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SGP-earls

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Foreword

I started this manual as a self-reference when I was a young SGP in the field and found myself repeatedly looking up the same AFIs and references. As I moved on to staff positions, I added questions from the field, and it continued to grow over the years. I shared it with my colleagues and was flattered that it became a de facto field guide to the SGP position. You always want to leave something of yourself that makes the AF a better place, and I like to think that this is something that will live on after I've gone. To that end, I've asked Maj Caleb James to take over editing and updating the SGPearls once I've left. I hope it continues to be a useful resource for years to come.

Safe flying,

Col Todd "Quattro" Huhn, USAF, MC, SFS, MPH

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 HCOS 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. Much of the material will already be familiar to an experienced SGP, but 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 AFMAN 48-149 (2.8), but 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.

Note the wording on this: the SGP is the "most qualified flight surgeon". Not necessarily the highest ranking. Not necessarily the most experienced. But the most qualified.

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

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

There are people (i.e.: HCOS/CC or SGH) who are the touchstone for the business of medicine, but the SGP has the stick on medical standards and their applications. That means the SGP will need to have solid lines of communication with line CCs.

> *DAFMAN 48-123. 2.10. Chief of Aerospace Medicine (SGP),*
>
> *2.10 …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 48-133 2.5.4.. The MTF SGP shall:

2.5.4. Will serve as chairman of the deployment availability working group (DAWG) and AMRO board. (T-2). Alternatively, the SGH may serve as the DAWG and/or AMRO board chairman if the MTF/CC determines that the SGP is not available or capable of overseeing these functions. In these instances, the MTF/CC will advise the MAJCOM/SGP, ANG/SGP or AFRC/SGO of the change in DAWG/AMRO board chair.'

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, specifically, was appointed as the PHEO (AFI 48-101 1.4.15), but the new AFI 10-2519 changes the requirements to require an MPH or relevant experience. If no one on base has the requirements (Doctorate + MPH / degree / experience), contact the MAJCOM SGP for advice. They may authorize an exception.

2.3.6.1.1. The primary PHEO must be a senior AFMS officer with a clinical degree (e.g., Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), or Doctor of Veterinarian Medicine (DVM) and must have either a Master of Public Health (MPH) degree or related (e.g., Master of Science in Public Health, Master in Health Affair), or at least four years of experience in public health or preventive medicine. (T-1). See Chapters 6 and 7 for ANG and AFR PHEO-POC requirements.

2.3.6.1.2. The alternate PHEO must be a senior Medical Corps or Public Health Officer and must have either a Master of Public Health degree or related (e.g., Master of Science in Public Health, Master in Health Affair), or at least four years of experience in public health or preventive medicine. If the primary PHEO is a DVM, the alternate PHEO must be a senior Medical Corps officer. (T-1).

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

All profile officers work with MSME, AMRO, 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 PRAP. (T-1)

AFI 48-133 2.5.9 (The MTF/SGP)

2.5.9. Will serve as the MTF senior profile officer (SPO) IAW AFI 48-101, Aerospace Medicine Enterprise. 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) Waiver requests from the ANG for this requirement, if the SPO is not a FS, must be submitted to the National Guard Bureau SGP. (T-2)

2.5.10. Will serve as the installation's final medical authority on DR and/or MR and the application of medical standards as it applies to AF Form 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 almost always the IOEMC, is responsible for installation occ health, and should count on being the 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. 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 AFOM and return to their AFSC without working in a flight med clinic.

Further, AFI 44-102 1.3.3.1., similar to the previous reference from AFI 48-101, states that the SGP is the "most qualified flight surgeon". Not necessarily the *highest ranking*. Not necessarily the *most experienced*. But the *most qualified*. An SGP must strive to be not only the best physician, but also the best officer that they can be.

AFI 48-133 (The MTF/SGP),

2.5.5. Will share responsibility with the SGH for training all providers and answering questions related to the appropriate completion of profiles and duty (including fitness) limitations and the MEB process. ***(T-2).*** *The SGP will ensure that all primary care managers (PCM) understand the purpose of the AMRO board and the processes used by the AMRO board to meet its mission.* ***(T-2).***

8. The "PRAP 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,*
>
> *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)*
>
> *AFMAN 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 the most highly qualified, credentialed, flight surgeon. That means they have to be setting an example for other providers, not just as an officer, but also as a physician. 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. I recommend creating a recurring calendar appointment for ½ day of clinic per week. Make that appointment before the schedule fills with meetings, but remember…as the committee chair, the SGP can move meeting times if they need.

> *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.*

11. The SGP needs to know base operations, including classified ones.

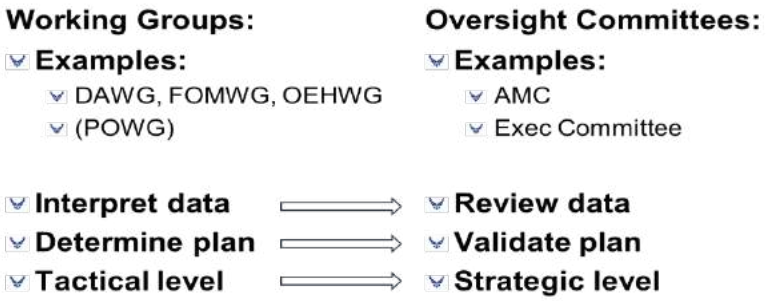
AFI 48-101 1.4.15 requires that the MTF/SGP maintain a Top Secret clearance so they can provide operational, occupational, and medical support for individuals who work in classified environments. If the MTF/SGP billet is not properly coded as requiring a TS, DoDm 5200.02_AFMAN 16-1405 4.2.e.(2) directs the CC (MDG/CC) to submit an ACR to authorize the position be upgraded IAW the requirements spelled out in AFI 48-101 1.4.15.

> *AFI 48-101 1.4.15.2,*
>
> *"[The MTF/SGP shall]: Maintain at least an active Top Secret security clearance. (T-1) If this level of clearance is not already possessed, as soon as the SGP is selected, he/she shall be processed for the appropriate clearance (N/A for ARC). (T-1)"*
>
> *DoDm 5200.02_AFMAN 16-1405 2.13 i.,*
>
> *"i. (Added) (AF) Commanders will ensure military and civilian personnel are properly cleared for access to classified information or sensitive positions. (T-1). At a minimum, the commander will:"*
>
> *(note: Commanders are defined in 2.13.f(6) as the direct military unit commander, in this case, the MDG/CC as the SGP's CC)*
>
> *DoDm 5200.02_AFMAN 16-1405 4.2.e.(2).*
>
> *"(Added) (AF) The commander must review the criteria listed in Section 4.2.e.(3) to determine whether a billet has a justified T5 investigative requirement. (T-1). The commander will forward the authorization change request (ACR) request through the local manpower office, if there is a documented evidence that T5 investigation is required. (T-1) The servicing Manpower Office will update MPES with the updated position sensitivity level and corresponding security access requirement code."*

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 AOMED 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 metrics – "If you don't inspect it, you can't expect it." This is also where many meetings fail: reporting metrics, but not using them 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. Note – this isn't the same as a huddle.

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.

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.

HINT: *There is a set of example AMC minutes in the appendix to show how to use stoplights and otherwise document information quickly and effectively.*

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 AFMAN 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, the AF now uses an AMRO-Board to pre-screen and limit discussion at the DAWG. The AMRO-B findings are submitted to the DAWG for endorsement.

> AFI 48-101 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 48-133 5.2.5. AMRO board/DAWG at the supporting MTF will administratively manage the DLC, AAC 31, 37, 81, ALC-C, and RILO (initial and annual) cases from the GSU and MUNSS sites as outlined in this publication. (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 AFMAN 48-149, *Flight and Operational Medicine Program*.

OPTIONAL: POWG – PRAP Operational Working Group:

The POWG is the PRAP 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 PRAP 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 PRAP team to meet regularly and review updates, case management, training, etc. Depending on the size of your PRAP, consider rolling it into FOMWG or the PRAP AMRO 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).
> 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. As noted above, while the SGP is not *required* to be the PHEO, it is standard for them to serve as one.

> *AFI 10-2519 2.3.6.1.7. The PHEO must be the primary medical representative to the Threat Working Group and a member of the EMWG.* ***(T-2).***

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 when 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 consider submitting an annual schedule AMC and ProStaff. 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. There is a sample agenda of topics on the next page of this manual.

AFMAN 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	PRAP Topic
January	Profiles (AF 469 / 422)	Profiles and PRAP
February	MEB (IDES) Program	Perm Decertifications
March	TB Program	PRAP medications
April	Travel medicine / Malaria Prophylaxis	After hours care for PRAP
May	Deployment Preparation	Deployment PRAP
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 PRAP impacts

SUMMARY TABLE OF SGP MEETINGS:

Meeting	Frequency	Role	Authority	Reference
Flight/Op Med Working Group (AKA GM)	Weekly	SME - AOMP	SGP	AFMAN 48-149 3.3.3.
PRAP Susp Review	Weekly - Monthly	Chair	Lead CMA	Not required, but a good management option as a 1041-style PRAP 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.
AMRO-B	Twice Monthly	Chair	SGP	AFI 48-133 4.4.3.2.
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 PRAP	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 reporting					
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	AFMAN 48-149 9.3.4.8	
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	AMRO	AMRO-B	AFI 48-133 1.3.4.	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	AFMAN 48-149 7.2.1.	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	AFMAN 48-149 3.3.3.2.	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 (AFMAN 48-149 3.3.3.1.) 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.,	
Duration from potential IRILO until DAWG determination	<45 days	AMRO-B	DAWG->MDG Exec Comm.	AFI 48-133 4.5.3.1.1.	DAWG will report to to Exec Comm via AMC. AMC may meet quarterly, but metric is due monthly
Duration from DAWG determination for IRILO until case transmitted to DP2NP	<30 days	AMRO-B	DAWG->MDG Exec Comm.	AFI 48-133 4.5.3.1.2.	DAWG will report to to Exec Comm via AMC. 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	AMRO-B	DAWG->MDG Exec Comm.	AFI 48-133 4.5.3.1.3	DAWG will report to to Exec Comm via AMC. AMC may meet quarterly, but metric is due monthly.
Overdue rate for Annual RILO	%	AMRO-B	DAWG->MDG Exec Comm.	AFI 48-133 4.5.3.1.4.	DAWG will report to to Exec Comm via AMC. AMC may meet quarterly, but metric is due monthly.
DLC Quality review	Locally determined	SGP	ProStaff	AFI 48-133 2.5.3.2.	Sample may be included in peer review
Code 31 reviews	Not established	AMRO	AMRO-B	AFI 48-133 A3.2.1.2.3.	The DAWG will also report on metrics to the exec comm via AMC. If more than 300 days, AMRO-B will consult with PCM (DAFMAN 48-133 2.3.1.2.)
Code 81 confirmation / reconciliation	Not established	MSME	AMRO and OEHWG	AFI 48-133 A3.1.2.3.	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 48-133 4.5.2.	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 group 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 it's 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 < 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 it's 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	AFMRA/AG3PF	DAFMAN 48-108 3.17.1.1.1.	Data is entered by the PEBLO into the VTA database
Number of PEBLO's assigned and training	Not established	DAWG	AFMRA/AG3PF	DAFMAN 48-108 3.17.1.1.3 & 3.17.1.1.4.	Data is entered by the PEBLO into the VTA database
MTF determined metrics, such as average days from Code 37 to submission of NARSUM	varies	DAWG	AMC	DAFMAN 48-108 3.17.3	Data is determined and tracked at the local level to manage the IDES process.

THE SGP AS A LEADER

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

Some SGP's fail shortly after assuming duties. Others fail after years of complacency. Being an effective SGP is a difficult matter of balance; an SGP has to juggle being a physician, an industrial hygienist, an instructor, a health inspector, an aircrew member, and many other roles.

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.

COMMON SGP PITFALLS:

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 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.

   Being able to nest your priorities within your boss's priorities is essential to succeeding as an SGP.

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 HCOS 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. Consider a weekly, informal, meeting with other execs; 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. 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. Don't be afraid to contact the MAJCOM SGP. It's their job to support, teach, and advise, so reach out early and often. If they aren't already having a regular t-con with the SGPs in your MAJCOM, ask to start one. Getting everyone together, even once a month, is invaluable. 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 labors, but because of the perception of their labors.

Most people outside of the AOME have poor visibility on the SGPs duties, and this is compounded because many duties pull the SGP out of the MDG. Just like in risk communication, if there are holes, people make up stories to fill in the blanks.

There are a few ways to fix that. First, use Outlook and populate the calendar with meetings and clinic times, 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. (This has the added effect of keeping you honest.,,)

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. One approach is to break the WAR into sections discussing the roles of the AOME. This shows your boss how you're meeting the previously agreed upon priorities (Pitfall #1) and how working with the team (Pitfall #2). See example on the next page.

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.

PRAP

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

FOMC

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

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 PRAP 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 take the time.

There will be multiple calls for awards throughout the SGP's tenure. Some are MDG awards, while others are AF wide - such as the SoUSAFFS 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 ORMS CC and the squadron superintendent. This ensures that names go forward with leadership's blessing, and also that packages are 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 meetings around it. 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? 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/HCOS 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 HCOS, all at once. It's a Win-Win-Win.

NOTE: *Many SGPs have offices in the command section, which is helpful if you need to build communication with the rest of the exec team. But if you have younger docs, ask the MDG/CC about moving your office to the clinic, or at least spend your admin office time there. Being "local" allows you to provide the mentorship that the younger docs need (and crave).*

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.

The SGP doesn't operate in a vacuum. (Ok, maybe if you're working 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.

Also, take a look at the notes in Pitfall #8. Is your office in the clinic? Or are you hidden away in Tiptoe Alley? Young docs need you at their side.

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 the EHR. 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 metrics aren't just numbers, but 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 upward 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?

SUCCESSFUL LEADERSHIP – WHAT "RIGHT" LOOKS LIKE

The last section noted how SGPs fail, but what traits do successful SGP and Sq/CC leaders possess? To explain that, I'm going to use one of my favorite leadership tactics: Deferring to an expert.

Col Cotton served as the USSTRATCOM/SG as well as the AFMRA Aerospace Med Consultant. He published his 12 traits of leadership in the SoUSAFFS Flight Lines journal, but kindly gave permission to include them in the SGPearls as well.

Leadership

John J. Cotton, Col, USAF, MC, SFS

There are thousands of books, articles, and websites devoted to leadership. We also get some principles in PME and from mentors, but it is clear that the "secret" to being a good leader is elusive, and sometimes *illusive.* That is to say that there is no one single effective leadership style. What follows are 12 principles that served me well in my two tours as a squadron commander.

1. **Embody the Air Force Core Values.** Every belief system needs a touchstone, a "true north," and for us it is our Core Values. Do the right thing, aspire to excellence, and serve your people and the mission. Adhering to them is 90% of success.

2. **Be authentic.** Be the best **you** that you can be. Being authentic and sincere fosters trust. Don't pretend to be something that you're not because all façades are easily (and inevitably) seen through. When that happens, you lose credibility and respect.

3. **Develop a leadership philosophy, communicate it, and be consistent.** In my experience, Airmen respect a system where the rules and expectations are well known and uniformly applied. Tell your Airmen what you hold important, what "redlines" exist for you, and how you view life, the Air Force, and everything. When they face a dilemma, they need to be able to ask themselves (or have their superiors ask them), "What would the Squadron Commander do?" and know the answer.

4. **Develop emotional intelligence (EQ).** EQ focuses on empathy, the control of emotions, and honest self-reflection. I truly believe that it adds "meat" to the "bones" of any leadership philosophy. View situations from another person's perspective to help you gain better insight into the issue and reduce your blind spots and the pitfalls of "optics" in decision-making. Manage your emotions so you can make better decisions and avoid regrettable consequences (e.g., don't email angry – ever!). Be honest with yourself – the good and the bad. Acknowledge your limitations, admit your mistakes, address where you may have made a bad call, and work to overcome them or do better. EQ cultivates an environment of dignity and respect, which in turn leads to better stability, teamwork, and productivity. Finally, EQ helps you to connect and communicate with your Airmen. As the adage goes, "People don't care how much you know until they know how much you care." Really knowing your people and taking an interest in their overall well-being will get the best out of them and make your squadron better.

5. **Know and support your commander.** Don't forget who – and what – you are working for. It is great to have a squadron and people to lead, but you also have to nest your priorities within those of your MDG/CC and your WG/CC (remember who signs your OPR!). If your squadron's activities are not supporting theirs, then you need to recage your gyros and figure out how to do so.

6. **You are not an Air Force of one.** While responsibility for your squadron ultimately rests on your shoulders, you have a supporting cast to help you. Seek feedback from your MDG/CC, bounce ideas off your fellow Sq/CCs, and phone a friend/mentor. But don't forget your Superintendent, the First Sergeant, your Flt/CCs, and NCOICs. Sharing your decision-making process with others adds granularity to your leadership philosophy and enables better decisions upstream, downstream, and sidestream. This also means that there are things that can be delegated so that you don't get overwhelmed.

7. **Do the "housekeeping."** Make sure the little things reflect the qualities that you want you and your organization to stand for. Be on time, meet suspenses, do what you say you'll do, be courteous and professional, adhere to dress and appearance, customs and courtesies, and fitness standards, proofread correspondence, keep a neat workplace. Strive for a reputation of dependability, effectiveness, and honor.

8. **Be flexible, but principled in your flexibility.** Commanders live in the gray space between black and white. You will sometimes have to make exceptions or deviate from a standard or norm. When you do, make sure that there is good reason to do so, that it is defensible and comports with your leadership philosophy, and that your rationale is effectively communicated to all involved.

9. **Be humble and give credit where credit is due.** Respect the responsibility of command. It's not about you, it's about the success of your organization, which is a reflection of you. Recognize hard work, good work, good deeds, and great ideas. Conversely, do not place blame. Instead, focus on how/why a problem occurred and its solution. Try to seek win-win situations inside and outside your unit. This helps you lead out of inspiration, not fear.

10. **Never stop growing or learning.** Leadership is an evolutionary process. There are lessons to be gained from every situation, and what works in one may not work in another. Always seek to improve – and at times change – how you lead. Actively seek the growth and betterment of your people and your unit, as well.

11. **Be accessible and be there for your people.** Don't rule from an ivory tower. Get out and get to know your people. Engage with them and participate in activities with them. Take an interest in their lives, and do what you can to help them. Have an open door policy: let them know when your door might necessarily have to be shut and when it will always be open. In other words, there are times when you can't talk with an Airman, but there are also other times when you will clear your entire schedule for them.

12. **Enjoy the privilege of being a commander.** By this, I don't mean that you should revel in the title, the parking space, the social invites, or people standing up when you enter the room. Rather, enjoy the tour. You are shaping people's lives, affecting the mission, and making a difference. Have fun with your people and savor every minute of it because it is arguably the best job in the Air Force.

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 for 24 hour qtrs.
- 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 headaches if IDES or other actions are required.
- IDES: Emphasize 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: PRAP (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 SGP, as one of the highest ranking physicians in the MTF, is also a mentor for young physicians on career progression. With the new 95% max promotion rate at all levels, PME has become a larger discriminator. While SOS isn't as necessary, ACSC and AWC are strong discriminators for promotion and highly competitive programs, such as AAPL, CPE, and some assignments.

There are four pyramids (Operational, Clinical, Academic, and Leadership). While people are free to move between pyramids, there are certain gates which are required to move to certain levels, and people need to ensure they're accomplishing those items to be able to move.

Academic –Many people try to break into the academic pyramid with an OPR push line to be a program director, but they haven't been on GME staff previously. That means that even though they would make an excellent PD, they'll never be considered. It's similar to a push line to be a MDG/CC for someone who was never a Sq/CC – it's just not going to happen. If someone is interested in academics, they need to join a GME staff first, perhaps as an associate PD. The best way to find those opportunities is to contact the department chair at USUHS, but if there is no joy at the department level, contact the Dean of Students for direction.

Clinical – IMHO, the clinical track is the second most commonly requested. It meets the leadership track at the clinic directorship level, as well as at the SGH/SGP level. At the O4/O5 level, expect pushes to be SGH or SGP. Many higher ranking people in the pyramid seek master clinician SEIs or cross over (or try to) to the academic pyramid. These cross-overs often run afoul of the aforementioned PD paradox.

Operational – Although one can argue that the clinical pyramid is operational, this specific pyramid is geared toward embedded medical assets outside the MTF. An SME is an example, though there isn't much opportunity to advance through the pyramid solely as an SME. Most of the advancement in the operational pyramid requires moving into AFSOC, CCATT, and integrating with embedded medical units.

Leadership – This is by far the most well-known pyramid, and is almost a default assumption for high performing officers. That doesn't mean people have to follow the leadership track, but if they show leadership skill, there will be pressure for them to climb this pyramid. Expect pushes for Flt/CC at O3/O4, and SGH/SGP/Sq CC at O4/O5. The leadership tract crosses over with the clinical tract at low levels with clinical directors, as well as at higher tiers at the SGH and SGP level.

PROMOTION BOARDS

Promotion boards have changed (and will be changing) between 2021 and 2023. Prior to the 2021 board, there was no merit based component to promotion to O4 and O5 in the MC and DC. Unless the member was specifically identified as Do Not Promote (DNP), promotion happened automatically on the six-year anniversary of their previous promotion. O6 promotions were merit based, but still tied to the anniversary.

Starting in 2021, O5 promotions became merit based with line numbers and were no longer associated with anniversary dates. This means that some MC and DC members promote up to 12 months earlier than they otherwise would have. O4 promotions continue to be automatic, unless a DNP was assigned. O6 promotions were already merit based, but pin-on moved from anniversary to line numbers.

Each MAJCOM has a very small number of "definite promote" recommendations from their CC. To help ensure these go to the right folks, A1 consults with the senior corp representative (ie: MAJCOM SGP, SGN, etc) during the MLR. This ensures unique corps responsibilities that the line may not be familiar with, such as SGP, SGH, PHEO, etc, are taken into account. While the MAJCOM corps rep doesn't have a final say, their endorsement is taken seriously. That said, some items, such as board certification and PME are major discriminators and almost required for a DP.

WHERE TO FROM HERE?

The expectation is that young flight surgeons will "learn the ropes" during their first few years. This may be in the MTF or as an SME, but they will need to become adept in clinical medicine as well as other ancillary duties. That includes being familiar with the core AOME meetings, such as AMRO, OEHWG, FOMWG, and AMC. After they hit O-4, they have moved far enough up the clinical and operational pyramids that they'll be looked at for SGP roles.

SGP billets are broadly grouped as Tier 1,2, or 3 based on the mission size and complexity. Generally speaking if there are fewer than 500 fliers, they fall under Tier 3, and over 1000 puts them as Tier 1. But that's only a general rule, and the Tier may shift up or down based on airframe/mission complexity, if the base hosts other organizations, the size of PRAP mission, etc.

The Tier 3 slots will nominally be filled by a young O-4. Tier 2 may be filled by an experienced O-4 or an O-5, and Tier 1 will be filled by A-1L via the Colonel's Board with either an O-6 or a very experienced O-5.

O-6 (Tier 1)	O-5 (Tier 2)	O-4 (Tier 3)
Andrews	Aviano	Altus
Barksdale	Beale	Andersen
Davis-Monthan	Cannon	Bolling
Eglin	Charleston	Buckley
Hurlburt	Columbus	Dover
Kadena	Dyess	Eielson
Lackland	Edwards	F E Warren
Lakenheath	Ellsworth	Goodfellow
Langley	Elmendorf	Grand Forks
Nellis	Fairchild	Hanscom
Offutt	Hickam	Holloman
Ramstein	Hill	Incirlik
Robins	Kirtland	Keesler
Tinker	Luke	Kunsan
Travis	McChord	Laughlin
	McGuire	Little Rock
	Minot	Los Angeles
	Moody	MacDill
	Osan	Malmstrom
	Pope	Maxwell
	Randolph	McConnell
	Scott	Misawa
	Shaw	Mountain Home
	Vance	Patrick
	Wright-Patterson	Petereson
	Yokota	Seymour-Johnson
		Sheppard
		Spangdahlem
		Tyndall
		Vandenberg
		Whiteman

RUNNING A TRAINING PROGRAM

Whether its teaching new flight surgeons how to use AIMWTS, training a CMA for PRAP, or showing a new PCM how to conduct AMRO reviews, the SGP will often find themselves in a teaching role. One of the most common challenges is to in inherit a program and students in a pipeline, with no clear plan how to complete their training. Goals are nebulous, progress isn't tracked, and there is no way to hold a member accountable if they fail to progress.

Unfortunately, training plans often consist of little more than a checklist of tasks. For example, the 48G1 to 48G3 upgrade checklist, or the commonly used CMA checklist derived from that plan, may identify a goal, such as 'write an aircrew waiver'. But they don't address the tasks necessary to accomplish the goal, nor the steps needed to accomplish those tasks. That leaves trainees unsure how to proceed, and instructors unable to measure proficiency, knowledge, or skills.

STEP 1: IDENTIFY A GOAL

Identifying the goal is the simplest step, but it's *only the first* step. Checklists, such as the Flight Med upgrade, identify goals but don't provide any input on **how** to achieve that goal. Without a roadmap, trainees are unsure how to progress and trainers get frustrated with a perceived lack of progress.

As example goals, let's use two from the above-mentioned upgrade checklists: "**Renew an Aircrew Waiver**" and "**Conduct a PRAP patient visit,**" and move to Step 2 to identify the tasks necessary to achieve those goals.

STEP 2: IDENTIFY THE GENERAL TASKS NEEDED TO ACCOMPLISH THE GOAL

Continuing with the example of an aircrew waiver, what are the general tasks necessary to renew a waiver? Broadly speaking, the flight surgeon needs to identify waiver requirements and use AIMWTS to renew the waiver before it expires.

What about general tasks to conduct a PRAP patient visit? At the most basic level, the CMA-in-training needs to provide standard of care medicine during a patient care visit, and ensure PRAP and SF documentation are clear and accurate.

The specific steps needed to accomplish these tasks are broken down in Step 3.

STEP 3: IDENTIFY THE SPECIFIC STEPS NEEDED TO ACCOMPLISH THE TASKS

While both of the following tasks could be broken down much further, and individual steps could even be broken down even more, this provides an example overview of how tasks are broken down into steps to achieve the initial goal.

Continuing with the goal of 'renew an Aircrew waiver', the flight surgeon must complete the task to 'identify waiver requirements and use AIMWTS to renew the waiver' by doing the following:

1. Identify the member's waiver requirements in the MSD and AF waiver guide
2. Log into AIMWTS
3. Navigate to the workflow screen
4. Locate the member's existing waiver
5. Navigate to 'waiver actions' and 'renew waiver'
6. Update the member's information in 'demographics'
7. Navigate to the AMS screen
8. Write the AMS *(this step could/should be broken down much further)*
9. Sign the waiver

To achieve the goal of a 'PRAP patient visit', the CMA-to-be must 'provide standard of care medicine during a patient care visit, ensuring PRAP documentation and SF identification is clear' by doing the following:

(Let's gloss over the standard of care portion…)

1. Verify patient identity
2. Identify the patient as PRAP
3. Perform an H&P with SOAP note IAW standard-of-care medical practice
4. Identify potential SF from the visit
5. Adjudicate the potential SF with reasonable medical decision making
6. Document the adjudication
7. Complete the PRAP notification form if notification is required
8. Complete a warm-handoff to the notification desk IAW clinic SOP's if notification is required

STEP 4: DERIVE THE LEARNING OBJECTIVES FROM STEP 3

Now we're at the fun part:

Learning objectives are the "meat" of any training program. They are also the most commonly overlooked piece. This is where even the most well intentioned training plans can break down. If a plan lacks clear learning objectives and timeframes, trainees can languish for weeks or months, unsure what to do to advance. Further, there is no way for an instructor to identify a non-progressing trainee and perform appropriate administrative actions.

WRITING SMART LEARNING OBJECTIVES:

Learning objectives needs to be SMART: Specific, Measurable, Achievable, Relevant, and Time-bound. Using our above examples:

Write an AMS for waiver renewal:

- ✓ Specific: Write an AMS for waiver renewal
- ✓ Measureable: All material from the AF Waiver Guide is included
- ✓ Achievable: Is this reasonably achievable by the student? (Yes.)
- ✓ Relevant: Are the steps to accomplish it relative to achieving the goal?
- ✓ Time-Bound: After 2 hours of training with the SGP

Identify and document SF

- ✓ Specific: Identify and document SF
- ✓ Measurable: 95% accuracy
- ✓ Achievable: Is this reasonably achievable? (Yes.)
- ✓ Relevant: Are the steps to accomplish it relative to achieving the goal?
- ✓ Time-Bound: After one week of training and chart review with the lead CMA

Now that we have SMART components to achieve the steps to achieve the initial goal from the checklist, we can write the learning objectives.

MAKING SMART LEARNING OBJECTIVES SPECIFIC:

Learning objectives need to be specific, stating who needs to do what, where, when and how. Some people find it easier to remember this as "*Who, what, where, when, and how*," while others prefer to remember ABCD, or *Actor* (trainee), *Behavior* (what do they need to do?), *Conditions* (Where and When do they do it?), and *Degree* (How many times? How accurately?).

The steps don't have to flow in ABCD pattern, but all elements should be present.

Waiver renewal:

- ✓ A = Flight surgeon
- ✓ B = Identify waiver requirements and draft an AMS
- ✓ C = Within AIMWTS
- ✓ D = Meeting all AF Waiver Guide requirements

PRAP Patient visit:

- ✓ A = CMA trainee
- ✓ B = Identify and document SF
- ✓ C = during standard-of-care patient care visits
- ✓ D = 95% accuracy

Combining the SMART examples from above with the ABCD breakdown gives us clearly stated learning objectives to clarify the checklist goals of "renew a waiver" and "conduct a PRAP patient visit."

> *"After two hours of training with the SGP, flight surgeons must demonstrate how to identify waiver requirements from the MSD and draft an AMS within AIMWTS, including all relevant items from the AF Waiver guide.*

and

> *"After the first week of training, CMA Trainees must demonstrate the ability to identify and document SF with a minimum of 95% accuracy when performing a standard-of-care PRAP patient care visit."*

This gives a much clearer picture to everyone of what needs to happen for those checklist items. The formal training plan itself would consist of the previously defined Goal, Tasks, Steps, and Learning Objectives to provide both the trainee and trainer the step-by-step process by which to achieve their goal.

STEP 5: EVALUATE THE PROGRAM

Last but not least, a good training program has a built in self-check. Oral and written feedback from students is the classic means of evaluating programs, but objective observation is also very valuable.

For instance, in addition to asking trainees if they found the training effective and how to improve it (if applicable), check to see if post-training behaviors changed. Did waiver compliance increase with fewer expired waivers? During peer reviews, was there a decrease in missed documentation for SF?

CAUTION: *Avoid "In Training" labels for personnel in the pipeline*

Why?

- *There is no formal "In Training" title, so labeling a CMA or Flight Surgeon "In Training" leads to confusion over what they can and cannot do. Are they a CMA? Can they provide AMDs? Programs have been hit during inspections when providers were asked to perform tasks that they weren't authorized to do, but which others thought they could because the provider's title was "XXX (In Training)".*
- *Also, a formal "in training" title lets students languish in limbo and lets the instructor get by without a SMART training program. If students are considered untrained until they complete the program, there is an impetus to hold both the student and instructor accountable.*
- *Bottom line: it's much better to use a binary system: Either a person is qualified or they are not.*

THE EXEC TEAM: COORDINATING WITH THE EXECS

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

SUMMARY SUSPENSION

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. DHA-PM 6025.13 Volume 3 discusses this under Volume 3, Enclosure 3, Section 2.p *Initiation of Clinical Adverse Action Due Process*. Using this process for short terms, up to 30 days, replaces what used to be known as an abeyance, and is not required to be reported by the provider on future licensing reports, nor to the national provider database.

A suspension for under 30 days 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 suspension, the provider is not allowed to practice their affected privileges, even under supervision.

This would 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. The Credentials Function Chair must notify the provider, in writing, that their privileges are in suspension and which privileges are affected. The notice must also state that an investigation is being performed and will be reviewed by the Credentials Function, and that if the investigation isn't completed in 30 days, the (non-reportable) suspension automatically turns into a (reportable) summary suspension > 30 days. Because of the short time frame, it may require an Ad Hoc Credentials Function meeting rather than waiting for the next formal function. DHA is creating a Clinical Adverse Action Notification Form, but as of now, it has not disseminated one.

SUMMARY SUSPENSION

A significant step up from short term suspension is a suspension > 30 days. All suspensions of privileged providers lasting greater than 30 calendar days are to be reported to the National Practitioner Database, state(s) of licensure, and other applicable certifying/regulatory agencies starting 1 Feb 20 IAW per Enclosure 3, Section 2(i)(3)(b) and the DHA Directors 30 Sep 19 Memo (Tab 1) 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 (see below).

A suspension shouldn't exceed six months, though AFMRA/SGHQ can issue a waiver if more time for investigation is needed. Similarly to a short term suspension, 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 quality investigation.

IMPAIRED PROVIDERS

Since the Air Force wants to encourage impaired providers to self-identify rather than conceal impairments, there are certain protections granted 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 suspension.

The requested restrictions must be reported to the MTF/CC for concurrence, then to the AFMRA/SGHQ. In addition, the providers must be enrolled into and managed by an Impaired Healthcare Provider Program. 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 adverse action has been initiated. In other words, a provider cannot "get out of a suspension" by claiming impairment after an adverse action investigation has begun.

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 treatment, there are time limits. 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 completing the treatment program.

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 after suffering a fractured arm. If the condition is temporary, it can be managed with an AF 469, with the profile placed in their provider file. This isn't considered an adverse action and it is not reportable. A more permanent condition would be reviewed by the credentials function and the AFMRA/SGHQ who determines 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. But 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.

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 has the lead and is required to provide an Individual Suicide Event Report (ISER) to MAJCOM/MH and AFMRA. Ask MDG MH to cc: the local acting 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 the 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 aerovac 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 needs to attend regardless (AFMAN 48-149 2.8.1.). AFMAN 48-149 para 3.3.3. 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. It's a good way to find low-hanging fruit to return flyers to duty and shorten the log. The goal is to never have an aviator on the 1041 who is medically able to fly, but merely needs a piece of paper stating so.

If someone should have visited the clinic for a RTFS but hasn't, have a tech email them to return to the clinic and annotate that in the 1041 notes section. The 2nd notification gets copied to their Flt CC and SGP, and the 3rd notification goes from the SGP to their DO or CC. 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.

The notes section of the DD 2992 can be used to document the last t-con or appointment with long term DNIF's to show compliance with the expecation 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.

AIMWTS TIPS AND TRICKS

AIMWTS is built with a workflow to identify upcoming waivers, addendums, and other items. It's very helpful, but there are a few quirks and items to watch closely.

Tip #1: Keep the Workflow clean so you can identify oddities

> Take 10 minutes per week for AIMWTS housekeeping. Look at the "Pending Aeromedical Summary Signature" folder. Are there old shells cluttering it up? Cancel them. Do you have pending addendums? They are often simple questions that can be quickly answered. Take a peek at the Pending Waiver Authority (PWA) folder and scroll through each one to see where it is. (See also Tip #4)

Tip #2: Do a quick scroll of upcoming waivers.

> Open the "Renewal Due in the next 6 months" folder and "view all in list". Click "Waiver Content" and the "ACS" tab of the AMS. Scroll through quickly by clicking the tiled folders above the AMS to immediately identify diagnosis and ACS requirements. This gives SA on which need to be started early (specialty consult and ACS referral) and which are easy (Under the new MDS, some might no longer need a waiver. Contact MAJCOM and retire them!).

Tip #3: Make sure waivers are forwarded for disposition

> A common mistake is to sign waivers in the "Pending AMS Senior Reviewer Signature" folder, but not forward the waiver for approval. Navigate to "Waiver Actions" and choose "Forward Waiver" to send it to the approval authority.

Tip #4: Check the "Pending Waiver Authority" folder regularly.

> There is a certain MAJCOM, which many of us send waivers to, which refuses to use "Request Addendum". Instead, they 'forward' the waiver back to the base to address questions. When that happens, the waiver sits in the PWA folder, since AIMWTS thinks that the local SGP is now the waiver authority.
>
> The only way to identify this is to look at the waivers sitting in PWA, open each one, navigate to "Waiver Actions" and select "Waiver History/Status". Then look at the bottom of the action list to see if the waiver was forwarded back to the base. You can see what questions they had if you click on the blue text. Once you update the waiver, you'll have to forward it back to them for disposition.

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 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 Pearls:

- To ensure the MAJCOM and ACS have time to process them, require all waivers hit the SGP's desk for senior review NLT 30 days prior to expiration and NLT 60 days if ACS is involved. It may get some griping at first, but once it's normalized, it will greatly promote waiver management.

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

- 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. Bonus points if you supply the MAJCOM/SGP with a journal article, consultant, or other evidence.

- Lastly, if a member is separating or retiring, the waiver should normally be left to expire rather than retiring it, unless they are transferring to ARC or ANG. (DAFMAN 48-123 5.5.4.5.7.)

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 2992 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. *(Yes…this isn't technically a "requirement". But unless you want ETPs and hard feelings, practice good expectation management.)*
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 2992'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 2992. 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. (DAFMAN 48-123 para 5.3.5.) During deployments, members are exempt from PHA requirements, so there is no need to request a PHA extension. (DAFMAN 48-123 para 6.8.4 and AFI 48-170 para 3.3.5.3.) However, they may still need a DD 2992 extended (see below.)

DD 2992's: If a flier has a DD 2992 expiring during deployment, the home station may need to contact the MAJCOM SGP for permission to extend it. The old version of AFI 44-170 used to allow the local FS to extend for deployment + 90 days, but that was omitted when AFI 48-170 came out. If extending a 2992 on a member, include a note on block 13 of the DD 2992 that the extension was authorized by the MAJCOM SGP IAW DAFMAN 48-123 para 1.6.10.3.

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. DAFMAN 48-123 5.5.4.2.3. provides the verbiage to use in AIMWTS2 when retiring the waiver. Most MAJCOM SGP's accept an emailed explanation of why the waiver is ready for retirement, 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. The authority will annote the retired portion as *retired* and renew the waiver indefinitely for the other condition.

EXCEPTIONS TO POLICY

There was some debate over including this section, since it's a means to circumvent a medical disqualification. 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. The majority of ETP requests are for UPT, and AFI 36-2105 discusses them briefly in chapter 5 and medical based ETPs in Table 5.2. The final approval authority for medical ETPs is the AF/CV (AFI 36-2105 2.1.) Though the AFI isn't specific, AFMRA clarified that the package can be turned off by any of the CCs in the chain.

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 (assuming each of them concur).
2. With MAJCOM/CC concurrence, 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 final approval.
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 in AIMWTS without also forwarding the PEPP exam. Remember – AETC and AFRS 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.)
- Omitting clearance statements on SWA and MOD exams.

Commonly missed items on the physical exams:

- Not including all required ARMA/AR-MOD/AR-Etc for members who need more than one.
- Not indicating if the AR- is SAT or UNSAT. (i.e. "*AR-MOD SAT*")
- Static Line and SWA applicants require both uncorrected and corrected DVA
- Make specific statements on TM mobility with valsalva on the DD FORM 2808, such as: *"TMs mobile with valsalva bilaterally"*
- Occult blood (stool) exam: Must be listed on 2808, Block 73. USMEPCOM Regulation 40-1, for applicants over 40 years old (USMEPCOM Form 40-1-9). If applicant is over 50 years old, a DRE with FOBT is also required
- Prostate exam: Must be listed on 2808, Block 73. USMEPCOM Regulation 40-1, for applicants over 40 years old (USMEPCOM Form 40-1-9)
- Digital rectal exam: Must be listed on 2808, Block 73. USMEPCOM Regulation 40-1, for applicants over 40 years old. If applicant is over 50 years old, a DRE with FOBT is also required (USMEPCOM Form 40-1-9)
- Static line, MOD, and SWA must include in Block 73, "*Note: Applicant possesses no fear of heights, depths, dark, or confined spaces*"

Still more "Gotchas"

- DIVERS:
    - MANMED 15-102; All diver candidates must be immunized against both Hepatitis A and B. Diver candidates must have two doses of Hepatitis A immunization and at least the first two out of three doses of Hepatitis B immunization prior to the start of diver training. Documentation of immunization record or positive titers will suffice
    - BUMEDINST 6200.15A: female divers must be counseled on the potential hazards to the fetus inherent in diving. This counseling must be documented on the DD Form 2808, block 73.
    - Divers require complete intact neurological examination consisting of: Cranial Nerves II-XII grossly intact bilaterally; Strength 5/5 throughout; Sensation intact to light touch throughout; Cerebellar intact (RAM, FTN, HTS); Mental Status NML, A&Ox4, serial 7s intact from 100; Romberg Negative; Gait NML; Reflexes 2+ symmetric.
- SPECIAL WARFARE AIRMEN:
    - SWA applicants require both the 'no fear' statement above and a signed statement from the applicant IAW Department of the Army Pamphlet 40–502: (13) SERE statement, *"I have no fear of heights, depths, dark, or confined spaces"*
    - SWA applicants must have, "*Note: Applicant possesses the ability to hold breath for 60 seconds subsequent to deep breathing,*" in Block 73
    - SWA applicants must have, *"*(is) qualified for Special Warfare Duties/Airborne/MFF/ Combat Dive**,*" listed in block 78

Medical exam validations are in DAFMAN 48-123 para 1.6 and the PEM. As a general rule exams are good for 24 months unless otherwise stated. But there are a number of exceptions due to date changes, and validity date (date of training, date of commissioning, date of graduation, etc). I recommend reviewing the specific exam in question in paragraph 1.6.

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. The MAJCOM SGP office also reviews MICT and offers suggestions for improvement plans and spot checks "green" items.

But wait…if the MAJCOM SGP office doesn't have direct authority, why bother listening to their inputs? 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 MAJCOM office is saying that justification for a "green" isn't sufficient, or that the "get well plan" is flawed, expect that eventually the local Wing CC will hear 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.* They focus on 'green' items to ensure they are, in fact, green. When completing the MICT checklist, anticipate questions and include information so the reviewer knows it wasn't merely pencil whipped. It's a little work up front, but quarterly updates are simplified and it saves time 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 in your MICT plan 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 AFMAN 48-149

1. Is the SGP appointed in writing? 2.8. (which refers to AFI 48-101, 1.4.13.3.)
2. Are patients empaneled appropriately? 3.2.1.
3. Is all medical care provided outside of the MTF reviewed in a timely manner? 3.3.1.1.
4. Do all notes contain an aeromedical disposition?
5. Has the Lead CMA received the one time USAFSAM training? (6 months) 5.2.3.
6. Are the METALS completed appropriately? (50% time) 3.3.2.5.
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? 4.4.1.13.
8. Are SME's credentialed within the MTF? 4.4.1.14.
9. Does the FOMWG meet weekly? 3.3.3.1.
10. How/when is AIMWTS reviewed? (Minimum monthly, usually at the FOMWG) 3.3.3.2.

HINT: *While the above yes/no checklists are handy, there is a sample summary program evaluation in the appendix that uses open ended questions to assess the AOME. Open ended questions prevent pencil whipping and force you to understand the essential program relationships.*

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.

These operational shop requirements are defined in AFMAN 48-149 3.3.2.2. & 3.3.2.6. and include:

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

***NOTE**: What about logging flight hours for flight surgeons if they can't fly in local aircraft? For example, B-2s and B-1s don't have seats available for a flight surgeon.*

- *Flight surgeons can log (some) hours in a simulator.*
- *AFMAN 11-202 vol 1, 3.10, states, "3.10.3. Certified flight simulator. Flight surgeons may log no more than 50% of their minimum flight hour requirement in a certified flight simulator, provided that the flight simulator simulates an aircraft that cannot accommodate a flight surgeon as onboard aircrew."*
- *AFMAN 11-402 para 3.9.3.4. <u>used to</u> disallow flight surgeons from logging simulator time, but that was changed in the 27 May 21 AFGM release. Now it specifically includes flight surgeons as eligible to log simulator time IAW the above 11-202 restrictions.*

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 (AFMAN 48-149 3.3.2.5.). 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. Flight surgeons need to balance that non-clinical workload with their clinical duties, and the 50:50 split is a good starting place. *Ultimately, it's more important to have a balance between METALS and clinical duties than it is to have a specific ratio.*

MAKING DMRSI WORK FOR YOU

DMRSi data is used to determine the full time equivalent (FTE) hours that individuals spend, which in turn drives manpower decisions. Correctly logging DMRSi is especially important in FOMC since it directly relates to the 50:50 clinical to operational split. Some people make the mistake of logging "Crazy 8s", meaning that they simply mark every day as 8 hours on Code XXXX. This sends DHA a message that people aren't overworked, and there is no need to adjust manpower (ie: Provide relief to overworked medics).

Your local SGA can provide you with a copy of the full DMRSi spreadsheet, and there should be a copy kept on the RAMpage on the Kx as well. The DMRSi codes have descriptions, but the descriptions are sometimes lacking. For example, "BJAA", which is used for clinical activity in Flight Med, PRAP, and BOMC, is described simply as "Credentialed Provider."

The AFMOA FY 18 METALS guidance (the most recent one), posted on the Kx, provides more insight into the types of duties associated with the various DMRSi codes. For example, it clarifies that "BJAA" 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. That's important to know, since the USAF considers time flight surgeons spend on many non-patient contact 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. Some GPM's 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, DMRSi 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 PRAP clinic is designated as BJAC, to designate is as a flight med ambulatory care program, but as a separate team.*

This table is a summary of the more common codes used in FOMC, along with the official description from the DMRSi reference, and a quick reference compiled from the AFMOA guide.

Code	Activity	Official Description	Quick reference
BJAA	Flight Medicine (Includes PRAP and BOMC Encounters)	Credentialed Provider	Any clinically related care, including waiver writing, or profile review. Does not include occ health exams, which are FBEA, or MEB related items which are FEDC
EBAA	Medical Group (MDG) Command Section	MDG/CC, MDG/CV, MDG/CCC, immediate secretarial/admin staff; Used by ALL staff attending an official MDG function - MDG/CC Call, MDG/CCC Call, MDG/CC Change of Command, etc.) *Not used for First Sergeant (see EBCB)	Used when attending an official MDG function
EBCC	Committees and Meetings	Includes committees authorized by AFI or MTF regulations; e.g. Exec Comm, ECOMS, CCM, DQ, EOC, Pop Health, MRC, E&T, AMDS Council, Nursing Practice, Dental Exec… List is not all inclusive. (Use applicable section code to document Staff/Flight meetings.)	Committees authorized by AFI or MTF regulations, such as AMC, DAWG, FOMWG, etc. OEHWG falls under FBEA
EBCF	Operational Medicine Readiness Squadron (OMRS) Command Section	OMRS/CC, SEM, immediate admin staff. Used by ALL staff attending official OMRS functions: Commander's Call, Change of Command, etc..	Used when attending an official OMRS function, such as a Sq Commander's Call

EBCL	MTF Supervisory Tasks, Appraisals, Awards, Details	Writing Decorations and Awards, EPRs/OPRs, Civ Appraisals, Personnel Counseling, etc.. MTF directed details - MOD, NCOD, Cash Count, Drug Inspection, Provider Reception…. (Do NOT use for Drug Demand Reduction (DDR) detail; for DDR Detail use FCGA)	Used when writing OPR/EPRs, or other award packages
EBDA	Clinic Management	Includes SGA, SGN, Group Practice Manager (GPM), and the Health Care Integrator (HCI) - (GPM and HCI use the clinic/section they support to report available time). Responsible for planning, directing, and coordinating direct patient care for multiple clinical work centers. Establishment of discrete special work centers will vary depending on the scope, size, and complexity of the MTF mission, but a Clinical Management Department Head will have oversight of several clinical work centers and report directly to a Deputy Commander or MTF Commander/Commanding Officer. Will be used to document Peer Reviews.	Used for peer reviews
EBFA	Education and Training	Conducts and supports authorized in-house, organized training and education programs (other than GME or GDE) assigned to the MTF.	Used for in-house organized education and training programs
FALA	Continuing Education and Other Non-Readiness Training	Includes all continuing health education programs, regardless of location or source of instruction (e.g. CPR/ACLS, SAPR, Wing Safety Day...) Does NOT include Readiness Training or PME (use GBAA) or travel to/from training (use FDGA)	All CME programs, regardless of location and source of instruction. (Wing Safety day, CPR, etc.

FBBA	Public Health	Assesses and reduces incidence of diseases and their effects on BASOPS and on neighboring communities; evaluates and maintains the occupational health of military and civilian personnel; protects the health of personnel by preventing food-borne procurement activities; and supports preventive medicine and occupational health programs and maintains liaison with other agencies and communities. Includes Hearing Conservation.	PH shop visits. Use GGA8 for pandemic response not otherwise captured.
FBEA	Bioenvironmental Engineering	Medical service surveillance over human beings and their living and working environments, to ensure that potential hazards to individual and community health are identified, evaluated, eliminated, or controlled.	Occ health exams, OEHWG, and investigation of specific shop concerns. Use FCGA for shop visits themselves.
FCGA	Support to Non-MEPRS Reporting Activities	Support to Non-MEPRS Reporting Activities includes the time and expenses incurred by a fixed MTF, when performing medical or non-medical related services for, or loaning personnel to, non-MEPRS reporting activities. This includes time and expenses incurred in support of headquarters, regional, and base activities.	Aircrew training (LS, survival, etc), Line consultation (safety briefs, PEX, etc), Expert opinion (legal, PA, etc), Squadron and shop visits.

FEDC	MEB	Includes the labor-hours expended to complete the MEB Narrative Summary and all related documentation and coordination required to complete an assessment of the Service member's condition, fitness for duty, and ancillary services ordered specifically for the completion of the MEB Narrative Summary. Physicians should document labor hours in FEDC when reviewing the Narrative Summary (NARSUM) for a Physical Evaluation Board and Review-in-lieu-of (RILO) Medical Boards.	NARSUM review and MEB duties
GAAA	Personnel Reliability Assurance Program (PRAP) Admin Qualifications and Deployment Planning and Administration (Includes PHA Providers)	PRAP related administrative work, certifications, qualifications, etc.. The administrative work includes multi-disciplinary (Dental, Mental Health, Immunizations, Public Health, etc.) administrative evaluations. AND Planning and administration of individual or unit deployment requirements (including deployment lines), such as security clearances, immunizations, preparation of orders, equipment issue, and port calls. Time spent by PCM Providers performing PHA records review (patient not present) will use GAAA to document labor hours for conducting PHA record reviews when the patient is not present.	PRAP admin work, such as PHA reviews or certification reviews

GBAA	Readiness Peacetime/Wartime/Disaster Preparedness Training	Time and expenses incurred by the fixed MTFs while participating in exercises that practice or rehearse peacetime readiness or disaster training and operations. Includes Recalls, Attack Response, MCCP, Alt Facility, DCCP, MCRP, Major Accident Response, Natural Disaster Exercise, Mobility Exercises, ORIs, UEI, MAJCOM Exercises, Flying w/Crew, CSP, CMRT, NBC Med Defense, Chem Warfare, RSV/Corps Training, Formal Readiness Courses, AF Staff College Skills Training, Professional Military Education (e.g. ALS, COT/BOT, NCO/SNCO/SNCO Academy; excludes travel – PME travel = FDGA), and promotion (WAPS) testing.	Flying, PME time, formal exercise for disaster or readiness
GFAA	Physical Training	Active duty time spent in organized/directed fitness. Voluntary fitness time (outside of unit organized sessions) is NOT REPORTED. Includes the regulated testing and evaluation of unit or individual physical fitness, to include participant time and the time spent in organizing and supervising such testing. Note that GS Civilians report fitness time taken during duty hours as non-available time (02.01)	PT performed during duty hours. Does not include after-hours fitness training.
GGA8	Pandemic Virus	Time and expenses related to a pandemic virus (e.g. COVID-19), but not otherwise specified elsewhere.	Pandemic virus response not specified elsewhere

FOMC EMPANELMENTS AND WAIVERS

AFMAN 48-149 3.2.1.1. directs FOMC to empanel personnel with an DD 2992 as well as non-FLY personnel who fall under SOD categories. Whereas in the past, a MAJCOM/SGP waiver was required to empanel others, that has now been delegated to an MTF/CC waiver.

Some MTF's push to maximally enroll non-fliers to reduce WOMC empanelments, or argue that occupational exams (e.g. firefighter) are too complicated for WOMC. But firefighters get occ exams from BOMC, and changing enrollment to reduce empanelment in WOMC is not critical to successful completion of the local aeromedical or installation mission. (AFMAN 48-149 3.2.1.5.)

That said, per DHA PI 6025.11 16.b(5), operational clinics are defined as those using BJA* or BKA* MEPRS codes. And operational clinics are empaneled at 550:1 (7.c). So most FOMCs will take on non-FLY patients to hit the 550 target. 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).

At a non-PRAP base, chances are SFS is empaneled to WOMC. But as PRAP personnel, they earn a 550:1 provider to oversee AUoF per DHA. Unfortunately, no extra staff was programmed into WOMC to cover this ratio by the AF CONPLAN. Consider taking SFS into flight med to maintain the 550:1 ratio and provide AUoF oversight. Another option is to enroll the entire OG into FOMC to maintain squadron unity. That's a very simple way to bring AFE, SERE, weather, and other FLY-related Airmen into flight med.

Ultimately, enrollment of non-fliers is a discussion between the MTF/CC and the MTF/SGP (AFMAN 48-149 3.2.1.5.), but its good practice to discuss any proposals with the MAJCOM/SGP for a sanity check before that meeting.

FLIGHT MED EXTENDERS (AEROSPACE NP AND PA)

In 2020, the AF provided guidance for NPs and PAs to attend the AFOM and become certified to provide aeromedical determinations on some patients.

Why only some patients?

This gets to a matter of US and international aviation law. Both federal and international aviation agencies require a physician to conduct 'flight duty exams' for anyone who plays a role in control or navigation of the aircraft, including radio officers (laws were written in the 1960's).

'Flight duty exams' are analogous to FAA flight physicals or returning to flying following special issuances, so in our parlance, these would be FLY PHAs and return-from-waiver UPs. In such cases, a physician flight surgeon is required to *perform*, not merely co-sign, PHAs for those AFSCs listed in Tab W of the MSD, and a flight surgeon must also sign the UP following an approved waiver.

Flight surgeons (48xx) are included in Tab W since we often perform tasks such as running radios, assisting with nav, or other activities related to aircraft control.

So what can an APA or ANP do?

An APA or ANP may perform PHAs for AFSCs not listed in Tab W, they may assist in drafting waivers for any AFSC, and may sign as the author of a waiver (physician must still sign as senior reviewer). In addition, since the FAA doesn't require aviators to see a flight surgeon (FAA AME) for routine medical care, APAs and ANPs may also see fliers of all AFSCs for routine medical care, including making them UP or DOWN. If a flier from Tab W has a waiver, an APA or ANP may still see them and provide an "UP" for conditions not related to the diagnosis of their waiver, or a "DOWN" for the waiver condition. However, a physician would need to see the patient to provide an "UP" for conditions related to their waiver diagnosis, including RTFS following waiver approval.

This also applies at the MAJCOM level, where the Tab W AFSC's require the waiver approval authority to be a physician. For example, if the MAJCOM SGPA is not a physician, they could review the waiver request, but the MAJCOM SGP (physician) would need to sign the approval.

FOMC METRICS: PITFALLS AND POLICIES

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 bases sometimes find having 24HR in the morning gives a sick-call-ish schedule and loading mostly FTR in the afternoon provides predictability in the latter half of the schedule.

Remember you can book a patient into an afternoon 24HR slot and still see them in the morning during a 'sick call' time. 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 day-to-day, 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 manage occasional surges.

PITFALL: SME'S DISENGAGE FROM THE CLINIC

How it happens: It's easy to lose visibility on where SMEs. 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 AFMAN 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.

4.4.1.13. SME personnel must be fully integrated with the MTF (RMU/GMU) and work under clinical supervision of the SGP. (T-2). SGPs should coordinate with line commanders to ensure that sufficient time is spent covering MTF responsibilities which include clinical workload (initial flying class exams, waivers, initial review in lieu of (IRILO), MEBs, PHAs, etc.), METALS, and squadron operational support activities. Note: MAJCOM SGPs can intervene and modify time requirements for specific subsets to meet operational needs.

4.4.1.14. 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, each with appointments at 0800 and 0830 (counted as two open appointments, not four), schedule their appointments at 0800, 0815, 0830, and 0845 to let the algorithm count all four appointments on the calendar.

PITFALL: PRAP APPOINTMENTS ARE DESIGNATED AS 20 MINUTES, BUT THAT'S NOT ENOUGH 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.

PITFALL: SMES (OR PRAP PROVIDERS) RUNNING UNUATHORIZED CLINICS IN THE LINE SQUADRONS

How it happens: SMEs and PRAP providers lobby for an office at the squadron for METALS, but then they start providing care out of that office. These are popular with the line, so the office becomes a de facto clinic - in conflict with Joint Commission standards.

Impact: If the ancillary clinics do not meet Joint Commission standards, the MDG can lose its certification, effectively shutting down ALL care on base.

Fix: The in-house clinics are very popular with the line, so it's a question of getting to "Yes if…"

The Joint Commission has standards for business occupancy for extension of care (a clinic using space in a non-clinical building). The standards are much lower than they would be for a clinic in the MTF, but they still must be met if care is provided. Most of them are straightforward: tiled floors, infection control procedures, a handwashing sink in the room, etc. The MTF Facility Manager can provide the complete list and the Line CC can decide if any necessary modifications are reasonable.

But remember that medical care given outside of the MTF must still meet standards of care, so vitals, questionnaires, etc, must still be completed.

The consequence of not doing the above is a significant citation from Joint Commission, and if they find that the violation was a willful violation, they can deny certification to the MTF itself, shutting down all medical care provided on base. *(And since you've now read this section, you know the rules, and a future violation would therefore be willful. Just sayin')*

THE FLIGHT SURGEON EXAM – WHERE IS IT?

Flight surgeons can self-enroll via this link:

https://aetc.geniussis.com/Registration.aspx?aid=29

They can also register via USAFSAM under the tab labeled "Catalog" and using the radio dial labeled, "Flight Surgeon Qualification Exam."

https://aetc.geniussis.com/PublicWelcome.as

Once enrolled, students can access the "FS Toolkit & References" via the 2nd tab below the Exam tab on the left of the screen. In addition to useful AFOM information, it also contains information useful in the exam itself.

GO AND NO GO PILLS

Fatigue countermeasures are discussed in AFI 11-202 V3 (and MAJCOM supplements) as well as AFMAN 48-149 6.2. 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

MANAGEMENT OF LEFTOVER GO PILLS

BLUF: A flight surgeon cannot legally collect leftover Go-pills and dispose of them on behalf of the ultimate users (fliers). However, the users themselves could return the pills to a DEA registrant, whether that be the MTF pharmacy (if they are a registered site) or a drop box at some other location. A flight surgeon is allowed to waste (dispose) of their excess inventory via several methods IAW 21 CFR 1317 subpart C.

The governing AFI is fairly straightforward, merely noting that the MTF will abide by current DEA regulations. Things get complicated from there.

> AFI 44-102 8.11.4. *MTF pharmacies will comply with current DEA regulations regarding acceptance of previously dispensed controlled substances back into the pharmacy. Deployed pharmacy locations are authorized to accept controlled substances back for destruction if mission needs dictate. Appropriate documentation of acceptance and disposition will be maintained. (T-0, 21 U.S.C. Chapter 13)*

There are two main areas that need to be considered: disposal of meds that have been dispensed to an ultimate user, and the wasting of inventory meds by a medical provider.

DISPOSAL OF MEDS THAT HAVE BEEN DISPENSED

The part of the CFR that deals specifically with disposal is primarily in the CFR 21, Ch 2, part 1317 under "disposal"

eCFR :: 21 CFR Part 1317 -- Disposal

The DEA registrant (ie: MTF pharmacy) may request to be authorized to accept medications for disposal per § 1317.40. subpart A

(a) Manufacturers, distributors, reverse distributors, narcotic treatment programs, hospitals/clinics with an on-site pharmacy, and retail pharmacies that desire to be collectors shall modify their registration to obtain authorization to be a collector in accordance with § 1301.51 of this chapter. Authorization to be a collector is subject to renewal. If a registrant that is authorized to collect ceases activities as a collector, such registrant shall notify the Administration in accordance with § 1301.52(f) of this chapter.

The registrant must maintain a copy of the destruction on a DEA Form 41 per 21 CFR § 1304.21(e)

(e) Record of destruction. In addition to any other recordkeeping requirements, any registered person that destroys a controlled substance pursuant to § 1317.95(d), or causes the destruction of a controlled substance pursuant to § 1317.95(c), shall maintain a record of destruction on a DEA Form 41. The records shall be complete and accurate, and include the name and signature of the two employees who witnessed the destruction. Except, destruction of a controlled substance dispensed by a practitioner for immediate administration at the practitioner's registered location, when the substance is not fully exhausted (e.g., some of the substance remains in a vial, tube, or syringe after administration but cannot or may not be further utilized), shall be properly recorded in accordance with § 1304.22(c), and such record need not be maintained on a DEA Form 41.

A non-registrant (subpart B) may also dispose of controlled substances from ultimate users and other non-registrants per §1317.30, but non-registrants are pretty much limited to the ultimate user, the user's heir, and LEOs.

WASTING OF EXCESS INVENTORY

But what about the practitioner who has extra medication that they want to waste (destroy)?

The DEA put out a letter in 17 Oct 2014 that clarified directions for institutions who needed to waste inventory that was intended for immediate administration (ie: a syringe). But it also emphasizes that practitioners shall continue to record the destruction of pharmaceutical wastage IAW 21 CFR § 1304.22 (c). That paragraph discusses record keeping for individuals "authorized to dispense", which the CFR specifically defines as including practitioners. More importantly, the letter refers the practitioner to the Part 1317 of the CFR to discuss disposal of practitioner waste.

IAW 21 CFR § 1317.05 (a) answers practitioner waste of inventory.

There are several options, including on-site destruction IAW subpart C of the manual (see below), delivery to a reverse distributor's registered location, or to contact the local DEA special agent in charge of administration in the area via a Form 41.

The DEA agent may authorize transfer to a registrant (ie: pharmacy) authorized to receive substances for transport / disposal, delivery to a DEA agent / office, or destruction in the presence of an agent or other authorized person. If these requests are regular, the agent may authorize the practitioner to dispose of controlled substances without prior application. On site destruction would seem to be the most logical and simplest approach.

On-site destruction, per Title 21, chapter II § 1317 subpart C

> § 1317.95
>
> (d) On-site destruction. If the controlled substances are destroyed at a registrant's registered location utilizing an on-site method of destruction, the following procedures shall be followed:
>
> (1) Two employees of the registrant shall handle or observe the handling of any controlled substance until the substance is rendered non-retrievable; and
>
> (2) Two employees of the registrant shall personally witness the destruction of the controlled substance until it is rendered non-retrievable.

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 DAFMAN 48-123 para 5.7 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. Patients and CCs prefer to keep things simple and attend 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.

THE "OF 178 TRAP" FOR PRE-EMPLOYMENT EXAMS

A common request to BOMC is to provide pre-employment occupational examinations. Along with the examination is a form, the OF 178. It is an obsolete form, but it's still in common use, as there isn't a true replacement to it. It starts out as a helpful form with a listing of job requirements (sees color, has use of fingers, etc) and a physical examination checklist. However, Part D then asks the provider to recommend to 'hire' or 'not hire'. ***It is illegal for us to state that someone should not be hired based on a medical condition.***

The way to address this is to complete the form, "Memorandum in Lieu of OF 178" which does not require you to break the law. The memorandum allows the provider to list restrictions for the hiring authority to consider, rather than making an illegal recommendation to not hire based on medical issues.

For example, there may be an applicant for a flightline driving position that requires 20/20 vision, but the applicant can only be corrected to 20/40. You would complete the memorandum and say, "Qualified with the following restrictions: Applicant does not meet the requirement for 20/20 vision" and the hiring authority would decide if they can reasonably accommodate the individual, perhaps in an administrative role.
Or, there may be an applicant to the CDC who needs to routinely lift 40 pounds, but they have medical issues that prevent them from doing so. Rather than breaking the law by saying, "do not hire" in Part D, you would indicate on the memorandum that they are "Qualified with the following restrictions: unable to routinely lift 40 pounds." The hiring authority will decide if they can reasonably accommodate them, perhaps in a room with smaller children.

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 worker termination exams in the USAF.

There are a number of not-quite-so-obvious laser shops throughout the base. The SFS armory may have an armorer who adjusts laser sights. 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.*

RESPIRATORY PROTECTION

There tends to be some confusion over what is required by OSHA and what is encouraged. The following regulations explain that while certifications are required, they can generally be met via standard Air Force training programs and appointments.

AFI48-137 2.19.3 states that the Unit Commander "*Designates a unit Respiratory Protection Program administrator, typically the worksite supervisor, who is qualified by appropriate training or experience that is commensurate with the program IAW 29 CFR 1910.134(c)(3). (T-0) The administrator must have attended a respiratory protection training course (e.g., OSHA Training Institute or equivalent) or be certified by the BE Flight Commander (or equivalent) as technically proficient to administer the program. (T-3)"*

AFI48-137 2.7.3. states that the Installation Commander or Equivalent *"Designates an installation Respiratory Protection Program administrator who is qualified by appropriate training or experience commensurate with the complexity of the program to administer or oversee the respiratory protection program and conduct the required evaluations of program effectiveness IAW 29 CFR 1910.134(c). (T-0) The administrator must be a fully qualified Bioenvironmental Engineer or Bioenvironmental Engineering Technician,) or a civilian Industrial Hygienist. (T-3)*"

AFI48-137 2.14 states that Bioenvironmental Engineering (BE) "*2.14.1. Serves as the installation Respiratory Protection Program administrator and executes all aspects of an installation level program IAW 29 CFR 1910.134 and this instruction unless otherwise specified. (T-1)*"

CFR 1910.134(c) states …*"The program must be administered by a suitably trained program administrator.* " and 1910.134(c)(3) states, "*The employer shall designate a program administrator who is qualified by appropriate training or experience that is commensurate with the complexity of the program to administer or oversee the respiratory protection program and conduct the required evaluations of program effectiveness*."

Lastly, the BEEs have a Bioenvironmental Engineering Program Management Guide, which discusses training in Section 3.4:

> *"The designated IRPPA must have the appropriate level of training or experience necessary to oversee an RPP that can be complex in nature.19 A BE officer (BEO) or BE technician with the correct level of training or experience can fulfill the responsibilities of the IRPPA. An industrial Hygienist also meets the requirements to fulfill the responsibilities of the IRPPA. OSHA only requires the program administrator have an adequate level of training or experience to deal with the complexity of the RPP at the worksite.20 This translates into being trained and having practice with various aspects of the RPP. For example, the designated administrator can identify, analyze, and control respiratory hazards in multiple workplaces based on learned techniques. BEOs and BE technicians receive RP training through their initial technical training courses. However, it is a best practice that BEO's and BE technicians continue to seek ways to keep their knowledge and experience current. Enrolling into courses/webinars offered by AIHA, training sessions offered during Occupational Safety and Health symposiums, or OSHA certified training course(s) will enable BEOs and BE technicians' ability to lead the RP program."*

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.

But what about other, more mundane occupational events?

> Per OSHA standard 1905.5(a), "You must consider an injury or illness to be work-related if an event or exposure in the work environment either caused or contributed to the resulting condition or significantly aggravated a pre-existing injury or illness."

That sounds like we have to report everything!

Not necessarily. Para 1904.5(b)(2) lists conditions that are not considered work related, even if they occur in the work environment:

- At the time of the injury or illness, the employee was present in the work environment as a member of the general public rather than as an employee.
- The injury or illness involves signs or symptoms that surface at work but result solely from a non-work-related event or exposure that occurs outside the work environment.
- The injury or illness results solely from voluntary participation in a wellness program or in a medical, fitness, or recreational activity such as blood donation, physical examination, flu shot, exercise class, racquetball, or baseball.
- The injury or illness is solely the result of an employee eating, drinking, or preparing food or drink for personal consumption (whether bought on the employer's premises or brought in). For example, if the employee is injured by choking on a sandwich while in the employer's establishment, the case would not be considered work-related.
  Note: If the employee is made ill by ingesting food contaminated by workplace contaminants (such as lead), or gets food poisoning from food supplied by the employer, the case would be considered work-related.
- The injury or illness is solely the result of an employee doing personal tasks (unrelated to their employment) at the establishment outside of the employee's assigned working hours.
- The injury or illness is solely the result of personal grooming, self-medication for a non-work-related condition, or is intentionally self-inflicted.
- The injury or illness is caused by a motor vehicle accident and occurs on a company parking lot or company access road while the employee is commuting to or from work.
- The illness is the common cold or flu (Note: contagious diseases such as tuberculosis, brucellosis, hepatitis A, or plague are considered work-related if the employee is infected at work).
- The illness is a mental illness. Mental illness will not be considered work-related unless the employee voluntarily provides the employer with an opinion from a physician or other licensed health care professional with appropriate training and experience (psychiatrist, psychologist, psychiatric nurse practitioner, etc.) stating that the employee has a mental illness that is work-related.

If the event is work related, does that make it OSHA reportable?

Maybe. OSHA standard 1904.7 states, "You must consider an injury or illness to meet the general recording criteria, and therefore to be recordable, if it results in any of the following: death, days away from work, restricted work or transfer to another job, medical treatment beyond first aid, or loss of consciousness. You must also consider a case to meet the general recording criteria if it involves a significant injury or illness diagnosed by a physician or other licensed health care professional, even if it does not result in death, days away from work, restricted work or job transfer, medical treatment beyond first aid, or loss of consciousness."

That's pretty vague…what does "days away from work" mean?

Per 1904.7(b)(3), if an injury or illness involves one or more days away from work, its OSHA reportable. That counts calendar days, starting with the day after the event. There are more details, covering weekends, holidays, and other specifics in the subsequent sub bullets at this link.

(https://www.osha.gov/laws-regs/regulations/standardnumber/1904/1904.7)

Would this mean a 'light duty' profile is reportable if there are no specific limitations?

That's addressed in 1904.7(b)(vii), "If you are not clear about the physician or other licensed health care professional's recommendation, you may ask that person whether the employee can do all of his or her routine job functions and work all of his or her normally assigned work shift. If the answer to both of these questions is "Yes," then the case does not involve a work restriction and does not have to be recorded as such. If the answer to one or both of these questions is "No," the case involves restricted work and must be recorded as a restricted work case. If you are unable to obtain this additional information from the physician or other licensed health care professional who recommended the restriction, record the injury or illness as a case involving restricted work."

Wouldn't it automatically be considered "medical treatment beyond first aid" if they see a medical provider?

Not always. For purposes of this reporting, medical treatment does NOT include visits solely for observation or counseling, or diagnostic procedures (including x-rays, blood tests, or eye dilation).

So what is, "treatment beyond first aid"? What does OSHA consider first aid?

For purposes of this rule, first aid is defined in 1904.7(b)(ii)(A-N):

- Using a non-prescription medication at nonprescription strength (for medications available in both prescription and non-prescription form, a recommendation by a physician or other licensed health care professional to use a non-prescription medication at prescription strength is considered medical treatment for recordkeeping purposes);
- Administering tetanus immunizations (other immunizations, such as Hepatitis B vaccine or rabies vaccine, are considered medical treatment);
- Cleaning, flushing or soaking wounds on the surface of the skin;
- Using wound coverings such as bandages, Band-Aids™, gauze pads, etc.; or using butterfly bandages or Steri-Strips™ (other wound closing devices such as sutures, staples, etc., are considered medical treatment);
- Using hot or cold therapy;
- Using any non-rigid means of support, such as elastic bandages, wraps, non-rigid back belts, etc. (devices with rigid stays or other systems designed to immobilize parts of the body are considered medical treatment for recordkeeping purposes);
- Using temporary immobilization devices while transporting an accident victim (e.g., splints, slings, neck collars, back boards, etc.).
- Drilling of a fingernail or toenail to relieve pressure, or draining fluid from a blister;
- Using eye patches;
- Removing foreign bodies from the eye using only irrigation or a cotton swab;
- Removing splinters or foreign material from areas other than the eye by irrigation, tweezers, cotton swabs or other simple means;
- Using finger guards;
- Using massages (physical therapy or chiropractic treatment are considered medical treatment for recordkeeping purposes); or
- Drinking fluids for relief of heat stress.

There are many other questions and answers covered in the OSHA website at

https://www.osha.gov/laws-regs/regulations/standardnumber/1904/1904.5

and

https://www.osha.gov/laws-regs/regulations/standardnumber/1904/1904.7

There will be some times when the determination of illness or injury isn't clear cut. In such cases, look to see if the disease developed suddenly (injury) or over time (illness).

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 there is a good indexed one at:* http://www.cdc.gov/niosh/docs/1970/79-116.html

HEARING CONSERVATION PROGRAM (HCP)

Let's use as an example the most common occupational illness: hearing loss. 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.

The OEHWG determines, based on the COHER, who needs to be enrolled. 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 BEEs 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.

Fortunately, by the time a case 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'*.

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 and OSHA.

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*:** When patients have an audiogram, review it with them! It's amazing how many never had a provider explain what the numbers mean.

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

Excellent information is also available 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 consider 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.*

WORKPLACE ACCOMODATIONS FOR MEDICAL CONDITIONS

AFI 36-2706 chapter 6.5 provides the process for an employee to request workplace accommodations for medical conditions and 6.5.6. directs, "[the employee] must inform the employer that an accommodation is needed." This is the key to beginning the process, and medical documentation to support accommodation is not pushed from the medics, but is requested by the worksite, *if, and only if,* the employer requires medical documentation to determine if the worker requesting accommodation has a disability. However, para 6.5.6. also states, "… If the individual with a disability states that he or she does not need a reasonable accommodation, the employer will have fulfilled its obligation."

In other words, if a worker doesn't request accommodation, there is no justification to provide medical documentation to the worksite, and it would be an unauthorized release. If a worker requests accommodation, medical documentation would only be provided at the employer's request.

If the employer has question over a worker's ability to execute their duty, or if the member feels they aren't being adequately accommodated, there are prescribed roles for medics to become involved on a case-by-case basis as defined in AFMAN 48-146 para 7.4.2.3.1 via an AF 1754. 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. Civilians may need to 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 included with other existing deliveries?

If the member is active duty, then restrictions or accommodations are listed on an AF 422, and they may require an IRILO if their medical condition prevents them from fulfilling their primary purpose of employment. If the member is civilian, expect e 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 this approach works well:

- ✓ 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. DoDi 1010.16, 15 Jun 2020, notes on page 7, para 2.4.f(3), that absent a specified time period when prescribed, Schedule II-V substances will be considered expired 6 months after the most recent fill date. If the member has a script over 6 months old, it is considered invalid for DDR purposes. Document the old script and note that it is invalid per the above reference, to save yourself from the inevitable OSI call after they interview the member.

- ✓ 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

PHEO DUTIES AND RESPONSIBILITIES

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), or at least four years experience in public health or preventative medicine. If the primary PHEO is a DVM, then the alternate must be a physician. (AFI 10-2519 2.3.6.1.)

So, what does the PHEO do in an emergency? That was once summed up in Table A4.31 of AFI 10-2501 and AFI 10-2519 2.3.7. Although they were rescinded, the information remains valuable, so you can combine the two into a basic checklist:

	Upon initial declaration of a public health emergency by the Commander, the PHEO ensures notification of the MTF/CC, MAJCOM/SGP, and installation Public Health.
	Coordinate with Public Health to ensure information is relayed to the United States Air Force School of Aerospace Medicine (USAFSAM) and the local civilian health department. (USAFSAM will become the clearinghouse of epidemiological information to the MAJCOMs and AFMOA, and will provide information to 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.

PUBLIC HEALTH EMERGENCY DEFINITION AND DETERMINATION

Only the installation commander (Wg CC) can declare an event to be a Public Health Emergency (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.

PHEs 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

In addition to public health emergencies, AFI 10-2519 also addresses "Incidents of Public Health Concern" in para 1.3. These are cases where there is a potential impact to base operations due to a disease, but it doesn't meet criteria for a public health emergency. A case of measles at the CDC or meningitis in the dorm might be 'incidents of public health concern.'

Typically, public health emergencies are either environmental (e.g. flood with displaced personnel) or disease (e.g. novel outbreak). In the first case, conditions often mimic a deployment and military personnel may easily relate to the food, water, hygiene, and disease challenges of the deployed environment. The second, that of an outbreak, is more difficult, as people often create 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.

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.

The importance of risk communication and anticipating questions cannot be overstated. The MDG ProStaff is on the front lines of patient education, so educate the staff on risk communication

points and ensure they pass a consistent 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

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, and they'll likely be running the tactical level responses while the PHEO is engaging with leadership and MAJCOM on a more strategic level. The alt. PHEO is most likely the Public Health Officer, but alternatives include using a senior flight surgeon or the SGH, especially if the PHO is inexperienced.

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*

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: (44 hours)

- *PHEM Sustainment Course* – 24 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.

TIC / TIM AND CONSEQUENCES

Why is this in the section on PHEO and not in the occ health section? Truth is, it could easily be under either (or both). The presence of Toxic Industrial Chemicals and Toxic Industrial Materials near your base provides a vulnerability to either intentional or accidental release. As an SGP, its essential to know what these vulnerabilities are, as well as being able to recognize the toxdromes associated with them.

Rather than try to list all of these right here, check out the American College of Medical Toxicologists, who have a free CME course on chemical and radiologic agents of opportunity. It goes into great depth on potential TIC/TIMs.

ACMT - Chemical and Radiological Agents of Opportunity for Terrorism - San Diego (menlosecurity.com)

PHEO – RISK COMMUNICATION

Whether it's talking to the parents of a child with a positive lead test, or meeting with PA to discuss pandemic response, risk communication is one of the key skills for a PHEO. Being able to communicate effectively with people that may not want to hear what you have to say, while projecting an air of confidence, though not of arrogance, is a difficult skill to master. This section will cover the basics, but it will take practice. Consider meeting with PA or roleplaying a Q&A session with your staff to develop the skills.

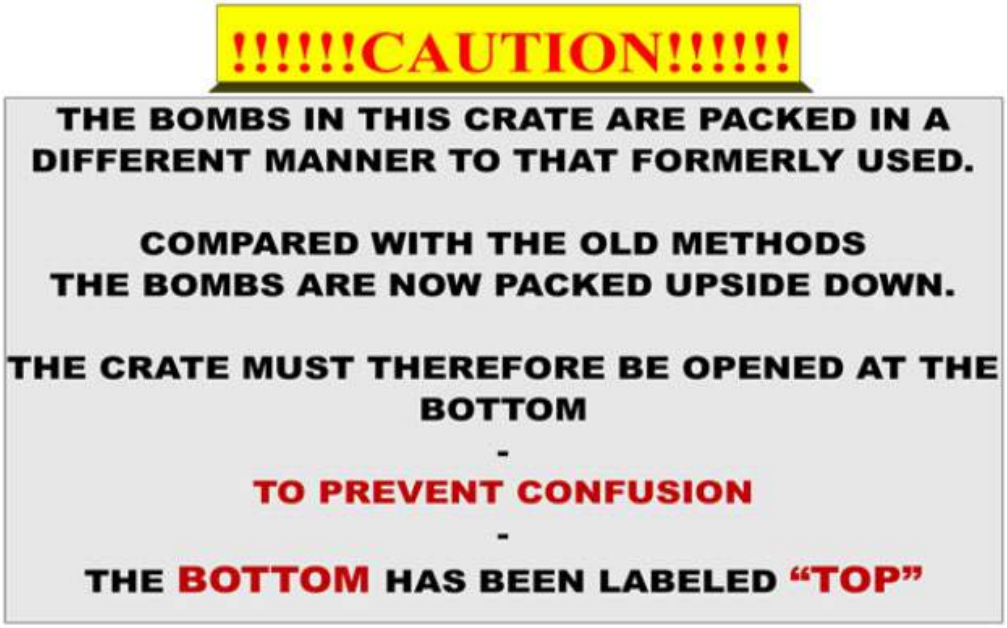
So, what is Risk Communication?

- The exchange of information about the expected type and magnitude of an outcome from a behavior or exposure; it's a two-way dialogue concerning risk or perceived risk.
- *In simpler terms,* it is telling people who don't trust you something that they don't want to know about something that they don't want to believe is happening…And having them pay attention to you.

What isn't Risk Communication?

- An attempt to convince people you've done the "right thing"
- A one-way communication of information
- A one-size-fits-all message

Ultimately, risk communication comes to effectively providing evidence-based information to the public. Sometimes this is done as a precaution and sometimes it's done after-the-fact, but regardless, the goal remains the same: improve audience understanding and action.



(Label from World War II crate of bombs)

THE EPA'S SEVEN CARDINAL RULES OF RISK COMMUNICATION

The EPA has a guide for risk communication with seven cardinal rules. It's pasted below, with the added caveat to coordinate with PA. The guide is available at: https://www.orau.gov/cdcynergy/erc/Content/activeinformation/resources/EPA_Seven_Cardinal_Rules.pdf

(Adapted by Dr. Vincent T. Covello from the 1988 EPA Seven Cardinal Rules of Risk Communication)

Rule 1. Accept and involve the public as a legitimate partner.

Two basic tenets of risk communication in a democracy are generally understood and accepted. First, people and communities have a right to participate in decisions that affect their lives, their property, and the things they value. Second, the goal of risk communication should not be to diffuse public concerns or avoid action. The goal should be to produce an informed public that is involved, interested, reasonable, thoughtful, solution-oriented, and collaborative.

Guidelines: Demonstrate respect for the public by involving the community early, before important decisions are made. Clarify that decisions about risks will be based not only on the magnitude of the risk but on factors of concern to the public. Involve all parties that have an interest or a stake in the particular risk in question. Adhere to highest moral and ethical standards: recognize that people hold you accountable.

Rule 2. Listen to the audience.

People are often more concerned about issues such as trust, credibility, control, benefits, competence, voluntariness, fairness, empathy, caring, courtesy, and compassion than about mortality statistics and the details of quantitative risk assessment. If people feel or perceive that they are not being heard, they cannot be expected to listen. Effective risk communication is a two- way activity.

Guidelines: Do not make assumptions about what people know, think or want done about risks. Take the time to find out what people are thinking: use techniques such as interviews, facilitated discussion groups, advisory groups, toll-free numbers, and surveys. Let all parties that have an interest or a stake in the issue be heard. Identify with your audience and try to put yourself in their place. Recognize people's emotions. Let people know that what they said has been understood, addressing their concerns as well as yours. Recognize the "hidden agendas," symbolic meanings, and broader social, cultural, economic or political considerations that often underlie and complicate the task of risk communication.

Rule 3. Be honest, frank, and open.

Before a risk communication can be accepted, the messenger must be perceived as trustworthy and credible. Therefore, the first goal of risk communication is to establish trust and credibility. Trust and credibility judgments are resistant to change once made. Short-term judgments of trust and credibility are based largely on verbal and nonverbal communications. Long term judgments of trust and credibility are based largely on actions and performance. In communicating risk information, trust and credibility are a spokesperson's most precious assets. Trust and credibility are difficult to obtain. Once lost they are almost impossible to regain.

Guidelines: State credentials; but do not ask or expect to be trusted by the public. If an answer is unknown or uncertain, express willingness to get back to the questioner with answers. Make corrections if errors are made. Disclose risk information as soon as possible (emphasizing appropriate reservations about reliability). Do not minimize or exaggerate the level of risk. Speculate only with great caution. If in doubt, lean toward sharing more information, not less – or people may think something significant is being hidden. Discuss data uncertainties, strengths and weaknesses - including the ones identified by other credible sources. Identify worst-case estimates as such, and cite ranges of risk estimates when appropriate.

Rule 4. Coordinate and collaborate with other credible sources

Allies can be effective in helping communicate risk information. Few things make risk communication more difficult than conflicts or public disagreements with other credible sources.

Guidelines: Take time to coordinate all inter-organizational an intraorganizational communications. Devote effort and resources to the slow hard work of building bridges, partnerships, and alliances with other organizations. Use credible and authoritative intermediaries. Consult with others to determine who is best able to answer questions about risk. Try to issue communications jointly with other trustworthy sources such as credible university scientists, physicians, citizen advisory groups, trusted local officials, and national or local opinion leaders.

Rule 5. Meet the needs of the media.

The media are a prime transmitter of information on risks. They play a critical role in setting agendas and in determining outcomes. The media are generally more interested in politics than in risk; more interested in simplicity than in complexity; and more interested in wrongdoing, blame and danger than in safety.

Guidelines: Be open with and accessible to reporters. Respect their deadlines. Provide information tailored to the needs of each type of media, such as sound bites, graphics and other visual aids for television. Agree with the reporter in advance about the specific topic of the interview; stick to the topic in the interview. Prepare a limited number of positive key messages in advance and repeat the messages several times during the interview. Provide background material on complex risk issues. Do not speculate. Say only those things that you are willing to have repeated: everything you say in an interview is on the record.

Keep interviews short.

Follow up on stories with praise or criticism, as warranted. Try to establish longterm relationships of trust with specific editors and reporters.

Rule 6. Speak clearly and with compassion.

Technical language and jargon are useful as professional shorthand. But they are barriers to successful communication with the public. In low trust, high concern situations, empathy and caring often carry more weight than numbers and technical facts.

Guidelines: Use clear, nontechnical language. Be sensitive to local norms, such as speech and dress. Strive for brevity, but respect people's information needs and offer to provide more information. Use graphics and other pictorial material to clarify messages.

Personalize risk data: use stories, examples, and anecdotes that make technical data come alive. Avoid distant, abstract, unfeeling language about deaths, injuries and illnesses. Acknowledge and respond (both in words and with actions) to emotions that people express, such as anxiety, fear, anger, outrage, and helplessness. Acknowledge and respond to the distinctions that the public views as important in evaluating risks. Use risk comparisons to help put risks in perspective; but avoid comparisons that ignore distinctions that people consider important. Always try to include a discussion of actions that are under way or can be taken. Promise only that which can be delivered, and follow through. Acknowledge, and say, that any illness injury or death is a tragedy and to be avoided.

Rule 7. Plan carefully and evaluate performance.

Different goals, audiences, and media require different risk communication strategies. Risk communication will be successful only if carefully planned and evaluated.

Guidelines: Begin with clear, explicit objectives - such as providing information to the public, providing reassurance, encouraging protective action and behavior change, stimulating emergency response, or involving stakeholders in dialogue and joint problem solving. Evaluate technical information about risks and know its strengths and weaknesses. Identify important stakeholders and subgroups within the audience. Aim communications at specific stakeholders and subgroups in the audience. Recruit spokespersons with effective presentation and human interaction skills. Train staff - including technical staff - in communication skills: recognize and reward outstanding performance. Pretest messages. Carefully evaluate efforts and learn from mistakes.

There are a number of other guides which discuss message crisis communication available online, such as the one found at: http://www.riskcommunication.samhsa.gov and my personal favorite, https://www.atsdr.cdc.gov/risk/riskprimer/vision.html#myths.

QUATTRO'S QUICK TIPS

- Develop your plan and message
    - Speak to the audience's interests, not yours
    - Present three messages, in order:
        - Empathy. *"As a parent myself, I share your concerns…"*
        - Teamwork. *"We're working with local and national experts…"*
        - Way Forward. *"We expect to have supplies in 2-3 days…"*
    - Keep message short (27 words, 9 seconds, 3 messages)
        - What you need the audience to know
        - What the audience wants to know
        - What will most likely be misunderstood?
    - Perception of risks:
        - Voluntary risks are more accepted than risks perceived to be imposed.
        - Risks under an individual's control are more accepted than risks perceived to be controlled by others.
        - Risks with clear benefits are more accepted than risks perceived to have little or no benefit.
        - Risks fairly distributed are more accepted than risks perceived to be unfairly distributed.
- Take a lesson from Disney when answering questions.
    - "*Yes and…"*
    - *"I'm glad you brought that up. Here's how we're…"*
    - Tie answer back to one of your three messages.
- Use Non-Verbals to your advantage
    - Limit Notes (just facts)
    - Be Organized
    - Dress Professionally
    - Set A Relaxing Tone
        - Eye Movement (slow, sweeping, eye contact)
        - Hand Movement/Position
            - Open and Above Waist
            - Avoid - Large Movements, Crossing Arms, Clasping Hands, Making Fists, or Hands in Pockets
        - Posture
            - Lean Slightly Forward
            - Avoid Rigid Positions
- Arrive early and stay late.
- Keep your promises

COMMUNICATION PITALLS:

1. **Information overload**

   Providing people who aren't ready or willing to receive information with more-and-more information about a risk or plan.

   You've probably already experienced this admitting a patient from the ER. They need to be admitted, but they don't want stay and they won't listen to you explain why. Why is that? Maybe they consider hospitals a place to go do die. Maybe they're more concerned about how their family, partner, or pet will be if they aren't home. Maybe they're more concerned about how to pay for the bills. Whatever the reason, you won't be able to have meaningful communication until you identify the barrier and address it first.

   You may also see this in people who feel that the media is overplaying the risk (as they often do…) or that because something hasn't happened yet, it's not going to happen in the future.

   Avoid this trap:

   Break this cycle by not assuming the solution is realistic for everyone. Try to identify the reason why people aren't ready to receive the information. Many times, the person won't want to admit the real reason out of embarrassment or fear, but you can address it by saying things like, *"Many times, people are worried about XYZ. Let's talk about that for a moment…"*

2. **Using fear to make your point.**

   Allowing negative emotions to drive the message may be memorable, but not in a good way.

   Rarely does a PHEO consciously use fear as a tool, but it often comes as a result of not addressing the first pitfall. The usual pattern is that someone is reluctant to listen to the message, and the PHEO gets annoyed. (*Why aren't they listening? Don't they care? Are they stupid? Don't they respect me?*) As a result, the PHEO uses more and more emotional language as these negative emotions creep into their message.

   But people can only worry about so many things at once. And using fear may actually make things worse by making people feel helpless, or feeding into a preexisting belief that the danger is already overstated. (The corollary error is to understate risk.)

   Avoid this trap

   Use neutral language. Be honest. Be conscious of preexisting beliefs and include acknowledgement of these concerns when crafting the message. If using graphics to make a point, don't merely show graphs of how bad things are, but show how people can respond. That will help reduce feelings of helplessness.

3. **Appearing uncertain, or using negative language.**

Most people don't think in terms of likelihood, and hear uncertainty when you can't give absolutes.

As medical professionals, we realize there are very few absolutes. But people will tend to pick up on words like 'may' or 'could' and focus on the negative outcomes. Instead of listening to the 99.99% chance something won't happen, they'll say, "So…you're saying there is a chance…" Or they focus on the negative and miss your positive messages.

Avoid this trap

Avoid the Five N's: No, Not, Never, Nothing, None. Avoid speculating and instead of saying, "*XYZ won't happen*," or even "*XYZ might happen,*" use language like, "*We're planning for XYZ "* or "*We want to be ready in case XYZ happens.*" You may have to share more information than you planned, to avoid looking like you're hiding something. But remember pitfall #1 and share it in a way that addresses the real question.

And if you don't know, acknowledge that you don't know (yet) but ask them to provide contact information and follow-up with an answer.

4. **Expecting your credentials to impress people.**

State your credentials, but don't overstate them. People probably don't know what many of the initials mean, and the more you draw attention to yourself, the less you draw attention to your message.

Trust and Credibility Factors:

- 50% Empathy/Caring (establish this during opening comments. See Quick Tips)
- 15-20% Honesty/Openness
- 15-20% Dedication/Commitment (to whom/what?)
- 15-20% Competence/Expertise
- Body Language

People are bombarded with messages from so-called experts on social media daily. By the time you take the mike, your audience has probably already googled you, your med school, and your MPH program. If the person introducing you provides your credentials, that's fine – it's expected that they'll talk you up as an expert and that's OK.

Avoid this trap

Introduce yourself, thank the previous speaker for the introduction and move into your first empathy/caring message. You may even emphasize your qualification while doing so. For example, "*As a primary care (preventative care) physician, I value being a part of my patients' and their family members' daily lives. So when XX asked me to come here today, I jumped at the chance to speak with you and answer your health questions...*"

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

The PHEO may be pulled into focused site visits to homes or workplaces for suspected public health hazards. Common scenarios are lead paint in base housing or mold growth in a worksite or home. Being able to project confidence s is an important part of being the PHEO, and these are excellent opportunities to practice 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

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, CCs receive AF 469s with mobility restrictions and have no objections. However, they may occasionally disagree. When that happens, DAFMAN 48-108 provides a series of steps to help resolve the disagreement.

1. The CC is required to contact the SGP within seven duty days (para 2.12.4.3. and 3.4.2.)
2. The SGP reviews the MR and discusses the case with the PCM as needed. The MTF must re-adjudicate and resubmit the profile within seven duty days of the CC's objection. (3.4.2.)
3. The MTF/SGP should have a discussion with the CC about COCOM medical standards; even if the CC opts to keep the member on mobility, they may not be deployable to certain COCOMs. (3.4.2.2.)
4. If the MTF/SGP and CC still disagree, the profile will stand as a medical recommendation, but the CC can choose to follow it or not. The rationale for the decision will be documented in the EMR. (3.4.2.2.)
5. If the CC non-concurs on an AF 469 that drives and IRILO, the IRILO still needs to proceed, even with their non-concurrence. (3.4.2.3.)

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, 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 fosters disagreement between CCs and medics.

Be aware that the COCOM may have certain requirements, and even though the member's CC 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 very clear distinction between unfitting and unsuiting conditions, that distinction came under question with the new DoDi 1332.18 appendix 1. But the updates to the DoDi were was mainly in regards to hereditary conditions, and don't mean you should be writing NARSUMs for unsuiting items. Developmental conditions such as ADHD and other potentially unsuiting conditions, including personality disorders, generally do not constitute a compensable physical disability and are not cause for referral to the IDES.

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.

The Airmen Medical Readiness Optimization (AMRO) program is a weekly meeting for patient treatment teams to review AF 469s of patients under their care, much like FOMWG reviews DD 2992s. And, just like FOMWG, they are expected to have some type of patient contact every 30 days. The AMRO presents their findings to the AMRO Board (AMRO B), who presents a summary to the DAWG. The AMRO B is chaired by the SGP and can apply a Code 37. This keeps the DAWG from bogging down in specifics but still lets the treatment teams discuss management in depth.

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 2.7.1. 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. 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 DAWG is also tasked with reviewing selected diagnostic or medication usage queries. MSME will present such queries at least 10x per year, typically focusing on conditions that would trigger a DLC. This allows the DAWG to identify people who may have otherwise missed detection from the AMRO. DAFMAN 48-133 4.5.2. talks about this responsibility, but a common schedule 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 48-133 (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. Consider the case of a patient born with gastroschisis. Due to the network of scars on his abdomen, his AC would 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 15 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.

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.

Many of the other 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. But what do we do about the 6'8" Airman? Fortunately, this is specifically addressed in AFI 36-2905.

Anthropomorphic concerns, such as our 6'8" Airman, are non-medical in nature and AFI 36-2905 para 5.2.8.1 clarifies that a medic cannot grant an AC exemption for non-medical issues, using an Airman's individual physique as an example of a non-medical issue.

Fortunately, AFI 36-2905 para 3.6.8. includes an "out" for Airmen who fail an AC, but pass all the other components with at least 80 points. In those cases, the member would be screened for BMI and if they pass, receive a passing grade for body composition and be marked "exempt" from AC by the FAC. If they fail the BMI screen, then they would be given a body fat assessment (BFA), which, if passed, would also result in an "exempt" from AC by the FAC. This allows for physically fit Airmen to not be penalized for off-nominal anthropomorphics.

The take home message is that there are rare times, apart from pregnancy, that an AC exemption is reasonable. And there are also times when an AC waiver may be warranted, but from the FAC and not from a medic. 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, apply it to the individual items to increase sensitivity.

For purposes of 2.25.11 referrals, you can 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: *These referrals are a valuable tool to identify Airmen who "fly below the radar" and either require IDES action or are not optimally medically managed. The SGP will review the case to ensure the Airman has reached maximal medical benefit and will consider the impact of the condition on duty & mobility. Duty or mobility impacts, not fitness limitations, drive IDES actions, and it's important to remember that a referral for medical review does not always prompt IDES action*

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

The IRILO process evolved because a significant number of cases referred through the integrated disability evaluation system were returned to duty after undergoing costly Veterans Affairs compensation and pension (VA C&P) examinations and the cumbersome IPEB process. DP2NP screens the IRILO and serves as the gatekeeper for the IPEB. Physicians at DP2NP periodically meet with the PEB physicians to get a feel for which conditions/treatments are likely to be found unfit or returned to duty.

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 DAFMAN 48-133 4.4.1.1. reserves that to the AMRO-B. Once the Code 37 is set, it can technically be removed by the AMRO-B as well (4.4.1.2.), but that would be a very rare situation. Code 37s are generally only removed once the FL-4 is returned from AFPC/DP2NP.

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 AMRO-B. Some bases avoid the hassle by waiting to assign the Code 37 until the NARSUM is written. While this guarantees good metrics by maximizing the 30 day window, DAFMAN 48-133 2.3.4.3. states that instead of waiting, bases should apply the Code 37 and merely make note of the reason for the delay in ASIMS and AMRO-B minutes.*

Should you recommend RTD or IPEB?

The hardest part of the IRILO worksheet is deciding to recommend RTD or refer to IPEB. DP2NP considers each case individually and thresholds for specific conditions can be moving targets, influenced by manning posture, force shaping, end strengths, mission changes, etc. However, there are trends that can help decision making.

FACTORS THAT MAY INFLUENCE RTD VS. IPEB REFERRAL

- < 4 year time in service (TIS) = DP2NP is likely to refer to IPEB vs. C code
- 8 years TIS = AF "buys" EPTS conditions
- 10-12 years TIS = DP2NP is more likely to RTD, even if a "high deployer"
- 15 years TIS = DP2NP is 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 injectable medications or medications that need cold chain usually results in IPEB referral.
- Any condition requiring frequent specialty care (less than 6 month intervals), interventional procedures, or use of implantable devices subject to malfunction in a deployed setting will usually result in IPEB referral.

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 maintain a physically active and healthy lifestyle – including ability to meet fitness goals.

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

https://kx.health.mil/kj/kx8/AFPCMedicalRetentionStandards/Documents/Forms/HideFolders.aspx?RootFolder=/kj/kx8/AFPCMedicalRetentionStandards/Documents/Templates%20and%20Forms&

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 AFI44-102 from 2015, para 5.1 and AFI36-3212, para 1.8 for detailed instructions on medical hold and elective surgery.

Medical Hold: DP2NP is the only entity that can authorize Medical Hold, 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. There are multiple reasons for this window, including changes to VA benefits, potential need to repeat the VA C&P, and to avoid having the individual require post-surgical aftercare in the window after separation when their Tricare benefits change. If an active duty service member has been referred to the DES and is within 6 months of separation, the MTF must coordinate any requests for elective surgery through DP2NP before proceeding with non-emergent surgery

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 need to to stabilize. In those cases, they can place the member on Convalescent Care for 6-12 months. The member maintains their Code 37 and an updated NARSUM is submitted in 6-12 months. 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, the formal (local) MEB process starts. The MEB will nearly always refer the case to IPEB, however, there may be new information that changes the prognosis. If so, the MEB may recommend 'return to duty' to alert the PEB to return the case to DP2NP for re-disposition.

Some people try to hold a "virtual" MEB by simply routing the package without having the members discuss the case. That's a bad policy. It's very important to review and discuss the case during the MEB; DAFMAN 48-108 recognizes this and notes that any exception to an in-person board requires an exemption from the SGH or SGP (para 3.10).

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. Doublecheck the VA compensation & pension package.
    - 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.
    - If the VA documentation convincingly suggests the presence of another potentially unfitting condition, such as a total or severe social and industrial impairment for a mental health condition, consider addressing this in the addendum.
2. Make sure that all of the claimed conditions are mentioned and annotated unfitting or unsuiting as necessary in the addendum.
3. Review the date and content of the NARSUM.
    - If significant time or events have passed, give a brief update on any changes in the condition.
    - When making any updates, be specific. For example, if 6 months have elapsed for Epilepsy, "No interim seizures or medication changes" is better than, "No updates required."

HINT: *Hold the MEB immediately after the AMRO-B, since all the necessary members are already sitting in the room.*

SAMPLE ADDENDUM ADAPTED FROM AFMRA:

Before submitting the NARSUM package to the IPEB, 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 when nothing new is found:

"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 DAFMAN 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 often used informally to refer to the entire processing of a case, to include processing through AFPC with DP2NP and/or the PEB. But the MEB is actually 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 it's important to determine if the problem lies with the formal (local) MEB, IRILO, IPEB, FPEB or VA. In almost all cases, it's not the formal MEB that's the problem, but rather an outside process, collectively referred to in AFI 48-133 as the "informal MEB."*

A FEW OTHER COMMON PITFALLS ABOUT MEB'S (DAFMAN 48-108 PARA 3.8):

- While the PCM is welcome to contribute to discussion, only physicians can be voting members of the board.
- Two person boards are allowed, but a third physician must weigh in if there is a split.
- In the event of a mental health MEB, at least one member must be a psychiatrist, or a psychologist with a doctorate in psychology.
- Interns and residents may not be voting members, but civilians may.
- The SGP is required to provide training on duties to the MEB board members.
- While the SGP serves as the MEB president, with the SGH as alternate if the SGP is unavailable. Alternate SGP and SGHs, once appointed by the MDG/CC in writing, serve in the same MEB authority if the primary is absent.

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, which include the vast majority of cases which are processed via the Integrated Disability Evaluation System (IDES). 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.

NOTE: *If the SM elects (or is directed) to process through the Legacy Disability Evaluation System (LDES), the case does not process through the VA. Instead, the rating is determined by the PEB using the VASRD. Therefore, it's probably best to refer all cases for musculoskeletal conditions to physical therapy for range of motion and functional assessment. To rate a musculoskeletal condition, the VASRD requires ROM measured by a goniometer. LDES cases submitted without a measured range of motion are almost always returned without action, causing delays in processing.*

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

Service members have the option to appeal an unfit finding at the FPEB, and can request to appeal other decisions made by the IPEB by providing new evidence to support their appeal. This board meets at JBSA-Randolph and consists of at least one physician, one personnel officer/civilian, and (if needed to break a tie), a third voting member. If the member agrees with the 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 JBSA-Randolph 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.

NOTE: *The FPEB began conducting telephonic/virtual hearings during the COVID-19 pandemic. It's unclear if this practice will persist after the pandemic.*

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, MH treatment with suicide attempt 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.

NOTE: *When reviewing the line of duty (LOD) section in the NARSUM for members with EPTS conditions and less than 8 years of TIS, consider the difference between acute exacerbations vs. service aggravation. Service aggravation is a permanent worsening or shift in the baseline trajectory of the condition beyond natural progression.*

For example, a 2-year Airman who was hospitalized for acute MH exacerbation with suicidal gesture, and who never disclosed prior service MH hospitalizations for suicide attempts, does not necessarily constitute service aggravation. Fact is, they are no worse off than baseline and may even be improved due to treatment available in the military.

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, they will be separated with a lump sum payment of 10 x 2 month's pay.

BUT, SM's who elect to accept a lump sum payment will have their VA compensation payments deferred until the amount of that lump sum has been "paid back". For example, if the SMs VA compensation payment is $600 per month, and the SM accepts $18,000 severance pay, the VA will withold their tax-free disability compensation pay for 30 months.

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 significantly in the next three years, the individual may be placed on TDRL. For example, a patient with disqualifying PTSD will be placed on TDRL for 6 months, and 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 who has at least 15 years of active duty until the 20 year mark if they're in a critical field or a wounded warrior. The PEB will typically not grant LAS unless the member formally requests it, the commander supports it, and the condition is medically stable presenting no significant risk of harm to the member or detriment to the mission.

This is a rare event and the member needs to understand they're required to maintain all other active duty standards. If the member's condition worsens, or if the member desires, they can request a RILO to evaluate for medical retirement. 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 DAFI 36-2910 para 1.1, an illness, injury, disease or death sustained by a member while in a qualified duty status is presumed in the line of duty (ILOD). 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 for active duty service members. 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 for active duty.

HINT: *DAFI36-2910, including Attachment 2, and AFMAN 41-210 section 4E are the governing documents for LOD's.*

DAFI36-2910 lists specific circumstances which trigger an LOD determination. If the member's referred condition is the result of any of these circumstances, ensure the LOD is appropriately addressed in the NARSUM. If the member is being referred for an EPTS condition that was not service aggravated, an AF348 must be accomplished." (para 1.8.3)

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 such that the illness, injury or disease occurred prior to military service, or between periods of service, and was not aggravated by trauma or the unique aspects of military service, then the medical officer should initiate an AF348 informal LOD determination. (the NILOD-EPTS-NSA now requires a 348). 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 judgment is 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.

INFORMAL LOD

If an LOD determination is required, but an administrative LOD is not appropriate, then a medical officer should initiate 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 typically a 4N/4A. 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.

HINT: *In the event of death, DAFI 36-2910 para 1.6.1 directs you to complete an AF348 for an informal LOD determination.*

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 appointing authority (usually the Wing/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. However, opinions regarding whether or not the current state of a pre-existing condition is consistent with, or beyond the realms of, natural progression, or whether or not the causal relationship for a medical condition is consistent with the mechanism and nature of the claimed injury, can be very helpful. There will be an investigating officer who will work with the CO to make the final LOD 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. DAFI 36-2910 attach 2 (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 the intemperate use of alcohol.

- If the condition is a medical condition such as cirrhosis, you should initiate the AF 348, but the case will likely be found "NILOD" due to misconduct (A2.1.3.).
- If the member has an injury as a result of intemperate alcohol use (i.e. – a fight) then an informal LOD is appropriate to let the CC determine if misconduct was the cause.

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 circumstances were questionable or the injuries are more than minor, simple, self-resolved injuries, then initiate an AF348 for the CC – especially if there is potential for long term disability.

Motor Vehicle Accidents Accidents associated with alcohol use, excessive speeding, reckless driving, or failure to abide by seatbelt or helmet law, complicate 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 initiate an AF 348 for the CC for an informal LOD.

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*

** You're probably 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. For injuries that do not require an AF348, a good HPI documenting the circumstances or where, when and how the injury occurred generally suffices unless the history suggests the possibility of misconduct or a non-qualifying duty status (such as ARC or AWOL).*

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, DAFMAN 48-108 para 2.3.4.3. and 2.4.2 state that the case may exceed the 30 day window because of medical evaluation, stabilization or other legitimate reasons. 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 Appendix 2 to Enclosure 3, paragraph 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 fitness 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. Although submitting the IRILO could result in potential delays in the SM's retirement date, it can often be financially advantageous to the SM in the long run.

There are some people with plans to retire who will come in and ask (or insist) their PCM "do an MEB" because they are under the misconception that if they are found unfit, they will get an in increase in VA compensation. This is not true in almost all cases. Retiring SMs are able to file a claim for all their conditions directly with the VA without going through the IRILO and DES process. The VA will rate their conditions in the same way and will backdate their payment based on the retirement date as long as they begin the process while still on Active Duty. So there really is no reason to potentially delay someone's retirement just because the SM wants "an MEB"

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 potentially DQ), high cholesterol (not potentially DQ), and an ingrown toenail (not potentially DQ). The DAF form 618 merely instructs people to include conditions, "… which contribute or may contribute to make the qualifications of the individual for worldwide duty questionable." If the DAWG has determined his HTN, cholesterol, and ingrown toenail aren't disqualifying, there is no need to list them on the AF Form 618.

The PEB must address all conditions on the 618, so unless the condition was referred and deemed medically disqualifying by DP2NP or the ARC/SGP on IRILO, avoid "add-ons." This is particularly true with ARC cases as this can be a source for LOD issues and return-without-action. Don't worry; 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 are not disqualifying (or might be disqualifying but are not at this time) (not included in the disability rating)*
3. *Conditions that are not unfitting and not compensable or ratable. This includes potentially unsuiting conditions such as alcohol use disorder and attention deficit hyperactivity disorder*

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 permanently worsened the condition beyond normal progression, resulting in it becoming unfitting. For example, 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, mark "Admin LOD=yes", and leave this column unmarked.

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 aggravated by military duty.*
- *Acute exacerbations (with a return to baseline function) are not the same as permanent worsening of a condition beyond natural progression. Additionally, adverse outcomes commonly accepted as risk from treatment (including surgery) for an EPTS condition also do not necessarily constitute service aggravation.*
- *For ARC cases, PEBLOS are often mistaken in thinking a condition has to be ILOD to be listed on the DAF 618 and referred to the PEB. If the ARC/SGP found a N-ILOD condition medically disqualifying in addition to the ILOD condition requiring the DAF618, the N-LOD condition still needs to be listed, but check "no" for incurred while entitled to basic pay, "yes" to existed prior to service, and "no" for permanently aggravated by service.*

5. ***"I did all that you said. Why did DP2NP send the case back for more tests?"***

The most common reasons cases are returned without action are:

1. Legacy DES cases which lack specific tests (e.g. PFTs for asthma; range of motion for musculoskeletal conditions), symptom log for epilepsy or migraines, etc.) required to rate the condition according to the VASRD.

2. Unclear eligibility for disability compensation due to a missing or inappropriately processed LOD determination for cases involving ARC service members, potential misconduct, or EPTS conditions.

3. Inconsistent or outdated information requiring clarification or updated addendum. For example, the commander says the SM can't do anything, but the AF469 has no duty limitations.

The old AFI 41-210 listed the following as requirements. While they are no longer included in an AFI or AFMAN, they are still a useful cross-check to make sure the NARSUM is thorough.

- ***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

7. My patient is asking me if he should do IDES or LDES. What's the difference?

Years ago, PEBs used to decide both the fitness AND the disability rating for the SM. Then, the SM would file a claim through the VA and could go months after discharge before receiving any VA compensation. The IDES was created to roll the VA decision into the DES process so that the SM's VA evaluation and decision on compensation would already be done at the time of discharge. Because of the VA step, IDES cases take much longer to process than LDES. For the same reason, IDES is usually more financially advantageous to the SM.

So unless the SM is chomping at the bit to get out and start a civilian job they've been hired into within the next couple weeks, it's best to default to IDES. Usually, SM's must request (and the MTF CC must approve) LDES, and once decided, there's no turning back. Exception: ARC SM's who already have favorable VA disability ratings might also prefer LDES to avoid going through another VA evaluation since there's a chance their VA rating percentage may go down. This is especially true now that the VASRD is being re-written.

PERSONNEL RELIABILITY AND ACCOUNTABILITY PROGRAM (PRAP)

Most people know the Personnel Reliability Program (PRP) as the DoD-wide oversight program for nuclear surety. However, fewer are aware that PRAP includes PRP, Arming / Use of Force (AUoF), which provides oversight for the AF security forces troops, as well as the Presidential Support Program (PSP).

AF members who have critical or controlled access and knowledge of nuclear weapons are on PRP. It provides a measure of reliability oversight by the Certifying Officer (CO), with copious inputs from medical, to ensure that those members in such roles are held to the highest standards of reliability. It is essential to remember that PRP is the COs program, and medics are consultants. We make recommendations, but only recommendations.

In the "old days", security forces (AFSC: 3PO or 31P) had reliability standards in AFI 31-117, attach 2, but they dealt mostly with mental health conditions and were seldom referenced or enforced. Defenders at nuclear capable bases fell under PRP because they were considered to have controlled access. That changed after the PRP was scrutinized in 2014, when Defenders were removed from PRP. Although they potentially had controlled access to nuclear devices, they did not have the knowledge component. To offset this, the AUoF standards in AFI 31-117 were 'beefed up' to provide improved oversight of Defenders, not just at PRP, but also across the AF.

But wait! This isn't a nuke capable base. We don't have PRAP.

> PRAP includes both PRP and Arming / Use of Force (AUoF). All Defenders fall under AUoF, and all bases have Defenders. Therefore, EVERY base has PRAP, and EVERY SGP must be familiar with PRAP.

But, this isn't a nuke capable base. We may have AUoF, but we don't have PRP.

> Before assuming PRP duties, AF members undergo an administrative qualification, where they are scrutinized to ensure they meet PRP standards. This happens while they are still at non-nuclear capable locations. And while they are admin qualified, they are under constant review and any issues must be passed to their gaining commander (PRP CO). So…you still need to know PRP even if you're not at a nuke base.

HISTORICAL PERSPECTIVE

The Early PRP Clinic Years

Pre-2003, PRP patients were seen throughout the PCO clinics and the primary CMA's job was to review and fix mistakes throughout the day, rather than see patients, while also conducting 100% annual review of every chart and 100% review of all new certifications. In addition, medical was expected to track suspension recommendations, ensuring CO's were given new recommendations as patients "timed out". At that time, all SFS were also on PRP and held to PRP standards. Also, any off-base medical care drove a suspension recommendation and return-to-status visit, using an off-base care form, typically colored bright orange (AKA "The Orange Form"). During this time, ACC owned the bombers while AFSPC controlled missiles, and both had different PRP supplements for bases to follow. As the primary CMA at Minot under this dual MAJCOM system, Quattro can provide first-hand testimony that it was not optimal.

Starting in about 2003, he brought PRP patients together into a newly formed PRP clinic to centralize their care and reduce the amount of "clean up" from missed notifications and missed potentially disqualifying information (PDI, now called 'Suitability Factors' or 'SF'). This model was recognized as a best practice and eventually drove the AF-wide model. However, even as medical PRP improved, there were lapses in other aspects of the nuclear program.

Early AFGSC Years

As a result of several high-profile incidents, it became apparent that our nuclear focus was being lost amid the conventional commands. In 2009, AFGSC formed to provide a better strategic focus and to bring a nuclear-oriented 4-star to the table. Along with that, a new staff directorate, A10, was formed to represent the nuclear skillset. AFGSC brought bomber and missile PRP together, which helped a great deal with running a unified program.

Shortly after this unification came a drive by AFGSC/SGP to standardize PRP across AFGSC bases. A PRP course was developed for USAFSAM and a "Policy Guidance Memorandum" (PGM) was published to provide step-by-step instructions for AFGSC medical PRP. It standardized AFGSC PRP notification stamps and forms, but also drilled into specific details, outlining precise clinic procedures for filling medications or reporting PDI, and even the exact color shade to be used for forms. There were also published lists of medications and required suspension periods, as well as lists of PDI, including such mandatory reportable items as "surgery" or "head injury".

Unfortunately, as published guidance, the PGM was an inspectable item, so failure to follow it to-the-letter resulted in significant, though rather silly, IG findings.

- Using the wrong shade pink paper for a certification form? *Failure to follow guidance.*
- The 45 year old MSgt who had a circumcision at eight days of age? *Surgery – must be passed as PDI.*
- The 1LT who cut himself shaving? *Head injury – required suspension and pass as PDI.*
- The SSgt who took three OTC motrin after spraining her ankle, when the instructions say to take one to two? *Drug misuse – permanent decertification.*

Those of us who lived through these years remember such unintended impacts, which is why we balk at providing lists of suitability factors or allowable PRAP medications.

It was during this time that Quattro began working with the ASIMS development team to develop a PRP ASIMS module. The interface was designed to allow medical to track their recommendations, and to allow squadron monitors to review recommendations. The vision was to use ASIMS as the primary notification tool for routine notifications, much like ASIMS is used as for DD 2992 and quarters notifications. Unfortunately, full implementation stalled shortly after beta testing due to desire by SG-10 to use a yet-to-be-developed E-PRP platform instead. However, many bases continue to use ASIMS' PDI letter feature to communicate with units, since it maintains the associated HIPAA disclosures.

The "Report"

In 2014, OSD took note that PRP had become overly administrative and that the burden of responsibility had shifted from the individual to medical. This report, coupled with a very unfortunate incident involving an AFGSC General and an Orange Form, resulted in a massive overhaul to the PRP and elimination of supplemental guidance below the service level. This revocation of the PGM and rewriting of the AFMAN formally removed SFS from PRP, forming PRAP as a consolidated program to oversee both PRP and AUoF. More importantly, it returned the onus of responsibility from the MDG to the member.

Post report Era

In the years that followed the changes to the AFMAN, numerous other changes took place, most notably, the formation of an Admin Qual Cell. Prior to the cell, members would sometimes PCS to a base and be found unfit for PRP duty, leaving them to 'steal' a PRP billet for several years. The AQC pre-screens applicants, and as of 2018, that pre-screen can count as the initial cert review, lessening the review required by the gaining base.

PRAP PROGRAM MANAGEMENT

There are a number of PRAP manuals floating around, some better than others, and most based on one Quattro wrote back in 2005. This section provides highlights that all SGPs should know, and provides tips and insights. But to become adept requires practice and networking with experienced CMA's at the IG, MAJCOM, and other bases.

The first pearl is that PRAP is simple – if you practice good medicine.

People make it difficult, but it's simple if approached as an occupational medicine program and the focus stays on medical care. Programs that suffer tend to be ones which focus on administrative aspects of PRAP and let medical care slide. Make solid medical decisions, and solid PRAP recommendations will follow. It becomes difficult when providers let the program drive medicine, rather than focusing on their patients.

The second pearl is to keep PRAP simple.

Within the PRAP, there is a tendency to react to problems by creating more management rules, checklists, and policies. But in most cases, the problem isn't solved by creating additional administrative burden. As a matter of fact, program complexity from an overabundance of rules may be what caused the problem. Instead of this knee-jerk reaction, apply mishap training to look for the chain of events that led to the problem. See if you can pare down rules and policies to generate more ownership among medics.

The third pearl is to stay involved in PRAP.

One common trap for SGPs 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 SGP, as Lead CMA, is the executive representative and is responsible for medical PRAP 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. Think of it as the relationship between 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?*

PRAP KEYS TO SUCCESS

While entire books could be (and have been) written on how to manage PRAP, 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. **PRAP is a culture from the top down.**
   The rest of the MTF will take their cues from the execs…are they modeling PRAP 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. **PRAP 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 PRAP 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 PRAP 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 PRAP 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.

THE ROLE OF THE CMA

The CMA is first and foremost a medical provider, and must practice good medicine to practice good PRAP. That means taking a good history, assessing how the condition impacts the patient, documenting response to treatment, and providing anticipatory guidance. If that's being done, then most PRAP concerns are already addressed.

Very few CMA's start out with the intent to practice poor medicine, but they enter a downward cycle. They focus on administrative duties, so appointments are curtailed and documentation is rushed. Without appointments, patients go off-base, creating more paperwork, and more reviews. This drives lower availability, encourages more pencil whipping, 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 providing solid medical care, 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, PRAP leaves much of the decision making to the CMA's discretion.

The Lead and Alt Lead CMA must set the tone for the other CMAs and ensure they provide consistent reporting – not just within flight med, the PRAP clinic, or WOMC, but also in mental health, dental, and other ancillary clinics. That requires frequent communication between clinics and providers.

NOTE: *Most CMA's, especially newer ones, excel at funneling information. 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.*

Occasionally, you may be asked if a manning assist, IMA, or other individual can be appointed as a CMA. While that may be possible, you need to look carefully at the type of privileges and license they hold. For example, you may be asked about a provider on supervised privileges. That's a no-go for CMA appointment per the definition of a CMA in DoDM 5210.42:

> "[CMAs must be]…Awarded *regular clinical privileges* for independent practice according to Military Service regulations by the healthcare facility responsible for the provider's place of duty, or if not privileged for independent practice, then be supervised by a physician who is privileged to practice independent." (Emphasis mine)

AFI 44-119 goes into detail on what is meant by "regular clinical privileges" in para 6.28.1,

> "6.28.1. Regular Privileges. Regular privileges are granted to providers only after full verification and review of credentials. Regular privileges allow the provider to independently provide medical care within defined limits."

This is different than supervised privileges, which are discussed in 6.28.2.,

> "6.28.2. Supervised Privileges. Supervised privileges will be granted to providers who lack the necessary licensure or certification for independent practice if all minimal educational requirements are met…"

So, if they are on supervised privileges, then they have not been awarded regular clinical privileges, and do not meet the DoD requirements to be qualify as a CMA.

But what if you had a highly trained person that was out of practice, maybe due to working staff jobs? They couldn't be a CMA, but they could still help. For example, they could be appointed to provide initial certification reviews per DoDM 5210.42 Appendix 2, Enc 3, b, which states,

> "As part of the required screening process, the *CMA or other medical personnel specifically trained and designated* will evaluate health history and records to determine the candidates' medical qualifications under PRP standards."

They could also provide other locally mandated chart reviews / daily audits, etc, as long as the local procedures don't specify that the reviews must be accomplished by a CMA. But, the interpretation of items (ie: SF) would have to be made by a CMA.

SUITABILITY FACTORS (THE INFORMATION FORMERLY KNOWN AS PDI)

Potentially Disqualifying Information, or "PDI", is an obsolete term. "Suitability Factors" (SF) is the current term to refer to issues that may impact someone's ability to execute PRAP duties. Going back to the funnel/filter analogy from the last section, the CMA must filter out SF from the rest of the information they've collected via their funnel.

As mentioned before, most CMAs excel at funneling, but struggle with filters. As a result, many bases over-rely on blanket rules to always report some issues, whether they impact duty or not. But many items fall on the fence between impacting duty (reportable SF), and being minor irritations that don't rise to the level of duty impact.

Avoid the trap of over-reporting by creating an expectation for your CMAs to document impacts of conditions. By doing so, you create a requirement for them to ask questions to the patient on life and work impacts. CMAs quickly find that the time spent asking those questions and documenting responses is more than made up for by resolving potential SF on the spot and negating the need for reporting. And asking those questions is good medical practice, for both PRAP and non-PRAP patients.

The explanation of why an item is non-SF 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 HA might need more detail. Likewise, stress on a PHA could be easily explained as, "*Stress in proportion to job. Good coping. No impact. No SF.*"

NOTE: *Mental Health 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 use, suicidal ideation, etc) 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. Often, these items are of little consequence and there is no need to report them.*

DAILY REVIEWS:

Daily reviews are an optional review that many programs use to confirm the PRAP determination from an appointment is consistent with the documentation. There is no requirement for such reviews, but they can help catch minor trends before they evolve. Some bases require a CMA to do these reviews, but consider using a trained and appointed 4Nx instead of a medical provider. It's easy to skip on documentation if you're writing for another provider, but much harder if its being reviewed by a non-clinician. *(Remember the previous warnings about CMAs focusing on admin duties at the expense of good documentation and patient care?)* Plus, if the documentation makes sense to a non-medical provider, chances are it's been done well. Key issues are:

- Documentation appropriate for medication or care provided?
- CMA signature and PRAP determination present?
- Do Mental Health and medical outpatient records' notes match up?

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 records 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. Also, 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 PRAP 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 OPERATIONAL WORKING GROUP (POWG) - OPTIONAL

The POWG is the PRAP equivalent of the FOMWG or AMRO. It's 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 a simple matter to hold a POWG either as a separate meeting, or rolling it into FOMWG or the PRAP clinic's AMRO.

Also, 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 PRAP Module, since it generates the data for any specific time frame.

Typical metrics reported to the NRC:

- Recommendations made for suspensions and decertifications
- Certifications received, number completed, and average time to completion
- Suitability Factor letters sent (not including those included with suspensions, decertifications, or certifications)

If the POWG is held independently, minutes should be submitted to the AMC. Consider appointing the Alt Lead CMA to the AMC and have all CMA's attend. The FOMC CC and flight docs are all expected to attend the AMC; the PRAP CMA's should be involved as well.

DECERTIFICATIONS

There is considerable leeway within medical PRAP for decertification, but decertification is mandated for drug abuse or failed compliance following alcohol dependency. Most cases aren't so cut-and-dry, and a decertification recommendation falls into the gray area of a prolonged suspension with a prognosis that isn't consistent with continued PRAP duties. But there is no need to exhaust the limit of suspension before recommending decertification.

To start, have an informal discussion with the CO. They're probably aware of the pending decert, but this provides opportunity to address concerns before the official recommendation is sent. For style points when making the recommendation, do it early in the day to give the squadron time to process it.

Also, 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 PRAP informed of major events and allows one last quality check before the letter goes out.

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 PRAP. 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 look to see if stated policies are actually practiced.

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

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, to answer with, *"I don't know yet, but I'll ask LtCol Snuffy, our Lead CMA, and get back to you."* Expect the following questions to test knowledge of local program and AFMAN 13-501:

- What is the purpose of the PRAP? (*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 PRAP leads and how to contact them.
- Who conducts the training? How often? (*appx 1 to Enc 3, 3. g-i*)
  - Articulate that training is done by the Lead / Alt Lead CMA and MDG Monitor, and 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, probably in Dental or Mental Health.

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.

Quattro jokes 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 walk away 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 PRAP 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.

PRAP, HIPAA, AND OTHER 4 LETTER WORDS

Because PRAP 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 PRAP Status, technically, it could be a violation of the minimum disclosure rule. Providing information in an SF letter that would not reasonably affect PRAP 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 PRAP status.

HIPAA disclosures are a painful issue. Some clinics believe that by having the member sign a PRAP 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. After running 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 PRAP

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 PRAP 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 an orange 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 PRAP 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 PRAP 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 people 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 <u>not</u> one of them, and <u>there is no number over which pain must be reported</u>.

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?). People fixate on pain 7/10 or higher because it's reasonable to expect that the provider is going to treat pain at that level. They may prescribe narcotics, limited duty, or other PRAP impacting action. At high levels, pain might also cause fatigue, inability to concentrate, or other effects. In other words, it's the treatment and effect of pain, not the pain itself, which might affect PRAP duties.

Your CMA's have probably already addressed the pain level in their note. Look under "objective". Does it say "In no acute distress"? That's a good start. But it's even better to make a simple and clear statement on the effects of subjective pain, "*Pt reports no effect on concentration and pain does not impact daily activity or duty."*

What if the pain is severe enough to affect PRAP duties? One common technique is to tell the CO that the member has "*Distracting pain*." ***Please <u>don't</u> say 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 criteria 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.

There are a number of different types of mishaps defined in AFI 91-204, each with its own rules and approaches.

***NOTE**: If the event happens to include NATO assets or personnel, the investigation and report will run according to NATO STANAG 3531, 3102, Flight Safety Co-operation in Common Ground/Air Space, 3318, Aeromedical Aspects of Aircraft Accident and Incident Investigation, and Air Standard 85/02A, Investigation of Aircraft/Missile Accidents/Incidents (with US reservations). If USAF assets are involved as well, the USAF will conduct an investigation.*

MISHAP CLASSIFICATION PER AFI 91-204:

Class A Mishap—A mishap resulting in one or more of the following:

1. Direct mishap cost totaling $2,000,000 or more.
2. A fatality or permanent total disability.
3. Destruction of a DoD aircraft.
4. Permanent loss of primary mission capability of an AF spacevehicle.

Class B Mishap—A mishap resulting in one or more of the following:

1. Direct mishap cost totaling $500,000 or more but less than $2,000,000.
2. A permanent partial disability.
3. Inpatient hospitalization of three or more personnel. This does not include individuals hospitalized for observation, diagnostic, or administrative purposes that were treated and released.
4. Permanent degradation of primary or secondary mission capability of a space vehicle or the permanent loss of secondary mission capability of a space vehicle.

Class C Mishap—A mishap resulting in one or more of the following:

1. Direct mishap cost totaling $50,000 or more but less than $500,000.
2. Any injury or occupational illness that causes loss of one or more days away from work not including the day or shift it occurred. When determining if the mishap is a Lost Time Case, you must count the number of days the employee was unable to work as a result of the injury or illness, regardless of whether the person was scheduled to work on those days. Weekend days, holidays, vacation days, or other days off are included in the total number of days, if the employee would not have been able to work on those days.
3. An occupational injury or illness resulting in permanent change of job.
4. Permanent loss or degradation of tertiary mission capability of a space vehicle.

Class D Mishap—An on-duty mishap resulting in one or more of the following:

1. Direct mishap cost totaling $20,000 or more but less than $50,000.
2. A recordable injury cost or illness not otherwise classified as a Class A, B, or C mishap.
3. Any work-related mishap resulting in a recordable injury or illness not otherwise classified as a Class A, B, or C mishap. These are cases where, because of injury or occupational illness, the employee only works partial days, has restricted duties (does not include medical restriction from flying or special operational duties by AF Form 2992) or was transferred to another job, required medical treatment greater than first aid, or experienced loss of consciousness (does not include G-loss of consciousness). In addition, a significant injury (e.g. fractured/cracked bone, punctured eardrum, any laser eye injury) or occupational illness (e.g. occupational cancer (mesothelioma), chronic irreversible disease (beryllium disease)) diagnosed by a physician or other licensed health care professional must be reported even if it does not result in death, days away from work, restricted work, job transfer, medical treatment greater than first aid, or loss of consciousness.

Class E Mishap—A work-related mishap that falls below Class D criteria. Most Class E mishap reporting is voluntary; however see discipline-specific safety manuals for a list of events requiring mandatory reporting.

AIRCRAFT MISHAPS

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 1.5.17.5.4. and AFI 91-204 2.11.) 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 typically 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.

It's important to remember that the SIB members, including medical members, are not covered entities under HIPAA. This means that when the SIB receives medical information, is not covered by HIPAA, but rather the Privacy Act. It is the medical member's duty to inform interviewees that HIPAA does not apply, but that their personal information will still be protected. (AFI 91-204 3.5.3.) This does not necessarily apply for AIBs, where other board members may not be required to review and deliberate on relevant medical information.

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

IF YOU SUSPECT DECOMPRESSION SICKNESS

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.

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.

NOTE: *The AF Safety Office, Human Safety Division, developed an excellent ISB medical response checklist that clearly summarizes preparation and response for mishaps. Download it and customize it as your 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 2992 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 report is releasable. JAG maintains reports from Class A AIBs at https://afjag.af.mil/AIB-Reports/ . There is also an archive found at https://www.airforcemag.com/docs/type/accident/*

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 2992'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.

WEAPON MISHAPS – DIRECTED ENERGY, SMALL ARMS, NUCLEAR, ETC

For the purposes of AFI 91-204, a weapons mishap is one that falls into one of the following mishap categories:

- nuclear
- guided missile
- explosives
- small arms (on-duty only)
- chemical agents
- directed energy

Common examples are accidental firearm discharge by an SFS troop, or MXS troops being exposed to non-ionizing radiation from a radar system.

Commonly, flight surgeons may be asked to assist in a weapons mishap by collecting toxicology or medical history. AFMAN 91-221, Weapons Safety Investigations and Reports, directs the use of AFI 91-204, Safety Investigation and Hazard Reporting, which provides the authority to collect medical specimens for toxicology testing and medical histories in support of mishap investigation.

The key is this guidance only supports toxicology and medical history gathering for weapons safety mishaps, it does NOT support Deficiency Reports (DULL SWORDS). If a weapons mishap occurs, commanders are covered by AF Guidance to request toxicology and the medical history; however, commanders cannot do the same for a DULL SWORD investigation without seeking Wing JA assistance in the matter.

The AFGSC SE team is working with AFSEC to include DULL SWORD investigations with mishaps, but at this time, it requires a command direction for (non-clinically indicated) toxicology.

RADIOFREQUENCY RADIATION EXPOSURE (DIRECTED ENERGY DEVICE) MISHAPS

All suspected RFR exposures must be investigated and reported in AFSAS. AFOSH Std 48-139 and 48-9 detail the requirements for the investigation. The BEE's will review the tech manuals to determine outputs, then measure or estimate the levels of the alleged exposure.

It takes a significant amount of RFR to the eye to cause long-term effects (i.e.: cataracts), so unless there was more than 5 times the maximum permissible exposure (MPE), no medical effects are expected and no exam is required. Those levels would be expected to cause noticeable burns and pain. However, meeting with a patient may defuse concerns, so evaluations may be prudent even in low-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.) Meet 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 (DIRECTED ENERGY DEVICE) MISHAPS

If there is a suspected laser exposure, AFI 48-139 outlines the exams and steps to take. Additionally, AFMAN 48-149 discusses it in 7.2.2. If results are normal, then an occupational injury did not occur, but the investigation must still be documented.

1. The member should immediately report to the Medical Treatment Facility whenever eye exposure to laser light is suspected.
   a) Contact the Installation Laser Safety Officer (typically the BEE lead) to begin an investigation.
   b) Notify the DoD Tri-Service Laser Injury Hotline at 1-800-473-3549, (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*. (AFMAN 48-149 7.2.2.3.)
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]

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

GROUND MISHAPS

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

The flight med clinic may be pulled in to obtain 72 hour / 14 day histories, conduct medical exams, and order toxicology testing. There is no written requirement for any of the above, but it's generally best to treat the ground mishap like an aircraft mishap of the same classification.

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 AFMAN 91-221 *Weapons Safety Investigations and Reports* and a summary is below.

All of the following are "Pinnacle" events, meaning that they are of immediate 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 example of a BROKEN ARROW is the crash of an aircraft 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. This is the equivalent of a "near miss", so it's the most common flag word used. An example is damage to a transport vehicle that isn't carrying a weapon. If there is a major unreported medical issue in a PRP Critical Airman, it could also result in a DULL SWORD.

- **"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 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"
AFMOA	Air Force Medical Operations Agency	The former agency that provided operational support and which is now combined with AFMSA to form AFMRA
AFMSA	Air Force Medical Support Agency	The former HAF SG level agency that provided oversight to MAJCOM's on waivers, standards, and creates AF level guidance. It combined with AFMOA to form AFMRA.
AFMRA	Air Force Medical Readiness Agency	The HAF SG agency that provides AF level medical oversight and support, typically via the MAJCOMs.
DHA	Defense Health Agency	The agency that now runs non-operational medical services for the DoD.
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.
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, and folks awarded wings before this change were grandfathered.

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 medical school*	Capt Smith, a GMO flight doc. (4 years school + 1 year internship)
 **Senior Medical Corps Badge**	7-15 years experience *Counting medical 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 post-residency 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
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: AFMAN 48-149 para 3.3.2.5.
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: DAFMAN 48-123 para 5.7.3.
SIB: AFPAM 91-211 A4.7 and onward. Includes labs to order.
SME's are fully integrated into the MDG in garrison: AFMAN 48-149 4.4.1.13

Soft Contact Lens Program: DAFMAN 48-123 5.7.1
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 10-250, *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
- DAFMAN 48-123, *Medical Examinations And Standards*, 8 December 2020

- AFI 48-133, *Duty Limiting Conditions*, 7 Aug 2020
- AFI 48-135, *Human Immunodeficiency Virus Program*, 12 May 2004
- AFI 48-145, *Occupational And Environmental Health Program*, 05 Mar 2008
- AFMAN 48-149, *Flight And Operational Medicine Program (FOMP*), 13 Oct 2020
- 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*

APPENDIX OF SAMPLES

SAMPLE METALS LIST

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 PRAP 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
PRAP/PSP Program Management and Chart Reviews	BJAB	1	X						PRAP 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 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 PRAP 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 PRAP Programs / issues	BJAB	1						X	Initial standarization by deifnition only occurs once
Review of Local PRAP 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.

DEPARTMENT OF THE AIR FORCE
MEDICAL GROUP (MAJCOM)
BASE X AIR FORCE BASE, SOMEWHERE, USA

This Month, 2020

MEMORANDUM FOR XX MDG/CC

FROM: XX MDG/SGP

SUBJECT: Aerospace Medicine Council Meeting Minutes

1. **PLACE: MDG Conference Room**

2. **DATE AND TIME OF MEETING: This Month, 2020. 1300-1400**
Yes…AMC is only one hour. AMC shouldn't be running longer than that (nor should any meeting for that matter). Remember, AMC is an executive oversight forum for reporting. It should not be a decision making body. The subordinate groups should already have identified trends, formulated COA's to fix them, and be reporting the results of those COA's to AMC. The AMCs that run three or more hours are the ones that don't have effective working groups.

This template looks like it's very long, but that's because of all of the comments and lists of optional items. Once those are removed, the actual minutes will only be a few pages.

3. **ATTENDANCE:** *Make sure to have a list of the positions that are required to attend, rather than making a list of only people who show up. That makes it very clear if a required attendee is not present when you mark "ABSENT" for their name. Also, mark if they are "LATE". It doesn't take many times of being conspicuously called out in writing for people to make sure they're in in place and on time.*

Also, don't stress over quorum; if you don't have quorum, you can still hold the meeting. All you need to do is approve any decisions at the next meeting, which you'd do as part of the minutes review anyway.

RANK	FULL NAME	POSITION
Colonel	S. Geepea	Chairperson
Civ	Typist person	Recorder
Maj	B. Kieper	BEE Flt CC
Maj	L. Teebeii	PH Flt CC
	ABSENT	FOMC Flt CC

TSgt	H. Fahck	AOPT
		MSME
		ETC

4. **REVIEW OF PREVIOUS DOCUMENTS:** *Send minutes out ahead of time to allow people to review them. Then you don't have to go through line-by-line and can quickly make changes or approvals*

4.1. Previous AMC minutes
4.2 DAWG minutes (amended to remove HIPAA information)
4.3 OEHWG Minutes
4.4 FOMWG minutes (amended to remove HIPAA information)

Discussion: *Note any approval or disapproval of previous documents for this committee. List corrections or additions, if any, with page and paragraph. Or state Nothing Significant to Report (NSTR).*

5. **RECURRING AGENDA ITEMS:**

5.1. FLIGHT AND OPERATIONAL MEDICINE PROGRAM (FOMWG):
[OPR: Capt D. Phibb, FOMC/CC]

There are a lot of data points to report here, but rather than having multiple paragraphs, combine them into a chart or stoplight table

Aircrew DNIF rate (Goal = below 5%)

Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec
3.5%	4.6%	4.8%	6.5%	3.8%	3.5%	2.9%					

Discussion: NSTR

Aircrew Waiver Completion rate (Goal = no overdue)

	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec
Completed	3	2	4	1	3	3	2					
Overdue	0	0	1	0	2	0	0					

Discussion:
March: Overdue waiver due to patient availability for ACS appointment. Waiver since completed.
May: One overdue due to Airman PCS'ing in with expired waiver. MAJCOM SGP contacted to address. Second overdue due to member deployment. FOMWG will request extension from MAJCOM SGP if identified in the future. [INFO] OPR: Capt D. Phibb, FOMC/CC

5.2. METALS COMPLIANCE: Plan approved 11 Jan 2019. See attachments for breakdown of METALS taskings. (Compliance goal = 90%) [OPR: Capt D. Phibb, FOMC/CC]
You don't have to go into extreme detail here, since the slides presented to AMC and attached to the minutes will have individual aspects of METALS. When you develop the METALS plan, make sure the items are easily measured so you can report compliance. Avoid METALS priorities like "clinic support" since that's not a quantifiable metric. Instead, use measurable goals, such as "DNIF < 5%" or "Clinic 24HR and FUT access within DHA standards."

Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec
70%	80%	75%	70%	50%	60%	65%					

Discussion:
Line support is not meeting goal, with measured negative impacts to wing operations. Review of MEPRS found flight surgeons spending 90-95% of time in clinical duties and only 5-10% supporting operations (METALS). Current access model has flight surgeons cross-covering HCOS to maintain HCOS access in "Green". SGP meeting with OMRS and HCOS CCs to immediately cease cross-coverage. SGP will elevate to MDG/CC as needed. [EDC: DD/Mon/Yr. OPR: LtCol S. Geepea, SGP]

5.3. Mission Training Rates: [OPR Capt D. Phibb, FOMC/CC]
FS Mission Qualification Training status rate = 4/5 completed. 80%
4N0X1F completion of advanced Flight Medicine training = 7/7 complete. 100%.

Discussion: Capt G. Mo has completed 75% of MQT training, up from 50% last month.

The optional areas below don't need to be reported or included, but you can split them up for an annual report, perhaps by having some of them reported every month or every quarter. Or, you may choose to report one or more via a chart, similar to above.
Flyer dental readiness
Clinic access (customer satisfaction)
PRAP compliance
Soft Contact Lens Program
Ground testing
Air evacuation

5.2. OCCUPATIONAL AND ENVIRONMENTAL HEALTH PROGRAM:
[OPR: Maj B. Kieper]
This summarizes the major trends and COA's from the OEHWG. Just like above, you can use stoplight charts to quickly convey information and trends. Include:
OEHME completion rate
OEH Site assessments
High and medium risk health risk assessments
Flight Surgeon category 1 annual workplace shop visit rate
Open DOEHRS High Priority special assessments; status of RACs
Workplace assessment completion rate for Fetal Protection Program

Workplace Metrics

	TOTAL
OCat 1 Shop IH Inspections	12/12
Occupational Health Medical Exam Currency	91.6%
Respiratory Protection Pgm Currency	99%
Hearing Conservation (Threshold Shifts)	
Temporary Shift (Goal < 10%)	14 (9%)
Permanent Shift (Goal < 5%)	5 (3%)

Legend	Meeting Expectation	Behind Expectation

If you don't want to use a stoplight, you can also provide the information written out in text, as illustrated below. But a stoplight showing this would convey the information much more concisely – and be easier to update.

Discussion: 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. COMPLIANT with Air Force Standard for Pregnancy Profiles. (INFO: OPR: Maj B. Kieper)

The optional areas below don't need to be reported or included, but you can split them up for an annual report, perhaps by having some of them reported every month or every quarter. Or, you may choose to report one or more via a chart, similar to above.

Industrial mask fit testing
Confined space permits
QNFT mask fit testing
Occupational illness and injury rates
Industrial ventilation program
Thermoluminescent Dosimetry Program
Radioactive materials permits
HAZMAT authorization report
Initial threshold shift rate
Permanent threshold shift rate

Discussion: NSTR.

5.3. FORCE HEALTH READINESS PROGRAM: OPR: Lt R. Eddie

Here is where you can report the major DAWG metrics / trends / COAs. It includes the IMR rate and DAWG required metrics.

A2.6.2. Pre and post deployment processing tracked and reported

Monthly DAWG Metrics

This Month 2019	TOTAL	Monthly Trend (Last 3 Months)
Medical Mobility Ready (MMR)	82.3%	⇩
Medically Mobility Capable (MMC)	4.2%	⇩
Medically Mobility Limited (MML)	13.5%	⇨
Code 31	25 Days	⇨
Code 37	73 (3.9%)	⇩
Code 81	22 (1.7%)	⇩
ALC Code C	3 (0.3%)	⇩

Red arrow indicates negative drop in numbers; Green arrow indicates positive drop in numbers
Yellow arrow indicates number remains the same as previous month

Monthly ASIMS Metrics

This Month 2019	MDG	OMRS	HCOS	Base
Overall (Goal: ≥ 80%)	77.8% ⇩	98.5% ⇩	78.9% ⇩	81% ⇨
Immunology	99.7% ⇧	98.5% ⇧	97.4% ⇧	98.1% ⇩
Dental	98.7% ⇧	100% ⇧	98.7% ⇧	97.8% ⇨
Lab	99.3% ⇨	100% ⇨	100% ⇨	99.3% ⇨
DLC	88.9% ⇩	69.1% ⇩	81.6% ⇩	85.4% ⇧
PHA	100% ⇧	97.1% ⇧	97.4% ⇧	98.6% ⇧
Equipment	100% ⇨	100% ⇨	100% ⇨	99.4% ⇨

* Collected first working day of the month
Red arrow indicates negative change in numbers; Green arrow indicates positive change in numbers
Yellow arrow indicates number remains the same

Discussion: NSTR

5.4. COMMUNITY HEALTH PROGRAM: OPR: Maj L Teebeii

Just like above, this section can be conveyed in several short stop light charts, showing total number, number complete, and compliance.

Management of LTBI
Medical employee health program compliance
Food and facility inspection rate
Surveillance

The optional areas below don't need to be reported or included, but you can split them up for an annual report, perhaps by having some of them reported every month or every quarter. Or, you may choose to report one or more via a chart, similar to above.

Water vulnerability assessment
Food safety assessment
Immunization rate in DoDDs teachers and daycare providers
Communicable disease report
Child lead screening
Mosquito surveillance
Environmental sampling (potable water, swimming pools, etc)
Animal bite protocol compliance
Community outreach to promote health installation (tobacco use, nutrition, physical activity and other health behaviors).

Discussion: NSTR

5.5. HUMAN PERFORMANCE PROGRAM: OPR: TSgt H Fac

This section is often overlooked and omitted. It may not need to be updated or reported at each AMC, but it is required at least annually. No need to include the plan every time, but it's a good idea to at least say, "Plan presented and approved at XX meeting." Consider doing a review every six months to keep on top of it.

1. An AMC validated prioritized list of local human performance sustainment threats developed.
2. A plan in place for mitigating or minimizing the adverse effects of each local threat.
3. Indicators to measure mitigation strategy effectiveness developed and utilized for each identified local threat.

   Discussion:

   Plan presented and approved at 1 Jan 20 meeting. Due for review and update during Jul 20. [INFO]

5.6. EMERGENCY RESPONSE AND DISASTER MANAGEMENT PROGRAM: OPR: Maj Phee Oh

This entire section can be reported with a table. No need to make a long section for it.

AFSC trained rate
TA required exercise completion rate/status. (Focus on AME specific exercises as directed by SGP to meet local training requirements.)
TA personnel fully trained IAW AFI 10-2501.
Discussion: NSTR

5.7. REVIEW OF ANY NEW HHQ AFIs, POLICIES, OR TASKINGS: OPR:XXXXXXX

5.8. STATUS OF MDGI AND OIs FOR CURRENCY/REVIEW/REVISION: OPR:XXXXXX

6. **OLD BUSINESS:** *There typically isn't old business, since there typically isn't much new business specific to AMC. See below.*

7. **NEW BUSINESS:** *Remember…AMC is an executive oversight forum. The decisions should be made at the working group level and reported to AMC. New business would normally be channeled to AMC from its subordinate working groups and tracked via their reports, so it's not normal to have new business introduced at AMC.*
If you find yourself with a great deal of new business items at AMC, chances are the AMC is being mis-used as a flight management meeting or the working groups aren't doing their jobs.

8. **ITEMS REFERRED TO OTHER COMMITTEES AND/OR INDIVIDUALS:** *As opposed to the new business section, which is not commonly used, this category is frequently used. If something is brought up at to the AMC as "new business", it is normally not appropriate to manage at AMC and should be referred to the appropriate working group for resolution.*

1. Termination of cross-coverage of HCOS to allow for improved METALS support (see 5.2). [EDC: DD/Mon/Yr. OPR: LtCol S. Geepea, SGP]

9. **ADJOURNMENT:** (TIME ADJOURNED)

10. **NEXT MEETING:** DATE, TIME AND PLACE OF NEXT SCHEDULED MEETING

TYPIST PERSON, GS-05, DAF
Recorder, AMC

S. GEEPEA, LtCol, USAF, MC, FS
Chairperson, AMC

Attachment:
This Month AMC Slides

Approved as written/noted:

MDG CC PERSON, Col, USAF
Medical Executive Committee

AOME Program Evaluation Summary

Requirement	Reference	Expectation	Documentation	Compliance
Where does the SGP fall in the leadership chain?	AFI 48-101 para 1.4.13.3	Directly subordinate to the MDG CC as a 3 letter stand alone.		
What steps has the SGP taken to establish relationships with the LAF?	AFI 48-101 para 1.4.14.1.	Must develop and maintain relationship. Examples include attending OG meetings, CC calls, etc		
Does the SGP have a top secret clearance?	AFI 48-101 1.14.15.2	SGP maintains at least a TS		
How familiar is the SGP with flying and operational missions?	AFI 48-101 1.4.15.3	Seek opportunities for familiarity, which may include flying, visiting MAF, attending pre-D briefs, etc.		
What responsibilities does the SGP have for chairing meetings?	AFI 48-101 1.4.15.4.2	Chair DAWG, OEHWG, FOMWG (or flt/CC), PHEWG (if PHEO)		
Is the SGP involved in planning exercises?	AFI 48-101 1.4.15.9	Provide consultation to Wg IG/plans and medical readiness for developing plans and exercises		
How often is the AMC held?	AFI 48-101 1.6.1.2.	At least monthly, but no less than quarterly		
Who reviews your AMC minutes?	AFI 48-101 para 1.6.1.2.	Minutes are reviewed and approved by MDG exec comm.		
Who attends AMC?	AFI 48-101 1.6.1.3	SGP, OIC and NCOIC of AOP, BE, FOM, Opto, PH, MSME, health promotion, all FS, and dental (since they're now part of OMRS)		

Requirement	Reference	Expectation	Documentation	Compliance
Is the SGP involved in non TA meetings?	AFI 48-101 para 1.6.6.	SGP may (or must) attend ESOH Council, TWG, Med Readiness Comm, Force protection WG, Wg/Sq flight safety meetings, pop health WG, installation restoration program advisory board, Ops Grp exec staff, IEMWG.		
Flight / Operational Med				
What indicators do you use to validate the program?	AFI 48-101 para 2.4	DNIA, DNIF reported to Grp/Sq ops CCs, METALS plan, FS MQT training, 4 Fox training, IFC		
How are these tracked?	AFI 48-101 para 2.6.2	at least quarterly and potentially at the OG staff meetings		
OEH				
What indicators do you use to validate the program?	AFI 48-101 para 3.4	OEHME > 90% current, OEHSA completed annually, Cat / Cat 2 health assessments within tmieline > 90%, DOEHRS closed within 60 days, Cat 1 annual visits > 90%, RACs used appropriately, Fetal protection < 5 days at >90%		
How are these tracked?	AFI 48-101 para 3.6	At least quarterly to MDG exec committee, indicators briefed at OEHWG and to ESOH council (as appopriate)		
Can I see your last PMR? (Program Management Report)	AFI 48-145 2.7.2	Consolidated PMR is produced at OEHWG and provided to the installation CC annually. Should include pertinent information from FOMC, BE, and PH PMRs.		

Requirement	Reference	Expectation	Documentation	Compliance
What do you do with the PMR once it's reviewed?	AFI 48-145 2.9.11	SGP ensures OEHWG produces the consolidated PMR (FOMC+BE+PH), has it approved by the Wing CC and forwards to MAJCOM ESOH Council (MAJCOM BE)		
Force Health				
What indicators do you use to validate the program?	AFI 48-101 para 4.4	IMR, DHRA and DAWG metrics		
How are these tracked?	AFI 48-101 para 4.4	monthly to MDG exec and force health protection / medical readiness (ie - IMR, DHRA) monthly to sq, grp, or wing leadership		
Community Health				
What indicators do you use to validate the program?	AFI 48-101 para 5.4	LTBI, medical employee health compliance program 95%, public health surveillance programs, water surveillance programs, BBP tracking for medics exposed, health surveillance on tobacco use, obesity, physical activity, and nutrition		
How are these tracked?	AFI 48-101 para 5.6	briefed to AMC and MDG as needed and as determined by SGP		
human performance sustainment				
What indicators do you use to validate the program?	AFI 48-101 para 6.5	AMC validated list of local human performance sustainment threats developed, plan to mitigate them, and indicators that plan is working		

Requirement	Reference	Expectation	Documentation	Compliance
How are these tracked?	AFI 48-101 para 6.7	briefed to AMC and MDG as needed and as determined by SGP, as well as to OG Staff meeting prn		
Emergency Response / Disaster management				
What indicators do you use to validate the program?	AFI 48-101 para 7.4	each TA member is trained and has completed excercies, etc		
How are these tracked?		reported to AMC as determined by SGP		

SAMPLE CONSOLIDATED PMR: NARRATIVE FORMAT.

HEADQUARTERS
AIR FORCE GLOBAL STRIKE COMMAND (AFGSC)

CY2019

CONSOLIDATED OCCUPATIONAL HEALTH ANNUAL PROGRAM MANAGEMENT REVIEW

Introduction and Executive Summary

The Consolidated Occupational Health Program Management Review (PMR) is required by AFI 90-801, *Environment, Safety, and Occupational Health Councils*, dated 4 Aug 2016, and AFI 48-145, *Occupational and Environmental Health Program*, dated 11 Jul 2018. Its primary objective is to allow leadership at HAF, MAJCOM, and installation-level, along with Occupational and Environmental Health (OEH) Program leaders and process owners, to critically evaluate OEH Program performance and implement improvements. Please refer to the PMR AFMRA spreadsheet for raw data.

The PMR is a component of the Occupational and Environmental Health Management System (OEHMS). It drives an in-depth analysis of local OEH programs and a critical assessment to identify potential risk reduction opportunities, improve compliance, and pursue continuous improvement. Additionally, it documents local performance and communicates that performance to provide the opportunity for input, action, and support at all leadership levels. This document consolidates individual PMRs from Flight Medicine, Public Health, and Bioenvironmental Engineering to capture all stages of the OEH enterprise.

Demographics and Staffing

Based on the UMD assessment, there are currently X vacancies across the flights involved with the Occupational Health programs. Flight Medicine has X/Y Flight Docs, X/Y Nurses, and X/Y Medical Technicians, (whatever else is in Flight Medicine). Public Health is staffed with X/Y Officers, X/Y Civilians, X/Y SNCOs, X/Y NCOs, and X/Y Amn. Bioenvironmental Engineering is staffed at X/Y total authorizations.

Performance Measures

Overall Alpha AFB performance measures were strong throughout the year. Bioenvironmental had some minor challenges

Bioenvironmental Engineering Performance Measures

Completion rates are defined as whether shop visit reports are completed and signed within the required timeframe as outlined in section 4.3. of AFI 48-145.

ɔ Completion te	hop Completion ate	Completion e	ards w/ ɔls	ds Assigned to Gs	ɔle Exposure entage	essed for ds
95%	98%	95%	97%	99%	3%	92%

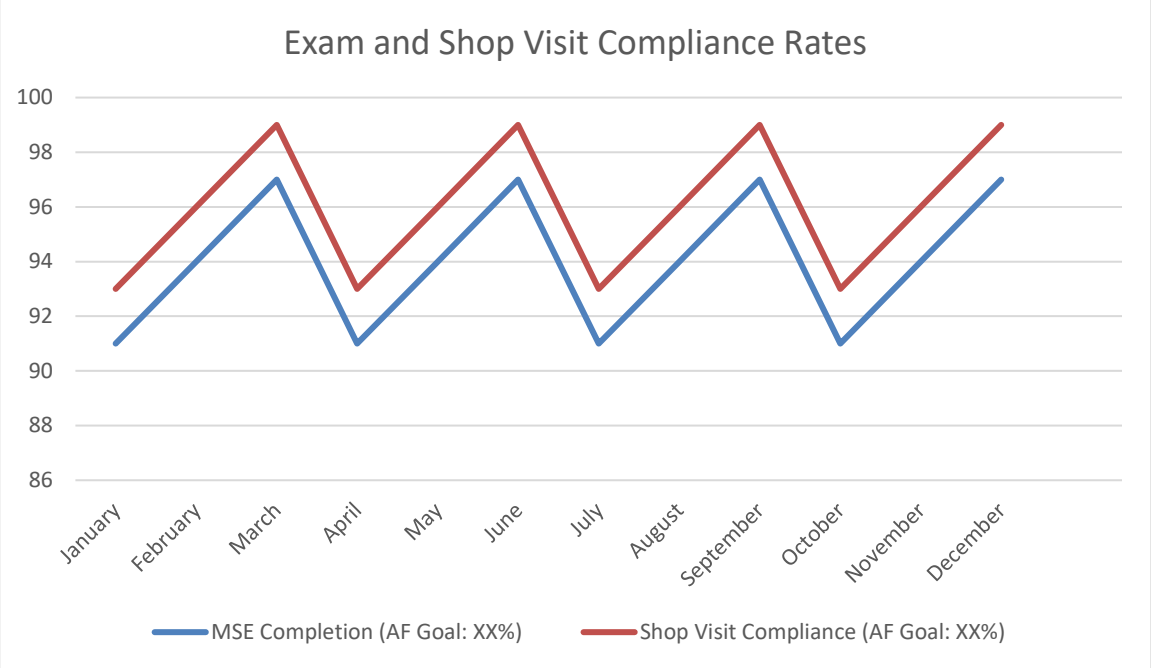
Installation wide systemic deficiency trends: This section is designed for Bio, PH, and Flight Medicine to identify and elevate significant compliance/deficiency trends across the installation. This can be used to garner installation wide support for corrective actions and/or funding.

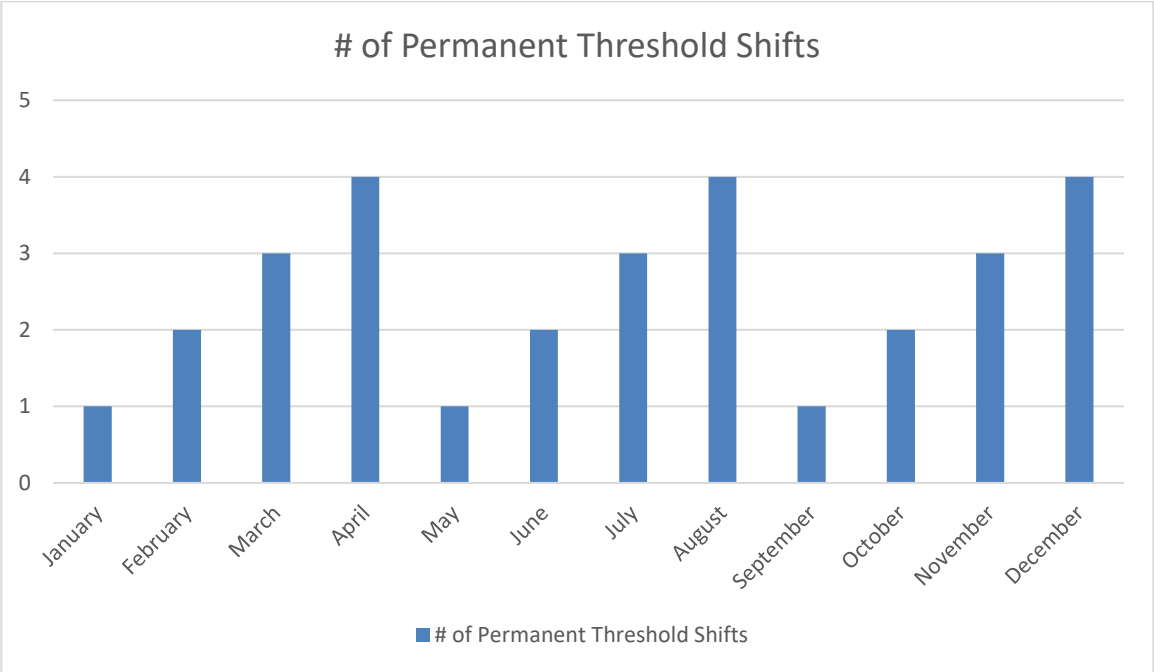
1) 4/8 shops visited this year had improper storage of respirators and other personal protective equipment.
2) 7/8 shops visited by Public Health were not properly updating there ASIMS rosters on the required interval.

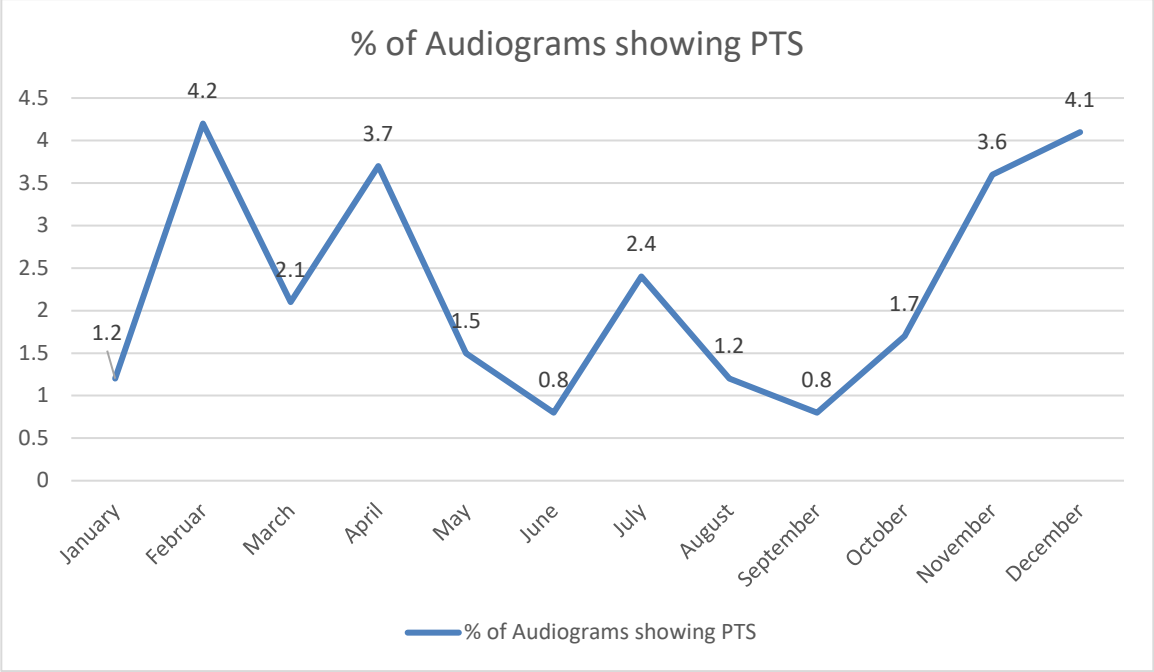
Public Health Performance Measures

Occupational Medical Surveillance Exam Compliance (AF Goal: 90%): Comprehensive evaluation of total medical surveillance exam compliance rates.

Public Health Shop Visit Compliance: Compliance rates for PH required shop visits to Category 1 and Category 2 shops.




# of Permanent Threshold Shifts
5
4
3
2
1
0
January
February
March
April
May
June
July
August
September
October
November
December
# of Permanent Threshold Shifts


% of Audiograms showing PTS
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
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4.2
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1.5
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January
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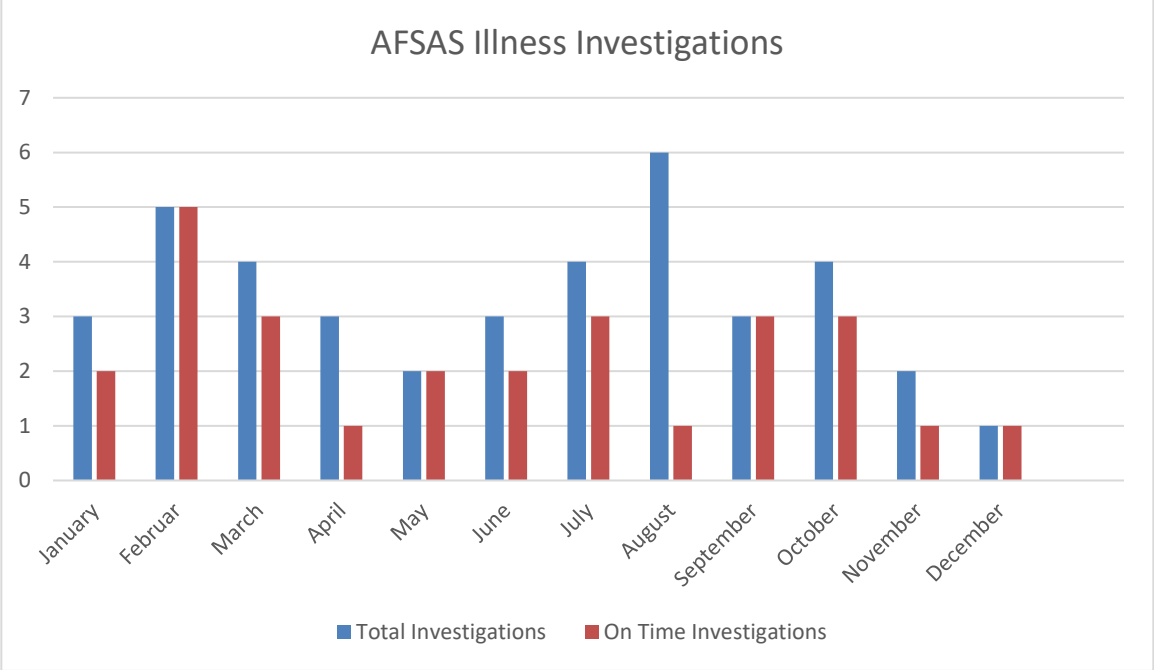
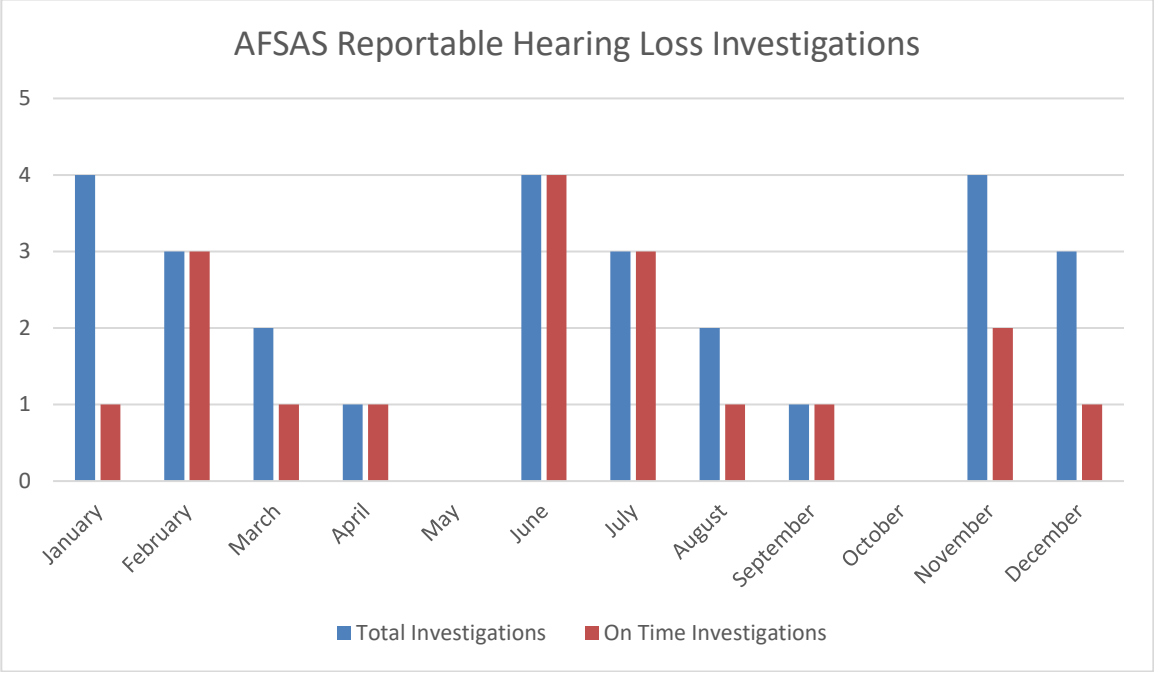
December
% of Audiograms showing PTS





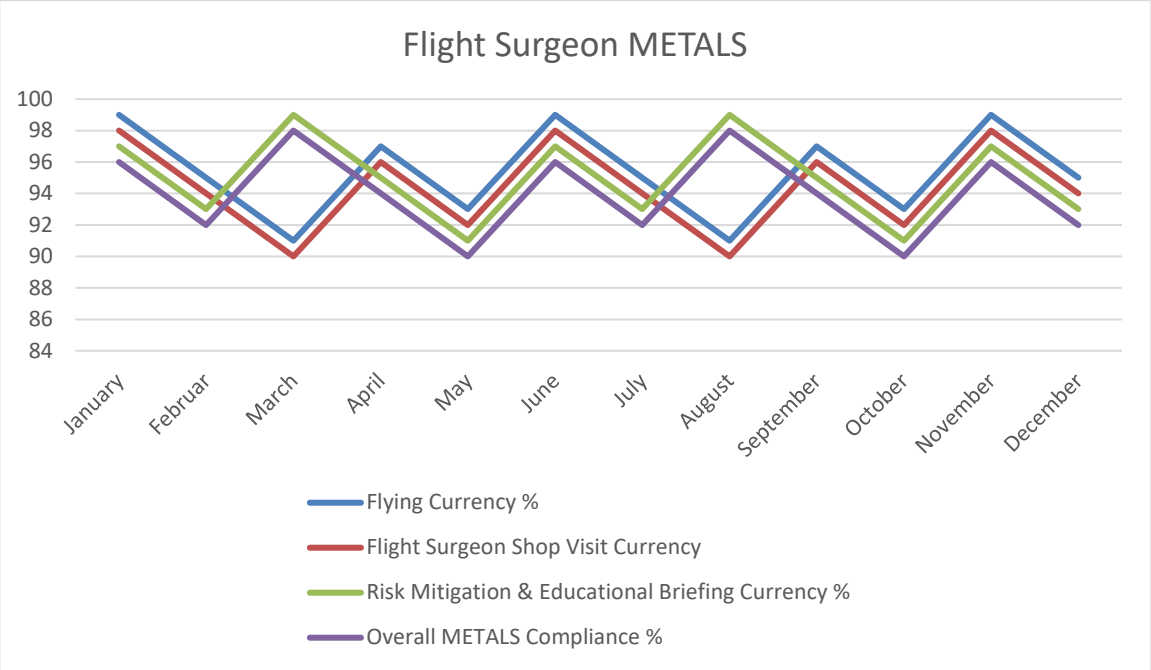
Flight Medicine Performance Measures

Flying Currency %: Each flight surgeon is required to maintain flying currency by logging an average of 4 hours flight time per month over a 3 month period.

Flight Surgeon Shop Visit Currency: A flight surgeon is required to visit every high hazard shop at least once per calendar year.

Risk Mitigation & Educational Briefing Currency %: Flight surgeons provide briefings to operational squadrons and medical group staff on various subjects related to applicable topics. For example, flight surgeons may brief pilots on fatigue management and medical staff on medical profiles.

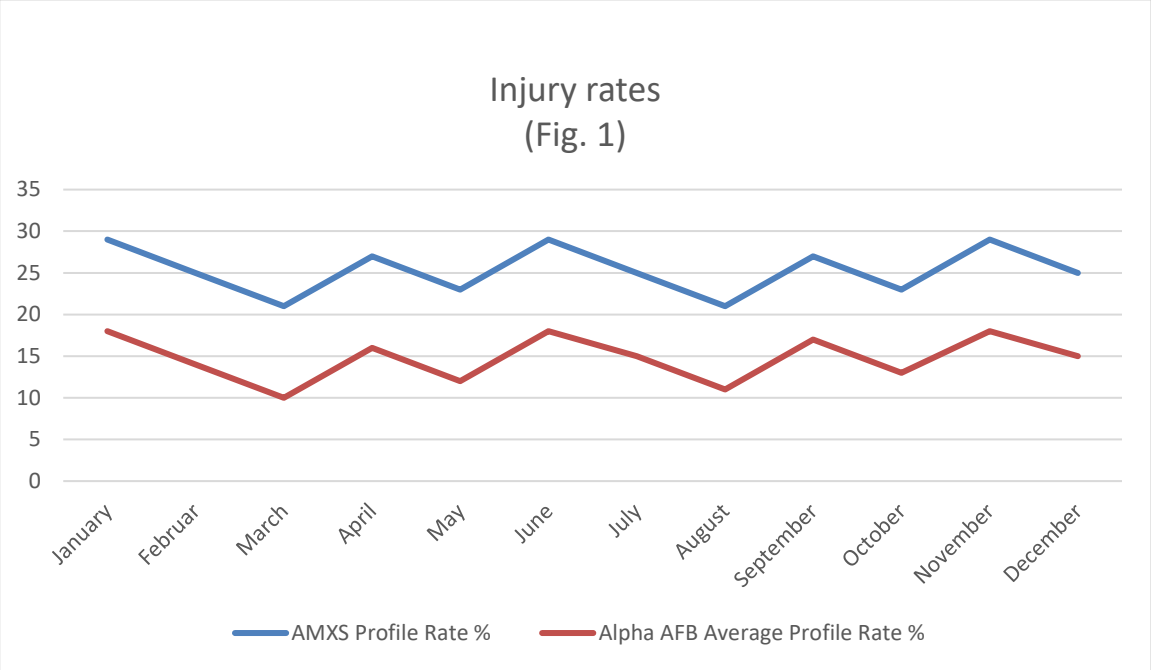
Overall METALS Compliance: Flight surgeons are required to spend 50% of their duty time on clinical operations and 50% of their time accomplishing the other operational duties, some of which are included in the Occupational Health Program.



Prioritized List of Local Human Performance Sustainment Threats

As a preventative medicine service seeking to optimize the human weapon system, the flight and operational medicine service identifies human performance threats and develops mitigations. Below are the top identified threats within Alpha AFB.

1) Musculoskeletal injuries among aircraft maintenance personnel.
   a. The injury and profile rate among AMXS personnel is disproportionately high compared to the base average. (Figure 1)
   b. FOMC, working with physical therapy, developed a work hardening exercise program to prevent injury, based off the Army program, "Building the Soldier Athlete". A PT Tech will lead this program at the unit PT training sessions, 3x per week for six weeks, until the unit PTLs are familiar with it.
   c. Injury rates are being tracked via the Airman Medical Readiness Optimization Board and OMRS patient utilization statistics. Both have shown statistical decease since program implementation.



2) Fatigue among ground based operators.
   a. Ground based sensor operators, pilots, and controllers at Alpha AFB perform round-the-clock operations, resulting in fatigue and decreased performance.
   b. Shift cycling protocols were developed and presented to the schedulers to minimize circadian disruption when changing shifts.
   c. Working with CE, color changing lights will be installed in the operations centers, to provide blue spectrum light during night hours to promote mental alertness. (EDC: 60 days)
   d. Program effectiveness will be monitored via Eppsworth Sleep Questionnaires, given before and after the interventions.

Continuous Improvement/Best Practices

All Occupational Health Flights (FM, PH, BE) are continually seeking improvement and innovative methods for mission completion. Below are some of these Continuous Process Improvement initiatives and identified best practices within Alpha AFB OH programs.

1) BE is working with Occupational Therapy to initiate formal tracking of ergonomic related illnesses/injuries in AFSAS. This allows timely and accurate assessments with appropriate follow-up and can be initiated by any provider that would like to investigate the patient's workplace ergonomic factors.
2) PH is working with Flight Medicine to standardize Firefighter physical compliance. The administrative requirements are initiated in PH during the audiogram appointment. PH ensures all paperwork is completed, labs and x-rays are ordered and the Flight Medicine appointment is booked if required. This process ensures all requirements are completed prior to the appointment with Flight surgeon, reducing wasted time from incomplete requirements.
3) Flight Medicine Clinic integrated Physical Therapist into Flight Medicine to counsel and provide treatment techniques for members with identified low back pain to decrease occurrences in higher risk populations and lessen healing time.

Corrective and Preventive Actions

All flights are utilizing the Management Internal Control Toolset (MICT) to identify corrective actions and these are being worked by each flight. FM identified X CAPs in progress and Y CAPs were finalized/closed during CY2018. PH identified X CAPs in progress and Y CAPs were finalized/closed during CY2018. Lastly, BE identified X CAPs in progress and Y CAPs were finalized/closed during CY2018.

Below are the self-identified findings still requiring corrective actions:

1) ABC XYZ (Days Open: 365; OPR: SGPB)
2) ABC XYZ (Days Open: 10; OPR: SGPM)

Risk Assessment Codes (RACs)

There are currently XX open Health RAC 1s and RAC 2s. During calendar year 2018, XX Health RAC 1s and 2s were closed throughout the installation.

Top Installation Occupational Health Accomplishments

1) Revamped installation respiratory protection program and revalidated all 2773s.
2) MSE completion sustained at 95% 10/12 months of 2018.
3) Provided XXX risk mitigation and educational briefings to XX Squadrons/XXXX personnel.

Top Installation Occupational Health Challenges

The most significant challenges addressed by the BE Flights include the following:

1) The ability to staff civilian, contractor, and active duty personnel that are capable and well trained. The hiring process for contractors and civilians is a slow process and the pool to choose from is extremely limited. This affects mission effectiveness if personnel hired do not possess the desired skillset.
2) The BE office continues to have challenges with the frequency at which some tasks are completed by industrial shops. This limits the frequency which BE can conduct air sampling for the processes conducted. In turn, this sometimes causes a lapse in OSHA required sampling frequency.
3) A common challenge is mismatched information. PH/BE must work together to ensure that OEHED/COHER match with most UTD data. COHER should not be copied forward or locally saved, reviews need to happen before OEHWG so SGP can be aware of hazards and countermeasures in place before signing COHER.
4) Overcoming manning challenges to simultaneously accomplish Flight Surgeon METALs requirements, maintain flying currency, accomplish shop visits, and provide appropriate risk mitigation briefings to the Wing while still implementing Base Operational Medicine Clinic workflows.

Top Installation OH Goals

1) The top goal for 2018 was to increase efficiency of shop visits from BE, PH, and FM. The intent was to coordinate opening conferences with all three agencies to reduce the impact to industrial shops.

2) Another BE goal was to validate all 2763s and conduct any air sampling required to qualify effectiveness of ventilation systems across the installation. This goal was accomplished by X,

Y, and Z. or…. This goal is still being worked due to manning shortages and skillset challenges within the BE Flight.

3) The top goal for 2018 was to meet all Flight Surgeon METALS requirements: maintain flying currency, accomplish shop visits, and provide appropriate risk mitigation and educational briefings.

Alpha AFB Occupational Health Goals for 2019

1) Increase RP fit testing percentage to above 99%
   a. Update/train all shop RP POCs.
   b. Develop a process for notifying/following up w/members who are overdue and due w/in 30 days.
2) Keep admin PTS rate at 0%
   a. Schedule F/U 1 appointment at STS appointment, no more than 1 week post STS. This will leave 3 weeks for rescheduling if needed. Follow up with a phone call before the appointment.
   b. Up-channel STS pending F/U with enough time for PH leadership to engage to get F/U 1 and 2 completed.

Summary

The overall occupational and environmental (OEH) health program within Alpha AFB is healthy but there are areas that this PMR has identified for continuous process improvement. Flights have identified various challenges including X, Y, and Z. Our primary objective for the OH program in 2019 is X, Y, and Z.

JOE R. SNUFFY, Col, MC, SFS
Chief, Aerospace Medicine