14 days OR Acyclovir 800 mg 5 times per day for 14 days.
- Baseline testing for SHBV antibodies
- Tetanus status and booster if needed
- Follow up SHBV testing at 2, 4, 6 weeks, and at 3 months post exposure
- Consider rabies PEP (its OK to give the antivirals with RIG or rabies vaccine)
- Consider antibiotics against monkey mouth flora (skin infections)
- Consider ID consult.

SITE 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.

PHEO SITE 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.*

The clinic is negotiating a new contract for cleaning but will contact their current cleaners for resolution of the latrine and storage issues

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). 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:

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.

	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 AFMRA 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.

PHEO – KNOW YOUR ALLIES

The Medical Emergency Manager (MEM) is the PHEO's right-hand. They are the keeper of the phone numbers, AFI's, etc, and get things done. The MEM needs to be well versed in logistics, so an MSC or a civilian with corporate knowledge and continuity is ideal.

The alternate PHEO is very important since an emergency requires 24/7 operations. Although the alt. PHEO is most likely the Public Health Officer, consider using a senior flight surgeon or the SGH, especially if the PHO is inexperienced. This is NOT a slam on PHO's. They're an invaluable resource, but they will be busy leading the PH response. I'd rather the 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 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 training was accomplished. Not only is it required, it ensures you receive updates, memos, and other essential information.

Lastly, 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. In addition to public health emergencies, AFI 10-2519 also addresses "Incidents of Public Health" concern in para 1.3. Think of these as "PHE Lite", when a case doesn't quite rise to the level of a PHE, but is still of potential impact.

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 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 actions play to the public eye. For example, walking down the MTF hall in a Tyvek suit and PAPR is sure to incite panic. 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 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 knowing ahead of time what's likely to go bad puts you one step ahead.
- Water vulnerability assessment – Same rationale as above. This brief comes 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 hundreds of pages.

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. Review the materials that other base agencies provide, but it should be XP assembling, tracking, and routing the DCP for signature.

PHEO and MEM Training and Sustainment

PHEO training is summarized in AFI AFI 10-2519 (or will be once it finally gets published…):

Upon Appointment as PHEO: (70 hours)

- *PHEM Basic Course* - 40 hours. Complete within first year of appointment
- *IS 300* Intermediate Incident Command System (ICS 300) – 24 hours
- *DSCA Phase 1* – 6 hours

To be completed within 24 months of PHEO appointment: (100 hours)

- *Medical Mgmt of Chemical and Biological Casualties Course (MMCBC)* – 48 hours
- *Medical Effects of Ionizing Radiation Course* – 24 hours
- *DSCA 2* – 28 hours (For MAJCOM level PHEO's)

PHEO Sustainment: (40 hours)

- *PHEM Sustainment Course* – 20 hours. Complete within first 5 years of appointment, and when returning after 3 years outside the PHEO role.
- *IS 400 Adv ICS, Command and General Staff/Complex Incident* (ICS 400) – 20 hours

Upon appointment as MEM: (93 hours)

- *PHEM Course* – 40 hours
- *IS 100 Introduction to ICS* (ICS 100) - 3 hours
- *IS 120 An Introduction to Exercises* (ICS 120) - 5 hours
- *IS 139 Exercise Design and Development* (ICS 139) - 2 hours
- *IS 200 Single Resources and Initial Action Incidents* (ICS 200) - 3 hours
- *IS 300 Intermediate ICS for Expanding Incidents* (ICS 300) (Residence) - 24 hours
- *IS 700 NIMS, An Introduction* (ICS 700) - 3 hours
- *IS 775 Emergency Operations Center Management and Operations* (ICS 775) - 4 hours
- *IS 800 NRF, An Introduction* (ICS 800) - 3 hours
- *DSCA Phase 1* - 6 hours

To be completed within 24 months of MEM assignment:

- *IS 235 Emergency Planning* (ICS 235) - 5 hours
- *K0146 - Homeland Security Exercise and Evaluation Program Basic Course (Residence) Federal Emergency Management Agency (FEMA)* – 16 hours
- *DSCA Phase 2 (Air Force MAJCOM MEMs)* - 28 hours

MEM Sustainment:

- *PHEM Sustainment Course* – 24 hours. Complete within first 5 years of appointment, and when returning after 3 years outside the PHEO role.
- *IS 400 Advanced ICS, Command and General Staff/Complex Incident (ICS 400)* - 20 hours, taken in conjunction with PHEM Sustainment Course.

IMR PITFALLS

Individual Medical Readiness is a highly visible metric that SGP's will often be called upon to brief to Wing Leadership. Additionally, base metrics are reported to MAJCOM's who then brief the MAJCOM leadership. IMR rates are reported by unit at the base level, and by composite base at the MAJCOM.

Pitfall: In an effort to avoid breaking the 80% IMR goal, the MSME and DAWG reduce their "reds" by letting questionable cases slide rather than tagging them as Code -31 or beginning IRILO proceedings. Although the numbers look good on paper, UDM's don't know who's non-deployable in real life, and deployment lines are a mad scramble.

Remedy: Don't be led astray chasing IMR numbers. A poorly run DAWG and MSME may identify fewer "broken" Airmen and result in more "green" deployers….until the deployment line begins. Conversely, a well-run DAWG that identifies individuals in need of an IRILO can generate higher-than-average "red" non-deployers. Simply explain this paradox if questioned and always strive to be proactive rather than reactive. Run a solid DAWG and MSME, and the numbers will take care of themselves.

Pitfall: In an attempt to ensure both primary and alternate Airmen are cleared to deploy, UDM's add non-officially tasked alternate deployers to the ASIMS Deployment Clearance Module (DCM). This saturates the medical processing line, making it more difficult to accomplish a real-time clearance, which motivates the UDM's to load more alternates, which perpetuates the cycle.

Remedy: While on the surface, this would seem to make sense by reducing scramble for replacements, in actuality, it has the opposite effect. The medics have no way of knowing who is "real" and who is an alternate, so they are forced to provide immunizations, malaria prophylaxis, CW/BW kits, and DHRA forms for individuals who are not officially tasked to deploy. That directly violates AFJI 48-110, 3.2.e and AFI 48-122 2.16.5.2.2. & 3.4.2, and is arguably 'fraud waste & abuse' due to the cost of these kits. Break the cycle by educating UDM's to only load deployers who are actually tasked, and assure them that the medics (when not saturated by the above) can accomplish timely medical clearance for alternates. Then back up words with actions.

HINT: *To improve IMR metrics, get buy-in from the line. Just as you expect to hear from the MAJCOM SGP if your base rates slip, make it an expectation for Sq CC's to hear from you if their unit rates drop. The AF requires 80% IMR "green", but a former Wing CC of mine mandated 85% as his minimum value. He announced this at the IMR brief with all of his Grp and Sq CC's. We as medics did nothing different, but monthly IMR stats went from 81% to 87% almost instantly.*

AF 469 SPECIAL CASES: NON-RATED AND NON-CONCURRENCE

Occasionally, there are cases when AF 469's are used for off-nominal situations, or times when the CC non-concurs with the limitations. This section addresses those cases.

Non-Rated Periods

When an Airman has a prolonged medical course and is unable to work effectively due to their medical condition, there is a process to prevent their EPR/OPR from reflecting degraded performance. The process is directed in AFI 36-2406 in para 3.12. It's a lengthy paragraph which goes into great detail on the types of individual circumstances that might qualify. However, para 3.12.1. is much more specific, and much more likely to apply. The most likely scenario is maternity leave lasting more than 80 days.

When a member meets the criteria for a non-rated period, the PCM can recommend to their Commander to have the member non-rated for EPR/OPR purposes during that time. The Commander retains approval authority, but they are likely to have questions, so it would be wise to speak with them before submitting the recommendation.

When that happens, the PCM submits an AF 469 with their recommendation, using wording such as, "Per AFI 36-2406 para 3.12.1., member is recommended for a non-rated period from XXX to YYY"

MSME may need to include this recommendation in the post-pregnancy process when submitting the maternity leave recommendation. If that's the case, it would be fairly easy to draft the new 469 with the dates for maternity leave while updating them in ASIMS.

AFI 36-2604

3.12.1. Medical (physical, physiological, and/or psychological conditions; hospitalization, maternity, and/or convalescence in excess of 80 days, including, but not limited to, Airmen in Patient Status) Documentation: The Airman's provider will initiate the recommendation for a non-rated period to the Airman's unit commander using AF Form 469, *Duty Limiting Condition Report*.

Commander Non-Concurrence with Mobility Restrictions

Most of the time, CC's receive AF 469's with mobility restrictions and have no objections. However, they may occasionally disagree. When that happens, AFI 10-203 provides a series of steps to help resolve the disagreement.

1. The CC is required to contact the SGP within seven duty days (para 2.17.4.2.1. and 3.4.2.)
2. The SGP reviews the MR and discusses the case with the PCM as needed. If the SGP feels that the MR was unnecessary, they can remove it. If the SGP agrees with the PCM, they need to discuss it with the CC. (para 3.4.1.1)
3. If the SGP and the CC still disagree, the case is elevated to the next CC in the Airman's chain (usually the Group/CC). If the Grp/CC non-concurs as well, MSME generates a new AF 469 with the MR but also with a statement that the Airman's Sq and Grp CC non-concurred and the Airman is available for mobility. (para 3.4.2.2.)
4. After both the CC and the next higher CC non-concur with the MDG, the base level SGP must advise the MAJCOM SGP (para 2.7.2.).

Caveats:

Consider the CC's position. While the member may not meet *all* the criteria to be mobility qualified, they may be able to perform their specific job downrange. For instance, a bad knee might limit an SFS troop from going to an austere location, but maybe not an admin troop from working in an established overseas base.

Even though the CC is required to contact the SGP within seven duty days, you can fully expect that they won't do so until a deployment tasking actually drops. Probably best not to fall on your sword over this. Just be ready for a quick turn.

Although there is no requirement to contact the MAJCOM SGP until after the Group/CC non-concurs, it's a good idea to call the MAJCOM SGP early in the process. Their voice of experience may be enough resolve the case before it elevates to the Group/CC level.

Be aware that the COCOM may have certain requirements, and even though the member's Sq and Grp/CC's approved the member to deploy, the Airman may not be able to deploy to that particular location without waiver. Make sure to communicate this early in the discussions so the CC's don't send a member, only to have them turned around and sent home by the COCOM once they arrive.

DEPLOYING WITH MEDICATIONS

Speaking of deployments…

It's not unusual for an SME to deploy with a supply of Go or No-Go pills with them. This can be tricky since some countries have specific rules about the amount of narcotics that can be brought into country. Additionally, the AF uses different definitions for some terms, such as "dispensing" than the rest of the US. And…there is no defined AFI process.

Since there isn't a defined process, we have to look for analogous ones. The International Narcotics Control Board (https://www.incb.org/) has country specific recommendations as well as guidelines for emergency relief work – the closest civilians come to deploying. In their model guidelines, the INCB has a sample memo with a medication inventory as well as the name, address, and title of the person carrying the meds, and the same info for the company supplying the meds. It also has a brief description of why the meds are being carried.

Fortunately, this information is easily provided by hand-carrying the AF 579 along with a memo on MDG letterhead, signed by the SGP, which names the physician carrying the meds and explains that they are being carried to support a deployment. Additionally, it's always wise to bring a copy of your medical license. Those three documents will provide the recommended information by the INCB and will go a long way toward smoothing out any potential issues.

HINT: *The INCB also has country specific recommendations for bringing medications abroad. As part of the deployment intel gathering process, take a few moments to cross-check for obscure rules or paperwork.*

https://www.incb.org/incb/en/travellers/country-regulations.html

RELIGIOUS EXEMPTION FROM IMMUNIZATIONS

The Army owns DoD immunizations; AFI 48-110 is a relabeled copy of AR 40-562, which discusses religious exemptions in section 2-6 b.(3). The most important point is that this is an Administrative Exemption, not a Medical Exemption. This means that although medics may be asked to consult on the request, it is a command process, not a medical one. The medical role is limited to providing information on the medical risks of forgoing vaccinations.

Medics, along with JAG and Chaplains, are consulted during routing of the request. Be cognizant of this role and don't stray from the medical lane by routing, endorsing, or otherwise processing the request. Offer medical counseling to the patient, document the advice was given via MFR, and return the package to the Commander.

AR 40-562 (AFI 48-110) Immunizations and Chemoprophylaxis for the Prevention of Infectious Disease

Chapter 2: Program Elements and Clinical Considerations
2-6 Exemptions
b. Administrative exemptions
(3) Religious exemptions.
(a) Servicemembers. Immunization exemptions for religious reasons may be granted according to Service-specific policies to accommodate religious beliefs of a Service member. This is a command decision made with medical, judge advocate, and chaplain input.
1. Requests for religious exemption must comply with the provisions of the applicable policy and/or regulation for the Servicemember requesting religious accommodation. For the Army, religious accommodation policy is provided in AR 600–20. For the Navy and Marine Corps, waivers are granted on a case-by-case basis by the Chief, Bureau of Medicine, and Surgery. For the Air Force, permanent exemptions for religious reasons are not granted; the MAJCOM commander is the designated approval and revocation authority for temporary immunization exemptions. For the Coast Guard, CG–122 is the designated approval and revocation authority for religious immunization exemptions. USCG requests must be forwarded through the appropriate chain to Commandant CG–122 via CG–112.
2. A military physician must counsel the applicant. The physician should ensure that the Servicemember is making an informed decision and should address, at a minimum, specific information about the diseases concerned; specific vaccine information including product constituents, benefits, and risks; and potential risks of infection incurred by unimmunized individuals.
3. The commander must counsel the individual that noncompliance with immunization requirements may adversely impact deployability, assignment, or international travel.
4. Per DODI 1300.17 and applicable service regulations will be provided whether Servicemembers with pending active requests for religious exemption are temporarily deferred from immunizations, pending outcome of their request.
5. Religious exemptions may be revoked, in accordance with Service-specific policies and procedures, if the individual and/or unit are at imminent risk of exposure to a disease for which an immunization is available.

Note: *There is an interesting discussion of religious exemptions in the 12 April 13 issue of Vaccine, "What the World's Religions Teach, Applied to Vaccines and Immune Globulins", which can be accessed through the Kx medical library via ClinicalKey.*

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 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 receive either a lump sum payment (separation with severance pay) or a monthly payment (medical retirement). The money is not meant to be a welfare program, but rather to compensate for a shortened military career. That's an important distinction and it's vital to understand.

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.

Although in the past, there was a distinction between unfitting and unsuiting conditions, that has become less of an issue with the new DoDi 1332.18 appendix 1, which *in essence*, directs the base to submit a NARSUM and let AFPC make the determination for admin vs. medical separation.

HINT: *AFPC maintains an excellent web page that details timelines, roles, and DES programs. Study it and encourage patients to read it as well.*
https://www.afpc.af.mil/Portals/70/documents/17_SEPARATION/02_Disability%20Program/Air%20Force%20DES%20Road%20Map%20for%20AFPC%20Website%20-%2005SEP2018.pdf?ver=2018-09-05-163112-397

DEPLOYMENT AVAILABILITY WORKING GROUP: THE DAWG

The DAWG is tasked with a number of duties related to the IDES. It tracks the timelines and outcomes related to IRILO's and MEB's, reviews cases for potential action, approves AC exemptions from fit testing, and oversees 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. Some providers try to game the system by writing for 89 and 299 day profiles, so address that in ProStaff early. Also remember that the DAWG is mandated to meet monthly, but IRILO processing suffers if everything has to wait for presentation at the DAWG before taking action. An effective technique is to review IRILO cases weekly with a smaller Pre-DAWG team (SGP, rotating PO, MSME) and report the findings to the DAWG for approval. That allows the programs to meet timelines while maintaining DAWG oversight & record keeping, and it keeps the DAWG meeting from bogging down in case review. (I called my meeting the "Puppy", since it was a "Pre-DAWG").

NOTE: *Some bases apply an immediate Code 37 to prevent PCS of potential IRILO cases, even before the condition is stabilized. That makes it difficult to meet the 30 day metric from Code 37 to NARSUM submission. It's also unnecessary; the MPF checks for AAC 31's as part of PCS processing per AFI 36-2110 para 2.17.1. If they find a Code 31, they'll refer the case to the MTF for review and reclama the orders if necessary.*

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 MDG peer review process. If for some reason you can't do that, have your PO's do a formal quality review when they sign off profiles in ASIMS.

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

Sample DAWG surveillance review schedule:

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.

FITNESS TEST COMPONENT EXEMPTIONS

The fitness program and its exemptions are primarily covered in AFI 36-2905, but there is some cross-over with AFI 10-203 (duty limiting conditions). While questions about fitness exemptions are common, there are three areas that seem to come up most often: Fitness waivers after an IRILO, Abdominal circumference waivers, and Commander referrals for chronic fitness exemptions.

Fitness Waivers after an IRILO

Members who undergo an IRILO often have fitness exemptions driven by the medical condition that prompted the IRILO. After they've returned from the IRILO, what happens to the fitness recommendations? What happens if the member fails their fitness test – can they still be admin separated?

It's actually a fairly simple answer. Continue to profile the patient appropriately, and ensure they are able to return as close to full function as possible. If their condition continues to require fitness exemptions, there is no problem renewing the exemptions regularly. However, new exemptions may be an indication that the member's condition is deteriorating and may drive the need for a new RILO.

Also, the patient needs to understand that although they were returned to duty from an IRILO, they are not exempted from other AFI's and standards. For example, they could still face admin action for failing a PT test.

Fitness Waivers after an Pregnancy

Although the MPF will manage the deployment restrictions post partum, there is also a 12 month fitness exemption. An AF 469 with something along the lines of the below text can communicate that to the unit.

FITNESS RESTRICTIONS: Temporary deferment from AF Fitness Assessments for 12 months after date of discharge from the hospital upon completion of pregnancy IAW Interim Change 1 to AFI 36-2905. The member will continue to participate in unit/personal fitness program unless documented medical conditions require non-participation. If there is any change in duties or condition member must report to Public Health or PCM for evaluation.

FITNESS RESTRICTIONS ONLY… NO CODES 31 or 81

DIAGNOSIS: Z02.79 ENCOUNTER FOR ISSUE OF OTHER MEDICAL CERTIFICATE

Abdominal Circumference Waivers

When determining an exemption, the two questions to ask are: Will testing this component injury my patient? And will testing this component give erroneous results? Taping a waist isn't likely to cause injury. However, AC is used as an analog for body fat, and some conditions give erroneous results. Consider both mass effect and metabolic effect as confounding factors. Pregnancy is a good example of both.

There are other factors that could cause a mass effect, rendering AC inaccurate. I had a patient born with gastroschisis. Due to the network of scars on his abdomen, his AC did not accurately reflect his body fat distribution. Clinical judgement is pretty clear on these cases. A small scar from previous appendectomy? Probably not a player. A small renal cyst? Nope. A 10 cm fibroid? That may be reasonable.

Metabolic cases are more common and more difficult. Nearly every patient who fails an AC complains of a "slow metabolism." But there may be cases when it is reasonable to exclude AC for endocrine reasons. A patient with Cushing's (either natural or iatrogenic from long term high steroids) will have altered body fat distribution, so an AC exemption until they are lab normal, and for an appropriate post-time (six weeks to six months) may be appropriate. Likewise, a well-controlled thyroid patient wouldn't warrant an exemption, but a new diagnosis might.

But the common requests for AC exemption aren't clinically plausible. Smoking cessation, inability to perform exercise, or mental health diagnosis don't preclude dietary weight loss, so they aren't valid reasons to provide AC exceptions. High insulin levels may cause abdominal fat, but high glucose does not, so the Type II DM patient with low insulin production is LESS likely to have a metabolic reason for high AC. And the 6'8" patient with a corresponding waist? Although he's not going to have a 32" waist, anthropomorphics are non-medical factors, so we wouldn't recommend it in that case, either.

A common request from members on an ALC with chronic fitness exemptions is that they should also be exempted from AC. They argue their medical condition doesn't let them exercise vigorously, so therefore, they shouldn't be held responsible for their AC. But that's not a valid argument. Just because they can't perform fitness test components doesn't mean they can't exercise to their own level, nor does it preclude them from eating a healthy diet.

The take home message is that there are rare times, apart from pregnancy, that an AC exemption is reasonable. The SGP, via the DAWG, should be the one approving an AC waiver, and it's not a bad idea to engage with the MAJCOM SGP beforehand.

Commander Referrals for Fitness Exemptions

AFI 36-2905 para 2.25.11 directs the CC to refer any Airmen to the SGP who have four fitness assessment component exemptions over a 24 month period. Para 3.2 defines component exemptions as a "body composition component", "aerobic component", and "muscular fitness component". It elaborates that the aerobic component consists of either the run or walk test, while the strength component includes both pushups and sit-ups. This is somewhat ambiguous, since it also uses 'component' to refer to each individual exercise. Since the goal is to identify broken Airmen, I interpret it to apply to the individual items to increase sensitivity.

For purposes of 2.25.11 referrals, I advise CC's on the following: being exempted from the run, but allowed to do the alternate aerobic walk test, would not count as a "component" exemption. However, being exempted from both the run and walk would be an exemption. Likewise, being exempted from either pushups or sit ups would count as a component exemption, and being exempted from both pushups and sit ups would count as two exemptions.

If we apply this to some examples:

1. Amn Snuffy is exempted from the run (completes the walk) and is exempted from sit ups at FA 1 and FA 2 six months later. Because they completed the aerobic component, but not the sit up component at either FA, this represents two component exemptions over six months.
2. Amn Snuffy is exempted from the run (completes the walk) and is exempted from situps at FA 1, 2, 3, and 4. This would represent four component exemptions and warrant referral to the SGP.
3. Amn Snuffy is exempted from the run (completes the walk) for FA 1, 2, and 4. They are exempt from situps on FA 3. This would represent only one exemption, during FA 3.
4. Amn Snuffy is exempted from run, walk, and pushups at FA 1. They complete the walk test, as well both pushups and situps, for FA2. At FA3, they are again exempted from run, walk, and pushups. This would warrant notification due to a total of four component exemptions between FA1 and FA3 (two at each).
5. Amn Snuffy is exempted from pushups and situps for FA 1. This represents two component exemptions.

NOTE: *It's important to note that a referral for medical review does not always drive IDES action. The SGP will review the case to ensure the Airman has reached maximal medical benefit and has been appropriately profiled, but in most cases, will not refer the case for IDES processing. However, it's a valuable tool to identify Airmen who "fly below the radar" and either require IDES action or are not optimally medically managed.*

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 DP2NP for an IRILO pre-review.

The IRILO is the DP2NP 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, DP2NP 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

There is a 30 day IRILO clock that begins after a Code 37 is placed by MSME and the DAWG directs an IRILO. Do not allow individual PCM's to place the Code 37; it sets up to break the 30 day window and AFI 10-203 4.2.2 expressly prohibits individual providers from setting a Code 37. Once the Code 37 is set, it can only be removed by DP2NP via the FL 4.

Don't wait until the monthly DAWG to discuss cases and complete the IRILO worksheet, or the 30 day window will be broken. Have the SPO and PO's review cases ad hoc with MSME during a Pre-DAWG, or have the (weekly) MEB review cases and present the findings to the DAWG. It keeps the program moving, and doesn't slow the DAWG with long discussions that only involve a few players.

HINT: *Once the Code 37 is placed, the NARSUM must be brought to the next DAWG. Some bases avoid the hassle by waiting to assign the Code 37 until the NARSUM is received by the DAWG. While this guarantees good metrics by maximizing the 30 day window, it's technically not the process from the AFI. (Use that information how you will…)*

Should you recommend RTD or IPEB?

The hardest part of the IRILO worksheet is deciding to recommend RTD or refer to IPEB. Each case is managed separately, but there are trends that can help.

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.
- Most GI disorders requiring special diets 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 (NARSUM)

The most important piece that the medics contribute to the IDES is the NARSUM. Its contents are dictated in AFI 41-210 para 10.6. and in AFMRA's NARSUM guide. There is no need to go into excruciating detail, but it needs to be able to stand on its own. Focus on how the medical condition impacts the member's ability to serve in their AFSC, deploy, and/or complete the FA.

As of June 2018, all NARSUM's, including mental health NARSUM's, must be submitted via the PDF templates located at:

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

When writing the NARSUM, include an explanation for any duty limitations 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 there are occupational impacts from multiple conditions, provide them for each condition. If the diagnosis is present but not unfitting, simply mention it in the medical history and move on.

If items on the NARSUM form don't apply, for example, "Hospital Course" for a non-hospitalized member, simply mark "Non-applicable" or "Non-contributory", rather than leaving the section blank.

Copying and pasting from AHLTA can save time, but take time to adjust fonts / line breaks / etc. The NARSUM is presented in a narrative, not bulleted, format, so it may take some time to clean up AHLTA'isms.

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. (Refer to the section in this manual for LOD determinations.)

Lastly, ensure that the NARSUM has clear prognosis, impacts, and recommendations. This is the most predictive piece of whether an individual is returned to duty or separated. Resources such as the Aircrew Waiver Guide and NARSUM guide to help with the predications. Focus on answering these three questions in the prognosis:

1. Is member likely to return to full duty within the next 12 months?
2. What requirements to provide treatment will there be beyond 12 months?
3. How will the severity of the condition change in the next 3 years?

Once the NARSUM is complete, upload to AHLTA via HAIMS – do not make the NARSUM an encounter note or it will be harder to find in the future.

NOTE: *The Aircrew waiver guide is a great resource for determining occupational impacts and recommended studies when writing a NARSUM. An additional resource is the NARSUM Guide, posted on the Kx at*
https://kx.afms.mil/kj/kx8/AFPCMedicalRetentionStandards/Pages/home.aspx

OTHER AREAS DP2NP MANAGES:

Refer to AFI 41-210 chapter 10 for details on admin and processing for medical hold and elective surgery.

Medical Hold: AFI 41-210 10-7-11. DP2NP 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. DP2NP is the approval authority for this, and usually will approve it, BTW.

Con Care: Occasionally, DP2NP will be need more time to see how a case develops before they can render a decision. These often involve trauma, surgical "cures", and other areas that may take a while to stabilize. In those cases, they can place the member on Convalescent Care for 6-12 months. The member maintains their Code 37 and a new NARSUM is submitted in 6-12 months with an update of their condition. In many ways, this is similar to the IPEB's temporary duty retirement listing (TDRL) status. The difference is that TDRL places a member in temporary retirement, pending re-evaluation, while Con Care maintains the member on active duty pending re-evaluation.

Because the member maintains Code 37 for an extended time, they may require DP2NP waivers for TDY. If that's the case, contact DP2NP to discuss what information would be necessary for that particular patient.

MEB = MEDICAL EVALUATION BOARD

If DP2NP decides the case needs to go to the IPEB, then the MEB process starts. The MEB technically refers to the panel of physicians consisting of the SGP, SGH, and a 3rd provider who evaluate the case at the MTF level. The MEB will nearly always refer the case to IPEB. However, in rare instances, there may be new information that changes the recommendation. In that event, the MEB would recommend 'return to duty' to alert the PEB to return the case to DP2NP for re-disposition.

The MEB addendum is an important, but short line, written by the PCM, to ensure that there have been no major changes since the time the NARSUM was written. It also must address any VA claimed conditions.

1. Look at the VA form 21-526EZ for "claimed conditions"
2. Doublecheck the rest of the VA compensation & pension package
3. Make sure that all of the claimed conditions are mentioned and annotated unfitting or unsuiting as necessary in the addendum.

SAMPLE ADDENDUM ADAPTED FROM AFMRA:

Before submitting the NARSUM package to the IRILO, the package author (PCM) needs to show they've reviewed the VA exam and discuss whether there were any new conditions that would be unfitting. In most cases, there won't be, but even if there are not, a statement needs to be included. Below is an example that covers the requirements:

"I have reviewed the C&P exam dated XXX performed by the VA medical examiner(s). The member has the following additional claimed conditions: XXX, YYY, and ZZZ. None of these conditions, individually and collectively, are unfitting IAW AFI 41-210 and AFI 48-123, as they do not interfere with the member's ability to perform the duties of his/her office, grade, rank, or rating."

"The original narrative remains current and accurate when compared to the member's VA exam. No update is needed" or "The following updates / clarifications are made…"

NOTE: *The term "MEB" is almost universally misused to refer to the process at AFPC or DP2NP, but an MEB is the base-level board, not the IPEB or IRILO. Patients often cite the MEB when complaining to the MDG, Congress, or on the web, so its important to determine if the problem lies with the MEB, IRILO, IPEB, FPEB or VA. In almost all cases, it's not the MEB that's the problem.*

A FEW OTHER COMMON PITFALLS ABOUT MEB'S (REF: AFI 41-210 4.61.1):

- While the PCM is welcome to contribute to discussion, only physicians can be voting members of the board.
- In the event of a mental health MEB, at least one member must be a psychiatrist. (AFI 41-210 4.64.6)
- Interns and residents may not be voting members, but civilians may.
- While the SGP or SGH must be president, the deputy SGP or SGH may serve as president if the primary is absent and if appointed in writing by the MTF CC.
- VA packages can be very, very long. However, look for the VA Form 21-526EZ (Application for disability compensation) and the VA Form 21-4138 (Statement in support of claim). They summarize the package and greatly streamline the MEB review.

IPEB = INFORMAL PHYSICAL EVALUATION BOARD

The next step after the MEB is the IPEB. This is the board at Randolph AFB that meets after the NARSUM 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 for more information. They may also determine that a condition is not disqualifying, and consult with DP2NP 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 complete the process and return 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 take appeals from members who disagree with the findings of the IPEB. The FPEB consists of a medical member (physician) and two personnelists. If the member agrees with IPEB 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.

If a member submits an appeal, they're given a hearing date and travel to Lackland to meet with a FPEB attorney. The attorney reviews their case and helps build their appeal, then they both appear before the board. Participants are under oath and 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. Usually, the attorney picks up on the potential for EPTS before the board, and the member will drop their appeal.

If the member disagrees with the FPEB, they can appeal to SECAF for final decision.

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 DP2NP 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 AFMRA 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

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

ADMINISTRATIVE SEPARATION – EPTS:

If a condition pre-dates service, for example, asthma as a teenager, then they may be separated without pay. This isn't common, except in 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's normally 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%).

Temporary Duty Retirement Listing (TDRL):

If a condition is disqualifying but has potential to change, the individual may be placed on TDRL. For example, a patient with disqualifying PTSD will be placed on TDRL for 6 months, and then reevaluated after they have (presumably) had therapy and distanced 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're in a critical field or a wounded warrior. However, if the member's condition worsens, or if the member desires, they can request a RILO to evaluate for medical retirement. This is a rare event and the member needs to understand they're 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, App 3 to Enc 3. 7.b.(4).

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

Most conditions are classified 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 the determination is made, 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. 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. The medic fills out AF 348, items 1 through 12. 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.

Once the AF 348 is complete, forward it to the Line of Duty Medical Focal Point (LOD MFP), who is nearly always the SGH. The LOD MFP sends the original to the member's commander for processing, a copy to medical record, and retains 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, 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 opine whether the event was line-of-duty. There will be an investigating officer who will work with the CO to make that determination.

SPECIAL SITUATIONS

There will times when it's unclear whether to initiate an informal LOD or classify the condition with an Admin LOD. In the cases when an admin LOD is not appropriate, the CC may initiate the formal LOD process with an AF 348, or you may initiate it with an informal LOD AF 348. AFI 36-2910 attachment 5 (summarized below) discusses common situations.

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 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 acceptable. If the injuries are more than minor, simple, self-resolved injuries, then initiate 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 remains 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, but there are caveats if the member has an illegal abortion. If she is placed on OB quarters, use an Admin LOD.

Refusal or Failure to Seek Treatment If someone has an unreasonable refusal to seek medical care or treatment, 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, there may be need to submit an informal LOD AF 348 to the CC for their determination before submitting the NARSUM.

Suicide Attempts or Gestures The CC will need to determine whether the member was acting out of misconduct or was mentally irresponsible at the time. They will require an AF 348 to help with that decision, so this will either flow from the MTF as an informal LOD or 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 an LOD if I put someone on 48 hour quarters since they can't perform military duties for more than 24 hours?" Yes. But it's an admin LOD, and 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 NARSUM has to be done within 30 days of diagnosis."***

   Actually, AFI 41-210 para 10.3 states it must be submitted within 30 days of work-up and definitive diagnosis. The newly diagnosed diabetic needs an IRILO, but not 30 days later, while still struggling to obtain control. It may take 3-4 months before the patient has a definitive diagnosis of "Type II Diabetes, requiring oral hypoglycemic agents".

   If the IRILO is sent without a definitive diagnosis, either it will be sent back for resubmission or the member will be adjudicated based on an unstable disease. The NARSUM must include a prognosis, and that requires a definitive diagnosis.

   NOTE: *Don't be pressured into approving a NARSUM if the patient lacks a clear prognosis. Call DP2NP 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 (page 32) para 5.

   The IDES process determines 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. 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. 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 IPEB 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, DP2NP 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're told 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 new PEBLO's, and causes no end of headaches to the MEB and IPEB. It's common for a patient to have a disqualifying condition, but other medical conditions that aren't 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). 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 the DAWG has determined his HTN, cholesterol, and ingrown toenail aren't 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 her 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. 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.

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 DP2NP 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, DP2NP will bounce the case back. Part of the problem is that the VA 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: *DP2NP 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 either the CC is afraid to commit, or a PEBLO who hasn't taught them what the letter needs to contain. The CC needs to be brutally honest. 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, the VA will still support their medical condition.

PERSONNEL RELIABILITY AND ACCOUNTABILITY PROGRAM (PRAP)

Don't expect to be a PRAP 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. Make the appropriate medical decisions, and the PRAP recommendations will flow. Where it becomes difficult is when providers let the program drive the medicine.

PRAP PROGRAM MANAGEMENT

Within the PRAP, there is a tendency to react to problems by creating more management rules. Instead of this knee-jerk reaction, 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's a team approach, with the Alt Lead CMA managing tactical operations and the SGP making managerial decisions. For comparison, the relationship is similar to that of a flying squadron CC and their DO.

NOTE: *Often, 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?*

PRP OPERATIONAL WORKING GROUP (POWG) - OPTIONAL

The POWG is the PRP equivalent of the FOMWG. It is a chance to disseminate information, manage patient cases, and ensure patients are receiving appropriate care. The POWG is not a required meeting, however, it's still a good idea.

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. The easiest way is to use the ASIMS PRP Module, since it generates the data for any specific time frame.

It's a simple matter to hold a POWG in conjunction with FOMWG and avoid keeping two sets of minutes. 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 have all CMA's to attend. The FOMC CC and flight docs are expected to attend the AMC; the PRP CMA's should be involved in the same manner

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)

THE ROLE OF THE CMA

The CMA's is first and foremost a medical provider. Programs that suffer tend to focus on the administrative aspects of PRAP and let medical care slide. Very few CMA's intend to practice poor medicine, but it becomes a cycle. They focus on administrative duties, so appointments are curtailed. Without appointments, patients go off-base, creating more paperwork, and more reviews. 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're a funnel, collecting data from a variety of sources, and a filter, applying medical knowledge to sort what's important. Unlike flight medicine which has clear medical standards of what is allowable, PRP leaves much of the decision making to the CMA. They need to make consistent decisions, sometimes without a specific AFI reference. 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 is filtering; applying medical knowledge and deciding what's important and what isn't.

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 to look for during record reviews, there is a difference in that suitability factors are more of a current vs. historical concern.

Like everything in medicine, documentation is key. The explanation of why an item is not a factor should be in proportion to the significance of the item. Documentation for a headache associated with an acute URI might be as simple as "HA from acute URI. No impact. No SF", 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. No SF"

Life Skills Support Center (LSSC) records are notorious for SF on intake screenings. Make sure to screen for issues such as of Letters of Reprimand (LORs), Art 15's, etc. If any such items stemmed from a medical cause (i.e.: underage alcohol (EtOH), suicidal ideation) make sure there's an appropriate evaluation. Other spots where stealth SF 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 SF 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. It may be there is no need to report these items if they are of little consequence.

DAILY REVIEWS:

Daily reviews are an optional once-over to confirm the PRP determination is in accordance with care given; it's not an evaluation of care, but of PRP determination. These can be accomplished by another CMA, or a properly trained and appointed 4-xx before filing the record. There is no requirement, but it can help catch minor trends before they evolve. Key issues to check are:

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

DECERTIFICATIONS

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 permanent decertification is only mandated for drug abuse or failed compliance following alcohol dependency. In most cases, a decertification recommendation falls into the gray area of a prolonged suspension with a prognosis that isn't consistent with continued PRP duties.

However, there is no need to exhaust the limit of suspension before recommending a decert. If a member shouldn't be on PRP, make the call. To make it easier on the unit, have an informal discussion with the CO first. In most cases, they'll already be aware, 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, even though it's not required, have the Lead CMA and/or Alt LCMA co-sign decert recommendations. A 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 also 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 since it requires more time to identify and pull records, re-file them, and monitor for PCA moves within units.

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. The other advantage is there is no need to track PCA's, since members can move between units and it doesn't affect how their charts are identified.

NOTE: *Create a terminal digit list of PRP personnel by first copying the ABC roster into Excel. Use the formula "=RIGHT(cell reference, 2)" to separate the last two terminal digits and then you can arrange that list in ascending order.*

PRAP KEYS TO SUCCESS

While entire books could be (and have been) written on how to manage a PRP, much of the advice distills to the following characteristics. Simply put, successful programs consistently do the following, and failing programs don't.

1. **Ensure good communication within the MDG.**
   Does all clinics talk regularly and work together?
   Do the MDG/CC, SGP, and ORMS/CC all have a solid working relationship?
2. **Ensure communication with the CC is clear and meaningful.**
   Can a layperson understand the recommendation?
   Is the MDG chaffing the CC with rubber-stamped letters and calls?
3. **Mental Health is a focus area.**
   There are deep vulnerabilities in Mental Health, and good programs address them with solid procedures, reviews, and communication.
4. **PRP is a culture from the top down.**
   The rest of the MTF will take their cues from the execs…are they modeling PRP culture or do they mutter and complain about it?
5. **Be professional and respectful of the IG team during NSI's.**
   They have a great deal of subjectivity and you want all of it working for you.
   When reporting for appointments, 5 minutes early is 5 minutes late.
6. **PRP is a team sport.**
   Your MTF will succeed or fail together. Everyone, from the MDG/CC to the 4A in pediatrics will receive the same score. Make it a good one.
7. **Practice good medicine and PRP comes naturally.**
   If providers ask patients about the impacts of their condition and document the answers, they're not only practicing good holistic care, but are 90% complete with the PRP assessment.
8. **Fix problems, not blame.**
   Use an SIB philosophy and look for root causes, not easy answers.
9. **Never miss a chance to be better.**
   Use SAV's, self tests, and commander's calls as opportunities to not only model a PRP culture, but hone skills.
10. **Get work done in a timely manner.**
    It's not going to get easier or go away the longer it sits.
    Be especially aware of PHA's and try to have them assessed for SF within 72 hours.

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 which consistently produce findings. While you should always be inspection ready, it's worthwhile to review these before the team arrives.

- Ensure the staff know local policies and procedures. The IG and NSSAV team will interview staff, then conduct an inspection to see if the stated procedures are actually being followed.
- Review the AFMAN for the "shall"'s and "will"'s , then vocalize them during interviews.
    - Does the training program involve the A-10 website and Lead/Alt Lead CMA training for CMA's? (AFMAN 13-501 appendix 1, Enc 3, 3.g.)
    - How do you ensure medical screenings, evaluations, and notifications are done in a timely manner? (AFMAN 13-501 Enc 2.14.c). Note: Although "timely" isn't defined, have a stated target goal, such as within 72 hours.
- Look at ancillary clinic policies, such as BOMC, ambulance services, optometry and PT. How are they ensuring timely review of PRAP records? How are they obtaining CMA reviews?
- 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 ADAPT 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 reflected in the OPR chart and vice versa?
- Pull and check all CO's records.
- Inspectors will ask about the sustainment program. Be comfortable talking about commander's calls, briefings, squadron stand ups, MICT, and individualized training on identified issues.
- Verify appointment letters for CMA's, technicians, and HIPAA letters for squadrons are up-to-date.

TIPS FOR A SUCCESSFUL INTERVIEW

The NSSAV (and IG) will interview key players and random MDG members about the PRP. This tests the culture of the MDG but also allows them to hear first-hand about policies and procedures. This is the first step in their compliance evaluations – after personnel have answered, the team will conduct a tests to see if those policies are actually practiced.

The team will purposely ask complex questions to junior staff members to test if people know who to approach with such questions. It's perfectly acceptable, and highly preferred, to answer with, "I don't know yet, but I'll ask LtCol Snuffy, our Lead CMA, and get back to you."

Bring a copy of the AFMAN to the interview, preferably a well-worn and tabbed copy with margin notes. It's good to pull answers from the AFMAN, but be careful not to over use it during the interview; interviewees appear unprepared if they stop to look up every answer.

Expect the following questions to test knowledge of local program and AFMAN 13-501:

- What is the purpose of the PRP? (*3. POLICY, a.b.*)
    - Articulate the importance of maintaining reliability for individuals with controlled or critical access to nuclear devices and their components.
- Who is the Lead CMA, Lead Monitor, etc?
    - Name the MTF PRP leads and how to contact them.
- Who conducts the training? How often? (*appx 1 to Enc 3, 3. g-i*)
    - Articulate that training includes the A10 slides. Explain that though the AFMAN says 15 months, A10 slides are an annual requirement, so you train annually.
- Who makes the determination if potential issues are SF? (*Appx 2 to Enc 3, 2.b.(1).*)
    - The CMA.
- What conditions drive mandatory decertification? (*Appx 4 to Enc 3, 2. a-f*)
    - The "Big Six". Memorize them, but have the AFMAN tabbed as well.
- How do you manage restricted reporting following sexual assault? (*Enc 3, 2.b(1-2)*)
    - Articulate your policy as an MTF. And expect that within 24 hours, a patient scenario involving restricted reporting will be run within your MTF.

There are only 3 unacceptable answers during an interview:

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

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.

I joke that an NSSAV is like an onion; the team's job is to peel away layers until someone cries. While it's never pleasant when a 3rd party questions your programs, it's the team's job to provide the most thorough evaluation possible. The NSSAV team will evaluate the same items as the NSI, but rather than simply identifying problems, they offer training and advice. They won't issue a score, so this is the time to be open about concerns, questions, and problems to get help polishing the program before the IG arrives.

NOTE: *The NSSAV is there to teach, so make them do it. Don't let them identify problems and then walk away. 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 will be less social than the NSSAV. They will be in constant communication with the MAJCOM, but policy prohibits the inspected unit from talking with the MAJCOM about the inspection without IG present. If you do need to talk about the inspection, arrange time with the IG so you can call the MAJCOM together. If you need to talk with the MAJCOM about day-to-day operations unrelated to the inspection, it's not a problem. Merely let the IG know beforehand so there is no perception that anyone is trying to circumvent the rules.

If the team identifies 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. Sometimes inspectors will find what looks like a major discrepancy 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. Calmly review their source documents. If it's a medical chart, 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 far less serious.

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 items that they hold back for further investigation are the ones that tend to have more serious problems.

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. NSI inspectors must validate findings with the MAJCOM, so if all else fails, politely request that disagreements be upchanneled for clarification. Pick which battles you can win, and stand up for what you are doing differently, but correctly. However, don't waste time and good-will by arguing minor points.

All of that being said, if you are in the wrong, admit it and implement an immediate fix.

Because PRP often involves passing medical information outside of the MDG, HIPAA is very important. Information sent from the MDG, such as an SF 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. Many bases ease their bookkeeping by using ASIMS to send SF letters.

HIPAA allows for the CO to have access to 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 they are passing 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 an SF letter that would 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 SF 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 clinics believe 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 (AFMRA/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 SF letters to the CO if not using ASIMS.

COMMON QUESTIONS IN PRP

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 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).

   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. Suitability factors should be reported with 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 SF after all.

   Finding this balance takes 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. 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, recommending suspension pending evaluation and the off-base care sheet was returned to the PRP clinic for CMA review. However, this shifted the onus of responsibility from the member to the MDG, so in response, it became standard for the unit to maintain the forms.

   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 that any type of off-base care forms are used.

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

   Years ago, it was commonplace to put 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 reports if the patient has a pain level 7/10. Should we do that?*

Short answer: There are very few "always report" conditions in the AFMAN. 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 at that level, it's 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 patient and found them to be coping.

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?! Remember, it's the *treatment and impact* of pain that matters. If you alert the CO that a member is having severe pain, their first response is, "Wow… sounds like they should see a doctor." 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 more importantly, it shows you're actually treating the patient.

Lastly, data shows an individual rating on the pain scale isn't reliable. Published studies found, "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 while flight docs gather evidence. Never lose sight that patient care and safety comes first.

When a mishap occurs, the SGP will work closely with Wing Safety to establish the ISB, and MAJCOM will be tasked with finding members for the SIB and AIB. Remember to notify the MAJCOM SGP as soon as possible to start the process.

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. The AIB is a legal board headed by JG, and its results are released to the public, so AIB cases can be a publically available resource for teaching.

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.

The governing document, AFI 91-204 para 2.11, requires that the base SGP maintain a list of flight surgeons, physiologists, and psychologists who have completed mishap investigation training along with their course dates. This list must be provided to the installation safety office as well as annually to the MAJCOM SGP (2.10.2.3). It's important to note that while para 2.10 and AFMAN 91-233 table 4.2 require that individuals involved in safety investigations be trained in the AMIP course, per Col Craig Pack, Chief of AF Human Factors Safety (email 27 Sept 18), either the AMIP course or AMP 301 are considered to meet that requirement.

The AF Safety Office, Human Safety Division, has developed an excellent mishap checklist that clearly summarizes preparation and response for mishaps. I highly recommend downloading it and customizing it as the local mishap response MDGI. A copy can be found at:

https://www.my.af.mil/gcss-af/USAF/AFP40/d/s6925EC13351A0FB5E044080020E329A9/Files/editorial/ISB%20Checklist,%20change%201.doc

ISB MEDICAL OFFICER RESPONSIBILITIES

Duties are spelled out completely in AFMAN 91-223 and the checklist supplied by SHE (link above) and are summarized below. If there is a fatality, there are other labs necessary (see section below).

- **Collection of 72 hour & 14 day histories.**
  - Keep blank copies of the forms in the mishap bag, and in the Mishap MDGI.
  - 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.
- **Laboratory testing (no fatality):**
  - The ISB flight surgeon may run pertinent labs locally, as deemed beneficial to medical management of the patient and/or the SIB.
    - Commonly useful labs: CBC, UA, SMA-18, and/or BAC.
    - If ordering labs solely for medical management, use CHCS or AHLTA.
    - If ordering labs for SIB purposes, do NOT use CHCS or AHLTA. Use a Form 0-79, *Laboratory Request Form*.
  - Toxicology (sent to AFMES): Use only grey and purple top vacutainers (or equivalent) for all blood collections. Do not use SST, CORVAC or Tiger Top tubes, as the gel can cause false negatives for some drug testing. Label all tubes with member's name, SSN, and collection date
    - 14 mL of NaF (gray top) tubes
    - 7 mL of EDTA (purple top) tubes
    - 50-70 mL of urine (no preservatives)
    - Skin should be cleansed with betadine or soap and water - no alcohol should be used for skin prep.
    - See below for collections in a fatality

NOTE: The *AFMES Guidelines for the Collection and Shipment of Specimens for Toxicological Analysis*, October 15, 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.
https://health.mil/Reference-Center/Forms/2016/04/04/Toxicology-submission-guideline

- **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's a fatality everything is under higher scrutiny. Chain of custody for remains is essential and may require the MO to be present at the site prior to and during removal of remains. Autopsies are required on all deceased operational aircrew (pilot, co, nav, engineer, etc), but may be requested on ancillary personnel bv the investigative flight surgeon or pathologist. The remains may need to be moved to Dover for autopsy and collection of samples, but no bodies can be moved or autopsies begun until the remains are released by the local county coroner. If stationed overseas, be familiar with the SOFA, as some countries treat a mishap as a homicide and may not release remains unless (or even if) the SOFA requires them to do so. That's a legal fight, so let MAJCOM JA engage with the local authorities.

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 patients. However, the flow of information 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.

All toxicological specimens from fatalities are preferably collected by the medical examiner at the time of autopsy. If a patient dies in a hospital post-mishap, supply any ante mortem samples from the hospital lab along with the postmortem samples.

The following is copied from the *AFMES Guidelines for the Colletion and Shipment of Specimens for Toxicological Analysis*, October 15 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 / location)*
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 fluids or organs can be recovered, 100 grams of muscle (psoas, peri-spinal or deep thigh preferred), and/or fat and red bone marrow should 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 (esp. spleen). If in doubt, submit as much tissue as is possible (do not submit fixed tissue for toxicological analysis). All specimens must be labeled with: sample type, decedent's name, SSN and autopsy number. A properly completed AFMES Form 18 (see Attachment 1) must be submitted with each case.

SAFETY INVESTIGATION BOARD: SIB

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 provide the AIB with 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 have a line-by-line reference for everything it includes, which can make for a very tedious experience. There will be a legal advisor on the board who usually has experience and templates, all of which 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://afjag.af.mil/AIB-Reports/ . It can be helpful to review previous reports involving similar aircraft.*

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.

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.

OTHER MISHAPS

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 to take. Additionally, AFI 48-149 discusses it in 2.2.7.

If results are normal, then an occupational injury did not occur, but the investigation must still be documented. 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.***

DCS

The most important piece of a DCS case is to get the hyperbaric service involved early. They are located at Brooke Army Medical Center and reachable at the following numbers:

- Duty day: 0700-1600 CST: 210-539-8000 (DSN 389-8000)
- After hours: 210-916-2500 (DSN 429-2500) Option 2, then 1, then ask for the hyperbaric physician on call.

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, we'll never have a major 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.

MISC.

ABBREVIATIONS, STAFF POSITIONS, AND ACRONYMS

STAFF POSITIONS

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, a call from J4 is from the Joint Logistics Cell, and when G9 is arranging a press conference, expect Army PA at the helm.

COMMONLY USED, BUT UNCOMMONLY UNDERSTOOD, ACRONYMS

Acronym	Literal Meaning	"Actual Meaning"
AFMSA	Air Force Medical Support Agency	The HAF SG level agency that provides oversight to MAJCOM's on waivers, standards, and creates AF level guidance.
AFMOA	Air Force Medical Operations Agency	
DTRA	Defense Threat Reduction Agency	The DoD level that oversees nuclear surety for the DoD. They may accompany USAF IG during an NSI.
MSWG	Medical Standards Working Group	The working ground made up of MAJCOM and AFMRA SGPs who discuss changes to the MSD and medication guides.
FOMCB	Flight and Operational Medicine Corporate Board	The body, also made up of MAJCOM and AFMRA SGPs who approve changes recommended by the MSWG.
AFMRA	Air Force Medical Readiness Agency	The "new" combined AFMOA + AFMSA agency under DHA.
DHA	Defense Health Agency	
U&TW	Utilization and Training Workshop	This workshop is how/where courses are built at USAFSAM. Typically made of SME's from the field.

MEDICAL BADGING AND AWARD OF SENIOR AND CHIEF TITLES

The update to AFI 11-401 made significant changes to badging for flight surgeons. Perhaps most significantly, to be permanently awarded the flight surgeon badge, the bearer must serve for a minimum of 36 months in a 48xx billet. This means the individual who attends the AMP during med school (or late in their career) but never actually serves as a flight surgeon may not wear wings. Don't worry; the newly trained flight surgeon is still authorized while working in FOMC.

FLIGHT SURGEON BADGING

The requirements for Senior and Chief flight surgeon badges have also changed, reducing the hours and allowing for sorties to substitute for hours – a boon to our pointy nosed brethren. The qualifications from table 4.1 are summarized below:

- Permanent award of flight surgeon badge:
  - Graduate AMP 101, 201, 202 (or service equivalent)
  - Unrestricted medical license
  - Assigned as 48xx and awarded 48xx AFSC
  - Badge will only be permanently awarded once assigned to 48xx billet and after serving 36 months as a flight surgeon

- Senior flight surgeon:
  - Permanent award of basic flight surgeon badge
  - At least 7 years rated service as a flight surgeon
  - At least 36 months on active flying status (API 5)
  - At least 275 total flight hours as a flight surgeon *or* 72 sorties while on operational flying duty as a flight surgeon (or pilot-physician)
  - Selected to serve as a base level SGP, ORMS/CC, or equivalent
  - Validated by USAF SG/SGP

- Chief flight surgeon
  - Permanent award of senior flight surgeon badge
  - At least 13 years rated service as a flight surgeon
  - At least 36 months on active flying stats (API 5)
  - At least 550 total flight hours as a flight surgeon *or* 144 sorties while on operational flying duty as a flight surgeon (or pilot-physician)
  - Serve in an assignment above base level
  - Validated by USAF SG/SGP

MEDICAL CORPS BADGING

It's common for docs to wear the wrong med corps badge. AFI 36-2903 and 36-2005 give the various requirements, but in summary:

	Badge	Requirements	Examples
	**Medical Service Corps Basic Badge (MSC)**	MSC's and Med students	2LT Snuffy, an HPSP student.
	**Medical Corps Basic Badge**	Graduated MD or DO with 1-7 years experience, *Counting med school*	Capt Smith, a GMO flight doc. (4 years school + 1 year internship)
	**Senior Medical Corps Badge**	7-15 years experience *Counting med school*	Capt Jones, a recent family med residency graduate. (4 years school + 3 years residency)
	**Chief Medical Corps Badge**	15+ years experience *Counting medical school*	Maj Jackson, an SGH internist with 8 years experience. (4 years school + 3 years residency + 8 years post-residency experience)

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 3.4.1.
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 1332.18
MEB Presumption of fitness: DoDI 1332.18 page 32
MEB Special tests required: AFI 41-210 para 10.6.10
MEB Special cases: No local MEB on MDG enlisted staff with discipline issues or MDG officers: AFI 41-210 para 10.1.4.6
MEB (unsuitable vs unfitness): DoDI 1332.18 Appendix 1
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.
SME's have same 50:50 time split as MDG FS in garrison: AFI 48-149 3.5.4.1
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 senior / chief flight surgeon badge: AFMAN 11-401 table 4.1, 23
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: AFI 36-2903 3.2.3.1.1
    (but…AFMAN 11-401 changed rules for flight surgeon badging…)
    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
DP2NP: 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

NARSUM SPECIAL STUDIES TO INCLUDE

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*

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									
			Frequency						
Metal	MEPRS	Priority	Daily	Weekly	Monthly	Quarterly	Annually	PRN	Rationale
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									
			Frequency						
Metal	MEPRS	Priority	Daily	Weekly	Monthly	Quarterly	Annually	PRN	Rationale
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 ORMS
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

SAMPLE LIFE SUPPORT CHECKLIST

ALL PURPOSE CHECKLIST

PAGE 01 OF 01 PAGES

TITLE/SUBJECT/ACTIVITY/FUNCTIONAL AREA: Flight/Missile Medicine Inspection Checklist for Aircrew Life Support

OPR: SGP

DATE:

NO.	ITEM (Assign a paragraph number to each item. Draw a horizontal line between each major paragraph.)	YES	NO	N/A
1.	Facility Visited:			
2.	Personnel conducting visit: Flight Surgeon/SME: FSO Technician/IDMT:			
4.	Life Support Technician contacted:			
5.	Is airborne dust and moisture kept within acceptable limits by use of the best possible air conditioning system and is shop temperature kept at 75oF with 50% relative humidity?			
6.	Do personnel practice good housekeeping?			
7.	Are work bench tops constructed of nonporous material that will not chip or peel?			
8.	Is a stainless steel sink with hot and cold water available and is it used for oxygen mask only?			
9.	Do all personnel working within the section practice good personal hygiene?			
10.	Are food stuffs of any kind prohibited from being around work areas where oxygen equipment is maintained?			
11.	Are personnel with skin/upper respiratory disease prohibited form working in the oxygen section and are those personnel assigned to temporary jobs outside the shop?			
12.	Are lint-free smocks worn in the oxygen section?			
13.	Are latex gloves worn when working on oxygen masks?			
14.	Are tools within the oxygen section clean and used only on oxygen equipment?			
15.	Other significant findings?			
16.	Recommendations			
	Signatures:			

AF FORM 2519, NOV 91 *(EF)* PREVIOUS EDITION WILL BE USED.