



DEPARTMENT OF THE AIR FORCE
AIR FORCE RESERVE COMMAND

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MEMORANDUM FOR NON-COLLOCATED WING COMMANDERS

FROM: HQ AFRC/SG
Air Force Reserve Command
555 Cherry Road
Robins AFB, GA 31098

SUBJECT: AFRC Guidance Memorandum to AFI 44-102

RELEASABILITY: There are no releasability restrictions on this publication.

References: (a) AFI 44-102, *Medical Care Management*
(b) DoDI 6055.06, *DOD Fire and Emergency Services (F&ES) Program*
(c) DAFI 32-2001, *Fire and Emergency Services (F&ES) Program*

By Order of the Commander, Air Force Reserve Command (AFRC), this AFRC Guidance Memorandum (GM) is the first instance of a to-be published AFRC publication. Compliance with this memorandum is mandatory. To the extent its directions are inconsistent with other AFRC publications, the information herein prevails in accordance with DAFMAN 90-161, *Publishing Processes and Procedures*. Ensure all records generated as a result of processes prescribed in this publication adhere to AFI 33-322, *Records Management and Information Governance Program*, and are disposed in accordance with the Air Force Records Disposition Schedule, which is located in the Air Force Records Information Management System. This guidance is applicable to all standalone Air Force Reserve Bases that require Base Operating Support (BOS) Fire and Emergency Services (F&ES) Programs. This guidance does not apply to collocated units that have a servicing Military Treatment Facility (MTF).

AFI 44-102 Sec 2.20.1 states "Section 2.20. of this instruction does not apply to Air Reserve Components (ARC). Air Force Reserve Command will follow MAJCOM policy and Air National Guard will follow National Guard Bureau policy." This provides guidance regarding the authority for AFRC policy.

Due to limited scope of ARC/Unit Training Assembly (UTA) privileges, Reserve Medical Unit (RMU) physicians cannot provide oversight as Emergency Medical Services (EMS) Medical Director or Competent Medical Physician (CMP) IAW AFI44-102 section 2.20.6.4. and 2.20.7.

At standalone installations with BOS F&ES programs delivering EMS, the RMU will appoint a privileged provider to serve in an advisory role, to review the relevant MOUs/MOAs

and to verify that medical oversight is occurring and assists the Installation Fire Chief select the best of the three options to obtain EMS Medical Director oversight.

As the EMS medical director provides direct oversight of care, an RMU provider cannot act as the EMS medical director. Therefore, the appointed EMS Medical Director should be the Medical Director or EMS Director of the facility that receives patients from the installation. For non-collocated bases this would likely be a civilian facility.

DAFI 32-2001, paragraph 3.5.6.1, directs the Installation Fire Chief (IFC) to develop an installation specific BOS F&ES Program that complies with DAFI policy and local/state requirements as needed. IFC will establish community partnerships through written mutual aid agreements which meet the standard level of care and response time standards set forth in DoDI 6055.06, DoD 6055.06-M, DoD Fire and Emergency Services Certification Program and AFI 32-2001, *Fire Emergency Services (FES) Program* and, if supportable with available assets, those standards in the community or region in which the installation resides IAW AFI 44-102.

Different courses of action to obtain EMS Medical Director oversight could include:

- i) Obtain MOU/MOA for EMS medical oversight from an entity/organization with whom the F&ES already has a relationship (recommended)
- ii) Obtain EMS medical oversight via contract
- iii) Obtain MOU/MOA with RegAF MTF that has a qualified physician who could provide the necessary medical oversight

Prior to finalizing MOU/MOA/contract, route and coordinate for JA, A4OE and AFRC/SG concurrence and approval.

Ensure that all records created because of processes prescribed in this publication are maintained in accordance with Air Force Instruction (AFI) 33-322, *Records Management and Information Governance Program*, and disposed of in accordance with the Air Force Records Disposition Schedule located in the Air Force Records Information Management System.

This memorandum becomes void after one year has elapsed from the date of this memorandum, or upon publishing of AFI44-102_AFRCSUP permanently establishing this guidance, whichever is earlier.

RAMIL C. CODINA, Colonel, USAF
Command Surgeon
HQ Air Force Reserve Command

**BY ORDER OF THE
SECRETARY OF THE AIR FORCE**

AIR FORCE INSTRUCTION 44-102



17 MARCH 2015

**Certified Current 22 APRIL 2020
Medical**

MEDICAL CARE MANAGEMENT

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

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This instruction implements Air Force Policy Directive (AFPD) 44-1, *Medical Operations*, and provides guidance for the organization and delivery of medical care. It implements various publications of Department of Defense (DoD), recognized professional organizations, the Joint Commission (TJC), the Accreditation Association for Ambulatory Health Care (AAAHC) and appropriate health and safety agencies. This instruction applies to all personnel assigned to or working in Air Force Medical Treatment Facilities (MTF), Air Reserve Component (ARC) medical units and Aeromedical Evacuation units, including Reserve and Guard personnel during their active duty and Unit Training Assembly periods, civilian, volunteer personnel and trainees. Contracts for support of Medical Care Management will contain language that contractor personnel must comply with AFI 44-102. This Instruction requires collecting and maintaining information protected by the *Privacy Act of 1974*. System of Records Notices (SORN) F044 SG D, *Automated Medical/Dental Record System*, and F044 SG E, *Medical Record System* apply. Forms affected by the Privacy Act have an appropriate Privacy Act statement. This AFI may be supplemented at any level, but submit all supplements to this Air Force Instruction (AFI) to Office of Primary Responsibility (OPR) for coordination prior to certification and approval. Refer recommended changes and questions about this publication to the OPR listed above using the AF Form 847, *Recommendation for Change of Publication*; route AF Form 847s from the field through the appropriate chain of command. Requests for waivers must be submitted through the chain of command to the appropriate tier waiver approval authority. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with Air Force Manual (AFMAN) 33-363, *Management of Records*, and disposed of in accordance with Air Force Records Information Management System (AFRIMS) Records

Disposition Schedule (RDS). The authorities to waive wing/unit level requirements in this publication are identified with a Tier number (“T-0, T-1, T-2, T-3”) following the compliance statement. See AFI 33-360, *Publications and Forms Management*, for a description of the authorities associated with the Tier numbers. Submit requests for waivers through the chain of command to the appropriate Tier waiver approval authority, or alternately, to the Publication OPR for non-tiered compliance items. The use of the name or mark of any specific manufacturer, commercial product, commodity, or service in this publication does not imply endorsement by the Air Force.

SUMMARY OF CHANGES

This document has been substantially revised and must be completely reviewed. Wing level requirements have been tiered and assigned an appropriate waiver level. Major changes include updated language regarding off-duty employment. Timelines for response to patient initiated communication were adjusted. A section on medical photography was added. Occupational Medicine guidance was streamlined with references to other Air Force Instructions. New training requirements were established for fetal heart monitoring. Guidance regarding the provision of Emergency Medical Service (EMS) by medical and fire personnel was added. New procedures for inpatient clinical standardization were addressed. Details for the Visiting Specialty Provider program were documented. Medication reconciliation policy was clarified and expanded. New information based on DoD guidance was added regarding management of concussion. Prescribing requirements for Mefloquine were added. Dietary supplement screening and adverse event reporting procedures were implemented. Emergency contraception policy was adjusted to comply with the latest federal guidance. Abortion policy was also updated to comply with federal law. Chapter 5 Medical Services Product Line was eliminated and necessary guidance moved into Chapter 2. The rest of the instruction was renumbered. Living donor approval procedures were streamlined. Optometry and Physical Therapy guidance were removed from this instruction and implementation guidance placed on the appropriate consultant knowledge exchange site. Mental Health guidance was removed and placed in the appropriate instructions. Alternative Medicine privileging guidance was moved into the appropriate instruction. Sexual assault response information was updated based on federal and Air Force level guidance. In addition AF Form 579 *Controlled Substances Register* was updated.

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Chapter 1

ROLES, RESPONSIBILITIES AND ORGANIZATION

Section IA—Areas of Responsibility

1.1. Purpose. This instruction provides guidance for the general delivery of patient care and management of clinical services throughout the Air Force Medical Service (AFMS).

1.2. Roles and Responsibilities.

1.2.1. The Air Force Surgeon General (SG):

1.2.1.1. Develops clinical policy as described in this instruction.

1.2.1.2. Designates the Air Force Medical Operations Agency as the responsible organization for execution of the guidance in this instruction.

1.2.2. Air Force Medical Operations Agency (AFMOA):

1.2.2.1. Provides corporate level guidance for implementation and execution of this instruction in conjunction with the Major Command (MAJCOM) Surgeons.

1.2.2.2. Recommends additions, deletions, or amendments to this instruction as appropriate.

1.2.3. MAJCOM Surgeons (MAJCOM/SG or equivalent) to include ARC/SG:

1.2.3.1. In conjunction with AFMOA, ensures commands implement these instructions.

1.2.3.2. Recommends additions, deletions or amendments to this instruction as appropriate.

1.2.4. Medical Treatment Facility Commander (MTF/CC). This includes Reserve Medical Unit (RMU) Commander and Guard Medical Unit (GMU) Commander unless otherwise indicated:

1.2.4.1. Complies with this instruction and ensures personnel under their authority comply as well. (T-1)

1.2.4.2. Where the MTF comprises a Medical Wing (MDW), the MDW/CC may delegate responsibilities outlined in this instruction to the Vice Wing or MDG/CC as appropriate.

Section IB—Organization and Functions

1.3. Overview (Refer to AFI 38-101, *Air Force Organizations* also).

1.3.1. The MTF Organizational Plan. MTFs are organized in accordance with (IAW) AFI 38-101, and include the office of the Chief, Medical Staff; Chief Nurse; and clinical services necessary to perform the wing/installation medical services mission. Aeromedical Evacuation Squadrons (AES) are organized IAW AFI 38-101. Commanders and supervisors in the chain of command subordinate to the MTF/CC control conditions of employment including place, time and means of work. Commanders exercise command prerogatives over military members. Standards for competent clinical performance and professional conduct of

privileged providers are matters for professional clinical peer review as outlined in AFI 44-119, *Medical Quality Operations*. The MTF/CC has ultimate responsibility for, and authority over professional standards and clinical performance. **NOTE:** Throughout this document when a reference to MTF occurs it includes RMUs and GMUs unless otherwise indicated. The scope of each MTF can vary with some facilities having a significantly more focused mission therefore some sections of this instruction may not apply to all MTFs, i.e. anesthesia services, etc.

1.3.1.1. All three letters (SGH, SGP, SGN, SGD, SGA, SGB) coordinate on OPRs, PRFs, awards, and decorations for their respective corps members. They also serve as members of the Medical Group Executive Committee.

1.3.2. Chief, Medical Staff (SGH):

1.3.2.1. The SGH is a Medical Corps officer, or civilian physician, who maintains regular privileges in their specialty, reports directly to the MTF/CC and is an active medical staff member. (T-1)

1.3.2.2. Is responsible to the MTF/CC for matters concerning provider regulations, quality and scope of medical care, utilization of medical resources, and medical policy and planning. (T-1)

1.3.2.3. Is responsible for and has oversight of the credentialing, privileging, and peer review process as outlined in AFI 44-119. (T-1)

1.3.2.4. May appoint an Assistant SGH, who is also a privileged physician.

1.3.3. Chief, Aerospace Medicine (SGP):

1.3.3.1. The SGP should be the most qualified flight surgeon. Depending upon rank and capability, this will be an Aerospace Medicine Specialist (Air Force Specialty Code AFSC 48AX) whenever one is assigned; or, when no 48AX is assigned, the SGP will typically be the senior flight surgeon, (AFSC 48XX). (T-1)

1.3.3.2. Is responsible to the MTF/CC for all aspects of aerospace medicine activities IAW 48-101, *Aerospace Medicine Enterprise*. Reports directly to the MTF/CC and is an active executive staff member. (T-1)

1.3.4. Chief Nurse (SGN):

1.3.4.1. For each MTF a qualified Nurse Corps officer is designated as the SGN. For each AES a qualified Flight Nurse is designated as the Chief Nurse. (T-1)

1.3.4.2. The SGN has primary oversight of the clinical nursing activities of non-privileged nursing providers throughout the organization, and collaborates with other clinical disciplines in the development of the organizational plan for the delivery of nursing care. (T-1)

1.3.4.3. The SGN ensures that all nursing personnel are competent to perform their assigned responsibilities, IAW AFI 46-101, *Nursing Services and Operations*. Advises the MTF/CC or AES/CC and the SGH about actions required in relation to the clinical performance for nursing personnel IAW AFI 44-119. (T-1)

1.3.4.4. The SGN reports directly to the MTF/CC and is responsible for all aspects of nursing care. (T-1)

1.3.5. Chief, Dental Services (SGD):

1.3.5.1. The SGD is the most qualified dental officer and is typically the senior dental officer. (T-1)

1.3.5.2. Is responsible to the MTF/CC for the clinical and administrative aspects of all dental activities. (T-1)

1.3.6. Administrator (SGA)/AES Director of Operations (DO):

1.3.6.1. For each MTF a qualified Medical Service Corps (MSC) officer is designated as the SGA. For each AES a qualified MSC officer is designated as the Director of Operations. (T-1)

1.3.6.2. Secures and manages medical resources and information to ensure the MDG is capable of meeting operational medicine and readiness taskings. (T-1)

1.3.7. Biomedical Sciences Corps Executive (SGB):

1.3.7.1. For each Medical Group a senior Biomedical Sciences Corps (BSC) officer is designated as its BSC Executive. (T-1)

1.3.7.2. The SGB serves as a special staff advisor on BSC issues including strategic and operational planning, design of services, resource allocations, and decisions regarding utilization and assignment of personnel within the Medical Group. (T-1)

1.3.8. Privileged Providers:

1.3.8.1. Privileged healthcare providers assume complete responsibility for evaluating their patients' medical and dental problems and for prescribing an individualized therapeutic program within the scope of their clinical privileges. This includes providing age and condition appropriate preventive services.

1.3.8.2. The responsibility for the care of each admitted inpatient must be assigned to a provider fully privileged for the scope of care appropriate to the inpatient unit. (T-0, TJC)

1.3.8.3. A provider will see and evaluate his/her designated inpatients at least once each day, and document the visit. (T-1)

1.3.8.4. A privileged provider granted privileges for the scope of care required of an Intensive Care Unit (ICU) will evaluate their patients in an intensive care environment at least twice each day, and document each visit. (T-1)

1.3.8.5. Privileged providers generally should not treat themselves or members of their immediate families. Professional objectivity may be compromised when the immediate family member or the provider is the patient.

1.3.8.5.1. In emergencies or isolated settings where no other provider is available, providers should not hesitate to treat their family members or themselves.

1.3.8.5.2. Providers may not prescribe medications listed on the controlled substances list for themselves or for their family members.

1.3.8.5.3. Except for the emergency or isolated situations mentioned above, providers may not prescribe medications for themselves.

1.3.8.5.4. Providers who prescribe medications not on the controlled substances list for their family members must ensure that the treatment is within their scope of privileges, an evaluation is completed, and documentation of that evaluation is placed in the family member's health record. (T-0, TJC, AAAHC)

1.3.8.5.5. Providers should not order labs, x-rays, consults/referrals or perform procedures on themselves.

Section 1C—Limited Scope Medical Treatment Facilities (LSMTF)

1.4. Definitions.

1.4.1. LSMTFs are medical elements, flights, or small medical squadrons with a credentialed medical provider that do not provide the scope of services found in a medical group. LSMTFs are typically assigned to a line squadron or group (e.g. Air Base Squadron, Mission Support Group or Air Base Group). In some cases, a LSMTF may report directly to a wing or MAJCOM. In the event multiple MAJCOM assets are involved, the parent and supporting MAJCOM approve the Memorandum of Understanding (MOU).

1.4.1.1. LSMTFs are officially designated in the AFMS Flight Path and also referenced in AFI 38-101.

1.4.2. Medical Aid Stations are small medical elements without a privileged medical provider and are typically located at a geographically separated unit or Munitions Support Squadron site.

1.4.3. Munitions Support Squadron (MUNSS) are geographically separated units responsible for receipt, storage, maintenance and control of United States War Reserve Munitions in support of the North Atlantic Treaty Organization and its strike missions.

1.4.4. Geographically separated units (GSU) are units that are not at the same physical location or base as the parent unit.

1.4.5. Line-owned Medical Clinics: There are circumstances where some privileged providers and non-privileged medical staff care for patients in an outpatient setting apart from the host MTF. One example of this would be AFSOC's Ambulatory Care Units. Although these medical assets are line-owned, unless designated as a MTF or LSMTF, medical care will adhere to the host MTF policies and medical staff bylaws. The MTF will support the provision of care in these settings as noted in AFI 48-149, *Flight and Operational Medicine Program (FOMP)*.

1.5. LSMTF Waiver Process.

1.5.1. LSMTFs may not have sufficient personnel to provide all services or meet all requirements described in this AFI. All services provided are done in a safe manner ensuring the highest quality care. Some required services/requirements may be provided by a supporting MTF or through civilian services.

1.5.2. If the LSMTF Commander identifies requirements in this AFI that cannot be met by the LSMTF, nor another supporting facility, then a request for waiver will be submitted

through the MAJCOM/SG(s) and AFMOA to AF/SG and delegated to the Director, Medical Operations and Research (SG3/5) as the final waiver approval authority. The LSMTF must have waivers revalidated every three years by sending an updated request through the MAJCOM/SG and AFMOA for concurrence by SG3/5. (T-1)

Chapter 2

POLICIES WHICH COVER MULTIPLE PRODUCT LINES

Section 2A—Treatment Documentation

2.1. Treatment Documentation: Every outpatient evaluation and treatment episode, (including anesthesia; Mental Health therapy, patient education, alternative medicine such as acupuncture and chiropractic; ancillary care such as physical or occupational therapy, nutritional medicine) will be documented and entered into the Outpatient Health Record, Dental Health Record or in an electronic health record in use in the Military Healthcare System. Radiology and laboratory episodes of care will be documented through the generation of reports and results, which must be included in the electronic or Outpatient Health record. In the event that the electronic or Outpatient Health Record is unavailable, the episode will be documented and scanned into a clinical note when the electronic system is available or annotated and sent to the records room for inclusion into the Outpatient Health Record. Inpatient evaluation and treatment will be documented in Essentris or in an electronic health record in use in the Military Healthcare System. (T-1)

2.1.1. Each MTF must have a written policy outlining procedures for documentation during periods of unavailability of the inpatient or outpatient electronic Health Record, as appropriate for the scope of the facility. (T-0, TJC, AAAHC)

2.2. Medical Photography. Photographs of patients for purposes of documenting medical care are permissible as long as appropriate procedures are followed. All clinically relevant photos may be uploaded into the electronic medical record. For additional guidance on patient photography please refer to AFI 35-104, *Media Operations* and AFI 35-109, *Visual Information*.

2.3. Documentation for Immunizations: Immunizations will be documented in the Aeromedical Service Information Management System (ASIMS) program or the current accepted AF electronic tracking application. Individuals entering data into ASIMS must complete the ASIMS training. Documentation will be IAW AFI 48-110_IP, *Immunization and Chemoprophylaxis for the Prevention of Infectious Diseases*. (T-0, AFI 48-110_IP)

Section 2B—Informed Consent

2.4. MTF/CC Responsibilities: The MTF/CC or designee at each MTF establishes specific guidance on informed consent, consistent with any relevant law and reasonable standards of medical practice. Although local policy need not list all procedures or itemize what disclosures must be made in specific types of cases, it must provide a method for providers in the MTF to obtain answers to specific informed consent questions such as extent of disclosures or whether to use written consent forms. (T-1)

2.5. Resolving Questionable Issues.

2.5.1. Providers shall consult the SGH, Staff Judge Advocate (SJA) and/or the regional Medical Legal Consultant (MLC) to determine any questionable standards concerning informed consent. (T-1)

2.5.2. Providers may obtain information concerning consent and disclosure practices from local medical institutions, state and national professional organizations, and from the MLC annual briefing.

2.5.3. The attending provider is ultimately responsible for assuring that informed consent is obtained and documented.

2.6. Informed Consent Documentation.

2.6.1. Verbal consent is not routinely acceptable however may be used in extreme circumstances demanding life or limb-saving action. The consent and reason for verbal consent will be documented in the medical record. (T-1)

2.6.2. Consent must be obtained and recorded prior to sedation or prior to any procedure requiring consent. Consent must be obtained prior to receiving any medication which may diminish the patient's competence to provide consent. (T-1)

2.6.3. The responsible healthcare provider documents informed consent on OF Form 522, *Medical Record-Request for Administration of Anesthesia and for Performance of Operations and Other Procedures* (or other locally required form), on AF Form 1225, *Informed Consent for Blood Transfusion*, or on the SF 600, *Health Record Chronological Record of Medical Care*. When OF Form 522 or AF Form 1225 is used, there must also be an entry or overprint in the medical record. (T-1) Minimum requirements for the documentation include:

2.6.3.1. The nature of the proposed care, treatment, services, medications, interventions, or procedures.

2.6.3.2. Potential benefits, risks, or side effects, including potential problems related to recuperation.

2.6.3.3. Reasonable alternatives to the proposed care, treatment, and service.

2.6.3.4. The relevant risks, benefits, and side effects related to alternatives, including the possible results of not receiving care, treatment, and services.

2.6.3.5. When indicated, any limitations on the confidentiality of information learned from or about the patient.

2.6.4. Dental informed consent will conform to AFI 47-101, *Managing Air Force Dental Services*. (T-1)

Section 2C—Treating Minors

2.7. General Guidelines in Treating Minors:

2.7.1. Special circumstances can occur regarding confidentiality, consent, and treatment of minors. In all instances where MTFs are authorized to provide care to minors without parental consent, personnel must make every effort to encourage the patient to inform parents of their medical issues. In most instances, parents can have access to a minor child's medical record, thus the minor shall be made aware that any care they receive may be discovered. (T-1) Confidentiality of a minor child's medical record is discussed in AFI 33-332, *Air Force Privacy Act Program*. For specific questions regarding guidance on consent and

confidentiality for minors, contact the SJA at the local base for advice, especially when the following situations arise as state laws may vary:

- 2.7.1.1. Reproductive counseling and care for pregnancy and pregnancy-related conditions.
- 2.7.1.2. Counseling for drug, alcohol and tobacco abuse.
- 2.7.1.3. Counseling and treatment for sexually transmitted diseases.
- 2.7.1.4. Medical conditions where there is an imminent threat to life or limb.
- 2.7.1.5. Contraceptive counseling and treatment.
- 2.7.1.6. Counseling and treatment following rape.

2.7.2. Treating Minors in the United States: MTF/CCs will comply with local state laws and/or Department of Health and Human Services (DHHS) regulations governing consent for medical treatment of minors, including state definition of a minor. For state-specific guidance, including the rare instances where state law may be overridden by federal law, contact the SJA at the local base for advice. (T-0, Local, State, DHHS regulations)

2.7.3. Treating Minors Overseas: When treating minors without parental consent outside the US and its territories, the MTF/CC must work within the general principles of American law, host nation sovereignty/Status of Forces Agreements and in consultation with the local Judge Advocate office. (T-1) MTFs, in consultation with local staff judge advocate/medical legal consultant, may tailor policy on treatment of minors to be sensitive to host nation sensibilities, including setting minimum ages of consent. In the absence of local guidance to the contrary, providers may obtain consent from minors for the conditions listed in paragraph 2.7.1. in this instruction.

Section 2D—Chaperones

2.8. Chaperones.

2.8.1. Each MTF shall develop local procedures regarding the use of chaperones, for the protection of both patients and providers. At a minimum, these local procedures must contain: (T-1)

- 2.8.1.1. Assurance of privacy for examination and treatment.
- 2.8.1.2. Strict privacy considerations for robing and disrobing.
- 2.8.1.3. Circumstances for presence of a chaperone at the patient's or provider's request.
- 2.8.1.4. Circumstances for presence of a chaperone during the exposure, examination or treatment of patient's genitalia, rectum or female breasts, and during hypnosis, if performed in the MTF.
- 2.8.1.5. Communication to the patient of the nature and purpose of the examination or treatment and the extent and purpose of disrobing.
- 2.8.1.6. Education and training requirements for providers and staff on the role of chaperones, procedures for identifying and reporting suspected misconduct, and procedures for resolving questions of the use of chaperones.

2.8.1.7. **EXCEPTION:** In circumstances involving immediate threat to life or limb, medical personnel are not required to offer the presence of a chaperone.

2.8.2. Each MTF must ensure the chaperone policy is made known and available to all patients. (T-1) Posting of the policy in patient exam and treatment areas is recommended.

Section 2E—Occupational Medicine

2.9. Occupational Medicine. For guidance on occupational medicine issues refer to Department of Defense Manual (DoDM) 6055.05-M, *Occupational Medical Examinations and Surveillance Manual*; AFI48-145, *Occupational and Environmental Health Program*; and AFMAN48-146, *Occupational and Environmental Health Program Management*.

2.10. Care Of DoD Civilians Injured or Ill in the Workplace or During Work Periods: DoD civilian employees who become ill or who are injured as a result of factors of DoD employment are eligible to and should when possible obtain acute/urgent and immediate follow up care from the military health system if the local MTF/CC has determined local resources and contracts can support. They may exercise their right to instead seek care from their private civilian healthcare provider. Employees seeking care in the civilian sector should apply for coverage through the appropriate compensation program. The employee should be directed to Civilian Personnel Services for guidance regarding how to file for a compensation claim.

Section 2F—Reportable Diseases and Conditions

2.11. What and How to Report.

2.11.1. Providers shall report diseases and conditions of public health or military significance as defined in the installation reportable events list developed annually by the Public Health staff, as well as any other unusual conditions or clusters to the Public Health Office IAW AFI 48-105, *Surveillance, Prevention and Control of Diseases and Conditions of Public Health or Military Significance*. (T-1)

2.11.2. Providers shall report all suspected or confirmed occupational illnesses and injuries and conditions of public health significance (including work related musculoskeletal disorders) to the public health office IAW AFMAN 91-224, *Ground Safety Investigations and Reports*. (T-1)

Section 2G—Human Immunodeficiency Virus (HIV)

2.12. HIV-Infected Patient Referral.

2.12.1. Medical personnel must refer Air Force active-duty members with newly diagnosed HIV infections to the San Antonio Military Medical Center (SAMMC), San Antonio, TX, for definitive diagnosis, treatment, and disposition. Refer to AFI 44-178, *Human Immunodeficiency Virus Program* for additional details. ARC members will be referred to their RMU/GMU or waiver authority for processing IAW AFI 48-123, *Medical Examinations and Standards*; AFI 10-203, *Duty Limiting Conditions* and AFI 44-178. (T-1)

Section 2H—Medical Nutrition Therapy

2.13. Medical Nutrition Therapy (MNT). MNT includes clinical nutrition assessment, diet modification and counseling, and specialized nutrition therapy.

2.13.1. MNT should be offered to patients with medical conditions such as: diabetes, pediatric failure to thrive, dyslipidemia, hypertension, malnutrition, high-risk pregnancy, renal disease and complicated inflammatory bowel disease.

2.13.2. MNT is obtained via referral to the Nutritional Medicine Service (BALA), a registered dietitian, or to authorized enlisted staff members who have completed specialized training in diet therapy. If no services are available on base, the patient may obtain MNT off-base however there will be out of pocket expenses since it is not a TRICARE benefit.

Section 2I—Chiropractic Care

2.14. General Guidelines.

2.14.1. Chiropractic evaluation and treatment are authorized for active duty in designated MTFs. Doctors of Chiropractic are offered appointment to the medical staff and are awarded privileges IAW AFI 44-119.

2.14.2. Use of supplemental funding for chiropractic evaluation and treatment is not authorized.

2.14.3. No private sector chiropractic services are authorized.

Section 2J—Emergency Medical Response

2.15. Automated External Defibrillators (AED).

2.15.1. MTFs will provide AED services as part of all basic life support provided within the MTF buildings. The MTF/CC may increase the frequency of refresher training to ensure proficiency of personnel. (T-1)

2.15.2. Required AED training:

2.15.2.1. All MTF personnel trained in BLS will be trained using the AED chapter in the BLS manual, as appropriate for the devices in that particular MTF. (T-1)

2.15.2.2. Training on AED protocols is required for Emergency Services staff directly involved in patient care. Aerospace Medical Service Specialty Personnel (AFSC 4N0X1) assigned to emergency services, acute care clinics, back-up/ on-call ambulance crews, or nursing units utilizing AEDs on crash carts must accomplish AED qualification training semi-annually. ARC personnel require this training when working/assigned to an AD MTF. (T-1)

2.16. Requirements for Basic Life Support (BLS) Training.

2.16.1. Each MTF/CC will designate, in writing, an Emergency Resuscitation training coordinator. (T-2)

2.16.1.1. The training coordinator will track the BLS currency of assigned members and those in-processing to the MTF. (T-1)

2.16.1.2. At DoD affiliated area organizations that are otherwise unable to obtain Emergency Resuscitation training, the MTF/CC designates a training coordinator for BLS provider/instructor training. Organizations requesting the training will provide funding. A Memorandum of Agreement will be established between the organization and the MTF outlining the responsibilities for each party. (T-1)

2.16.2. Personnel may register and train under the auspices of the American Heart Association (AHA) or in a BLS course based on published national guidelines for BLS, however the Military Training Network is the recommended resource for obtaining required certification cards.

2.16.3. Requirements for personnel (including civilians and contractors) involved in direct patient care. Direct patient care may be defined as a member assigned to the MTF who has access to a patient's Personal Identifiable Information (PII) and is hired (or volunteers) to assist in the direct medical/dental/psychological treatment or diagnosis of a patient.

2.16.3.1. Personnel must maintain current registration in a basic provider CPR (Cardio-Pulmonary Resuscitation) course: AHA BLS Health Care Provider course or an equivalent course based on published national guidelines for BLS. (T-1)

2.16.4. Requirements for medical personnel (including civilians and contractors) who are not involved in patient care, but are working in patient care areas:

2.16.4.1. All personnel must maintain current registration in the AHA BLS Heartsaver AED or an equivalent course based on published national guidelines. (T-1)

2.16.5. Requirements for non-medical personnel (including civilians and contractors) who are not involved in direct patient care and who do not work in patient care areas:

2.16.5.1. The local MTF/CC will determine the CPR/BLS requirement for these personnel. It is recommended all personnel obtain Heartsaver AED training as a minimum. (T-3)

2.16.5.2. Non-patient care areas possessing an AED will ensure personnel trained in Heartsaver AED (at a minimum) are present during normal business hours. (T-1)

2.16.6. HQs / FOAs / MAJCOMs (Administrative only facilities) are exempt from the above training requirement unless directed by the local commander. Clinicians mandated by AFSC to maintain life support certification will bring proof of training to their Unit Training Manager/Unit Deployment Manager for documentation in MRDSS. Members who practice at a local MTF will be trained and tracked by the MTF in which they practice. Member preparing for deployment will receive Just In Time training.

2.17. Advanced Life Support (ALS) Planning.

2.17.1. Each MTF must have a written plan describing how medical emergencies, including cardiac and stroke, will be handled for patients in the locality of the MTF. (T-1)

2.17.1.1. The MTF plan must address provision of ALS. (T-1)

2.17.1.1.1. Any clinical area that provides moderate sedation for procedures must provide ALS. (T-1)

- 2.17.1.1.2. In clinical areas other than those providing moderate sedation, facilities must evaluate the practice environment, patient population, state and community standards, and DoD guidelines in emergency response. See Department of Defense Instruction (DoDI) 6055.06, *DoD Fire and Emergency Services (F&ES) Program* for established timeline for initial ALS capability. The MTF/CC must delineate in writing the plan for ALS capability, including who is responsible for that service and confirm the service can meet the DoD timeline. (T-1)
- 2.17.1.1.3. If MTF personnel must provide intrinsic ALS capability based on the DOD timeline guidance, then the MTF must insure the necessary supplies and appropriately ALS trained staff are available to provide ALS care. (T-0, DoDI 6055.06)
- 2.17.1.2. The plan must describe MTF process(es) for recognizing and responding to patients whose condition appears to be worsening. At some facilities a Rapid Response Team (RRT) may be appropriate. Supplemental information regarding RRT training, competency, and variances for ambulatory care settings is posted on the AFMS Clinical Quality Management Kx page, under AFMS Strategic Plan Initiatives, Rapid Response Teams. (T-2)
- 2.17.2. If an MTF is not present, medical oversight of base emergency response and treatment should be coordinated through a Memorandum of Agreement with the receiving community healthcare organization.

2.18. Requirements for Advanced Life Support Training.

- 2.18.1. General Requirements for Advanced Life Support training (Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), and Neonatal Resuscitation Program (NRP) or equivalent courses) are noted below. **NOTE:** The term “certification” refers to the successful demonstration of written and cognitive skills with a passing grade in an ACLS/PALS/NRP course or the equivalent course based on published national guidelines. The term “training” refers to participation in an entire standard ACLS/PALS/NRP course or the equivalent. Note that test taking is not required for training. The Military Training Network is the recommended resource for obtaining required certification cards.
- 2.18.1.1. Some MTFs have ALS response teams on call at all times to respond to resuscitative cases. All personnel on this team will have the appropriate ALS training/certification. (T-1)
- 2.18.2. Exemptions, Waivers and Extensions: In some instances, the MTF/CC may provide exemptions or waivers from the requirements for ALS certification and training.
- 2.18.2.1. Exemptions: Individuals with sufficient critical care training and experience in managing cardiopulmonary arrest situations independently, and who are actively engaged in clinical care, may request a letter of exemption from certification from the MTF/CC. This exemption must be reviewed by the credentials function and reaccomplished every 2 years. Documentation pertaining to the nature and extent of each review will be maintained in the appropriate provider credentials file. (T-1)
- 2.18.2.2. Waivers: In select situations, the MTF/CC may waive the requirement for periodic ALS certification. Such situations may apply to civilian contractors who work

limited hours as well as in settings where there is adequate emergency back-up and ALS capabilities. This waiver authority shall be used sparingly, and not based on a person's inability to pass the certification. (T-3)

2.18.2.3. Extensions: In situations where a provider's ALS certification expires and the provider is not able to accomplish recertification, the MTF/CC may grant an extension for up to 3 months. The extension must be reviewed by the credentials function. (T-1)

2.18.3. Specific ALS training requirements:

2.18.3.1. ACLS certification is required by any privileged healthcare provider (physician, resident physician, physician assistant, or nurse practitioner) assigned to the Emergency Department or Urgent Care Center (UCC). In addition, ACLS certification is required by any privileged healthcare provider who provides moderate sedation or general anesthesia to adults (18 years and older), regardless of the clinical area where the care is provided. If the MTF does not have an ALS response team, then privileged healthcare providers responsible for inpatient care areas with cardiac monitoring (Intensive Care Unit, Cardiac Care Unit, etc.) and Labor and Delivery would also need ACLS certification. Other health care providers (medical/dental) requiring ACLS are at the discretion of the MTF/CC.

2.18.3.1.1. ACLS training is required for nurses assigned to the emergency department or UCC. If the MTF does not have an ALS response team, then nurses assigned to inpatient care areas with cardiac monitoring (Intensive Care Unit, Cardiac Care Unit, etc.) and labor and delivery would also need ACLS training. ACLS training is optional for medical technicians assigned to the emergency department or UCC. Other health care personnel requiring ACLS are at the discretion of the MTF/CC.

2.18.3.2. PALS certification (or equivalent course, such as Advanced Pediatric Life Support) is required by any privileged healthcare provider (physician, resident physician, physician assistant, or nurse practitioner) assigned to the Emergency Department or UCC. PALS certification (or equivalent course) is also required by pediatric providers assigned inpatient pediatric duties. In addition, PALS certification (or equivalent course) is required by any privileged healthcare provider who provides moderate sedation or general anesthesia to infants, children, and/or adolescents (before the 18th birthday) regardless of the clinical area where the care is provided. Other health care providers (medical/dental) requiring PALS are at the discretion of the MTF/CC.

2.18.3.2.1. PALS training (or equivalent course) is required for nurses assigned to the emergency department, UCC or assigned duties requiring care of inpatient pediatric patients. PALS training (or equivalent course) is optional for medical technicians assigned to the Emergency Department, UCC or assigned duties requiring care of inpatient pediatric patients. Other health care personnel requiring PALS are at the discretion of the MTF/CC.

2.18.3.3. NRP certification is required by any privileged healthcare provider (physician, resident physician, physician assistant, nurse practitioner, nurse anesthetist, or midwife) who routinely attends a delivery.

- 2.18.3.3.1. NRP certification is required for nurses and technicians who work in Labor and Delivery, the Newborn Nursery, and the Neonatal Intensive Care Unit.
- 2.18.4. Timing of training: Required initial life support training will be accomplished within 6 months of this publication revision, or within 6 months of assignment to the areas noted above, whichever is later. The local MTF/CC may grant an extension of an additional 6 months. (T-3)
- 2.18.4.1. Retraining and/or recertification will occur as dictated by the overseeing organization (ACLS, PALS, or NRP). (T-0, ALS Governing Policies)

2.19. Fetal Heart Rate Monitoring (FHRM) Training.

- 2.19.1. Formal, multi-disciplinary fetal heart rate monitoring training which incorporates common terminology via the National Institute of Child Health and Human Development (NICHD), is required for any nurse or privileged healthcare provider (physician, resident physician, midwife, or nurse practitioner) assigned to or providing patient care in antepartum testing, labor and delivery triage and inpatient obstetric units. This course is required every two years and within six months after arrival for new personnel who have not received prior training. (T-1)
- 2.19.2. **Medical technicians require initial formal fetal heart rate monitoring familiarization training on basic concepts to include common terminology and recognition of normal fetal monitor tracing.** This training must be completed prior to completing orientation in the above duties. The familiarization training will be required every two years. Certificates of completion will be loaded into the Air Force Training Record (AFTR). (T-1)

- 2.19.3. Timing of training: Required initial fetal heart rate monitoring training will be accomplished within 6 months of this publication revision, or within 6 months of assignment to the areas noted above, whichever is later. The local MTF/CC may grant an extension of an additional 6 months. (T-3)

2.20. Emergency Medical Service (EMS).

- 2.20.1. **EMS is the provision of the full spectrum of emergency care from recognition of the emergency, access of the system, the provision of care in the out-of-hospital environment, including both pre-hospital emergency treatment, with or without transportation, and the treatment and physical transfer of patients between medical treatment facilities.** It includes medical response to disasters and the provision of medical care at mass gatherings. It is composed of elements of public health, public safety, emergency response and disaster services, and traditional health care. **EXCEPTION:** Section 2.20. of this instruction does not apply to the Air Reserve Components (ARC). Air Force Reserve Command will follow MAJCOM policy and Air National Guard will follow National Guard Bureau policy.

- 2.20.2. It is the policy of the Air Force that these services, including augmentation by contract and/or mutual aid agreement, shall meet the standard level of care and response time standards set forth in DoDI 6055.06, DoD 6055.06-M, *DoD Fire and Emergency Services Certification Program* and AFI 32-2001, *Fire Emergency Services (FES) Program* and, if

supportable with available assets, those standards in the community or region in which the installation resides. (T-0, DoDI 6055.06 and DoD 6055.06-M)

2.20.3. Program Descriptions:

2.20.3.1. Purpose. The purpose of this program is to establish minimum standards and a uniform approach toward rendering these services at Air Force installations worldwide.

2.20.3.2. The Air Force EMS Program operates primarily at the installation level. This program calls for the initial installation evaluation, a comparison with local community and DoD and Air Force standards, the development of a long-term EMS Strategic Plan to upgrade, where necessary, clinical services and EMS System performance, and an organized approach to management of EMS assets in day-to-day operations.

2.20.4. Waivers. Deviation and waivers to the EMS requirements contained within this instruction require approval through the AF/SG and delegated to the Director, Medical Operations and Research (AF/SG3/5). (T-1)

2.20.5. AF/SG3/5 will:

2.20.5.1. Establish an AF EMS Working Group (WG) led by the Chief, Health Care Operations. The AF EMS WG will identify and approve authorized equipment and supplies in accordance with determined level of care at each installation. Defense Health Program funds will not be utilized to purchase supplies and equipment that is normally contained on Fire response vehicles. The approved list of supplies and equipment will be posted on the AF/SG knowledge exchange and validated by chartered members of the AF EMS WG. (T-1)

2.20.5.2. Validate any upgrade requests in pre-hospital emergency services at AF installations that were validated by the AF EMS WG. (T-2)

2.20.5.3. Mandate AF personnel use the AF Form 552, *Patient Care Form*, to document pre-hospital care provided prior to the admission to a medical facility. **EXCEPTION:** Other pre-hospital forms may be used if part of a local agreement established to standardize emergency medical response teams functioning in the local community. (T-3)

2.20.6. Medical Treatment Facility Commander.

2.20.6.1. The MTF/CC has ultimate oversight and accountability for their installation EMS and will ensure that the installation EMS meets, to the maximum extent possible, community standards for timeliness of response and professional level of care in accordance with DoDI 6055.06. (T-0, DoDI 6055.06)

2.20.6.2. Meeting the requirements of DoDI 6055.06 can be accomplished through a synergistic use of on and off base military and civilian capabilities. Installations will determine how best to deliver EMS with ALS capabilities and follow established guidelines. (T-2)

2.20.6.3. MTFs will provide risk assessments for upgrade to ALS platforms through their MAJCOM/SG. MAJCOM/SGs will review the risk assessment then forward to the AFMS EMS WG for validation. (T-1)

2.20.6.4. The MTF/CC will appoint a privileged physician as EMS Medical Director or a Competent Medical Physician (CMP). Training and experience in EMS systems and pre-hospital care, highly desirable. (T-2)

2.20.7. EMS Medical Director or CMP.

2.20.7.1. The EMS Medical Director or CMP will review and approve EMS Strategic and Operational Plans on an annual basis to include approval of which component, (*i.e.*, MTF, Fire Department, or civilian ambulance service) provides pre-hospital emergency treatment and/or emergency transport. (T-2)

2.20.7.2. The EMS Medical Director or CMP and local MTF EMS Program Manager will provide shop visits to the Fire Emergency Services (FES) on a semi-annual basis. CMP/EMS Program Manager will ensure training plans and programs are up to date, and medical supplies/equipment are in working order. (T-2)

2.20.7.3. The EMS Medical Director or CMP, in consultation with the installation Chief of the Medical Staff (SGH), shall have authority over EMS personnel and assets pertaining to pre-hospital emergency response, including but not limited to:

2.20.7.3.1. Providing oversight of EMS related education for personnel involved with the EMS System. (T-2)

2.20.7.3.2. Certifying FES personnel on protocol requirements commensurate with the level of service they are providing. (T-1)

2.20.7.3.3. Reviewing AF Forms 552 to identify any trends or areas requiring additional training. (T-3)

2.20.8. Medical Logistics or Clinical Engineering. AFMS will fund expendable medical supplies and equipment for USAF Fire Department personnel in accordance with Memorandum of Understanding (MOU) between the AF Deputy Surgeon General and the Air Force Civil Engineer (AF/A7C). The lists will be kept current on the AF EMS Program Managers Knowledge Exchange Website at <https://kx2.afms.mil/kj/kx9/NREMT/Pages/home.aspx>. See paragraph 2.20.5.1. of this instruction for the process for determining, coordinating and approving the list. Please refer to AFI 41-209, *Medical Logistics Support* for further details. (T-1)

2.20.9. Fire and Emergency Services (FES).

2.20.9.1. Provide care at Emergency Medical Responder (EMR) non-transport (NT) level at AF installations. (T-1)

2.20.9.2. Any FES role in EMS above the EMR level must be clearly articulated in a Memorandum of Understanding/Agreement (MOU/A) per DoDI 4000.19, *Support Agreements* and AFI 25-201, *Intra-Service, Intra-Agency, and Inter-Agency Support Agreements Procedures*. (T-0, DoDI 4000.19) The MOU/A must be coordinated and approved by the MAJCOM/A7 and MAJCOM/SG with concurrence of the EMS WG before the FES Flight can assume any level of care beyond EMR/NT. (T-1)

2.20.9.3. At installations where the fire department performs emergency medical transport duties, those firefighters assigned to the primary emergency medical transport

vehicles (EMTV) will not be assigned to any other emergency response vehicle. Secondary EMTV may be cross-staffed at the discretion of the Fire Chief. (T-1)

2.20.9.4. Storage and handling of pharmaceuticals will meet the federal requirements of the Food and Drug Administration (FDA), DEA, TJC, and state or local standards and requirements. (T-1)

2.20.9.5. FES will use AF Form 552 to document emergency care provide to patients. FES will provide the AF Form 552 to Tricare Operations and Patient Administration (TOPA) office on the next duty day. TOPA personnel will distribute the AF Form 552 to the appropriate areas as necessary. (T-2)

2.20.9.6. For further information, please review AFI 32-2001.

2.20.10. USAF EMS Program Manager Responsibilities:

2.20.10.1. Serves as the Consultant to the 4N0X1 Career Field Manager (CFM) on all EMS matters.

2.20.10.2. Serves as the Air Force EMS State Director. The Air Force is recognized by the National Registry of Emergency Medical Technicians (NREMT) and the National Association of State EMS Officials (NASEMSO) as an independent agency and therefore operates in an equivalent status to an independent State for the purposes of NREMT and NASEMSO.

2.20.10.3. Appointed as the Air Force Liaison to the NREMT. Personnel should contact the USAF EMS Program Manager on all matters prior to contacting the NREMT.

2.20.10.4. Appointed as the Air Force Liaison to the NASEMSO.

2.20.10.5. Consults with 4N0X1 CFM to establish certification and recertification policies for Air Force members who hold any level of certification with the NREMT. The NREMT is a private certifying organization who establishes guidelines and does not hold authority over state offices, state agencies or equivalent organizations.

2.20.10.6. Provides program guidance to local level EMS Site Coordinators on education programs, six (6)-part EMS program folders requirements, curriculum, and instructor requirements.

2.20.10.7. Approves all continuing education (CE) topics greater than 2 hours for the Air Force. This includes any subject covered in the National EMS Education Standards. Other topics must be approved by the USAF EMS Program Manager prior to the offering date.

2.20.10.8. Provides guidance to the NREMT and course coordinators on approved EMS CE within Air Force. Notifies the NREMT and EMS training sites of CE approval.

2.20.10.9. Conducts/coordinates EMS instructor training programs for all programs assigned an Air Force Agency Codes/Agency Affiliations with the NREMT

2.20.10.10. Manages all Agency Codes/Agency Affiliations with the NREMT via maintaining Training Officer access to all Air Force affiliations on www.nremt.org.

2.20.10.11. Investigates possible breeches of program integrity.

2.20.10.12. As directed by Headquarters, in consultation with CFM and Air Force Emergency Medicine Medical Director, conducts medical incident investigations and functions as the subject matter expert in malpractice cases involving enlisted personnel in the performance of EMS duties. Notifies the NREMT Executive Director, in writing, of revocation of certification requests when applicable.

2.20.11. EMS Site Coordinator Responsibilities:

2.20.11.1. Acts as liaison between students, medical treatment facility (MTF) executive staff, local medical community, and USAF EMS Program Manager.

2.20.11.2. Must attend formal training in educational theory and practice, curriculum design and development, instructional materials design, evaluation and use; will coordinate attendance via USAF EMS Program Manager. (T-2)

2.20.11.3. Coordinates and/or conducts 24 hour refresher training for EMTs and 48 hour refresher training for Paramedics (authorized sites only) and skills training and validation for all assigned NREMT personnel. (T-1)

2.20.11.4. Ensures on-line recertification documentation is complete and accurate on www.nremt.org before approving/submitting IAW CFMs policy of 31 January recertification deadline. (T-1)

2.20.11.5. Maintains accuracy of all members affiliated with unit NREMT agency code/affiliation. (T-1)

2.20.11.6. Maintains 6-Part EMS program folder IAW established requirements found on the Knowledge Exchange (T-1)

2.20.11.7. Maintains current EMS Course Coordinator and Medical Director Appointment letter; provides USAF EMS Program Manager current copy. (T-2)

2.20.11.8. Maintains current educational material, i.e., textbooks that meet or exceed the current Department of Transportation (DOT)/National Highway Traffic Safety Administration (NHTSA) National EMS Education Standards/Instructional Guidelines. (T-2)

2.20.11.9. Submits Annual Site Report to USAF EMS Program Manager NLT 31 March each year. (T-1)

2.20.11.10. Notifies the USAF EMS Program Manager, in writing, of medical incident investigation cases involving enlisted personnel in the performance of EMS duties. (T-1)

2.20.12. Composition of Medical Technicians Utilized in Ambulance Services.

2.20.12.1. Approved BLS Platforms. Must be staffed with two (2) Nationally Registered Emergency Medical Technicians (NREMT), with at least one (1) 5-level 4N0X1 or higher. (T-1)

2.20.12.2. Approved ALS Platforms. Must be staffed with at least one (1) 5-level or higher Nationally Registered Paramedic and one (1) 5-level NREMT. (T-1)

Section 2K—Inpatient Clinical Standardization

2.21. ICU Standardization. MTF/CCs with ICUs will ensure the ICU leadership participates in ICU Collaboration meetings and adopts approved protocols, guidelines, operating instructions, and/or checklists. The protocols developed by the ICU Collaboration forums are coordinated with the affected MTF/CCs and approved by AFMOA prior to implementation. Additional information is available on the AFMS Clinical Quality Management Kx page, under AFMS Strategic Plan Initiatives, ICU Collaboration. (T-2)

2.22. Modified Early Warning Score (MEWS). MTF/CCs with an inpatient scope will ensure a local policy is adopted that implements an early warning decision support tool. Additional supplemental information is available on the AFMS Clinical Quality Management Kx page, under AFMS Strategic Plan Initiatives, MEWS. (T-2)

Section 2L—Visiting Specialty Provider Program

2.23. Visiting Specialty Provider (VSP) Program. It can be advantageous and cost-effective for the AFMS to support a VSP Program for remote and OCONUS MTFs. In most cases this means the care the visiting provider is rendering is not normally available at the host MTF. Host MTF/CCs must ensure that appropriate follow-up care is provided for patients who receive care from visiting providers and that the host MTF personnel are properly trained, equipped and prepared to deal with potential complications of care provided under the VSP Program. (T-2)

2.23.1. A Memorandum of Agreement (MOA) between the host and supporting MTF is required and must include plans to address the following critical items:

2.23.1.1. Appointment of a Point of Contact (POC) at both facilities to ensure compliance with all requirements of the program. (T-2)

2.23.1.2. Orientation of the visiting provider(s) to the host MTF, its mission, capabilities and clinical limitations. (T-2)

2.23.1.3. Education from the visiting provider(s) for any host MTF staff expected to assist in the care of patients. This detailed teaching will focus on their specialty, potential patient population, potential procedures, anticipated follow-up requirements, possible adverse outcomes and their management. (T-2)

2.23.1.4. Warm patient hand-offs. Prior to departing the host MTF, the visiting provider must have a face-to-face discussion and provide appropriately detailed information regarding patient care delivered during their visit to the responsible host MTF provider(s) who will provide follow up care and assume responsibility for the patients in the absence of the visiting specialty provider. (T-2)

2.23.2. Visiting specialty providers should, to the greatest degree possible, plan their visits such that they are locally available during the period of time when complications from treatment or surgery are most likely to occur.

2.23.3. Visiting specialty providers will recommend to the host MTF a potential list of treatments/procedures. The host MTF SGH will approve this list following coordination with appropriate MTF staff. The performance of any procedures not specified on the approved list must be approved in advance by the host MTF SGH. (T-2)

2.23.4. The supporting MTF/CC is responsible for providing the credentials and privileges of the visiting provider to the host MTF via a credentials transfer brief IAW 44-119. (T-2)

2.23.5. Peer review of care rendered at the host MTF by the visiting specialty provider will be coordinated between the host MTF and the supporting MTF. This arrangement will be outlined in the MOA. (T-2)

Section 2M—Medication Reconciliation

2.24. Medication Reconciliation. Medication reconciliation is the process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider.

2.24.1. Medication reconciliation will occur when a provider receives a patient from another setting of care or provider of care or believes an encounter is relevant. This includes performing medication reconciliation prior to discharge from an inpatient facility. (T-1)

2.24.2. Each MTF will develop policy that insures medical reconciliation is completed in accordance with civilian accrediting bodies and the National Patient Safety Goals (NPSG). (T-1)

2.24.2.1. This policy will address, as appropriate for the MTF, special patient populations such as patients with complex medical needs, wounded warriors and/or patients from other branches of the service. Due to their often complex medication therapies, the management and reconciliation of multiple medications in the wounded warrior population is of especially high importance to the AF and DoD. AF MTF policy will seek to maximize patient safety and the prevention of accidental overdose and suicide. (T-1)

2.24.2.2. The medication reconciliation process should include:

2.24.2.2.1. Finding out what medicines the patient is taking.

2.24.2.2.2. Recording and sharing correct information about a patient's medicines.

2.24.2.2.3. Comparing those medicines to new medicines provided to the patient.

2.24.2.2.4. Making sure the patient understands their medication (what they are taking and why, dosage, and times) before they leave the MTF.

2.24.2.2.5. Encouraging the patient to bring their up-to-date list of medicines every time they see a provider.

Section 2N—Management of mild Traumatic Brain Injury (mTBI) in the Deployed Setting

2.25. Management of mTBI in the Deployed Setting. AF personnel will support the policies and procedures on the management of mild traumatic brain injury in the deployed environment as described in DoDI 6490.11, *DoD Policy Guidance for Management of Mild Traumatic Brain Injury/Concussion in the Deployed Setting* and combatant command (COCOM) guidance.

2.25.1. AF/SG is responsible for providing policy, guidance, and training on management of deployment-related concussion as outlined in DoDI 6490.11. Current training for medics is loaded onto the Advanced Distributed Learning Service (ADLS).

2.25.2. Commanders will follow COCOM guidance on reporting potentially concussive events, and report monthly to Joint Trauma Analysis and Prevention of Injury in Combat (JTAPIC) Program Office. The minimum required data fields are listed in DoDI 6490.11. (T-0, DoDI 6490.11)

2.25.3. The mechanism for tracking and submitting data will be IAW combatant command guidance.

2.25.4. All deployed medical personnel are required to follow the medical guidance provided in DoDI 6490.11 and COCOM guidance.

Section 20—Personnel Policies

2.26. Policy on Rest Standards.

2.26.1. Each MTF that operates 24 hours a day on a normal basis must have written policy on rest standards based on mission requirements, stating:

2.26.1.1. The minimum number of hours of uninterrupted rest between shifts of providing direct patient care. (T-1)

2.26.1.2. The maximum number of consecutive hours of direct patient care allowed. (T-1)

2.26.1.3. Time “on call”, either at home or in-house, is not considered “direct patient care” except for any time with actual direct patient contact. (T-1)

2.26.1.4. The waiver process when those standards must be broken for unusual circumstances. (T-1)

2.26.2. MTFs with Graduate Medical Education (GME) programs will abide by the Accreditation Council for Graduate Medical Education (ACGME) Standards for duty time and rest standards. <http://www.acgme.org/>. (T-0, ACGME Standards)

2.27. Policy on Off-Duty Employment.

2.27.1. Affected Personnel:

2.27.1.1. Medical Corps, Dental Corps, Nurse Corps, Biomedical Sciences Corps, Medical Service Corps, enlisted technicians and civilians who would be members of these corps/groups. Applicability to contract personnel depends upon the wording of the contract.

2.27.1.2. Civilian equivalents only need to comply with provisions of the Joint Ethics Regulation concerning off-duty employment. The MTF/CC may establish additional procedures if the local situation warrants such action. **NOTE:** Off-duty employment refers to all forms of off-duty employment; it is not confined to medically related areas.

2.27.2. Requirements:

2.27.2.1. All privileged providers must attend a briefing by the SGH upon arrival to each new duty station, and then annually, on the provisions and restrictions of off-duty employment. The Senior Corps representative will provide the brief to members of other corps not covered above. Commanders for officers or civilians permanently assigned to another organization but regularly performing duties within an MTF will have a written agreement with the MTF/CC on methods of fulfilling the requirements. (T-1)

2.27.2.2. MTF/CCs shall ensure internal review procedures are in place to monitor providers' compliance with off-duty employment provisions at least annually. (T-0, Health Affairs (HA) Policy 96-050, Policy for Off-Duty Employment By DoD Health Care Practitioners)

2.27.2.3. All healthcare personnel must first obtain the written permission of the MTF/CC. This written request must include: (T-0, Health Affairs (HA) Policy 96-050)

2.27.2.3.1. A statement acknowledging understanding of applicable DoD regulations.

2.27.2.3.2. A written statement from the off-duty employer acknowledging their understanding of the limitations on the DoD member's availability, patients for who services may be provided, compensation limitations and contract restrictions.

2.27.2.3.3. A statement acknowledging the impact on the civilian community and healthcare providers (e.g., statement from employer, local medical society, or the member's own assessment).

2.27.2.4. Permission should be coordinated through the unit commander, after coordination with the SGH, SGN, Senior Corps Chief or Career Functional Manager and through the Group or Wing Legal Advisor. MAJCOM and Air Staff personnel require permission from the MAJCOM/SG, United States Air Force Surgeon General (USAF/SG) or their designee, respectively; other non-MTF providers require permission from the most senior medical officer in their chain of command.

2.27.2.5. Commanders should consider factors such as hours per week, work site proximity, travel time, and impact on civilian communities and practitioners when reviewing such requests.

2.27.2.6. Squadron Commanders or higher authority may withdraw permission for personnel to engage in off-duty employment at any time.

2.27.3. Each military member approved for off-duty employment must:

2.27.3.1. Update the status of off-duty employment whenever there is any change in status. (T-0, HA Policy 96-050)

2.27.3.2. Submit an annual report to the MTF/CC certifying their compliance with applicable policy and regulatory guidance. MAJCOM, Air Staff and other non-MTF personnel should submit an annual report to the MTF/CC where they currently have active privileges. **EXCEPTION:** Personnel on terminal leave need not submit annual summaries. (T-0, HA Policy 96-050)

2.27.4. Restrictions for Off-Duty Employment:

2.27.4.1. Military healthcare personnel who are students in graduate medical education training programs may not engage in off-duty employment.

2.27.4.2. Military healthcare providers engaged in off-duty employment may not assume primary responsibility for the care of any patient on a continuing basis at the off-duty site. **EXCEPTION:** This does not apply to personnel on terminal leave.

2.27.4.3. Military healthcare providers may not provide off-duty healthcare services:

2.27.4.3.1. On military premises.

2.27.4.3.2. Involving expense to the federal government.

2.27.4.3.3. Using military equipment, personnel or supplies.

2.27.4.4. DoD healthcare providers may not solicit or accept compensation, directly or indirectly, for care rendered to any DoD beneficiary entitled to medical or dental care. Exceptions are listed below:

2.27.4.4.1. Active duty military dentists “moonlighting” in the civilian sector may provide care to individuals enrolled in the TRICARE Family Member Dental Plan, IAW HA Policy #97-019, Off-Duty Employment by DoD Dental Care Providers.

2.27.4.4.2. This prohibition applies to DoD healthcare providers who provide care that is a discreetly identifiable or coded service for which the off duty employer can seek reimbursement from TRICARE or the patient. For example, a retail pharmacist earning an hourly wage would not be barred under this rule from filling prescriptions for DoD beneficiaries because TRICARE or the patient is not billed specifically for the pharmacist's service.

2.27.4.5. A DoD healthcare provider may not refer a patient from an MTF to a facility in which the provider maintains off-duty employment. If such referral is unavoidable, the provider must document the reason in a letter to the MTF/CC. (T-1)

2.27.4.6. Off-duty employers must certify that they accept the compensation and availability limitations placed on DoD healthcare providers and agree that as a condition of off-duty employment, they will not seek reimbursement from TRICARE or directly from the patient for services provided a DoD beneficiary. (T-0, HA Policy 96-050)

2.27.4.7. Individual healthcare providers on off-duty employment must comply with local licensing requirements, Drug Enforcement Agency (DEA) requirements and provide their own personal liability coverage. The Air Force is not responsible for the actions of individuals working in off-duty employment. (T-0, HA Policy 96-050)

2.27.4.8. DoD healthcare providers will apply for annual leave for any off-duty employment obligations that require absence during duty hours. (T-1)

Section 2P—Patient Results and Communication Policies

2.28. Composite Healthcare System (CHCS) and AHLTA Documentation Issues.

2.28.1. Reviewing laboratory and radiologic reports.

2.28.1.1. Every provider must review pending laboratory and radiologic reports within three duty days. ARC providers will complete the review on the following Unit Training Assembly (UTA). (T-1)

2.28.1.2. MTFs should have systems in place to periodically run queries to ensure reports are being addressed in a timely manner.

2.28.2. Surrogates:

2.28.2.1. Providers must assign a surrogate in CHCS to review and act on laboratory tests or radiologic studies reported during their absence. (T-1)

2.28.2.2. MTFs should have systems in place to periodically run queries to ensure the surrogates are updated.

2.28.3. Information Management Sign-out:

2.28.3.1. When a provider is leaving a facility, during a PCS, separation or retirement, they must sign all outstanding orders and close out all encounters in the medical record (AHLTA/CHCS) before leaving. (T-1)

2.29. MTF Requirements for Tracking Test Results: MTFs, with SGH oversight, must:

2.29.1. Implement procedures for tracking diagnostic test results (laboratory and radiology) to ensure timely review by providers, timely notification of the patient and documentation in the medical record of any medically indicated actions taken. (T-0, TJC, AAAHC)

2.29.2. Define critical value thresholds and outline the notification process of critical results including standards for the timely completion of each phase of the process, depending on the test involved and the ordering clinical area. (T-0, TJC, AAAHC)

2.29.3. Develop and promulgate provider and patient responsibilities, providing a way to contact patients with results, i.e., telephone, secure messaging or mail address. (T-1)

2.29.4. Implement procedures for locating patients and notifying them of their test results. (T-0, TJC, AAAHC)

2.30. MTF Requirements for Ensuring Prompt Response to Patient-initiated Communications: MTFs, with SGH oversight, must:

2.30.1. Develop procedures to ensure patient-initiated communications to providers are answered promptly and documented in the medical record. (T-0, TJC, AAAHC)

2.30.1.1. The procedures must define standards for timely response based on whether the issue to be addressed is acute, routine, or involves wellness issues. The maximum expected response time goal for initial contact should be no greater than 12 hours for acute issues and no greater than 2 business days for routine or wellness issues. (T-2)

2.30.1.2. The procedures must assign responsibility for monitoring this process. (T-3)

Chapter 3

PRIMARY CARE PRODUCT LINE

Section 3A—Provision of Care Guidance

3.1. Provision of Care.

3.1.1. All MTFs will serve as the "Medical Home" to their enrolled beneficiaries IAW AFI 44-171, *Patient Centered Medical Home and Family Health Operations..* (T-1)

3.1.2. All primary care clinics, including but not limited to, Family Health, Pediatrics, Internal Medicine, and Flight Medicine, will provide patient-centered, evidence-based care to their beneficiaries through practices which optimize access to care, continuity, care coordination, communication and information sharing, patient and staff satisfaction, self-management support, and shared decision making. MTFs must ensure there will be adequate capability to administer periodic health screening examinations within the direct-care system or network for all beneficiaries. Frequency of periodic screening examinations will be governed by nationally recognized guidelines, such as U.S. Preventive Services Task Force (USPSTF) or other similar authority. (T-1)

3.1.3. Aerospace medicine provides occupational health consultation and direct operational support services, IAW AFI 48-101, *Aerospace Medicine Enterprise*, and AFI 48-123, *Medical Examinations and Standards*.

3.1.4. Emergency Services Availability. When an MTF is unable to staff an Emergency Department 24 hours a day, the MTF must publicize alternate sources of care. Acute or Urgent Care Centers do not qualify as Emergency Departments. (T-0, TJC, AAAHC)

3.1.5. The MTF/CC may organize any specialized medical or surgical service as a separate organizational element within the wing, group and squadron structures described in the most current OMG guidance.

3.2. Clinical Support Staff Protocols. The AFMS encourages the use of clinical Support Staff Protocols to optimize patient care and the utilization of support staff to function at the maximum level of practice. Additional guidance regarding execution of Support Staff Protocols can be found in AFI 46-101, *Nursing Services and Operations*.

3.2.1. AFMOA generated protocols will be reviewed by AFMS consultants and Career Field Managers and do not require approval by MTF Executive Committee of the Medical Staff (ECOMS) unless modified.

3.2.2. All staff involved with the use of approved Support Staff Protocols, to include nurses, medical technicians, Independent Duty Medical Technicians (IDMTs) and administrative clinic staff will have protocol training and competency documented in the individual's training record. (T-1)

3.2.3. All privileged provider staff involved with the use of approved Support Staff Protocols will have protocol training documented in the individual's Provider Activity File. Knowledge of the proper use of the protocols and support of the clinical staff is imperative for maintaining consistent patient care standards and safety. (T-1)

3.2.4. When clinical decision support staff protocol use falls outside of the usual scope of practice for a nurse, technician, or an Independent Duty Medical Technician (IDMT), a waiver must be requested by the MTF IAW AFI 44-119, *Medical Quality Operations*. (T-1)

3.3. Medication Administration.

3.3.1. Basic guidance on medication administration for nursing personnel is referenced in AFI 46-101, *Nursing Services and Operations*.

3.3.2. Prescribing privileged providers have the ultimate responsibility for the correct dispensing of pre-packaged medications maintained outside of the Pharmacy IAW Chapter 8, Pharmacy Services of this AFI.

Section 3B—Pseudofolliculitis barbae

3.4. MTF Pseudofolliculitis barbae Policy: MTFs will develop written policies and procedures for managing personnel with pseudofolliculitis barbae. Allowable length of facial hair during active inflammation will be no longer than one-quarter inch. This will be documented on the AF Form 469, *Duty Limiting Condition Report*. (T-3)

Section 3C—Use of Weight Control Drugs and Surgery

3.5. Use of Weight Control Drugs and Surgery.

3.5.1. Weight control medication is not approved for routine use in overweight active duty members. Furthermore, weight control medications will not be a standard part of the MTF formulary. However any active duty members who are overweight or obese should be counseled on diet and exercise. This preventive counseling should be documented in the medical record. (T-1)

3.5.2. Short term use (typically less than 3 – 6 months) of weight control medication may be considered in carefully selected obese patients with a Body Mass Index (BMI) of 30 kg/m² or greater, or in those with a BMI equal to or greater than 27 with significant comorbid risk factors (such as hypertension, dyslipidemia or insulin resistance syndrome). Drug therapy shall be used in conjunction with behavioral modification, monthly provider follow-up, dietary counseling, and appropriate aerobic exercise. At a minimum, these individuals require history and physical examination, fasting blood glucose, thyroid function studies and evaluation for secondary causes of obesity, as well as complete blood count, lipid profile and a 24-hour urine collection for urine free-cortisol where indicated. (T-1)

3.5.3. Use of appetite suppressants or lipase inhibitor drugs must be IAW AFI 48-123 when considering duty restrictions, deployment or flying status. If medication is used, an AF Form 469 is required prohibiting deployment for the duration of the short-term supervised therapy. (T-1)

3.5.4. Active duty members are not authorized to obtain bariatric surgical procedures.

Section 3D—Prescribing Requirements for Mefloquine

3.6. Prescribing Requirements for Mefloquine

3.6.1. Mefloquine can be used to protect our members deploying to specific areas of the world. However, mefloquine has specific contraindications and potentially significant side effects that require stringent prescribing requirements.

3.6.2. Prescribing and review requirements must be conducted IAW local and federal regulations. FDA recommendations can be found at <http://www.fda.gov>. (T-0, FDA Regulation)

3.6.3. MTF/CCs will ensure their Pharmacy and Therapeutics Function enforces and provides oversight of these requirements and conducts an annual drug utilization evaluation of mefloquine prescribing at their facility. All providers who prescribe mefloquine will be educated on these prescribing requirements. (T-1)

Section 3E—Dietary Supplements

3.7. Medical Screening

3.7.1. Healthcare providers will obtain a thorough history of dietary supplement use, to include herbal preparations, multivitamin, mineral, and other dietary supplements in the form of gels, pills, powders, and shakes. (T-2)

3.7.2. Dietary supplement use will be clearly documented in available medical record systems, and patients will be encouraged to discuss dietary supplement use with their healthcare providers. (T-2)

3.8. Reporting Adverse Events

3.8.1. Healthcare providers shall document and report any adverse event that they believe may be associated with dietary supplements. (T-2)

3.8.2. Adverse events shall be reported to a national dietary supplements adverse event surveillance system determined by Air Force Medical Operations Agency. For reporting procedure options consult the Health Promotion Knowledge Exchange site at <https://kx2.afms.mil/kj/kx4/HealthPromotion/Pages/home.aspx>. (T-2)

Chapter 4

MATERNAL-CHILD PRODUCT LINE

Section 4A—Preventive Services

4.1. Periodic Health Maintenance Examination.

4.1.1. MTFs must ensure there will be adequate capability to administer women's health periodic examinations within the direct-care system or network for all female beneficiaries age 18 years and older, and for those under the age of 18 years who are sexually active. These capabilities must include at least the following: Papanicolaou smear (Pap smear), pelvic examination, breast examination, family planning and contraceptive counseling for those desiring this service. (T-1)

4.1.2. MTFs must develop policies to ensure reporting Pap smears results to the patient within 14 duty days from collection of the specimen. **EXCEPTION:** At isolated clinics or overseas locations, report the results within 30 duty days. (T-1)

4.1.3. Nationally recognized guidelines, such as those published by the American College of Obstetricians and Gynecologists or the US Preventive Services Task Force (USPSTF), shall govern the frequency and content of periodic screening examinations. Medical readiness requirements may necessitate more frequent screening. Given the variation of recommendations from different guidelines, the provider should discuss aspects of screening with the patient and document this in the medical record. (T-1)

4.1.4. MTFs will follow the American Academy of Pediatrics (AAP) published *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents* or other similar authority for periodic health maintenance recommendations. (T-1)

4.2. Breast Imaging.

4.2.1. Screening mammograms may be performed in the MTF where the service is available or in the purchased care system when the MTF cannot provide the service. The initial screening mammogram and frequency of subsequent screening shall be guided by discussion between the patient and provider, guided by current guidelines and incorporating patient risk factors and personal preferences. (T-1)

4.2.1.1. Accepting self-referring/self-requesting patients who have not had a Clinical Breast Exam (CBE) prior to breast imaging is an acceptable practice within the AFMS. Each MTF must develop a local policy regarding self-referrals/self-requests for screening mammograms, which addresses the following areas: the process how a patient may schedule the mammogram, how the Primary Care Manager (PCM) will be notified of the patient's request for the mammogram, the process for identification/disposition of those requesting services more often than clinically indicated and the follow-up process for clinical breast care after the mammogram. (T-1)

4.2.2. MTFs must make diagnostic breast imaging available to women at any age who have been identified by their healthcare providers as requiring additional evaluation as indicated by individual risk factors. The procedure may be performed in the MTF where the service is available or in the purchased care system when the MTF cannot provide the service. (T-1)

4.2.3. Radiology Services will provide appointments within 30 calendar days of the request for screening mammography, and within five days for diagnostic breast imaging. (T-1)

4.2.4. Where the MTF provides the mammography service, providers (either the ordering provider or the interpreting radiologist, according to the written local practice) will notify the patient of test results within 14 duty days for screening mammograms and five duty days for diagnostic breast imaging, and assist the patient to make appropriate follow-up appointments. (T-1)

4.2.5. Mammograms shall only be performed at locations (in the MTF or in the purchased care system) that are accredited by the American College of Radiology (ACR), an accrediting body approved by the Department of Health and Human Services (DHHS) IAW 21 Code of Federal Regulations (CFR) 900, *Mammography Accreditation*, or a host nation equivalent for OCONUS locations. (T-1)

4.2.5.1. As the ACR and DoD have presently no mechanism for determining host nation equivalence, review of site procedures for ensuring clinical quality and appropriate dose delivery may be made by a Mammography Quality Standards Act (MQSA) qualified radiologist and medical physicist. This may be appropriate if host nation services are found to be a quality option. An initial MSQA survey performed by an AF medical physics consultant and a clinical site visit by the lead interpreting AF radiologist must be performed at the host nation facility prior to use of their mammography services. Annually or after any major equipment repair/modification the host nation facility must make available to the regional AF medical physics consultant a report that includes at a minimum: 1) an MQSA image quality phantom evaluation and 2) the mean glandular dose equivalent for a 50-50, 4.2 cm breast. Additional test results to show compliance with the ACR accreditation standards are highly encouraged. (T-1)

4.2.5.2. Telemammography may be practiced when appropriate accreditation of digital mammography acquisition and interpretation can be certified at both sites and procedures are in place to assure appropriate technologist oversight, timely interpretation, and a mechanism for diagnostic workup of patients requiring further evaluation in a timely manner. A challenging cost benefit analysis should be carefully weighed where this is considered for remote locations with sufficient population to warrant the service.

4.2.6. Local policy will guide breast imaging sign-out procedures:

4.2.6.1. Original breast images will be released to the patient or to an authorized designee upon request. (T-1)

4.2.6.2. Strict sign-out procedures will be instituted and maintained to ensure accountability for the films. Permanent transfer to another MTF is permitted. (T-1)

Section 4B—Gynecological Services

4.3. Gynecological Care.

4.3.1. Acute or emergent gynecologic services must be made available in the direct or purchased healthcare system. Patients with emergent problems shall be seen immediately, and those with urgent problems shall be seen within one duty day. Clarification of degree of

urgency should be accomplished through discussion between the referring provider and the gynecologic services provider. (T-0, TRICARE policy)

4.3.2. MTFs will ensure that routine gynecologic care is available within 28 calendar days. (T-0, TRICARE policy)

4.4. Emergency Contraception. See Chapter 8, Pharmacy Services, paragraph 8.4.6.

4.5. Induced Abortion (Refer to [Section 2C](#), *Treating Minors* also).

4.5.1. Federal Law (10 United States Code (U.S.C.) §1093) prohibits the use of DoD funds to pay for abortion. **EXCEPTION:** AF facilities (in the Continental United States and Outside the Continental United States) and appropriated funds may be used to perform abortions under the following circumstances: where the life of the mother would be endangered if the fetus were carried to term or in the case in which the pregnancy is the result of an act of rape or incest. (T-0, 10 U.S.C. §1093)

4.5.1.1. When an abortion is performed under circumstances where the life of the mother is endangered, MTF providers will certify the procedure is medically necessary and the life of the mother would be endangered if the fetus were carried to term. This certification will be documented in the medical record.

4.5.1.2. In the case of an abortion for rape or incest, MTF providers will document in the medical record their good faith belief that the patient was a victim of rape or incest. See Chapter 11 section 11.5. of this instruction for additional guidance on management of victims of sexual assault.

4.5.1.2.1. If a provider does not have a good faith belief the pregnancy is the result of rape or incest, then the provider should utilize the local ethical dilemma resolution process to resolve the situation.

4.5.2. Medical personnel who have a personal or moral objection to abortion need not perform or assist in the abortion procedure but are obligated to facilitate timely identification of a willing provider if the patient qualifies for an abortion at a MTF. **NOTE:** This applies only to personnel directly involved in performing the abortion procedure itself.

4.5.3. When the patient is an adult or an emancipated minor (as determined by the applicable law), only the patient's consent for the abortion is required. Consult the MLC or servicing staff judge advocate if there are questions of whether a patient is an emancipated minor.

4.5.4. When the patient is a minor, healthcare providers will follow state law (in the United States) or local policy (outside the United States) when obtaining valid consent, in accordance with Section 2C, *Treating Minors* of this instruction. If the law/policy allows the minor to provide consent when a healthcare provider deems her sufficiently mature, the MTF/CC (or SGH in the event that the MTF/CC is not a physician) will make that judgment. (T-1)

4.5.4.1. Consultation with the base legal services and the Medical Law Consultant are recommended whenever these situations arise.

4.5.5. The Air Force will respect host nation laws regarding abortion. The consent procedures described above in paragraphs 4.5.3. and 4.5.4. of this instruction apply in the absence of controlling host nation laws or legal requirements. (T-1)

4.5.6. Any complication resulting from an elective abortion procedure will be treated as would any medical problem/complication. (T-1)

4.5.7. Supplemental material regarding pregnancy termination is located on the Kx website at <https://kx2.afms.mil/kj/kx5/obgyn/Pages/home.aspx>.

Section 4C—Family Planning

4.6. Family Planning Services Provided (Refer to [Section 2C](#), *Treating Minors* also): MTFs will provide family planning services including contraceptives and sterilization through the direct or purchased care system. **NOTE:** Medical personnel who, for moral or ethical, religious or professional grounds, object to providing family planning services need not perform or assist in such procedures but are obligated to facilitate timely identification of a willing provider. Medical personnel should register their objections to the SGH or Department Chairperson on arrival to the MTF. This will allow sufficient time to make alternative arrangements for family planning services prior to the need arising. (T-1)

4.7. Sterilization (Refer to [Section 2C](#), *Treating Minors* also).

4.7.1. The patient requests sterilization by signing AF Form 1302, *Request and Consent for Sterilization*. The signature of a spouse or significant other is not required.

4.7.2. MTFs may perform sterilization procedures or refer patients to another MTF or civilian facility where the procedure is available.

Section 4D—Medical Care Related to Pregnancy

4.8. Standards (Refer to [Section 2C](#), *Treating Minors* and [Section 4E](#), *Newborn Care* also).

4.8.1. The Air Force adheres to the Newborns' and Mothers' Health Protection Act of 1996, and respects the standards published in the American College of Obstetricians and Gynecologists (ACOG) Manual of Standards in Obstetric-Gynecologic Practice and ACOG technical bulletins. In certain situations, an MTF may need to develop more specific guidance. All hospitals offering labor and delivery services shall be equipped to perform emergency Cesarean section (C-section) delivery per the guidelines published by the American College of Obstetricians and Gynecologists. (T-1)

4.8.2. IAW the Newborns' and Mothers' Health Protection Act, the following standards are expected:

4.8.2.1. Inpatient maternity care provided by the AFMS will be available for a minimum of 48 hours following a normal delivery, and for a minimum of 96 hours following delivery by C-section. No additional approval or authorization is needed for care that falls within these guidelines. (T-1)

4.8.2.2. The length of post-delivery hospital care shall involve consideration of maternal and infant health, a psychosocial assessment of the family's ability to care for a newborn infant, and the availability of follow-up care for both mother and infant. (T-1)

4.8.2.3. A mother and her newborn may be discharged from the hospital in less than 48 or 96 hours, providing that the decision is made by the attending provider(s) in consultation with the infant's mother. (T-1)

4.8.2.4. Adherence to this policy does not require a beneficiary to either give birth in a hospital, or to stay in the hospital for a fixed period of time following the birth of a child.

4.8.3. The AF/SG endorses the policy of ACOG and AAP *Guidelines for Perinatal Care*, "Although the Committee on Obstetric Practice believes that hospitals and birthing centers are the safest setting for birth, it respects the right of a woman to make a medically informed decision about delivery. Women inquiring about planned home birth should be informed of its risks and benefits based on recent evidence. Specifically, they should be informed that although the absolute risk may be low, planned home birth is associated with a twofold to threefold increased risk of neonatal death when compared with planned hospital birth. Importantly, women should be informed that the appropriate selection of candidates for home birth; the availability of a certified nurse-midwife, certified midwife, or physician practicing within an integrated and regulated health system; ready access to consultation; and assurance of safe and timely transport to nearby hospitals are critical to reducing perinatal mortality rates and achieving favorable home birth outcomes." Due to the two to three fold increased risk of neonatal death referenced above, the Air Force does not favor home delivery. If an elective home delivery on base is planned nonetheless, the installation Commander, in consultation with the MTF/CC, will first ascertain to his/her satisfaction whether the provider participating in the delivery is properly licensed by the host jurisdiction to perform the procedure and that the welfare of personnel on base is not jeopardized. (T-1)

4.9. Vaginal Delivery Sponge and Sharp Counts on Labor and Delivery Units.

4.9.1. Unintended Retained Foreign Object (URFO) events associated with vaginal delivery are considered sentinel events. MTFs will report these events to the local Patient Safety and Risk Manager. (T-1)

4.9.2. MTFs will develop a policy/operating instruction with a standardized method to account for sponges, sharps, needles and other miscellaneous items during a vaginal delivery. The policy will include the use of radio-opaque tailed sponges, pre and post procedural counting of sponges and needles and documentation in the patient record of who counted and that the count was correct. (T-1)

4.9.2.1. The MTF will comply with the algorithm, "Unintended Retained Foreign Objects During Vaginal Delivery" in Attachment 2 of this instruction, and develop a plan for orientation, training and sustainment. Monitoring and reporting the effectiveness of this process is critical, therefore, the MTF shall monitor for trends. (T-1)

4.9.3. MTFs will ensure only radio-opaque tailed sponges are stocked in Labor and Delivery and placed in all delivery packs for use. Sponges will remain originally configured and will not be cut. Staff will ensure a count sheet accompanies all delivery and precipitous delivery packs maintained on labor and delivery units. (T-1)

4.9.4. Two individuals, one of whom will be a Registered Nurse (RN), Advanced Practice Nurse (APN), or Physician (MD or DO), will perform all counts. Personnel will separate sponges being counted. Sponges will be counted audibly and concurrently viewed during the procedure. Additional sponges or items added to the field will be counted at that time and recorded as part of the count documentation to ensure accuracy. (T-1)

4.9.5. Labor and Delivery personnel will perform a “Call Out” when a sponge is placed in a body cavity and when a sponge is intentionally left in place. There will be written documentation of placement and removal of intentionally placed vaginal sponges. (T-1)

4.9.6. Provider called away from delivery. If the delivering provider is urgently called away from the delivery, the final count will be completed by two other qualified members of the labor and delivery team. One member will be an RN, APN, or MD/DO. (T-1)

4.9.7. The count sheet will not become part of the patient record. It will be discarded after use. The provider of care will document in the patient record who counted and that the count was correct, or the findings and results from actions implemented for unreconciled counts. (T-1)

4.9.8. Additional Counts. At any time a member of the team may request an extra count. The delivering provider will determine whether the patient’s status and/or the situation warrant the extra count.

4.9.9. Incorrect Counts. When the final count is incorrect, the counting process will be repeated, with special attention to performing a vaginal and/or rectal exam, opening of saturated sponges, inspection of the under-buttocks drape, and inspection of the floor and surrounding area. If the repeat count remains incorrect, a pelvic radiograph must be obtained for a potential URFO. The delivering provider along with the radiology team may determine whether a portable x-ray is adequate. If the count still cannot be reconciled, this must be documented in the patient’s record, an incident report must be completed, and the patient safety representative must be informed. (T-1)

4.9.10. Precipitous Deliveries. Precipitous deliveries occurring on labor and delivery, in the field, ambulances, emergency room, and clinics, in which obtaining a baseline count was not performed or able to be reconciled, the provider of care will perform a vaginal sweep, obtain an x-ray for URFO, complete an incident report and document the results of the pelvic exam and x-ray in the patient record. The incident report will be forwarded to the patient safety manager. (T-1)

4.9.10.1. Precipitous delivery packs maintained on labor and delivery units usually contain no countable items. Once opened, radio-opaque tailed sponges, additional countable items and a count sheet will be added to precipitous delivery packs. A baseline count will be performed if time permits. (T-1)

4.9.10.2. Precipitous delivery packs maintained in the field, ambulances, emergency room, clinics, and areas with pre-packaged delivery kits, do not need to be replaced if current, however, replacing the packs to meet URFO requirements is strongly recommended as the kits approach expiration. (T-1)

4.9.11. Patient transfer to OR or ICU. If the patient is moved from labor and delivery to another unit within the facility, a final count of the vaginal delivery equipment will be performed prior to transport, if the patient’s status permits. If a final count is not completed due to patient’s condition, this will be relayed to the accepting staff during hand-off communication and documented in the record. An x-ray for potential URFO will be obtained once the patient’s status permits. The results will be documented in the patient record. An incident report will be completed and forwarded to the patient safety manager. (T-1)

4.9.12. Patient transferred to civilian hospital. If patient is transferred to a civilian institution, and a final count is not completed, this information will be relayed to the accepting staff during hand-off communication and documented in the record. An incident report will be completed and forwarded to the patient safety manager. (T-1)

4.10. Trial of Labor for Vaginal Birth after Cesarean Section (VBAC).

4.10.1. MTFs shall provide the option for trial of labor for VBAC. Options include attempting a trial of labor at the local MTF, referring the patient to local civilian care or if OCONUS offering aeromedical evacuation to an MTF that has the ability to provide this service. (T-1)

4.10.2. MTFs providing a trial of labor to attempt a VBAC must have an obstetric provider with cesarean section privileges, a privileged provider of anesthesia (anesthesiologist or anesthesiologist), surgical support to include a circulating nurse, and scrub technician available in-hospital for the duration of active labor and delivery to perform an emergency cesarean section. (T-1)

4.10.3. Trial of labor to attempt a VBAC is NOT a contraindication to receiving epidural anesthesia for labor and delivery, or for the use of an oxytocic agent for induction or augmentation of labor.

4.10.4. Misoprostol (Cytotec) shall NOT be used for cervical ripening or induction of labor in patients who have had a previous cesarean delivery or major uterine surgery. If misoprostol is used in first or second trimester labor stimulations (e.g. in cases of embryonic or fetal demise) the lowest effective dose should be used and other medical or surgical options to affect the delivery should be considered. (T-1)

4.11. Epidural Anesthesia for Delivery.

4.11.1. MTFs shall provide the option of epidural anesthesia or analgesia for normal vaginal deliveries. Options include performing the procedure at the local MTF, referring the patient to local civilian care and if OCONUS offering aeromedical evacuation to an MTF that has the ability to provide this service. (T-1)

4.11.2. A physician with obstetrical privileges or a similarly privileged provider fully familiar with the case will remain readily available to manage the patient's progress. "Readily available" will be defined by MTF policy, based on the local situation. (T-1)

4.11.3. A physician with C-section privileges must concur with the plan of management. (T-1)

4.12. Use of Oxytocic Drugs in Pregnancy.

4.12.1. Prior to the initiation of an oxytocic agent, a provider privileged in obstetrics (obstetrician, family physician or certified nurse midwife) must evaluate the maternal and fetal status and progress of labor. When oxytocin is used during labor, a provider with C-section privileges shall be readily available. "Readily available" will be defined by MTF policy, based on the local situation. Personnel familiar with the effects of oxytocin and who are able to identify maternal and fetal complications shall be in attendance during administration of oxytocin. (T-1)

4.12.2. A physician with C-section privileges must concur with the plan for using the oxytocic agent, the management of labor, and, along with the facility, if emergently needed, must be prepared to initiate C- section within 30 minutes of the time the decision is made that C-section is indicated. (T-1)

4.13. Restrictions for USAF Military Personnel During Pregnancy and Profiles. The MTF employed obstetrical healthcare provider or the PCM with recommendations from the obstetrical healthcare provider will immediately inform Public Health of AD personnel who are pregnant IAW local procedure. They will provide recommendations on an AF Form 469 IAW AFI 10-203. If at any point the status of the pregnancy changes, the AF Form 469 will be updated appropriately. (T-1)

4.14. Assignment Curtailment in Isolated or Remote Areas.

4.14.1. Pregnant members assigned to isolated or remote areas without appropriate obstetrical care will have their assignments curtailed by the 24th week of pregnancy or earlier and are reassigned by AFPC. (T-1)

4.14.2. If local medical personnel are not capable of managing the early complications of pregnancy or the pregnancy is complicated, the member's assignment shall be immediately curtailed. (T-1)

4.15. Breastfeeding and Breast Pumping.

4.15.1. Breastfeeding provides optimal health benefits for both mother and infant throughout their life spans. Exclusive breastfeeding is optimal nutrition for the first 6 months of life. Gradual introduction of solids begins in the second half of the first year and complements human milk, which remains essential to nutrition during this period. Extensive medical research has documented that breastfeeding has significant health, nutritional, immunologic, developmental, emotional, social, and economic benefits to mother and baby. The AFMS recommends that supervisors of AF members who are breastfeeding work with the member to arrange their work schedules to allow 15-30 minutes every 3-4 hours to pump breast milk in a room or an area that provides adequate privacy and cleanliness. Restrooms should not be considered an appropriate location for pumping. The AF member must supply the equipment needed to pump and store the breast milk.

4.15.2. AF members who are breastfeeding or pumping remain eligible for field training, mobility exercises, and deployment. However, AFI 36-2110, *Assignments*, supports deferment from deployment for 6 months post-partum. AF commanders may consider supporting deferment of deployment for breastfeeding mothers for 12 months post-partum to ensure the full medical benefits of breastfeeding.

4.15.3. The AFMS encourages commanders' modifications of these activities and/or work conditions for Airmen who are breastfeeding, when possible. Nonetheless, duty requirements may not always be compatible with exclusive breastfeeding. In these cases, the AF member must decide in consultation with her medical provider whether to attempt to continue breast-feeding and/or pumping breast milk. AF Form 469 is not the mechanism for documentation that an AF member is breastfeeding.

4.16. Illness During the Prenatal Period.

4.16.1. Providers may not recommend convalescent leave during the prenatal period for pregnancy-related time off work.

4.16.2. Providers may authorize quarters as usual for up to 72 hours for medical issues not related to the pregnancy. For issues related to the pregnancy, use Obstetrical Quarters (OB Quarters) status. **NOTE:** There is no duration limitation on OB Quarters, but the attending provider must evaluate the patient at least weekly and document this evaluation in the medical record. (T-1)

4.17. Evaluation of Pregnant Civilian Employees.

4.17.1. When a civilian who is employed by the Air Force presents confirmation of pregnancy to the supervisor, the supervisor refers her to the MTF Public Health section.

4.17.2. Bioenvironmental Engineering evaluates workplace risks in conjunction with Public Health and Aerospace Medicine, advises the employee of any identified risks, and reports the risks with any recommended techniques for avoiding the risks to the employee and her supervisor.

4.17.3. When the obstetrical healthcare provider is a civilian, recommendations will be reviewed by a military medical provider through the Force Health Management section, who will make a final duty recommendation to the civilian employee and her supervisor. (T-1)

Section 4E—Newborn Care

4.18. Newborn Screening.

4.18.1. All state screening programs now perform the 29 screens and many perform additional testing, counseling and follow-up. MTFs must develop written policies and procedures for screening and treatment programs using state health requirements and the guidelines in the most recent edition of *Guidelines for Perinatal Care*, prepared by the AAP and ACOG. Results of newborn screening should be entered into the patient's medical record. (T-1)

4.18.2. Each MTF caring for newborns should develop and implement a prescribed formal process to address abnormal Newborn Metabolic screening results. The process should address the following issues:

4.18.2.1. Process for contacting the ordering provider

4.18.2.2. Knowledge of urgency of results

4.18.2.3. Need for and type of confirmatory testing

4.18.2.4. Appropriate follow-up with timely specialty care referrals.

4.18.3. MTFs are strongly encouraged to utilize their State Newborn Metabolic Screening programs for laboratory support, consultations and beneficiary follow up care. A formal process is defined as designated personnel capable of implementing actions immediately for critical results, contacting and ensuring ordering provider has adequate information for clinical follow up. The MTF personnel should be readily available to support referrals to appropriate levels of care within 12 hours of notification. (T-1)

4.18.4. MTFs must ensure newborn hearing screening is included in routine newborn screening (in compliance with local and state mandates in the absence of federal requirements).

4.19. Newborn and Intensive Care Nurseries: Refer to the most recent edition of *Guidelines for Perinatal Care* for functional capabilities, physical plant, equipment and procedures for intensive care and transfer plans for newborns.

4.20. Newborn Hospital Stay.

4.20.1. All breastfeeding newborn infants shall be seen by a pediatrician or other knowledgeable and experienced health care professional at 3 to 5 days of age as recommended in the AAP statement *Breastfeeding and the Use of Human Milk* (2012). (T-1)

4.20.2. For newborns discharged less than 48 hours after delivery, the PCM or attending physician shall provide follow-up IAW AAP statement *Hospital Stay for Healthy Term Newborns* (2010). For newborns discharged less than 48 hours after delivery, an appointment should be made for the infant to be examined by a licensed health care professional, preferably within 48 hours of discharge based on risk factors but no later than 72 hours in most cases. If this cannot be ensured, discharge should be deferred until a mechanism for follow-up evaluation is identified. Mother and infant shall be evaluated individually to determine the optimal time of discharge. The timing of discharge shall be the decision of the physician caring for the infant and not by policy established by third-party payers. (T-1)

Chapter 5

SURGICAL SERVICES PRODUCT LINE

Section 5A—Performing Surgical Procedures

5.1. Elective Surgery. Elective (non-emergent) surgery on active duty members performed off-base and not coordinated or approved by the MTF/TRICARE, (such as surgery at the member's expense), is prohibited without prior written approval of the member's Sq/CC and the MTF/CC. The MTF/CC will assess the risks and duty impact of the proposed surgery and report this information to the commander, respecting the patient's privacy to the extent practicable. Permission must be obtained prior to any non-refundable deposits (for surgery, airline tickets, etc.) being made; the potential for lost deposits will not be factored into the decision. In addition, non-emergent elective surgeries within 6 months of separation or retirement must have additional prior approval by HQ AFPC/DPANM, as required IAW AFI 41-210. (T-1)

5.2. Cosmetic Surgery.

5.2.1. Only privileged staff and residents in the specialties of plastic surgery, dermatology, otorhinolaryngology, ophthalmology, and oral-maxillofacial surgery may perform cosmetic surgery procedures. Contract providers are not to perform cosmetic surgery procedures. Civil service providers may perform cosmetic surgery procedures only if they are employed full-time by the MTF with no other opportunity to maintain their skill in cosmetic surgery. All patients, including active duty personnel, undergoing cosmetic surgery must pay applicable fees for cosmetic surgery. Excluded from this restriction is the excision or destruction of minor benign dermatologic lesions, which may be performed by qualified providers in any specialty. Waiver authority to this policy is the AFMOA/CC for requests for supplemental privileges for cosmetic surgery procedures to other uniformed and civil service specialists, on a case by case basis, providing adequate documentation of training and proficiency is submitted. (T-1)

5.2.2. Cosmetic surgery may be performed on a "space-available" basis only, and cosmetic surgery procedures may not exceed 15% of any privileged provider's caseload.

5.2.3. All cosmetic procedures will be coded with the proper International Classification of Diseases (ICD) code (current version). At present, the appropriate ICD-9-CM codes are in the V50 series: "Elective surgery for purposes other than remedying health status." Code V50.1 (ICD-10-CM Z41.1), "Other plastic surgery for unacceptable cosmetic appearance," is the proper code unless a more specific code exists in this series. Code V51 (ICD-10-CM Z42 series), "Aftercare involving the use of plastic surgery (excludes cosmetic plastic surgery)" may be used to indicate that a procedure is not cosmetic plastic surgery. (T-1)

5.2.4. The MTF/CC will establish a prepayment schedule for all patients and a tracking system for all cosmetic procedures, IAW the annual publication of the DoD Medical Reimbursement Rates and Procedures document. The established tracking system shall include data elements to include patient name, patient FMP/SS, surgery date, physician name, procedure name, ICD/CPT code, date payment estimated, date paid, amount estimated, actual codes performed and additional billing amount. (T-0, DoD Medical Reimbursement Rates and Procedures)

Section 5B—Anesthesia Policy, Practice and Services

5.3. Responsibilities.

5.3.1. The Consultants to the Air Force Surgeon General for Anesthesiology and Certified Registered Nurse Anesthetist (CRNA), working through AFMOA/SGH and AFMOA/SGN provides guidance in force distribution, readiness issues and anesthesiology practice.

5.3.1.1. Anesthesia is a recognized specialty by both nursing and medicine.

5.3.1.2. Provision of anesthesia and its related services by Anesthesiologists and CRNAs are determined by their licensure, certification and expertise. Thus, both Anesthesiologists and CRNAs are recognized as independent practitioners based on their respective scope of practices and will be held to these standards in credentialing and medico-legal issues. (T-1)

5.3.1.3. However, collaborative delivery of anesthesia in a team concept, such as the Anesthesia Care Team (ACT), has been shown to reduce mortality and morbidity compared to either anesthesia provider acting independently. Traditionally, ACT referred to a CRNA working in a medical directed environment with an Anesthesiologist. However, in the AFMS, ACT refers to any combination of Anesthesiologist or CRNA working as a team.

5.3.1.4. Collaboration is defined as the collective determination to reach an identical objective (the best, safest patient outcomes) and involves sharing knowledge, learning, and building consensus with mutual respect.

5.3.1.5. The ACT concept, which is collaboration among anesthesia providers in the delivery of anesthesia and its related services, will be the preferred practice model in the AFMS and is independent of specific training background. Most critical to this concept is teamwork with a designated team leader and clearly defined team member roles, both in the overarching organization and in daily operations. (T-1)

5.3.1.6. The anesthesia team in the AFMS will consist of a Chief of Anesthesia who assumes clinical oversight of the anesthesia department, a daily board runner and/or float, and the individual anesthesia provider for each surgical case. (T-1)

5.3.2. If anesthesia services are present, the MTF/CC will designate an anesthesia provider as the Chief of Anesthesia who is responsible for oversight of patient anesthesia care and MTF anesthesia services. The Chief of Anesthesia must:

5.3.2.1. Be a privileged anesthesia provider. (T-1)

5.3.2.2. Be the most clinically competent and experienced anesthesia provider assigned to the MTF. It is recommended that MTF/CC or their designee (i.e. SGH, Sq/CC) work in concert with both AF/SG Consultants for Anesthesia in determining the most qualified clinician for this position. (T-3)

5.3.2.3. In MTFs with more than 3 Operating Rooms the Chief of Anesthesia will likely be a board certified anesthesiologist. (T-3)

5.3.2.4. Ensure all anesthesia providers are actively involved in patient care. (T-2)

- 5.3.2.5. Verify all anesthesia providers are practicing within their full scope of practice. (T-2)
 - 5.3.2.6. Develop a peer-review process to critically evaluate the delivery of anesthesia and its related services on a regular basis. (T-1)
 - 5.3.2.7. Provide regular feedback, outcomes, and recommendations on anesthesia providers and clinical activities to the SGH or other designee. (T-2)
 - 5.3.2.8. Provide daily assignments appropriate for the patient's condition and clinical requirements, and that these needs are coordinated with the Operating Room Supervisor and the attending surgeons. (T-2)
 - 5.3.2.9. Certify that personnel develop a fail-safe mechanism to track the controlled drugs used by anesthesia services. (T-1)
 - 5.3.2.10. Ensure there is always a back-up provider (float) available in the event of an emergency. The back-up provider must be capable of immediately diagnosing and treating a medical emergency. (T-1)
 - 5.3.2.11. The Chief of Anesthesia will also coordinate with the appointed administrator for the Anesthesia Service (Flight/CC or Element Chief) on all matters concerning daily schedules, patient safety and quality, and any other related clinical requirements.
- 5.3.3. The MTF/CC will designate an anesthesia provider as the Flight Commander/Element Chief who is responsible for the administrative duties of the anesthesia services. The Flight Commander/Element Chief must: (T-1)
- 5.3.3.1. Be a privileged anesthesia provider.
 - 5.3.3.2. Be responsible for all administrative duties for the Department of Anesthesia, per the MTF guidelines of a Flight Commander/Element Chief.
 - 5.3.3.3. Support the Chief of Anesthesia in their duties of clinical oversight.
 - 5.3.3.4. Although the Chief of Anesthesia and Flight Commander/Element Chief could be the same anesthesia provider due to limited manpower resources, it is recommended that these positions be functionally separate.
- 5.3.4. Board Runner and/or Float:
- 5.3.4.1. The designated anesthesia board runner and/or float for the daily schedule will coordinate all anesthesia activities through the Chief of Anesthesia and Operating Room Supervisor to ensure patient care requirements are met. (T-1)
 - 5.3.4.2. One board runner/float/back-up anesthesia provider will be required for every four operating rooms or anesthesia procedures. (T-1)
 - 5.3.4.3. The board runner/float responsibilities include ensuring all patients are ready for anesthesia, coordinating with the operating room supervisor to execute the daily operating room schedule, providing scheduled breaks/relief for direct patient care anesthesia providers, carrying code/emergency/obstetric care pagers, and responding to any and all inquiries/consultations/emergencies for the MTF.

5.3.4.4. The functions and responsibilities listed above are a summary of anesthesia clinical practice and are not intended to be all-inclusive. MTF specific policies should be detailed in anesthesia department OIs in coordination with the AFI.

5.4. Managing Controlled Substances on the Anesthesia Service. This section applies only to MTFs without an automated storage/delivery system in place. With an automated storage/delivery system in place, the Pharmacy will be responsible for daily supply and re-stock of anesthesia medications. Automated storage/delivery system units with controlled substances located outside the pharmacy will be physically inventoried periodically according to MDG instruction. Any discrepancies will be immediately investigated and reported to MDG pharmacy leadership. (T-1)

5.4.1. In the event of no automated storage/delivery system, the Anesthesia Service:

5.4.1.1. May keep no more than a one-week supply of controlled substances.

5.4.1.2. Must keep controlled substances in double-locked cabinets (may be located on the anesthesia carts as required, or separately). (T-1)

5.4.2. The Chief of Anesthesia appoints an anesthesia provider as the Officer-in-Charge (OIC) of controlled substances in anesthesia.

5.4.3. A CRNA or anesthesiologist carries the keys to the controlled substances cabinets during duty hours.

5.4.3.1. The on-call anesthesia provider carries the keys after duty hours.

5.4.4. Personnel must never leave the controlled substances unattended on anesthesia carts. (T-1)

5.4.5. The OIC for controlled substances in anesthesia is responsible for a daily inventory of all controlled substances. The inventory is to be conducted by an anesthesiologist and another officer who is not an anesthesiologist.

5.4.6. Personnel must address appropriate controlled substance dosages as part of the monthly anesthesia audit. (T-1)

5.5. Use of AF Form 579, Controlled Substances Register. This section applies only to MTFs without a Pyxis, or other automated storage/delivery system in place.

5.5.1. All anesthesia personnel utilizing controlled substances must comply with the following: (T-1)

5.5.1.1. An AF Form 579 must be maintained for each controlled substance stocked by the anesthesia service.

5.5.1.2. Controlled substances must be signed out, at the time they are obtained from the cabinet, by the ampule, vial or syringe.

5.5.1.3. Any unused or unopened ampule, vial, or syringe must be signed back into stock using the received column on AF Form 579.

5.5.1.4. All controlled substances administered to the patient must be shown in 2 places on the anesthesia record (document the dosage appropriately).

5.5.1.5. Show incremental doses of controlled substances on the anesthesia record, and annotate the time given.

5.5.1.6. Enter a summary of all controlled substances administered to a patient and partial unit dosages wasted on the anesthesia record, and on any other local form as required. The anesthesia personnel assigned to the case must sign this summary entry. If personnel waste, drop, or contaminate partial unit doses, a professionally licensed officer must co-sign the summary entry. **EXCEPTION:** If another professionally licensed provider or nurse is not available, a medical, surgical or dental journeyman or craftsman may witness and co-sign the entry IAW local policy and procedures.

5.5.1.7. IDMTs will follow established anesthesia procedures IAW AFI 44-103.

5.5.1.8. The total amount of controlled substances administered, returned, and destroyed must match the net amount of the drug issued on the AF Form 579.

5.5.1.9. All incorrect balances and unaccountable substances will be reported to the SGH, the Chief of Pharmacy Services, or the Chief of Surgical Services. An AF Form 765, *Medical Treatment Facility Incident Statement*, will be completed promptly and forwarded to the MTF Risk Manager. AF Form 85, *Controlled Substance Inventory Adjustment Voucher*, must also be completed.

5.6. Availability of Anesthetics.

5.6.1. Anesthesia personnel:

5.6.1.1. Must have induction agents immediately available. (T-1)

5.6.1.2. Control these drugs according to guidelines in Chapter 8, **Pharmacy Services** of this instruction.

5.6.1.3. During the elective surgery schedule, stock all anesthesia carts with adequate supplies of induction agents.

5.6.1.4. Stock emergency and obstetrical anesthesia carts with adequate supplies for immediate use. Stock additional supplies along with other anesthesia drugs in a controlled area, workroom, and/or refrigerator.

5.6.1.5. Although personnel must keep an accurate record of incremental doses of drugs administered on anesthesia record, they need not record this type of drug on AF Form 579 under usual circumstances. (T-1)

5.7. Processing and Completing Records.

5.7.1. The Anesthesia Provider will:

5.7.1.1. Establish an anesthetic plan and document this on the anesthesia record. (T-1)

5.7.1.2. Write pre-operative orders for the patient on the AF Form 3066, *Doctor's Order* or appropriate electronic record in use at that time. (T-1)

5.7.1.3. Accompany the patient from the procedure room to the Post-Anesthesia Care Unit (PACU). (T-1)

5.7.1.4. Write post-operative orders for the patient on the AF Form 3066, *Doctor's Order* or appropriate electronic record in use at that time. (T-1)

- 5.7.1.5. Complete the record at the end of each procedure. (T-1)
- 5.7.2. Procedures performed by anesthesia providers not requiring an anesthesia record shall be documented in the medical record. (T-1)
- 5.7.3. The PACU nurse records all pertinent information regarding the patient's recovery from anesthesia. Local policy will define the parameters used for discharge or transfer. (T-1)
- 5.7.4. The physiological parameters at the time of the transfer/discharge must be clearly documented in the patient's record, along with discharge instructions, and a reference as to in whose care/custody the patient is released. (T-1)
- 5.7.5. The unit nurse receiving the patient makes an entry on the medical record.

Section 5C—Use of Sedation for Clinical Procedures

5.8. Use of Sedation for Clinical Procedures.

- 5.8.1. Sedation is part of the continuum of anesthesia. Definitions of the three levels of sedation are:
 - 5.8.1.1. Minimal sedation (anxiolysis) is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilation and cardiovascular function are unaffected. Patient care areas providing minimal sedation (anxiolysis) by oral pre-medication only may rely on standard peer review procedures.
 - 5.8.1.2. Moderate sedation/analgesia (conscious sedation) is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is normally maintained.
 - 5.8.1.3. Deep sedation/analgesia is a drug-induced depression of consciousness during which the patient cannot be easily aroused, but responds purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function usually is maintained.
- 5.8.2. Facilities must develop institution-wide protocols, with approval by the Executive Committee of the Medical Staff (ECOMS) for use of sedation to ensure consistency in all patient care settings. (T-1)
 - 5.8.2.1. This includes guidance for both physicians and dentists, defining what must be included in a pre-sedation history and physical, and when the history and physical is to be performed in relation to the actual surgery. (T-1)
- 5.8.3. Providers appropriately privileged to perform sedation determine the selection and use of oral or intravenous sedation. Peer review, with approval by the ECOMS, of sedation protocols is required, and will be accomplished IAW the MTF's program, under the purview of the SGH. (T-1)

5.8.4. Medical/Dental personnel must monitor sedated patients and be prepared for emergencies. This requires:

5.8.4.1. Qualified assistants. A qualified assistant must have current BLS certification (ACLS or PALS training is recommended, depending on the patient's age, but not required unless the assistant is administering the medications), and familiarity with the cardiovascular and respiratory side effects of the agents used. A qualified assistant must be trained in the use of monitoring equipment, be trained in the recognition and management of medical emergencies, and be familiar with code blue procedures and the contents of the crash cart. (T-1)

5.8.4.2. An emergency notification system. (T-1)

5.8.4.3. Monitoring equipment for blood pressure determination, cardiac rhythm and oxygen saturation will be readily available. All sedated patients will be visually monitored for level of consciousness and respiratory rate. (T-1)

5.8.4.3.1. When the patient is minimally sedated (anxiolysis), further monitoring will be provided as deemed necessary by the treating provider (if greater than 50% nitrous oxide is utilized, oxygen saturation and heart rate shall be monitored). (T-1)

5.8.4.3.2. When the patient is moderately sedated, oxygen saturation, heart rate and blood pressure will be monitored. Any additional monitoring may be utilized as deemed necessary for the particular care of an individual patient. (T-1)

5.8.4.3.3. When deep sedation is utilized, oxygen saturation, heart rate, blood pressure, and cardiac rhythm will be monitored. Equipment to monitor temperature will be immediately available. Additional monitoring may be utilized as deemed necessary for the particular care of an individual patient. (T-1)

5.8.4.4. Resuscitative equipment and medications are rapidly accessible. (T-1)

5.8.5. A privileged provider or qualified ACLS and/or PALS certified clinical nurse may infuse intravenous medication.

5.8.6. The use of propofol should be restricted to those trained in the administration of general anesthesia when it is being used for sedation without a definitive airway as per the American Society of Anesthesiologists recommendation.

Section 5D—Living Organ and Tissue Donation Participation for Transplantation or Research

5.9. Organ and Tissue Procurement Planning.

5.9.1. IAW DoD Directive 6465.3, *Organ and Tissue Donation*, all CONUS inpatient facilities must establish an organ and tissue procurement plan in conjunction with the nearest military transplant center (MTC) and local organ procurement organization and measure the effectiveness of their organ procurement effort. This must be documented in a Memorandum of Understanding (MOU) or a Memorandum of Agreement (MOA), which will require local legal review before enactment. (T-0, DoD Directive 6465.3, *Organ and Tissue Donation*)

5.9.2. Consistent with donor intent, all organs and tissues retrieved from DoD beneficiaries who had previously signed an organ donation consent form are first offered to one of the established MTCs.

5.9.3. DoD bills its retrieval costs to civilian organ procurement organizations or non-DoD transplant recipients as outlined in the current TRICARE Policy Manual, which can be accessed at: <http://manuals.tricare.osd.mil/>.

5.9.4. An affirmative or negative organ or tissue donation shown on a DoD-issued card or in a DoD-maintained database shall be considered by medical personnel to be guidance to the next of kin. If there is conflict with State law, donor election or donation documentation, medical personnel may follow local applicable law. (T-0, DoD Directive 6465.3, *Organ and Tissue Donation*)

5.9.5. MTF personnel shall immediately notify the Organ Procurement Organization (OPO) regarding any death, imminent death or when they recognize the potential for organ and/or tissue donation. (T-0, DoD Directive 6465.3, *Organ and Tissue Donation*)

5.9.5.1. Organ and tissue donation shall be discussed with the next-of-kin in every death in military MTFs unless the potential donor is determined to be medically unsuitable by the OPO or if the patient previously elected not to participate as a donor. This discussion or determination of unsuitability will be documented in the medical record. (T-1)

5.9.5.2. The MTF shall maintain a listing of patients who die and record the results of action taken to secure the donation of organs or tissues from each patient who dies. (T-1)

5.10. Living Organ and Tissue Donation Participation.

5.10.1. The DoD encourages, while avoiding coercion, all personnel covered under the DoD health-care system to donate tissues and organs and to advise their next of kin about their decision and any subsequent change in their decision.

5.10.2. When an active duty member wishes to be a living organ or tissue donor, the following process is followed:

5.10.2.1. The donor should be made aware of the risks and benefits of the procedure, including where complications might limit or prohibit further active duty service. A complete package, as outlined in the next paragraph, should be sent to the MTF/CC for final approval.

5.10.2.2. The organ donor package should include the following:

5.10.2.2.1. Letter from the donor requesting to be an organ donor. The letter documents the organ to be donated, approximate date of surgery, and – if known – the diagnosis and disease state or current treatment being rendered to the recipient.

5.10.2.2.2. Letter from donor's commander granting permission to be an organ donor.

5.10.2.2.3. Letter from donor's PCM, which documents that the donor can be reasonably expected to retain world-wide qualification following donation.

- 5.10.2.2.4. Acknowledgement of concurrence from MTF/SGH with attention to the ability of the donor's MTF to provide care in the case of complications from donation.
- 5.10.2.3. Once the package is complete, the MTF/CC will review and provide a final decision back to the requesting donor.
- 5.10.2.4. If the donor expects to separate or retire within 180 days of the donation, permission will be obtained from AFPC/DPANM and this memorandum will be included in the approval package. (T-1)
- 5.10.2.5. The donor will seek guidance and be informed of their health benefits and limitations by their TRICARE service benefits representative. Verification of this consultation will be incorporated in the approval package. (T-1)
- 5.10.3. The time allotted for an active duty member to serve as an organ donor will vary based on the procedure required.
- 5.10.3.1. AFI 36-3003, *Military Leave Program*, Table 7, Rule 36, allows the member's commander to approve up to 10 days of permissive TDY if the unit mission allows.
- 5.10.3.2. When the donor is admitted to the inpatient service, they are placed in inpatient status.
- 5.10.3.3. The donor will be placed on convalescent leave IAW military medical authority for an appropriate period of time after the procedure. (T-1)
- 5.10.4. AF participants in the DoD Marrow Donor Program will follow the same process as other organ donors; the DoD program command permission letters meet the requirement for documenting command permission. (T-1)
- 5.10.5. Donation of peripheral blood cells is exempt from this process.
- 5.10.6. Post-Mortem Sperm Donation.
- 5.10.6.1. MTF/CC shall ascertain whether post-mortem sperm collection is offered in the local community, and if so, shall generate an MOU or MOA to delineate the administrative process for accomplishing the sperm collection. If this procedure is not offered locally, the MTF/CC has no further obligation to locate such services. (T-1)
- 5.10.6.2. If an individual seeks post-mortem collection of sperm from a deceased AF member, the MTF/CC must determine if there are stipulations, in writing, by the deceased service member, that the deceased member has consented to the collection of sperm for the purpose of procreation, and has specifically identified the recipient of the sperm as the individual seeking the sperm. (T-1)
- 5.10.6.3. All costs associated with collection, transport, storage and subsequent use of the sperm will be borne by the requesting individual. (T-1)

Chapter 6

CLINICAL LABORATORY AND ANATOMIC PATHOLOGY SERVICES

Section 6A—General Guidance

6.1. General Guidance.

6.1.1. Each MTF follows DoD standards of laboratory practice defined in the DoD Clinical Laboratory Improvement Program (DoD CLIP) for registration, certification, proficiency testing, patient test management, quality control, personnel, quality improvement and inspection. Each MTF ensures that laboratories are inspected and accredited by the College of American Pathologists (CAP), the Joint Commission or other accreditation programs approved by the Office of the Secretary of Defense, Health Affairs. Transfusion Services and Blood Donor Centers will be accredited by the AABB and registered with the Food and Drug Administration (FDA). (T-0, DoDI 6440.2, Clinical Laboratory Improvement Program (CLIP))

6.1.2. Each MTF prepares a laboratory guide with:

6.1.2.1. A list of specific services and procedures it provides.

6.1.2.2. Specific instructions covering specimen requests and submission instructions.

6.2. Laboratory Services.

6.2.1. The MTF/CC designates a Chief or Flight Commander, Laboratory Services. In most cases, this will be a biomedical laboratory officer. If a laboratory officer is not assigned to the facility, a qualified medical director, trained IAW DoD CLIP and CAP requirements, may assume the additional duty of Chief, Laboratory Services. (T-0, DoDI 6440.2)

6.2.2. The MTF/CC designates a Medical Director. The MTF/CC appoints a staff physician trained IAW DoD CLIP and CAP requirements as medical director in situations where there is no assigned pathologist.

6.2.2.1. If the MTF does not have a staff physician that meets the DoD CLIP and CAP Medical Director education and experience requirements, the MTF will consult with AF/SG Pathology Consultant to assign a pathologist from a regional MTF as the medical director or pathology consultant. A civilian medical director or pathology consultant outside DoD will be locally funded. (T-0, DoDI 6440.2)

Section 6B—Blood Transfusion Services

6.3. Transfusion Services/Blood Donor Centers (BDC).

6.3.1. The laboratory chief ensures the transfusion service or blood donor center operates under the control of a trained, competent and experienced staff. Compatibility testing procedures shall adequately safeguard the intended recipient. (T-1)

6.3.2. The operation shall conform to military directives and current Good Manufacturing Practices (cGMP) as required by the FDA, AFI 44-105, *The Air Force Blood Program*, and

guidance from AFMOA to include the Air Force Blood Program Division. (T-0, FDA regulations)

6.3.3. Patients, or their guardians in the case of minors, who expect to receive blood product transfusions shall complete AF Form 1225, *Informed Consent for Blood Transfusion*, or suitable substitute/local form. This form documents the discussion between patient and provider regarding the risks and benefits associated with blood transfusions as well as the alternatives to receiving allogeneic blood. Also see paragraph 2.5., **Informed Consent Documentation** and Section 2C, **Treating Minors**; paragraph 2.7., **General Guidelines** of this instruction. (T-1)

6.3.4. The administration of blood products is documented on SF 518, *Blood or Blood Component Transfusion Medical Record*, or suitable substitute/local form to permanently capture all events and essential patient information associated with blood product administration. When the blood product is known to be non-US, non-FDA licensed, the transfusion service/ blood bank shall annotate the status of that product in the Remarks block of Section II. The annotation will state: "Non-US, non-FDA licensed product, patient follow-up testing is required." (T-1)

6.4. Blood Transfusion Follow-up for Products from Non-FDA sites.

6.4.1. DoD healthcare policy requires that beneficiaries receive medical treatment that meets or exceeds the established "standard of care." In regard to blood transfusion, this means that all transfused blood products must be FDA-compliant. Since U.S. personnel are deployed around the world and banked blood is perishable, it is not always possible to provide transfusion centers with FDA-compliant blood products. The use of non-FDA-compliant blood is sometimes necessary to save lives and may be the only alternative during combat operations or mass casualty events. (T-0, HA Policy 10-002, *Policy On the Use of Non-U.S. Food and Drug Administration Compliant Blood Products*)

6.4.2. Blood products from non-FDA registered blood banks/blood services may be used in DoD MTFs only when absolutely necessary for emergent treatment.

6.4.2.1. Examples of non-FDA registered blood banks/blood services include blood products collected by a "host nation" (foreign country) and provided to a DoD MTF or forward deployed EMEDS facility, blood collected under emergency conditions and transfused before FDA-approved blood donor tests are completed, or blood products that are transfused in a "host nation" (civilian or military) hospital.

6.4.2.2. Under such circumstances the attending physician or PCM (at DoD MTF) will verify and document in the electronic medical record the use of non-FDA compliant blood products and notify Public Health. Follow-up testing is required. (T-0, HA Policy 10-002) **NOTE:** Recipients of blood products from Armed Services Blood Program Office-determined equivalent countries are exempted from these requirements. (T-0, HA Policy 11-008, *Policy on the Establishment of Comparability of Foreign Nation Blood Supplies to Food and Drug Administration Compliant Blood Products*)

6.4.3. To the maximum extent feasible, a pre-transfusion blood specimen will be collected to establish a baseline for each of the current FDA-required blood donor infectious disease screening tests. If a pre-transfusion specimen cannot be obtained, a baseline blood sample should be collected as soon as possible post-transfusion. (T-0, HA Policy 10-002)

6.4.4. Each MTF will establish a process to ensure retesting of these patients at 3 months, 6 months, and 1-year post transfusion. Use of a patient tracking system such as the Patient Tracking Module in ASIMS is encouraged. All testing will be completed and documented in the patient's electronic medical record as soon as practical. If the patient will not remain at the same location to finish required testing, then the losing MTF must have a process to coordinate with the gaining MTF to ensure appropriate transfer of care. (T-0, HA Policy 10-002)

6.4.4.1. Patient follow-up also applies to U.S. patients transfused with non-FDA compliant blood given by host-nation healthcare facilities. As stated above, some countries are exempt from this requirement IAW HA Policy 11-008.

6.4.5. The patient will be given notice, prior to transfusion if feasible or as soon thereafter as possible, that the blood is not FDA-compliant, the reasons it is being provided, and the necessary patient follow-up. (T-0, HA Policy 10-002)

6.4.6. These guidelines not only apply to DoD beneficiaries stationed at established overseas bases, but to all deployed personnel in operational theaters to include Reservists and National Guardsmen. Proper follow-up care will continue following demobilization, separation and retirement from military duty.

6.4.7. Each transfusion of a non-FDA compliant blood product will be reported to the appropriate geographic AF MAJCOM, Unified or Specified Command, or Task Force Surgeon's office, who in turn, will forward data to the Armed Services Blood Program Office (ASBPO) and the appropriate Service Blood Program Office through the Joint Blood Program Office. (T-0, HA Policy 10-002)

Section 6C—Anatomic Pathology Services

6.5. Anatomic Pathology Services.

6.5.1. All MTFs without in-house anatomic pathology services will consult with the AF/SG Pathology Consultant to coordinate anatomic pathology services. (T-1)

6.5.2. The MTF/CC coordinates with the AF/SG Pathology Consultant for cytopathology services. All gynecologic cytology specimens will be referred to 59 MDW/SAMMC per AF/SG 2005 AF Cytology Center consolidation. (T-1)

6.5.3. Histopathology and cytopathology cases requiring consultation (second opinion) will be coordinated with the Joint Pathology Center Washington D.C. or another DoD MTF. Histopathology or cytopathology consultations referred outside of DoD will be locally funded. (T-1)

Chapter 7

RADIOLOGY AND RADIOLOGIC SERVICES

Section 7A—Radiology Administration

7.1. Filing Hard Copy Radiographs. All medical non-digital (hard copy) radiographs taken in any MTF, or forwarded from other facilities will be filed in AF Form 2700, *Radiographic Film Envelope*. Dental Radiographs will be handled in accordance with AFI 47-101, *Managing Air Force Dental Services*. (T-1)

7.2. Radiology Technicians.

7.2.1. Must complete a locally developed, formal, documented, skill-verification training program before administering intravenous contrast media. This will be documented in the electronic Air Force Training Record. (T-2)

7.2.2. After appropriate training, technicians may inject contrast media only under the direction of a physician who is immediately available.

7.2.3. The person responsible for the injection, who may be a technologist or registered nurse, must be aware of the signs and symptoms of an adverse effect and must monitor the patient for the development of these signs and symptoms during the examination. The supervising physician, or his or her physician designee, must be immediately available to respond promptly to an adverse effect. (T-1)

7.3. Stat Examinations, Early Interpretation and Critical Results Communication: Will be guided by the American College of Radiology Standard for Communication: Diagnostic Radiology and The Joint Commission guidance on critical results notification. There is considerable overlap and MTFs must be cognizant of the fact that stat performance and stat interpretation, “wet read,” are not the same thing. Critical communication of findings is independent of requested urgency of interpretation and takes urgency from the interpretation itself. (T-0, ACR Standard for Communication, TJC)

7.3.1. Urgent Examinations: When ordered “stat” either electronically or in writing, should be conducted as soon as can be arranged (immediately, or as soon as resources can be made available).

7.3.2. **Early Interpretation:** Interpretation without delay is required when the requesting provider annotates “Wet Read,” or when the priority for the study is classified as “stat (immediate),” “ASAP (as soon as possible),” or “notify” in the written or electronic order for Radiologic Consultation Request/Report. Where and when applicable, work list prioritization in the Picture Archiving and Communication (PACS) and Teleradiology Systems should be set up to force these examinations to the front of workflow.

7.3.3. The radiologist providing a preliminary interpretation when contacted or requested by the referring provider will document such communication in the final radiological report in lieu of an immediate final report. (T-1)

7.3.4. Critical Results: Unexpected and serious abnormalities must also be reported to the requesting provider as soon as possible after identification by the radiologist. This notification shall be documented in the final radiological report. A critical results list and procedures for notification must be established for each facility and each must have a means of tracking request and notification times for these procedures, something that is not native to CHCS, nor inherent in some PACS. (T-1)

7.4. Completion of Reports.

7.4.1. The final report is considered to be the definitive means of communicating the results of an imaging examination to the referring provider. The timeliness of reporting any radiological examination varies with the nature and urgency of the clinical problem. However, to the degree possible, final typed reports shall be completed and available to the referring provider within 3 working days from completion of the examination in facilities with full-time military or civilian radiologists. Mechanisms to speed report turn-around time should be viewed as essential to excellent patient care and may require ancillary personnel and technology support. At remote or solitary staffed facilities, mechanisms should be in place for local or teleradiology interpretation of urgent examinations. Routine examination may often be handled in the same way, but a temporary extension for local interpretation of routine examinations may sometimes be appropriate. (T-1)

7.5. Film Loaning and Transfer.

7.5.1. Films, or copies of original films, may be temporarily loaned or transferred to another MTF. All digitally archived completed examinations are locally available at all AF MTFs, minimizing need for such distribution.

7.5.2. Where appropriate, personnel at the originating facility maintain AF Form 614, *Charge Out Record*, in place of the original film envelope. Electronic charge-out processes are also acceptable. This is unnecessary when a copy is made on electronic media.

7.5.3. If a hard copy film file is permanently transferred to another medical facility, personnel retire the original envelope or AF Form 614, with any film files being retired that year.

7.5.4. Film and electronic media may be hand-carried by the patient by order of the attending provider.

7.5.5. Patients may hand-carry original mammography film or electronic copy (when digital), have them sent to a new facility, or request that they be forwarded after the patient's arrival at the new MTF, IAW paragraph 4.2.6. of this instruction. Copies of mammography film should be used for comparison only by exception.

7.6. Contract Employees' X-Ray Films.

7.6.1. X-Rays taken of contract employees during their period of employment or as part of their termination examinations become part of the employment records, as stated in the employment agreement.

Section 7B—Teleradiology

7.7. Teleradiology. Teleradiology is an evolving endeavor that will eventually result in the connection of all sites in the AFMS for the purpose of interpretation/comparison of images. Studies may be interpreted by any credentialed radiologist in the AFMS. The practice of teleradiology is currently conducted between individual sites. Further teleradiology guidance is forthcoming in an update to this instruction prior to additional changes brought about by the upcoming connection.

Chapter 8

PHARMACY SERVICES

Section 8A—Pharmacy Services

8.1. Organization.

8.1.1. The MTF/CC ensures that the pharmacy operates under the supervision of a pharmacist IAW federal laws, DoD and Air Force policy, and accepted standards of practice as defined by The Joint Commission, The American Society of Health-Systems Pharmacists (ASHP), The American Pharmacists Association (APhA), The Accreditation Association for Ambulatory Health Care (AAAHC), and The United States Pharmacopoeia. **EXCEPTION:** A designated medical corps officer may supervise a pharmacy as a “pharmacy officer” when a pharmacist is not available. The designated officer must follow the same standards as would a pharmacist in carrying out the duties of “pharmacy officer,” including review of inpatient orders and prescriptions for accuracy and completeness. (T-1)

8.1.2. Pharmacists or designated pharmacy officers provide direct supervision of pharmacy technicians.

Section 8B—Policies and Procedures

8.2. Policies and Procedures.

8.2.1. Pharmacies must develop policies and procedures, which provide:

8.2.1.1. Pharmaceutical care consistent with the facility’s scope of care and patient needs. (T-1)

8.2.1.2. Security measures to prevent the loss of pharmacy stock and unauthorized entry into the pharmacy. (T-1)

8.2.1.3. A perpetual inventory of schedule II, III, IV and V drugs. (T-1)

8.2.2. The Pharmacy Flight Commander, Pharmacy Officer or Element Chief supervises drug storage and preparation areas throughout the MTF and satellite pharmacy operations.

8.2.3. Pharmacies honor prescriptions from:

8.2.3.1. Privileged providers of the Uniformed Services, as described in AFI 44-119, and their civilian counterparts.

8.2.3.2. Veterinarians of the Uniformed Services.

8.2.3.3. Privileged providers of consulting referral military facilities.

8.2.3.4. Providers who are not employees of the United States government must be duly licensed by the jurisdiction in which they practice. (T-0, State Laws)

8.2.4. Pharmacies shall use policies and procedures adopted by the Pharmacy and Therapeutics (P&T) function of the medical staff and approved by the MTF/CC. (T-1)

8.2.5. Pharmacies shall publish a revised formulary at least annually, either in written or digital form, which is readily available to all medical staff. (T-1)

8.3. Patient Counseling.

8.3.1. Pharmacists and trained pharmacy technicians shall offer to counsel patients regarding drug therapy in general, and their newly prescribed medications in particular. (T-1)

Section 8C—Medication Dispensing

8.4. Medication Dispensing.

8.4.1. Pharmacies procure, dispense, recommend or use only drugs approved by the Food and Drug Administration (FDA). MTFs will not request or require military members to receive non-FDA approved drugs from any source, unless the exceptions in 10 U.S.C. §1107 apply. **EXCEPTION:** Pharmacies may dispense approved investigational drugs used in a clinical project using guidelines in AFI 40-402, *Protection of Human Subjects in Biomedical and Behavioral Research* and when US Presidential waiver authority precludes the need to obtain individual service member consent to receive investigational drug(s) IAW 10 U.S.C. §1107 and 21 CFR 50.23(d). (T-0, 10 U.S.C. §1107 and 21 CFR 50.23(d))

8.4.1.1. The pharmacy is the primary area for dispensing medications during normal operating hours. Exceptions and after hours dispensing must comply with all applicable pharmacy practice standards. Dispensing is defined as the provision of medication(s) for self-administration given to a patient during the course of a patient visit. Also refer to paragraph 8.22. for clarification on dispensing of Force Health Protection Prescription Products. (T-1)

8.4.1.2. Pharmacists will review all pharmaceutical orders occurring after normal duty hours and ensure that the dispensed medications are annotated in the automated patient profile. (T-1)

8.4.1.3. Providers dispensing medications outside of the pharmacy, i.e. after-hours clinics, will annotate the medication dispensed on the patient's SF 600, or SF 603, *Medical Record-Dental*, SF 558, *Emergency Care and Treatment*, or in the electronic medical record. Also see paragraph 8.22., Force Health Protection Prescription Products of this instruction. (T-1)

8.4.2. Patients may authorize adult third parties to pick up their prescriptions. An individual acting as the patient's representative can pick up a prescription for the patient under the following circumstances.

8.4.2.1. The patient has identified, either verbally or in writing, a family member, other relative, personal friend or any other person authorized to pick up prescriptions, or

8.4.2.2. If the patient is not present to give consent, the health care provider may use professional judgment to determine if it is in that patient's best interest to provide the prescription to the patient's representative.

8.4.2.3. Public Law 104-191, Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations specifically permit the conveyance of protected health information to the patient's representative when they are picking up medications for a

patient. Pharmacy personnel are permitted to and shall provide any necessary counsel to the representative regarding the medication or its safe administration to the patient. (T-0, Health Insurance Portability and Accountability Act of 1996)

8.4.3. Dispensing to inpatient/institutional care facilities outside the MTF is not authorized. Inpatient and institutional care facilities must have pharmacy services available. The MTF is not able to meet labeling and packaging requirements for other facilities. This does not apply to mutual aid situations at the discretion of the Pharmacy Officer and MTF/CC. (T-1)

8.4.4. Pharmacies may not curtail or withdraw civilian prescription service, nor restrict formulary drugs to any beneficiary class, regardless of the source of the prescription. **NOTE:** Limiting drug availability to specific patients is acceptable when the limitations are based on clinical considerations, such as efficacy and/or potential toxicity. Such limitations shall be accomplished using published disease management guidelines, or those developed cooperatively between members of the medical staff and the pharmacy. (T-1)

8.4.5. Over-the-counter (OTC) medication programs are permitted as long as the following conditions are met: Medications are included on the MTF formulary (i.e., the P&T Function determines them to be cost-effective alternatives to prescription products); the OTC medication program functions under the supervision of providers; medications are entered into CHCS/AHLTA; and, the medications are dispensed through the MTF pharmacy. OTC medication "hand-out" programs at MTF pharmacies without the above supervision or controls to ensure patient safety are specifically prohibited. (T-1) **EXCEPTION:** See paragraph 8.4.6. of this instruction for guidance regarding FDA-approved emergency contraceptive agents.

8.4.6. Emergency Contraception. MTF/CCs will implement procedures to ensure that FDA-approved emergency contraceptive agents will be ordered, stored, dispensed, distributed, and accounted for IAW this AFI. MTF/CCs should discuss with the MLC if there are host nation concerns. (T-1)

8.4.6.1. Emergency contraceptive medication must be dispensed IAW FDA drug approval notifications and guidance available at <http://www.fda.gov/> and documented in the medical record and the AHLTA/CHCS medication profile to screen for overlaps and contraindications before dispensing. (T-0, FDA Requirement)

8.4.6.2. Upon dispensing, every patient will receive the FDA-approved drug information handout provided by the manufacturer or downloaded from the FDA website. (T-0, FDA Requirement)

8.4.6.3. Males requesting emergency contraceptives from the pharmacist must present their military identification card along with the military identification card of the female beneficiary who will consume the medication. (T-1)

8.4.6.4. Procedures for the stock and replenishment of FDA-approved emergency contraceptives will be coordinated and monitored by the pharmacy and medical logistics departments. (T-1)

8.4.6.5. MTF Emergency Department (ED). ED distribution of FDA-approved emergency contraceptive medications must be under the supervision of a privileged medical provider and IAW with local MTF policy. (T-0, TJC Standard)

8.4.6.6. Medical personnel who object to dispensing emergency contraceptive medications or engaging in family planning services for moral, ethical, religious, personal, or professional reasons will not be required to engage or assist in such procedures unless the refusal poses a life-threatening risk to the patient. However, the MTF/CC must ensure alternate arrangements are available for the patient to obtain the medication with no delay in care. (T-1)

8.4.7. Active duty members are prohibited from obtaining medications, or using medications obtained from an Internet pharmacy not related to the TRICARE Pharmacy benefit. The Pharmacy benefit supplies medications through an MTF, a participating civilian pharmacy or through the DoD TRICARE Mail Order Pharmacy (TMOP) Program.

Section 8D—Formulary Management

8.5. Use of Formulary Drugs and Non-Formulary Requests.

8.5.1. The pharmacy will maintain a formulary that lists drugs and pharmaceutical preparations approved for prescription by the P&T Function, and/or by the Pharmacoeconomic Center basic core formulary list. (T-2)

8.5.2. Pharmacies and prescribing providers must use formulary drugs wherever possible. The drugs in the therapeutic classes represented on the DoD Basic Core Formulary (BCF) must be the first line agents at all MTFs. The MTF may supplement therapeutic classes on the BCF with other second line agents to meet patient needs. The MTF may include drugs on their formularies in therapeutic classes not represented on the BCF. (T-2)

8.5.3. Pharmacies need not honor prescriptions from non-referral medical facilities for drugs not on the formulary.

8.5.4. Non-formulary Requests: The MTF will have a written policy for requesting, processing, and filling non-formulary drugs. The process must include the provider documenting the request and then review and approval by a pharmacist. Documentation may be accomplished via e-mail, locally generated form, or DD Form 2081, *New Drug Request*, an equivalent form or equivalent computer-generated means via an AF-approved system (e.g., AHLTA note). If using the DD Form 2081, the sections marked “For Completion by the Chief of Department” and “For Completion by Therapeutic Agents Board” are optional. The intent is that the provider substantiates the need for a non-formulary medication, the pharmacist agrees, and the P&T Function reviews aggregate non-formulary requests. The goal should be a streamlined process where patients receive their medication within 24 to 48 hours of provider’s request. (T-1)

8.5.5. The pharmacy will submit a summary of non-formulary approvals to the P&T Function at each meeting. Frequent requests for a non-formulary drug shall prompt consideration for addition to the MTF formulary. (T-2)

8.5.6. When MTF enrolled patients are seen at a referral facility and prescribed medications that are not on the formulary at the MTF, the MTF pharmacy will utilize their established non-formulary request process to obtain the non-formulary medications for the patient. Referral MTFs must provide patients with at least a reasonable supply of medication when recommending long-term therapy, to allow the local MTF time to procure the non-formulary

medication. Referral from civilian facilities may require purchase in a civilian pharmacy until the medication can be obtained by the MTF. (T-1)

8.6. Air Force High Dollar Drug Program.

8.6.1. The local MTF arranges for or provides medications to treat conditions such as immunodeficiency diseases, transplants and other rare conditions. **NOTE:** In situations in which the cost to the MTF exceeds \$500 per patient per month, the Air Force High Dollar Drug Program at Wright-Patterson AFB may be utilized.

8.7. Generic Medication.

8.7.1. Pharmacies may fill prescriptions written by DoD providers for brand-name drugs with an FDA approved generic equivalent when available.

8.7.2. Pharmacies must fill clinically appropriate and otherwise legal prescriptions for formulary drugs written by civilian providers for eligible beneficiaries. Substitution of generic for brand-name products on prescriptions from non-MTF providers follows applicable state pharmacy practice guidelines. Pharmacies will not special purchase brand-name drugs to fill civilian prescriptions. (T-0, FY1994 National Defense Authorization Act and subsequent legislation)

Section 8E—Pharmacy and Therapeutics Function

8.8. The Pharmacy and Therapeutics Function.

8.8.1. This medical staff function must meet at least four times per year. It should include a physician, a pharmacist (if assigned), and a nurse. A majority of members or their designees must be present to conduct function business and must include a physician and a pharmacist (if assigned). (T-2)

8.8.2. Other interested personnel whose attendance can improve the function shall be included. (T-2)

8.8.3. Functions include:

8.8.3.1. Review of policies, acquisition, and use of drugs within the MTF and at remote sites for the IDMTs.

8.8.3.2. Review of medication errors for clinical improvement and patient safety opportunities.

8.8.3.3. Review of adverse reactions to drugs.

8.8.3.4. Evaluation of clinical data on new drugs and preparations requested for MTF use.

8.8.3.5. Pharmacy will present quarterly report results of National Contract Compliance Report reviews and results of Defense Medical Logistics Standard Support (DMLSS) Strategic Sourcing Module reviews. Pharmacy will make recommendations based upon the reviews to the P&T Function and report results to the MTF/CC, as appropriate (see paragraphs 8.9.4 and 8.9.5 of this instruction for more detail). (T-1)

*Section 8F—Drug Inventory***8.9. Drug Inventory.**

8.9.1. The MTF will:

8.9.1.1. Maintain controlled substances according to state and federal regulations. (T-0, 21 U.S.C. Chapter 13)

8.9.1.2. Conduct a complete and accurate inventory of all controlled substances every 2 years on 1 May (or the first duty day thereafter) of odd-numbered years. (T-0, DEA Requirement)

8.9.1.3. Minimize the potential for the dispensing of expired drugs through effective inventory management and identification and prompt removal of expired drugs. (T-1)

8.9.1.3.1. When only a month and year of expiration are provided for a drug, the drug may be used until the last day of that month, provided that the intended course of therapy would be complete and/or dispensed supply of medication would be consumed before the expiration date. (T-1)

8.9.1.3.2. Pharmaceutical inventory will be inspected at least monthly. (T-1)

8.9.1.3.3. Pharmaceuticals that will expire first shall be placed in a position to be used first. (T-2)

8.9.1.3.4. During the monthly inspections, pharmaceuticals that will expire within 30 days will be removed from inventory and securely stored in an isolated area separate from in-date pharmaceuticals. (T-1)

8.9.1.3.5. The storage area for expired pharmaceuticals will be clearly marked to prevent accidental dispensing. (T-1)

8.9.1.4. Conduct monthly audit of inventory of five selected non-controlled medications from the top 100 line items by dollar volume. The pharmacy flight commander or their designee will select the medications to be audited. Maintain documentation of the audit in the pharmacy, including: items audited, results, and actions taken. (T-1)

8.9.2. Schedule II drugs will be inventoried separately from schedule III, IV and V drugs. (T-1)

8.9.3. The pharmacy will maintain the files of inpatient unit and clinic inventories. (T-1)

8.9.4. National Contract List (NCL). Medical treatment facilities will comply with DoD/Veterans Affairs (VA) contracting efforts by aligning all pharmaceutical purchases with the NCL posted on the Defense Logistics Agency Troop Support (DLA-TS) website at: <https://www.medical.dla.mil/nationalcontracts/NationalContractsDrugLists.aspx>. Users must have a DMMOnline account to access these lists and reports. (T-1) At a minimum, the following actions will be taken:

8.9.4.1. Pharmacy will review additions and deletions on the NCL monthly, document reasons for not accepting NCL-mandated items (if applicable), and forward a list of approved changes to Logistics for action. (T-1)

8.9.4.2. Medical Logistics will process sourcing changes in DMLSS for all actions directed by the pharmacy. (T-1)

8.9.4.3. Medical Logistics and pharmacy will review National Contracts Compliance Reports (NCCR) monthly to ensure compliance with the NCL, following the procedures outlined above in paragraphs 8.9.4.1., and 8.9.4.2. of this instruction. The NCCR is available through the DLA-TS website at: <http://www.medical.dla.mil/nationalcontracts/nccrhome.aspx>. (T-1)

8.9.4.3.1. Pharmacy will review the NCCR monthly, document reasons for not utilizing NCL-mandated items (if applicable), and forward a list of approved changes to Medical Logistics for action. (T-1)

8.9.4.3.2. Medical Logistics will process sourcing changes in DMLSS for all actions directed by pharmacy. (T-1)

8.9.4.3.3. For NCL items in manufacturer back-order or national shortage status, Medical Logistics will ensure prompt return to the mandatory source after receiving notification of item availability from the Pharmaceutical Prime Vendor, DLA-TS, or AFMOA/SGAL. (T-1)

8.9.4.4. NCL/NCCR reports and documentation.

8.9.4.4.1. Pharmacy will report actions taken on the NCCR to the P&T function quarterly. The report will include the following: Current contract compliance percentage, total number of NCL items purchased, the number of items and cost for items identified as non-contract purchases, reasons for non-contract purchases, identification of items that can be purchased on-contract, and projected savings based on future compliance with contracted items. (T-1)

8.9.4.4.2. Pharmacy will maintain documentation of all NCL-related item selection actions and rationale for items not approved for change. The report will be maintained for a period of 2 years. (T-1)

8.9.4.4.3. Medical Logistics will maintain the list of changes approved by pharmacy for a period of 2 years. (T-1)

8.9.5. DMLSS Strategic Sourcing Module. Medical Logistics and Pharmacy will utilize DMLSS Strategic Sourcing Module to conduct a monthly price analysis of non-NCL items and other pharmaceuticals based on availability and price and report the results to the P&T committee quarterly. (T-1)

8.9.5.1. Pharmacy will identify clinically acceptable or therapeutically equivalent products with potential savings from the DMLSS Strategic Sourcing review, and forward an approved list to logistics for item sourcing changes. (T-1)

8.9.5.2. DMLSS Strategic Sourcing reports and documentation. (T-1)

8.9.5.2.1. Pharmacy will report actions taken on DMLSS Strategic Sourcing Module to the P&T function quarterly. The report will include the following: total number of items and cost of items identified as candidates for change based on DMLSS Strategic Sourcing pricing and estimate of cost avoidance for items purchased using the DMLSS Strategic Sourcing recommendations. Items identified that cannot be

changed or are rejected should be explained and documented in the report to the committee.

8.9.5.2.2. Pharmacy will maintain documentation of all DMLSS Strategic Sourcing-related item selection actions and rationale for items not approved or rejected for change. The report will be maintained for a period of 2 years. A history of DMLSS Strategic Sourcing actions is maintained in DMLSS

8.9.5.2.3. Medical Logistics will maintain the list of item selection changes provided by pharmacy for a period of 2 years.

8.9.6. Sample Report to P&T function: “The NCCR was reviewed for the first quarter of FYXX. The contract compliance percentage for this quarter was XX%. There were four NDCs (w, x, y, and z) that were purchased off-contract for \$XX. Items w and x were unavailable from the manufacturer, item y was purchased as a special-purchase brand name item, and item z was a new contract that was not ordered immediately after the contract was implemented. Changing item z to the contract item is projected to save \$XX dollars next quarter.”

8.9.7. Prime Vendor will be the primary source for pharmaceutical purchasing. Exceptions may be made for purchases of products unavailable from the Prime Vendor. (T-1)

8.9.8. Pharmaceutical inventory will be managed to ensure the stock levels of pharmaceuticals on-hand are not excessive, generally not greater than 14 days.

8.9.8.1. MTFs will establish drug inventory par or stock levels that reflect the level of care, prescription workload, and mission. (T-1)

8.9.8.2. Pharmacies may have situations that require stocking levels that are greater than 14 days, examples include: OCONUS facilities, contingency supplies, controlled substances, or special pricing. The pharmacy must be able to justify the costs and benefits of situations that may require greater stocking levels. (T-2)

8.10. Controlled Drug Inventory Process.

8.10.1. The MTF Commander will appoint a disinterested officer, non-commissioned officer (NCO) in the grade of E-7 or above, or a civilian of comparable grade to inventory the MTF's controlled drugs at least monthly. Appointee must be from a duty section that is not being inventoried. Personnel conduct the inventory in the facility's pharmacy and in all other locations where controlled substances are maintained. (T-1)

8.10.1.1. The disinterested inventory process shall include a monthly inventory of ALL Schedule II and Schedule III-V controlled items maintained in the MTF. The process shall also include a random sample comparison between the Medical Logistics controlled substance issue list and the pharmacy receipt list and a random sample review of pharmacy dispensing and clinic issue transactions. This comparison and review will ensure appropriate tracking and documentation of controlled substance movement throughout the facility. Sample sizes are at the discretion of the MTF/CC. (T-1)

8.10.1.2. Facilities will inventory newly controlled substances on the published effective date. Thereafter, each substance will be included in the biennial inventory. (T-1)

8.10.2. Inventory personnel will document any adjustments to the controlled substance inventory on the AF Form 85. (T-1)

8.10.2.1. The AF Form 85 is reviewed by the Pharmacy Flight and Squadron Commanders.

8.10.2.2. The final approval authority for the AF Form 85 is the MTF/CC. The MTF/CC may delegate this authority by appointing a designee, outside of pharmacy, in writing for medications in schedule classes II-V. (T-1)

8.10.2.3. The final approval authority for the AF Form 85 at locations without an MTF/CC, such as geographically separated units (GSUs), is the Director of Base Medical Services (DBMS) or equivalent. The DBMS may delegate this authority by appointing a designee, outside of pharmacy, in writing for medications in schedule classes II-V if they will be away from the base for greater than two weeks. (T-1)

8.10.3. Inventory personnel record the balance on each AF 582, *Pharmacy Stock Record*, or automated product (spreadsheet, data base or work processing reports) or AF Form 579, including the date of inspection, action taken, and signature. Automated equipment logs (e.g., Pyxis® log) are an acceptable substitute for the AF Form 579. (T-1)

8.11. Accountability of Controlled Substances.

8.11.1. Pharmacists use AF Form 582 or an automated product if maintained in a perpetual inventory, for each item to show all receipts and expenditures of schedule II, III, IV and V drugs including:

8.11.1.1. Ethyl alcohol. (T-1)

8.11.1.2. Alcoholic beverages used for medicinal purposes (wine, whiskey, beer, etc.). (T-1)

8.11.1.3. Other drugs designated for control by the MTF P&T Function. (T-3)

8.11.2. Pharmacy accounts for all AF Forms 579:

8.11.2.1. Issues a new, serially numbered AF Form 579 to inpatient units and clinics as needed. (T-1)

8.11.2.2. Brings forward the balance and serial number from the previous sheet. (T-1)

8.11.2.3. Accepts and maintains all completed forms. (T-1)

8.11.2.4. Initiates a new series of forms each calendar year after collecting all incomplete forms from the previous year. (T-1)

8.11.2.5. Uses automated methods to account for AF Forms 579 whenever possible. (T-1)

8.11.3. Pharmacists coordinate with Medical Logistics to ensure 21 CFR reporting requirements are met in the event of any unusual or excessive loss or disappearance of controlled substances from the pharmacy, inpatient units, outpatient clinics or any location to which the pharmacy distributes. Pharmacists must:

8.11.3.1. Notify their chain of command prior to filing the report of loss. (T-1)

8.11.3.2. Notify Security Forces and/or the Office of Special Investigations if theft is suspected. **NOTE:** Reporting forms may be found on the DEA website at: http://www.deadiversion.usdoj.gov/21cfr_reports/index.html. (T-1)

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)

8.12. Securing Drugs.

8.12.1. MTF personnel secure all controlled and non-controlled drugs. Local policy will determine which categories of personnel may be permitted to secure non-controlled drugs or to carry keys to secure areas. With the exception of Pharmacy (43PX and 4POXX) and other personnel authorized by name in writing by their squadron commanders, only licensed clinical staff may be authorized access to controlled substances storage areas. (T-1)

8.12.2. In the pharmacy, personnel store schedule II, III, IV, and V controlled drugs in either a safe or securely locked, substantially constructed cabinet, as described in 21 CFR 1301.75. A small working stock of schedule II, III, IV and V controlled drugs may be kept in the main dispensing area. All controlled drugs, whether stored in the main pharmacy or other locations in the MTF, must be inventoried at the beginning of each shift, at shift change, or at the end of the day by reconciling the prescription quantities dispensed with the balance on hand (unless automated equipment provides a continuously updated inventory). (T-0, 21 U.S.C. Chapter 13)

8.12.2.1. All discrepancies will be documented on an AF Form 85, which is submitted to the MTF/CC (or designee) through the chain of command, for review and approval. (T-1)

8.12.3. Pharmacists may dispense schedule II, III, IV, and V controlled drugs from automated dispensing equipment that meets the following requirements:

8.12.3.1. Equipment must store counted product in an internal chamber that requires scanning of a bar-code to dispense. (T-1)

8.12.3.2. Equipment requires unique user login password prior to accessing any product.

8.12.3.3. Equipment's bulk holding chamber is secured with locking device.

8.12.3.4. Equipment must store bulk product in a removable cassette or cell. (T-1)

8.12.3.5. Equipment must maintain a perpetual inventory of each removable cassette or cell. (T-1)

8.12.4. In addition to schedule II drugs, all prescriptions for schedule III, IV, and V controlled drugs dispensed from automated equipment must be double-counted either by hand or using a device that determines the quantity based upon the product's weight. (T-1)

8.12.5. Pharmacies dispensing schedule II, III, IV, and V controlled drugs from automated equipment must also meet the following security requirements:

8.12.5.1. Removable cassettes or cells containing controlled drugs must be removed from the equipment and secured in the pharmacy's safe or securely locked, substantially constructed cabinet at the end of each duty day. (T-1)

8.12.5.2. Cassettes or cells containing controlled drugs must be completely emptied and counted at least once every 3 business days. Quantities of controlled drugs in cassettes or cells may be obtained from the equipment's perpetual inventory for controlled drug inventories on the remaining 2 days. (T-1)

8.12.6. Schedule II drugs must be stored in a substantial double-locked cabinet in patient areas outside the pharmacy. All other controlled substances must be stored in a secure, locked cabinet. Access is restricted to those individuals authorized to prepare, administer or dispense controlled substances. (T-0, 21 U.S.C. Chapter 13)

Section 8G—Writing Prescriptions

8.13. Writing Prescriptions.

8.13.1. Authorized providers must:

8.13.1.1. Use electronic order entry for prescriptions whenever available. (T-1)

8.13.1.2. Review patient identification data for accuracy. (T-1)

8.13.1.3. If not using electronic order entry, use AF Form 781, *Multiple Item Prescription*, or equivalent computer-generated means via an AF-approved system (e.g., Essentris). Any alternate means used must have a provider's electronic or ink signature and all information that would otherwise be included on an AF Form 781 or electronic order entry. (T-1)

8.13.1.4. Write no more than three prescriptions on AF Form 781. (T-1)

8.13.1.5. Draw a line through unused blocks on AF Form 781. (T-1)

8.13.1.6. Separate prescriptions for drugs listed in schedules II from those in schedules III, IV, and V by writing them on separate AF Forms 781. (T-1)

8.13.1.7. Non-controlled drugs may not be prescribed on the same form as controlled drugs.

8.13.1.8. Write-in complete patient identification data on AF Form 781 (name, address and patient identification number). (T-1)

8.13.1.9. The prescriber name stamp must be used on all hand-written prescriptions. If a prescriber name stamp is not available, then the prescriber shall write full name, rank, corps, AFSC, and telephone number. The pharmacy may decline to fill such a prescription, if there is any uncertainty as to the identity of the prescriber. (T-2)

8.13.1.10. The prescribed amounts of controlled substances will be spelled out in addition to the written numeral amount. (T-0, 21 U.S.C. Chapter 13)

8.13.1.11. DEA numbers shall be included on any hand-written prescriptions for Controlled Substances. (T-0, 21 U.S.C. Chapter 13)

8.13.2. Providers may not write controlled substances prescriptions, including drugs controlled locally (at the MTF level) for themselves or members of their families.

8.13.3. The prescribing provider and the pharmacist are equally responsible for correctly prescribing and dispensing controlled substances (schedules II, III, IV, and V) under Title 21, U.S.C., sections 829 and 1309, concerning prescribing and dispensing controlled substances.

8.13.4. The prescribing provider signs prescriptions or documents them via CHCS electronic signature and dates them on the day of issue.

8.13.5. Prescriptions for chronic maintenance medications may be written for up to a 90-day supply. Non-chronic medications are written for an adequate quantity to treat the acute problem, as deemed by the provider. In most instances, these will not exceed a 30-day supply. (T-1)

8.13.6. Where feasible, the pharmacist contacts the prescriber to resolve problems of legibility, compatibility, dosage or quantity prescribed. The pharmacist verifies authenticity of prescriptions and may refuse to fill prescriptions that contain errors, omissions, irregularities, ambiguity, alterations or are contrary to the pharmacist's clinical judgment.

8.13.7. Pharmacies may accept faxed prescriptions for non-controlled substances and controlled substances in schedules III-V from provider's offices, hospitals or nursing homes in keeping with applicable state and federal laws.

8.13.8. When a provider prescribes a medication, controlled substance or otherwise, for another provider, a decision must be made by the prescriber concerning how that medication may affect the patient's ability to practice medicine. A Quarters Form or an AF Form 469 must be annotated with a copy to the SGH, if the medication is expected to impair a provider's ability to practice medicine. An annotation will be made on the SF 600 by the prescriber that the prescribed medication either is or is not expected to affect the patient's ability to practice medicine. (T-1)

Section 8H—Packaging Prescriptions

8.14. Packaging Prescriptions.

8.14.1. Package prescriptions using the *Poison Prevention Packaging Act* (16 CFR, Sections 1700-1704) and the *Poison Prevention Packaging Act of 1970* (15 U.S.C. Sections 1471-1474, Public Law 91-601). (T-0, 16 CFR 1700-1704, 15 U.S.C. §1471-1474)

8.14.2. When issuing prepackaged medications to clinics for outpatient dispensing by providers, include a label for the patient's name, patient education material, and directions for use with every container.

8.14.3. Prepackaged medications dispensed by a provider directly to the patient do not require prescriptions. Document the prescribed treatment on the SF 600/SF 603 and electronic equivalent (e.g., CHCS, AHLTA, or EHR). Dispensing outside the pharmacy is accomplished under the supervision of providers whose license allows dispensing directly to patients. The dispensing provider will ensure the accuracy of the medication order prior to dispensing to the patient. Providers must adhere to the same procedures and standards of practice as apply to dispensing from a pharmacy to ensure a single standard of care. (T-1)

8.14.4. Manufacturer samples may not be kept in the MTF or dispensed to patient.

8.14.5. Medications procured for the purposes of clinical investigation are dispensed only from the pharmacy according to an Institutional Review Board approved protocol. The process for participation in clinical investigations is outlined in AFI 40-402.

8.15. Labeling Prescriptions.

8.15.1. Only pharmacy personnel are authorized to label and transfer medications from the manufacturers' package to different containers.

8.15.2. Pharmacy prepares a label for each prescription and fastens it securely to each package or container before dispensing. The label must conform to requirements stated in Public Law 75-717, Federal Food, Drug, and Cosmetic Act of 1938, Sections 502 and 503 and 21 U.S.C. Sections 352 and 353. Pharmacy provides the patient with additional information when necessary to ensure that they use and store the drugs properly. (T-0, Federal Food, Drug and Cosmetic Act of 1938)

8.16. Refilling Prescriptions.

8.16.1. The provider authorizes a pharmacy to refill certain prescriptions by including refill authorization on the original prescription.

8.16.2. Pharmacies may not refill prescriptions for drugs listed in schedule II. Pharmacies may not refill prescriptions for drugs listed in scheduled III, IV, and V more than six months after the date of issue or more than five times total. (T-0, DEA Requirement)

8.16.3. Pharmacies normally honor prescription refills only if they have the original prescription on file. Pharmacies may request transfer of an original prescription provided that the validity of the prescription (e.g., that refills are available and the prescription is still active, etc.) is verified with the pharmacist at the transferring facility before filling the prescription. The transferring facility will discontinue the original prescription and note in the comment field of CHCS the name of the pharmacist or the technician, the facility and the date transferred. The receiving facility must ensure their database reflects the original fill date, prescription number, provider name and DEA number and the adjusted number of refills remaining. Prescriptions for controlled medications may be transferred once, while prescriptions for non-controlled prescriptions may be transferred more than once as necessary for patient needs. Transferring prescriptions shall follow federal law and where possible, local state pharmacy regulations. (T-0, 21 U.S.C. Chapter 13)

8.16.4. Prescriptions may be refilled when 75% of the quantity dispensed has been used by the patient, based on the directions for use and the quantity prescribed, or at the discretion of the pharmacist.

8.17. Mailing Medications.

8.17.1. Under usual circumstances, routine mailing of prescriptions to eligible beneficiaries by MTF pharmacies is not authorized.

8.17.2. Prescriptions may be mailed to patients enrolled at or routinely receiving care at an MTF in an emergency. Follow postal service regulations for mailing controlled substances.

8.18. Use of Pharmacy Automation Equipment (also see [paragraph 8.12.3](#) of this instruction).

8.18.1. Pharmacy automation equipment will be used to the maximum extent possible in the dispensing of outpatient prescriptions. In the event of a power outage or equipment malfunction, pharmacies must have appropriate downtime procedures to maintain accuracy in the dispensing process. (T-1)

8.18.2. Pharmacists will ensure that safety features designed into automation equipment are being used and access to safety overrides is limited. All overrides will be documented, including: reason for override, identity of personnel who accomplished the override, identity of witness to the override, and date and time of the override. (T-1)

8.18.3. Every manufacturer package intended for stock in automated dispensing equipment will be barcode scanned and logged in at the time it is placed into the equipment. Unclaimed prescriptions that are returned to stock must also be barcode scanned prior to being loaded into equipment. (T-1)

Section 8I—Inpatient Pharmacy Services**8.19. Inpatient Pharmacy Services.**

8.19.1. The Pharmacy Flight Commander or Element Chief will:

8.19.1.1. Determine the extent of services based on available staff, funding and workload. Any changes in services that will affect pharmacy operating hours must be coordinated with the squadron and MTF/CC. (T-3)

8.19.1.2. Develop a priority order of services provided as available resources change. (T-3)

8.19.1.3. Ensure that a pharmacist reviews all inpatient orders. (T-1)

8.19.2. Unit dose drug distribution will be used to the maximum extent possible. This system provides inpatient drugs under a direct copy of AF Form 3066, or an approved electronic order. A patient medication profile must be maintained on AF Form 3069, *Medication Administration Record* or an automated product. (T-1)

8.20. Sterile Product Preparation.

8.20.1. A pharmacist will supervise the preparation of intravenous admixtures by pharmacy staff and ensures non-pharmacy personnel preparing admixtures outside of the pharmacy are trained to follow the United States Pharmacopoeia Chapter 797 Standards (USP 797) for the preparation of sterile products. (T-1)

8.20.2. Pharmacies providing sterile products will implement and document the following programs:

8.20.2.1. Personnel training and evaluation in aseptic technique and random product sterility testing for each compounded sterile product (CSP) risk level used in the facility. (T-1)

8.20.2.2. Environmental quality and control monitoring to ensure ISO 5 environment. (T-0, USP 797)

8.20.2.3. Education and training of all affected MTF personnel on the handling, storage and transport of CSPs. (T-1)

8.20.2.4. Patient monitoring and adverse events reporting. (T-1)

8.20.2.5. CSP quality assurance to continually evaluate and improve the preparation of sterile products. (T-1)

8.20.2.6. Other programs necessary to meet the intent of USP 797. (T-1)

8.21. Bulk Compounding.

8.21.1. Pharmacists bulk compound pharmaceutical preparations using formulas from official compendia, other references or locally developed formulas only when a quality product can be ensured. Use:

8.21.1.1. AF Form 2381, *Pharmacy Master Formula*, for each item manufactured in bulk quantities.

8.21.1.2. AF Form 2382, *Pharmacy Bulk Compounding Chronological Control Log*, to assign lot numbers to each preparation.

8.21.1.3. AF Form 2380, *Pharmacy Manufacturing Control Data*, for each individual batch prepared.

8.21.1.4. AF Form 781, to account for all controlled drugs used in compounding.

8.22. Providing Force Health Protection Prescription Products (FHPPP).

8.22.1. FHPPP are defined in DoDI 6490.3., Deployment Health, AFI 10-403, *Deployment Planning and Execution* and AFI 48-110_IP. FHPPP include certain drugs, vaccines, and other medical products useful for protecting the health of deployed personnel that may be used only under a physician's prescription. Examples are ATNAA (atropine and pralidoxime chloride) and Diazepam autoinjectors, pyridostigmine bromide, certain antimicrobials, and antimalarials.

8.22.2. When requested by Air Force Component theater reporting instructions, all FHPPP shall be provided or issued under prescription by qualified personnel who have been instructed on the exclusion criteria (i.e., contraindications or those who are not required to take the medication for medical reasons) and other medical guidance applicable to the products. For guidance regarding bulk issue of FHPPP to troop commanders, see AFI 41-209, *Medical Logistics Support*. (T-1)

8.22.3. The medical record and CHCS drug file of all patients issued FHPPP will be documented with the drug name, strength, quantity, directions and name of ordering provider on an SF600 and on the deploying members DD Form 2766. (T-1)

8.22.4. Documentation and dispensing of FHPPP is a collaborative effort between Medical Logistics, Pharmacy and Deployment Medicine personnel. The MTF will develop a local policy to establish communication and coordination between departments for this purpose. (T-1)

8.22.5. For guidance on return of FHPPP see AFI 41-209, *Medical Logistics Support*.

8.23. Prescriptions for Deploying Personnel.

8.23.1. Pharmacies will dispense prescription medication to deploying personnel in a quantity sufficient to last for the duration of the deployment plus transit time unless otherwise prohibited by Federal law, combatant command guidance or provider judgment. (T-1)

8.23.2. When storage or logistical difficulties prevent the deploying member from receiving sufficient quantities of medications to last throughout the deployment, the deployer will enroll in the TRICARE Home Delivery (also known as TRICARE Mail Order Program) or the Deployment Prescription Program to receive medications through the mail. **NOTE:** Foreign countries may have local laws which prohibit mailing pharmaceuticals; ensure appropriate coordination prior to deployment. (T-1)

Chapter 9

ALLERGY AND IMMUNIZATION SERVICES

Section 9A—Responsibilities

9.1. Responsibilities.

9.1.1. AF/SG will:

9.1.1.1. Appoint, in writing, the Chief Consultant for Allergy/Immunizations (A/I).

9.1.2. The Chief Consultant to the AF/SG for Allergy/Immunology will:

9.1.2.1. Organize MTFs into allergy regions.

9.1.2.2. Designate, in writing, regional A/I consultants.

9.1.2.3. Determine/approve the content of the Allergy Extender Short Course.

9.1.2.4. Review course curriculum content of the Walter Reed National Military Medical Center (WRNMMC) A/I Technician Specialty Course during Interservice Training Review Organization (ITRO) process and recommend changes to the 4N0X1X AF Career Field Manager.

9.1.2.5. Determine minimum competency requirements for allergy extenders. Refresher curriculum will be reviewed at least every two years or as standards change or issues arise.

9.1.2.6. Review findings from allergy/immunizations patient safety root cause analysis to consider if changes should be made to A/I physician/technician training curriculum.

9.1.2.7. At a minimum, meet with the Regional A/I Consultants, 4N0X1X Career Field Manager and A/I enlisted consultant annually in person, via video teleconference or telephonically.

9.1.3. The Regional A/I Consultants will:

9.1.3.1. Establish and monitor the A/I services for each MTF within their region.

9.1.3.2. Provide consultative support to MTF providers within the region.

9.1.3.3. Approve use of allergy extracts not provided by the regional allergy support facility.

9.1.3.4. Coordinate with AFMSA Public Health (AFMSA/SG3PM) on issues pertaining to immunization related preventive health issues.

9.1.3.5. Visit local MTFs and conduct Site Visits as requested by MTF or MAJCOM SG. Site Visit findings must be forwarded to the respective MAJCOM SG within 60 days of visit.

9.1.3.6. Review each immunotherapy initiation request, allergy immunotherapy extract refill request, and other extract requests ordered by an allergy extender. If there are no contraindications for initiation or continuation of therapy, the regional consultant will then order or co-sign the orders for these requests.

9.1.4. 4N0X1 AF Career Field Manager (CFM) will:

9.1.4.1. Designate, in writing, an enlisted consultant for A/I.

9.1.4.2. Manage 4N0X1X personnel with Special Experience Identifier (SEI) 453 indicating Allergy/Immunization experience.

9.1.4.3. Review and approve all revisions to the course curriculum content of the WRNMMC A/I Specialty Course, during Interservice Training Review Organization (ITRO) process.

9.1.4.4. Determine Immunization Back-up Technician (IBT) and Immunization Augmentee (IA) training requirements.

9.1.4.4.1. Approve A/I and IBT/IA training requirements/course content at a minimum of every 2 years.

9.1.4.4.2. Approve all 4N0X1X CFETP A/I updates.

9.1.5. The Enlisted Consultant for A/I will:

9.1.5.1. Provide subject matter expertise on all A/I related issues.

9.1.5.2. Annually review the 4N0X1X CFETP, participate in 4N0X1X Utilization and Training Workgroup, and recommend training updates to the 4N0X1X CFM.

9.1.5.3. Provide updates on new vaccines, immunization schedules and policies and provide this information to MTF A/I personnel via email, newsletter and Air Force Medical Service Allergy/Immunization Knowledge Exchange Portal. All information will be coordinated with AF Public Health prior to release.

9.1.5.4. Visit local MTFs and conduct Site Visits as requested by MTF or MAJCOM SG. Site Visit findings must be forwarded to the respective MAJCOM SG within 30 days visit.

9.1.5.5. Collaborate with WRNMMC A/I instructors to update IBT Training Modules and end of course test at a minimum of every 2 years or as directed by the A/I Consultant and/or the 4N0X1X AF CFM.

9.1.5.6. Collaborate with WRNMMC Air Force A/I instructor staff annually for review and update (from last published date) of the Allergy QTP 4N0X1-11 and Immunization QTP 4N0X1-12. Post completed QTPs to AF e-publishing website.

9.1.5.7. Collaborate with the A/I course at WRNMMC to ensure Air Force training requirements are met.

9.1.5.8. Provide input, as requested, for any A/I related adverse event, patient safety root cause analysis and applicable AFIs, policies, and procedures.

9.1.6. The MTF/CC will:

9.1.6.1. Appoint, in writing, a privileged physician as the Medical Director responsible for the MTF A/I clinic/service, if the MTF provides allergy services. Where a trained allergist is not available, this physician will attend the Allergy-Extender Short Course. When allergy services are not provided, a privileged physician will be appointed, in writing, to be responsible for the MTF immunization clinic/service. This physician shall

be trained IAW the requirements found in AFI 48-110_IP for an immunizations medical director. (T-1)

9.1.6.2. Appoint, in writing, an Officer In Charge (OIC)/Noncommissioned Officer In Charge (NCOIC) of the Anthrax Implementation Vaccine Program (AVIP). (T-2)

9.1.6.3. Ensure personnel providing smallpox vaccinations and care to recipients, review the MILVAX website for additional information at least quarterly. Immunization clinic OIC/NCOIC will ensure all trained smallpox vaccinators are fully versed in the use of ACAM2000 before performing vaccinations. (T-0, Clinical Policy for the DoD Smallpox Vaccination Program 1 Apr 2008)

9.1.6.4. Ensure appropriate A/I Clinic staffing and IBTs deployed in FFDAB/FFPCM Unit Type Code (UTCs) are fully trained prior to deployment. These UTCs require at least one of the 4N0X1Xs to be a fully trained IBT (not substitutable). (T-1)

9.1.7. Designated Physician/Medical Director for Allergy and/or Immunization Clinic will: (T-1)

9.1.7.1. Provide the clinical oversight for A/I services.

9.1.7.2. Act as consultant for healthcare providers with questions/concerns related to Allergy immunotherapy and/or immunizations.

9.1.7.3. Annually review/approve Immunization Clinic's operating instructions. At a minimum, all A/I or Immunizations Clinics will maintain these operating instructions: (T-2)

9.1.7.3.1. Inventory/Cold Chain Management.

9.1.7.3.2. Deployment Procedures.

9.1.7.3.3. Forward Support.

9.1.7.3.4. Clinic Operations.

9.1.7.3.5. Emergency Management and Adverse Events.

9.1.7.3.6. An operating instruction will be maintained on point of service operations where this exists.

9.1.7.4. Utilize applicable AFMOA/AFMSA or MAJCOM guidance in conjunction with the Centers of Disease Control and the Advisory Committee on Immunizations Practices (ACIP) guidelines in establishing directives (standing orders) for vaccine delivery. (T-1)

9.1.7.5. At a minimum, conduct quarterly in-services for 4N0X1s with SEI 453. (T-2)

9.1.7.6. Attend regional refresher training every two years unless waived by the regional consultant or Chief Consultant to the AF/SG for A/I. (T-1)

9.1.8. MTF Chief Nurse (SGN) will: (T-1)

9.1.8.1. Provide oversight of nursing activities in support of the A/I program IAW AFI 46-101.

9.1.8.2. Provide support to the 4N functional manager as needed in the operations and oversight of immunization activities.

9.1.8.3. Provide direction for registered nurse training in the administration of immunotherapy and the practice of registered nurses in the allergy/immunizations clinic.

9.1.8.4. Ensure IBT program oversight is conducted through the nursing executive council.

9.1.9. MTF 4N Functional Manager (FM) will: (T-1)

9.1.9.1. Provide oversight of allergy/immunization activities to include training, documentation, sustainment and utilization of the A/I techs, IBTs and IAs IAW AFI 46-101, *Nursing Services and Operations*.

9.1.9.2. Ensure all 4N0X1Xs functioning full-time/assigned to an allergy or immunization clinic (other than IBTs) have completed WRNMMC A/I Specialty Course and AF 2096 (IAW AFECDC SEI skill set award) to reflect award of SEI 453 Allergy/Immunizations

9.1.9.3. Ensure position descriptions and state licensure include/cover immunotherapy and/or immunizations when using civilian/contract personnel for these services.

9.1.9.4. Provide oversight of all A/I, IBT and IA training programs and ensuring compliance with all documentation requirements to include AF Form 2096 updates.

9.1.9.5. Ensure all 4N0X1Xs (SrA-MSgt) with SEI 453 Allergy/Immunizations (excluding IDMTs) no longer working in A/I clinics maintain A/I currency by maintaining IBT training currency and biennial A/I recertification.

9.1.9.6. Ensure A/I Clinic is appropriately staffed. At a minimum, the A/I Clinic will be staffed with two personnel; one will be a fully trained A/I technician.

9.1.9.6.1. A/I techs with less than six months allergy/immunizations experience (starting from graduation A/I tech training) will not work independently and must be augmented by a current A/I tech.

9.1.9.6.2. Wherever immunizations (other than A/I Clinics) are provided, a fully trained A/I tech or IBT may be utilized as long as there is provider oversight and access to immediate pre-hospital emergency services, cardiopulmonary resuscitation (CPR) equipment and an ability to immediately treat anaphylaxis.

9.1.9.7. Appoint an IBT Program Manager (typically the MTF senior A/I technician).

9.1.9.8. Ensure compliance with patient care standards and National Patient Safety Goals. At a minimum, random A/I clinic vaccine spot inspection will be accomplished and documented to ensure expired vaccines are not stored in the A/I Clinic and vaccine lot numbers match information in ASIMS.

9.1.10. MTF Public Health Officer will:

9.1.10.1. Attend the Population Health Function to provide guidance on vaccine schedules/policies and, in conjunction with the regional allergist, act as consultant to healthcare providers for policy questions/concerns on immunizations. **NOTE:** ARC will provide guidance to the Aerospace Medicine Council (AMC). (T-2)

9.1.10.2. Serve as the primary POC for notifying installation commanders of the medically ready to deploy status of their Airmen. (T-2)

9.1.10.3. Provide guidance on required immunizations for deployments. (T-2)

9.1.11. Allergy/Immunization NCOIC will:

9.1.11.1. Be a current 4N0X1 SEI 453. (T-1)

9.1.11.2. Train new IBTs on the current accepted AF electronic tracking application to include data entry, updating vaccine lot number list, editing, deleting records, and how to document and transcribe records. (T-1)

9.1.11.3. Certify all initial training for IBTs. Only current A/I technicians may train IBTs. (T-1)

9.1.11.4. Report and manage all immunization-related incidents IAW AFI 44-119, *Medical Quality Operations*. (T-1)

9.1.11.5. Ensure proper cold chain storage and inventory management for all vaccines used within the MTF. All vaccines will be inventoried and rotated monthly; expiration dates must be checked daily. Vaccines that are stored outside the manufacturer's recommendations from the package insert should be reported immediately to Immunizations Medical Director, NCOIC, OIC, and MTF Executive Staff to ensure proper management and oversight of vaccine that may be unsuitable to use. **NOTE:** See paragraphs 9.14.2 and 9.15.3 of this instruction regarding specific guidance for cold chain management for anthrax and smallpox vaccines. (T-1)

9.1.11.6. Ensure all A/I techs and IBTs subscribe to the AFMS A/I Knowledge Exchange Portal. A/I techs are responsible to be knowledgeable of the content and standards on this website. (T-1)

9.1.11.7. Subscribe to the AF Medical Logistics website: https://medlog.detrick.af.mil/index.cfm?event=settings.general&stop_dir=true to receive Department of Defense Medical Materiel Quality Control (DODMMQC) messages. (T-1)

9.1.11.8. Ensure all A/I technicians and IBTs subscribe to CDC vaccine email updates at https://service.govdelivery.com/service/subscribe.html?code=USCDC_11_47 (T-1)

9.1.11.9. Maintain current appointment letters from the MTF SGP of IBTs who are authorized and clinically trained to administer Anthrax and Smallpox Vaccines per the 4N0X1X CFETP. (T-2)

Section 9B—Allergy Services

9.2. Allergy Extender Training Requirements:

9.2.1. The Allergy Short Course conducted at the 59 MDW, San Antonio, Texas. This is a one week formal didactic course that potential extenders are required to attend. This is a one-time course unless extender training lapses.

9.2.2. One week hands-on training within 6 months following short course completion, preferably conducted at their regional facility.

9.2.3. Refresher training will be accomplished every 2 years with the Regional Consultant. (T-1)

9.2.4. It is the responsibility of each MTF to ensure that an Allergy Extender (and alternate, highly recommended if primary is unavailable) is appropriately trained if the MTF desires to provide allergy services. (T-1)

9.2.4.1. MTFs may continue to provide allergy shots if the extender is absent as long as an ACLS/PALS trained physician is readily available. New allergy patients will not be started on therapy and/or skin testing will not be accomplished without an Allergy Extender readily available. (T-1)

9.3. Site Visits.

9.3.1. The Chief Consultant, Regional Consultants and the A/I Enlisted Consultant are responsible for assisting each MTF with their allergy services. Each MTF should undergo an annual self-inspection of their A/I Services. This can be performed by completing the SGH Allergy Checklist (found on the A/I KX site). At the request of the MTF a site visit by the Regional Consultant or the AF A/I Enlisted Consultant can be performed in lieu of the SGH checklist. These Site visits will be funded by the requesting MTF.

9.3.2. The completed checklist will be sent to the Regional Consultant who will review the results and make recommendations, if necessary. The Regional Consultant will send a consolidated report to the MTF's respective MAJCOM SG and to the Chief A/I Consultant to the AF/SG. (T-1)

9.4. Training Requirements for Registered Nurses to provide Immunotherapy.

9.4.1. With the approval of the MTF SGN, licensed Registered Nurses can administer immunotherapy, which is considered a prescribed medication .

9.4.2. IAW the Allergen Immunotherapy Practice Parameter Update (current edition) registered nurses will require specific allergy training and demonstrated competence in the technical aspects of administering immunotherapy, management and treatment of adverse events (local and systemic reaction), recognition and treatment of anaphylaxis, preparation of 10-fold dilutions, and appropriate documentation in Allergy (Immunotherapy) Record. Record of this training will be documented in the nurse's competency assessment folder. (T-1)

9.5. Initial Training Requirements for the Enlisted Allergy/Immunizations Technician SEI 453.

9.5.1. **Completion of the formal Allergy/Immunology Course J5AZA4N051 00AA, at WRNMMC, (WRNMMC A/I Specialty Course).** (T-1)

9.5.2. Six months of clinical experience upon graduation, in any allergy and/or immunization clinic position at the discretion of their supervisor IAW Air Force Enlisted Classification Directory (current edition). **NOTE:** For MTFs that do not provide allergy services and/or do not have adequate overlap with a current A/I trained technician, it will be the responsibility of the MTF 4N Functional Manager to send newly graduated 4Ns of the A/I specialty course to their designated Regional Allergy Clinic for a minimum of two weeks to gain clinical experience and complete all applicable tasks in the 4N0X1X CFETP Attachment 4 STS. These two weeks, which will be funded by the 4N's home station MTF, can be at any time within six months of the date of A/I course graduation. (T-1)

9.5.3. Once training requirements are met and all applicable tasks in the 4N0X1X CFETP Attachment 4 STS are signed off, member will submit an AF 2096 to obtain their SEI IAW AFI 36-2101. (T-1)

9.5.4. Civil service and contract Licensed Practical Nurses/Licensed Vocational Nurses (LPN/LVNs) are recognized and utilized in the AF as equivalent 5- and 7-level 4N0s. Utilizing LPNs/LVNs as enlisted allergy technicians requires completion of the formal Allergy/Immunology Course or other training and demonstration of competency acceptable to the supervising regional allergist. LPNs/LVNs must comply with all additional training requirements for Allergy Technician SEI 453 IAW this AFI. (T-1)

9.6. Allergy/Immunizations Technician SEI 453 Sustainment Training.

9.6.1. A 5-day allergy/immunization refresher training is required every 2 years at the MTF's regional facility. At a minimum, this training will consist of reverification of all A/I QTPs. Successful completion of this training will be documented in the individual's AFTR. (T-1)

9.6.1.1. A/I technician refresher training is funded by the MTF where the trainee is assigned. If an A/I technician has PCS orders to another A/I position, then the losing unit is responsible for ensuring A/I technician refresher training is completed no sooner than 6 months prior to PCS.

9.6.1.2. The 2 year period starts with the day the 4N0X1X graduates from the WRNMMC A/I Specialty Course or PCS from a regional facility. For members assigned and functioning in an Allergy Clinic at a Regional Facility, the allergist or senior enlisted trainer will annually document allergy proficiency and reverification of all A/I QTPs on an AF Form 623a in the member's AFTR. **NOTE:** Members assigned to USAFE or PACAF have the option for A/I recertification training every other recertification period at the following two Army Facilities: Landstuhl (Germany) or Tripler (Hawaii). (T-1)

9.6.2. 4N0X1Xs with SEI 453 SrA-MSgt (regardless of duty section) will maintain currency of skills through completion of biennial recertification at a regional facility. This will ensure MTFs will have adequate trained personnel to support the operational needs that may be disrupted due to leaves, TDYs, deployments or separations. (T-1)

9.6.3. A/I technicians will NOT engage in administration of immunotherapy, skin testing, any care specific to allergy, or IBT training of 4N0X1s if not current on recertification training. This lapse in certification will be documented in the individual's AFTR. (T-1)

9.7. Administration of Civilian Allergy Extract/Vaccine. If a patient is evaluated by a non-MTF civilian allergist or other civilian physician and started on allergen extract/vaccine that is not prepared by a military mixing facility (i.e. Walter Reed Regional Mixing Facility or Wilford Hall Mixing Lab), that patient will have their allergen vaccine administered by the civilian physician. Only the Regional Consultant may approve temporary use of allergy extracts not provided by the regional allergy support facility. (T-2)

9.8. Immunotherapy and Deployments. The risks associated with immunotherapy outweigh the benefits in the deployed setting. If the patient's symptoms are so severe that immunotherapy cannot be temporarily disrupted, the active duty member should be considered non-deployable due to his/her underlying allergic disease and be reviewed for meeting retention standards IAW

AFI 48-123, *Medical Exams and Standards*. **EXCEPTION:** On a case-by-case basis, those members deploying to a MTF that routinely provides immunotherapy could be considered for continuation of therapy.

Section 9C—Immunization Services

9.9. Utilization of Immunization Back-up Technician (IBT) and Other Staff in the Immunization Clinic.

9.9.1. Active Duty and ARC Registered Nurses (RN) may administer immunizations. Completion of the IBT Study Guide is highly recommended. **NOTE:** Any military specific vaccine, i.e. anthrax, smallpox or influenza will need vaccine specific training, to include all requirements in AFI 48-110_IP Appendix B, Military Training, as well as shot technique, dosage, reading manufacturer package insert, contraindications, adverse side effects and reporting system, emergency management of anaphylaxis, patient education/VIS and storage and handling of the vaccine. Record of this training will be documented in the nurse's competency assessment folder. (T-1)

9.9.2. Civil Service and contract RNs and LPNs/LVNs may administer immunizations if immunization is part of their position description. Completion of the IBT Study Guide is highly recommended for RNs. IBT training requirements are mandatory for LPNs/LVNs. LPNs/LVNs who have completed the formal A/I Specialty Course do not need to complete the IBT Study Guide provided that they are in compliance with initial and sustainment training requirements IAW this AFI for IBTs. **NOTE:** Any military specific vaccine, i.e. anthrax, smallpox or influenza will need vaccine specific training, to include all requirements in AFI 48-110_IP Appendix B, Military Training, as well as shot technique, dosage, reading manufacturer package insert, contraindications, adverse side effects and reporting system, emergency management of anaphylaxis, patient education/VIS and storage and handling of the vaccine. Record of this training will be documented in the nurse's competency assessment folder. (T-1)

9.9.3. IBTs provide back-up coverage in the immunization clinic, point of service immunization clinic setting, and support of mobility processing lines in the absence of an A/I Technician SEI 453 due to leave, TDY, PCS, or deployment.

9.9.3.1. IBTs supporting Deployment Processing Units will consist of a minimum of one 7-Level 4N0X1. (T-1)

9.9.3.2. IBTs will not routinely hold NCOIC positions in Allergy/Immunization Clinics without waiver approval from MAJCOM 4N FM. IBTs will not be awarded the SEI 453 without the completion of the WRNMMC A/I Specialty Course. This does not apply to ARC, since the ARC does not have allergy/immunization technicians. (T-1)

9.9.3.3. IBTs will not provide immunotherapy (allergy shots) for patients. (T-1)

9.9.3.4. IBTs will not provide initial or refresher immunizations training to other IBTs or IAs. (T-1)

9.10. Immunization Back Up Technician (IBT) Program.

9.10.1. MTF 4N Functional Manager provides oversight of the MTF IBT program and the IBT Program Manager is responsible for the management of this program. At a minimum,

the status of IBT training will be reported to the MTF Chief Nurse and MTF 4N Functional Manager during the Nurse Executive Function quarterly and will be included in the Status of Training (SOT) report to the MTF/CC monthly IAW AFI 36-2201. (T-2)

9.10.2. MTF Senior Leadership (MDOS Superintendent/4N Functional/Chief Nurse) will determine locally the number of IBTs for their facility. (T-2)

9.10.3. Unit Education/Staff Development Office or Base Education and Training Manager (BETM) for ARC will:

9.10.3.1. Administer and safeguard the IBT Exam. (T-2)

9.10.3.2. Provide IBT Program Manager with technician's exam score. Inform the IBT Program Manager (typically the MTF Senior A/I technician) to coordinate exam review with member. **NOTE:** Medical units may designate the MTF 4N Functional Manager or NCOIC, Immunizations Clinic as the IBT Program Manager. (T-2)

9.10.3.3. Notify IBT Program Manager, supervisor, and MTF 4N Functional Manager of failures and any re-tests. IBT Program Manager will ensure remedial training is conducted after each failure and documented in trainees' AFTR. **NOTE:** After third failure, MTF 4N Functional Manager and supervisor will take appropriate actions. (T-1)

9.10.3.4. Information regarding obtaining IBT exam can be found on the A/I Knowledge Exchange Portal or contact the WRNMMC A/I Specialty Course at ImmunizationAllergyCourse@amedd.army.mil.

9.10.4. IBT Program Manager will:

9.10.4.1. Provide the IBT Study Guide to selected technicians, documenting the beginning of IBT training in member's AFTR. Reference AFI 44-103, AF Independent Duty Medical Technician (IDMT) for any specific documentation requirements. (T-2)

9.10.4.2. Document the administration, completion and score of IBT exam in member's AFTR. Conduct IBT exam review with member. (T-2)

9.10.4.3. Ensure sustainment IBT training is accomplished and documented in all IBT's AFTR. Collaborate with immunization NCOIC to ensure a standardized training rotation is created within the facility for all IBTs to ensure integrity and quality of initial/sustainment training. Training can be conducted in main A/I clinics, or IBT Program Manager can visit clinics providing Point of Service care. **NOTE:** MTFs with more than one current A/I SEI 453 can delegate sustainment training and documentation to another current SEI 453. (T-2)

9.10.4.4. Ensure a process exists for tracking all IBT training and in-service attendance. (T-2)

9.10.4.5. Maintain current appointment letters from the MTF SGP of IBTs who are authorized and clinically trained to administer Anthrax and Smallpox vaccines. (T-2)

9.10.5. IBT Initial Training Requirements:

9.10.5.1. Must be a 4N051X or a 4N031 who has completed Career Development Courses (CDCs), is signed off on all core/duty tasks in the CFETP and is awaiting

upgrade. Additionally, the individual must have the recommendation of his/her supervisor and the MTF's 4N Functional Manager. (T-1)

9.10.5.2. Didactic and Clinical training requirements must be accomplished within 90 days. Start date begins on receipt of IBT study guide. Individuals who do not complete the entire training within 90 days will be required to start from the beginning of the IBT training program (with appropriate AFTR documentation). (T-1)

9.10.6. IBT Initial Didactic Training Requirements:

9.10.6.1. Must pass end of course exam with a minimum score of 70% before starting clinical training to demonstrate comprehension of didactic material. This will be documented on the member's AF 623a in the AFTR. (T-1)

9.10.6.1.1. Individuals failing the written test will be tutored by a 4N0X1X with SEI 453 before any retests. This will be annotated in the members' AFTR on the AF 623a. After a second failure, member will not be allowed to enter retraining as an IBT for a 120-day period. (T-2)

9.10.6.1.2. All IBTs will train to the knowledge level on anthrax and smallpox. Those appointed in writing by the MTF SGP will receive administration training and will be authorized to administer these vaccinations. Appropriate documentation will be made on AF Form 623a in individuals AFTR. (T-1)

9.10.6.1.3. IBTs will register at <https://vhcprojectimmunereadiness.com/>. Complete the following courses Introduction to Vaccination, Immune System 1, Immune System 2, Anaphylaxis, and Vaccine Storage and Handling. **NOTE:** MTF IBT Program Managers may select additional courses for technicians. (T-1)

9.10.7. IBT Initial Clinical Training Requirements:

9.10.7.1. A minimum of 15 duty days in an immunization clinic to include 10 duty days of providing pediatric immunizations and 5 duty days for adult immunizations with appropriate documentation procedures. **NOTE:** In unique circumstances due to time constraints (i.e. deployments), the timeframe required for clinical training maybe reduced. This requires recommendation from the IBT Program Manager only after successful completion of QTPs and demonstrated proficiency on all immunization tasks, with the concurrence of the MTF's 4N FM and approval from the MAJCOM 4N FM. (T-1)

9.10.7.2. Review of all related immunizations AFIs, MTF Instructions, and A/I Clinic Operating Instructions. Additionally, demonstrate proficiency in immunization documentation, patient education, patient screening, contraindications, and injection technique. All training will be documented in the member's AFTR on AF Form 623a and all tasks in the 4N0X1 Allergy/Immunization SEI STS portion of the CFETP (Section 4.14.). (T-2)

9.10.7.3. Reviewing and subscribing to the AFMS A/I Knowledge Exchange Portal is mandatory. IBTs are responsible to be knowledgeable of the content and standards on this website. At a minimum, IBTs will review this website quarterly. (T-2)

9.10.7.4. Register at the CDC website to actively receive updates governing immunization practices at http://service.govdelivery.com/service/subscribe.html?code=USCDC_11_47. (T-2)

9.10.8. IBT Sustainment Training will consist of:

9.10.8.1. A minimum of 8 hours of clinical training every quarter. To include 6 hours of training that meets requirements in AFI 48-110_IP Appendix B, Military Training and consists of vaccine storage and handling (cold chain management), vaccine characteristics, patient interviewing techniques, distinguishing valid and invalid contraindications, injection technique, documentation, managing and reporting of adverse events, management of anaphylaxis, ASIMS use, and AFI and policy review. (T-1)

9.10.8.2. A minimum of 2 hours of continuing education will include, but not limited to, in-service training, use of Vaccine Health Center (VHC) Immune Ready Module <http://www.vhcinform.org>, video training from CDC, vaccine epidemiology and newly licensed vaccines. In addition, members will annually complete the Immunization QTP 4N0X1-12. (T-1)

9.10.9. Missed IBT training.

9.10.9.1. IBTs that do not complete quarterly training will be required to spend 5 duty days working with a 4N0X1X with SEI 453 to meet the lapsed training. Documentation will be annotated in the member's AFTR on an AF Form 623a. (T-2)

9.10.9.2. IBTs that miss two consecutive quarters must restart the IBT training process outlined in 9.10.5. Initial Training Requirements. (T-2)

9.10.9.3. Upon return from deployment or extended TDY/training, IDMTs/IBTs will complete 8 hours of training within 30 days return to home station and thereafter will resume quarterly rotation for sustainment training. Those failing this requirement will be considered delinquent for IBT sustainment training the quarter in which they returned. For IDMTs/IBTs returning from deployment and signing in to their unit within 30 days of the end of quarter, required training as described in this paragraph will go towards the next quarterly training requirement and the member will not be delinquent for the quarter in which they returned. (T-2)

9.10.10. ARC IBT Program Requirements.

9.10.10.1. Designated Physician/Medical Director for the Immunization Clinic will, at a minimum, conduct biannual in-services for 4N0X1 IBTs. (T-2)

9.10.10.2. Immunization OIC/NCOIC will:

9.10.10.2.1. Function as the unit IBT Program POC. (T-2)

9.10.10.2.2. Must receive annual IBT training at an AD MTF by a current 4N0X1 SEI 453. (T-2)

9.10.10.2.3. Certify all initial training for IBTs. Training will include didactic pediatric and adult vaccines, plus adult clinical training. Train new IBTs on the current accepted AF electronic tracking application to include data entry, updating vaccine lot number list, editing, deleting records, and how to document and transcribe records. (T-2)

9.10.10.3. ARC IBT Initial Training Requirements:

9.10.10.3.1. Must be a 4N051X or a 4N031 who has completed Career Development Courses (CDCs), is signed off on all core/duty tasks in the CFETP and is awaiting upgrade. Additionally, the individual must have the recommendation of his/her supervisor and the MTF's 4N Functional Manager. (T-2)

9.10.10.3.2. Didactic and Clinical training requirements must be accomplished within 180 days. Start date begins on receipt of IBT study guide. Individuals who do not complete the entire training within 180 days will be required to start from the beginning of the IBT training program (with appropriate AFTR documentation). (T-2)

9.10.10.4. ARC IBT Initial Didactic Training Requirements:

9.10.10.4.1. Must pass end of course exam with a minimum score of 70% before starting clinical training to demonstrate comprehension of didactic material. This will be documented on the member's AF 623a in AFTR. (T-1)

9.10.10.4.2. Individuals failing the written test will be tutored by the unit IBT Program POC before any retests. This will be annotated in the member's AFTR on the AF 623a. After a second failure, member will not be allowed to enter retraining as an IBT for a 120-day period. (T-2)

9.10.10.4.3. All IBTs will train to the knowledge level on anthrax and small pox. Those appointed in writing by the MTF SGP will receive administration training and will be authorized to administer these vaccinations. Appropriate documentation will be made on an AF Form 623a in individual's AFTR. (T-2)

9.10.10.5. ARC IBT Initial Clinic Training Requirements.

9.10.10.5.1. Didactic and Clinical training requirements must be accomplished within 180 days. Start date begins on receipt of IBT study guide. ARC members will complete the didactic training within 90 days or 3 UTAs. Only the IBT Program POC will administer adult immunization clinical training within 90 days or 3 UTAs after member completes the didactic portion. Individuals who do not complete the entire training within 180 days or 6 UTAs will be required to start from the beginning of the IBT training program (with appropriate AFTR documentation). These IBTs clinically trained only to adult vaccines cannot deploy in any Unit Type Code (UTC) as an IBT. Their Unit Commander will coordinate training with local AD MTF to complete pediatric rotation training requirements. (T-2)

9.10.10.5.2. Subscription to alerts on the AFMS A/I Knowledge Exchange Portal is mandatory. IBTs are responsible to be knowledgeable of the content and standards on this website. At a minimum, IBTs will review this website bi-annually. (T-2)

9.10.10.5.3. Register on CDC website to actively receive updates governing immunization practices at http://service.govdelivery.com/service/subscribe.html?code=USCDC_11_47.

9.10.10.6. ARC IBT Sustainment Training will consist of:

9.10.10.6.1. A minimum of 8 hours of adult immunization clinical training bi-annually. To include 6 hours of training that meets requirements in AFI 48-110_IP Appendix B, Military Training and consists of vaccine storage and handling (cold chain management), vaccine characteristics, patient interviewing techniques, distinguishing valid and invalid contraindications, injection technique, documentation, managing and reporting of adverse events, management of anaphylaxis, ASIMS use, and AFI and policy review. (T-1)

9.10.10.6.2. A minimum of 2 hours of continuing education will include, but not limited to, in-service training, use of Vaccine Health Center (VHC) Immune Ready Module <http://www.vhcinform.org>, video training from CDC, vaccine epidemiology and newly licensed vaccines. In addition, members will annually complete the Immunization QTP 4N0X1-12. (T-1)

9.10.10.7. Missed ARC IBT training.

9.10.10.7.1. IBTs that do not complete biannual training will be required to spend 5 duty/3 UTAs days working with unit IBT Program POC to meet the lapsed training. Documentation will be annotated in the member's AFTR on an AF Form 623a. (T-2)

9.10.10.7.2. IBTs that miss two consecutive biannual trainings must restart the entire IBT training process. (T-1)

9.10.10.7.3. When ARC personnel return from deployment, IDMTs/IBTs will complete 8 hours of training within 120 days return to home station and thereafter will resume semi-annual rotation for sustainment training.

9.11. Immunization Augmentees (IAs).

9.11.1. IAs are typically trained to administer only one vaccine in a shot-line setting, e.g. influenza program. Immunizations Augmentees (IA) are only authorized to augment A/I techs and IBTs and are not authorized to provide vaccinations independently. 4N0X1s are the only enlisted AFSC authorized to be trained and utilized as an IA. Medical officers may be trained and utilized as IAs as long as medication administration is within their scope of practice. (T-1)

9.11.2. IA trainees will receive just-in-time training from an A/I technician (for ARC, unit IBT Program POC) which will include a briefing on the vaccine manufacture package insert, anaphylaxis, cold chain management, documentation and local emergency response protocols. (T-1)

9.11.2.1. Training will be re-accomplished if more than 90 days (120 days for ARC) have elapsed since administering that vaccine or if a different vaccine is to be administered.

9.11.2.2. IAs will not be used for smallpox or anthrax vaccination.

9.11.2.3. IAs will not be used to provide immunotherapy (allergy shots) for patients.

9.12. Immunization Administration Issues.

9.12.1. All facilities must have a written plan for the storage and monitoring of vaccines as well as standard operating procedures for power outages. (T-0, AFI 48-110_IP)

9.12.2. All refrigerators used to store vaccine will be connected to an alarm system IAW AFJI 48-110. (T-0, AFI 48-110_IP)

9.12.3. Medication errors, which include, wrong dose, wrong vaccine, wrong patient, wrong route or expired vaccine should be reported by the person most knowledgeable of the event to record information related to what, when, where, how, and any known contributing factors leading to the event IAW AFI 44-119. This information will be provided to the Patient Safety Monitor IAW local guidance. (T-1)

9.12.4. Any suspected adverse event should be report through Vaccine Adverse Event Reporting System (VAERS).

Section 9D—Vaccine Adverse Event Reporting**9.13. Vaccine Adverse Event Reporting System (VAERS).**

9.13.1. The National Vaccine Injury Compensation Program (NVIC) requires health care providers to report adverse events involving vaccines to VAERS. Refer to the NVIC Program vaccine injury table for events that require reporting <http://www.hrsa.gov/vaccinecompensation/table.htm>. VAERS forms and information can be obtained by calling 1-800-822-7967 or by accessing the VAERS web site at <http://vaers.hhs.gov/index>. Use form VAERS-1 (FDA) or submit electronic reports via the <http://vaers.hhs.gov/esub/step1> website. Hard copy forms can be submitted via fax at 1-877-721-0366 or by mail at the address listed in section 9.13.2.1. of this instruction. (T-0, National Vaccine Injury Compensation Program)

9.13.2. VAERS Form Distribution:

9.13.2.1. Send the original report form and any appropriate supporting documents to VAERS, P.O. Box 1100, Rockville, MD 20849-1100. If the VAERS form is sent electronically or via fax, then it does not need to be sent by mail.

9.13.2.2. Retain 1 copy for the Patient Safety Program at the reporting medical unit, which will typically involve the unit's P&T Function.

9.13.2.3. File a copy of the VAERS or MedWatch report in the patient's individual health record or annotate the relevant information on the report within the health record.

Section 9E—Military Specific Vaccines**9.14. Anthrax Vaccine Immunization Plan (AVIP).**

9.14.1. MTF/CC will appoint, in writing, an AVIP Medical OIC. The AVIP Medical OIC will: (T-1)

9.14.1.1. Ensure installation compliance IAW AF Implementation Plan for AVIP Program. Training course is available at www.anthrax.mil/education. Completed training will be annotated in the member's AFTR. Vaccinators will be responsible for

the information in the AVIP Implementation Policy, AVIP healthcare provider briefing slides located at www.anthrax.mil/AVIP2007, BioThrax package insert, AVIP tri-fold brochure (most current), and medical/administrative exemptions for the vaccine.

9.14.1.1.1. IBTs are trained to the knowledge level on the Anthrax Vaccine. IBTs are authorized to administer the anthrax vaccine once they have been appointed in writing by the MTF SGP and have received Anthrax Administration training supplied by the MTF. Authorized IBTs must be in compliance with all provisions outlined under paragraph 9.14. of this instruction.

9.14.1.2. Obtain the most current AVIP tri-fold brochures, and ensure a copy is given to each person being vaccinated (one for each dose). Order tri-folds by emailing usammadoc@det.amedd.army.mil or at www.anthrax.mil.

9.14.2. Cold chain management.

9.14.2.1. All DoD activities are required to prepare an Executive Summary (EXSUM) when suspicion that a vaccine has exceeded required temperature parameters of 2° to 8°C IAW Executive Summary (EXSUM Oct 2007) located at <http://www.usamma.amedd.army.mil/assets/docs/EXSUM%20SOP%2020%20Dec%202011.pdf> (T-0, Executive Summary Standard Operating Procedures 20 Dec 11)

9.14.2.2. EXSUM must be prepared in memorandum format (no longer than one page in length) and submitted to the United States Army Medical Materiel Agency (USAMMA) Distribution Operations Center (DOC) within 24 hours upon discovery of potentially compromised vaccine. EXSUM must be routed up the chain of command for review and endorsement before faxing to the USAMMA/DOC. **NOTE:** An EXSUM is not required for vaccine that has reached its expiration date. See Destruction SOP for disposal instructions located at www.usamma.army.mil/avip_index.cfm. (T-0, Executive Summary Standard Operating Procedures 20 Dec 11)

9.15. Smallpox Vaccination Program.

9.15.1. Newly assigned 4N0X1X with SEIs 453 required to administer Smallpox Vaccine will complete smallpox online training at the MILVAX Website www.vaccines.mil and document training in the AFTR on an AF 623a. (T-1)

9.15.1.1. IBTs are trained to the knowledge level on the Smallpox Vaccine. IBTs are authorized to administer the vaccine once they have been appointed in writing by the MTF SGP and complete training as described in paragraph 9.15.1. of this instruction. Authorized IBTs must be in compliance with all provisions outlined under paragraph 9.15. of this instruction. (T-1)

9.15.2. The DoD Smallpox tri-fold will be provided to individuals who receive the vaccine. (T-1)

9.15.3. Cold Chain Management.

9.15.3.1. All DoD activities are required to prepare an Executive Summary (EXSUM) when suspicion that a vaccine has exceeded required temperature parameters of 2° to 8°C IAW Executive Summary (EXSUM Oct 2007) located at http://www.usamma.army.mil/avip_index.cfm. (T-0, Executive Summary Standard Operating Procedures 20 Dec 11)

9.15.3.2. EXSUM must be prepared in memorandum format (no longer than one page in length) and submitted to the United States Army Medical Materiel Agency (USAMMA) Distribution Operations Center (DOC) within 24 hours upon discovery of potentially compromised vaccine. EXSUM must be routed up the chain of command for review and endorsement before faxing to the USAMMA/DOC. **NOTE:** An EXSUM is not required for vaccine that has reached its expiration date. See Destruction SOP for disposal instructions located at http://www.usamma.army.mil/avip_index.cfm. (T-0, Executive Summary Standard Operating Procedures 20 Dec 11)

Chapter 10

AUDIOLOGY SERVICES

10.1. Air Force Diagnostic Hearing Centers (AFDHC).

10.1.1. At the AFDHCs the Air Force provides hearing aids, replacement parts, accessories, batteries and repair services at no cost to members of the Regular Air Force, activated National Guard and activated Reserves. Retired members of the Uniformed Services utilize the Retiree Hearing Aid Purchase Program, if available, at the MTF. Dependents of active duty members will be referred to a network provider for hearing aid services, as per Tricare guideline. Dependents of retirees are currently not authorized for hearing aid service per Tricare guidelines. (T-1)

10.1.2. Only AFDHCs are authorized to purchase, prescribe, fit and issue hearing aids. All AFDHCs establish a reliable source of hearing aids and hearing aid supplies. The prescription of hearing aids and accessories for AD personnel will be limited to those instruments approved by the Department of Veterans Affairs (VA) and included on the VA purchasing contract. (T-1)

10.1.3. Any Air Force MTF with an assigned audiologist holding privileges to provide independent clinical services may be considered as an Air Force Diagnostic Hearing Center. AFDHCs provide comprehensive audiology assessments to determine site of lesion and etiology of hearing loss/vestibular disorders, hearing conservation services and appropriate treatment strategy.

10.1.4. AFDHCs issue replacement, backup, or reissue hearing aids when the member has orders for either mobility status or a permanent change of station to a remote overseas location.

10.1.4.1. The MTF/CC where member is enrolled sends the request for replacement or reissue hearing aids to the nearest AFDHC, or to the AFDHC that initially tested the member's hearing and prescribed the hearing aids. If a member with hearing aids has deployment or PCS orders to a remote overseas location and has not been evaluated at an AFDHC within the past 12 mos, he/she must be referred by his/her PCM to the nearest AFDHC at least 90 days prior to departure. (T-1)

10.2. Accessories, Spare Parts, Batteries.

10.2.1. The Air Force provides accessories based on the type of hearing aid issued. Accessories may include but not limited to:

10.2.1.1. Ear molds

10.2.1.2. A 60 day supply of batteries. **NOTE:** Issue replacement batteries at no charge to Active Duty only. MTFs without an AFDHC issue batteries according to local MTF guidance. Batteries for non-government issued hearing aids are not authorized.

10.2.1.3. In the case of deployment, member will be issued a supply of batteries and spare parts sufficient for the duration of their deployment.

10.3. Repair of Defective Hearing Aids.

10.3.1. Hearing aid repairs are only authorized for hearing aids dispensed at an active duty MTF (AF, Army or Navy).

10.3.2. Patients returning a government issued hearing aid for repair may receive a hearing aid on loan if available.

10.3.3. AFDHCs determine when a hearing aid has undergone an excessive number of repairs. The audiologist determines when replacement is needed.

10.4. Replacement Hearing Aids.

10.4.1. AFDHCs replace lost or stolen hearing aids only once per year at government expense. Exceptions can be made by the issuing audiologist on a case-by-case basis.

10.4.2. A hearing aid has a minimum life span of approximately 5 years. At the discretion of the AFDHC audiologist, hearing aids can be replaced within 3 years of issue or sooner if there is an excessive repair record or the hearing aid is no longer appropriate for the hearing loss.

Chapter 11

MEDICOLEGAL MATTERS

11.1. Medical Law Consultants (MLC).

11.1.1. The MLC advises commanders at medical facilities on all medical legal matters IAW AFI 51-302, *Medical Law*. The unit where the MLC is stationed provides funding and ordinarily authorizes temporary duty for the MLC to provide consultant visits to each MTF within the MLC's geographic area/region of responsibility at least once a year.

11.1.2. Refer to DoDI 6490.08, *Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members*, and 44-172, *Mental Health*, for further guidance on issues pertaining to communications between mental health providers and commanders.

11.2. Healthcare Provider and Patient Privileged Communications.

11.2.1. Medical records must only be released IAW provisions of the *Privacy Act of 1974* (5 U.S.C. § 552a), the *Health Insurance Portability and Accountability Act (HIPAA)* (Public Law 104-191) and DoD 6025-18R, *DoD Health Information Privacy Regulation*. (T-0, Privacy Act of 1974, HIPAA and DoDI 6025-18R)

11.3. Biological Specimens in Administrative or Judicial Proceedings.

11.3.1. Specimens as Evidence: Since the results of examinations of biological specimens as well as the specimens themselves may be used as evidence in military and civilian judicial or administrative proceedings, the AFMS cooperates in collecting and presenting such evidence under the circumstances described below. (T-1)

11.3.2. Principles Governing Handling of Biological Specimens.

11.3.2.1. Medical personnel with specific training in specimen collection may take biological specimens IAW the Air Force drug testing program and IAW the AF Sexual Assault Prevention and Response Program. Training requirements for sexual assault exams are listed in paragraph 11.5.6. of this instruction and training requirements for the Air Force drug testing program are listed in AFI 44-120, *Military Drug Demand Reduction Program*.

11.3.2.2. The individual must normally consent to any medical personnel collecting and testing biological specimens (such as blood) as evidence. Legal authorities normally document consent on AF IMT 1364, *Consent for Search and Seizure*. (T-1)

11.3.2.2.1. If an individual consents, medical personnel, with appropriate training, may collect biological specimens. Medical personnel trained in sexual assault examinations as listed in paragraph 11.5.6. of this instruction, may take biological specimens requiring visual examination of the unclothed body (such as dried fluids from the pubic area).

11.3.2.3. If the individual does not consent, contact the SJA to determine whether a search authorization or search warrant is available to authorize collection of a sample.

11.3.2.3.1. If the individual withdraws consent at any time, medical personnel shall stop the collection immediately and contact the SJA and the SGH before proceeding further.

11.3.2.3.2. If involuntary extraction of biological specimens is authorized, it must be performed in a reasonable fashion by personnel with appropriate medical qualifications. Normally, involuntary extraction of blood or other biological specimens should not be conducted on alleged victims of crime. Security Forces personnel shall assist medically trained personnel when appropriate. (T-1)

11.3.2.4. Military medical personnel may not take biological specimens solely at the request of and for the use of civilian law enforcement authorities.

11.3.2.5. MTF/CC will ensure procedures are in place to ensure that witnesses can identify specimens. (T-1)

11.3.2.6. MTF/CC will ensure specimens are kept either in the exclusive custody of an identifiable person or secured in an identifiable, tamper-proof location from the time personnel collect the specimen to the time it is offered as evidence. MTF/CC must be able to demonstrate that these precautions were taken. (T-1)

11.4. Reporting Serious Incidents.

11.4.1. Healthcare providers (including mental health providers) will report homicides, suicides, attempted suicides, robbery, aggravated assault, intentional prescription drug overdose and narcotic overdose episodes to the appropriate law enforcement or/and command authorities. (T-1)

11.4.2. IAW DoDI 6495.02, *Sexual Assault Prevention and Response (SAPR) Program Procedures*, healthcare providers will report sexual assaults to the Sexual Assault Response Coordinator (SARC) with the exception of those covered under Family Advocacy as described in below in paragraph 11.4.3. of this instruction. (T-0, DoDI 6495.02)

11.4.2.1. Active duty and military dependents 18 years of age and older are eligible for restricted reporting. The SARC will assess the circumstances to determine which reporting options are available. Healthcare providers will not report restricted reports of sexual assault to command authorities. (T-0, DoDI 6495.02)

11.4.3. IAW DoDD 6400.1, *Family Advocacy Program (FAP)*, healthcare providers will report child abuse and neglect, spouse abuse, adult victims who are sexually assaulted by a spouse or intimate partner and military dependent sexual assault victims who are under the age of 18 to FAP. Partner abuse reports to Family Advocacy may be eligible for domestic abuse restricted reporting. The FAP will determine which reporting options are available and notify legal authorities as appropriate. (T-0, DoDD 6400.1)

11.4.4. Military members, who are on active duty but were victims of sexual assault prior to enlistment or commissioning, are eligible to receive SAPR services under either reporting option. Support to an active duty service member is available regardless of when or where the sexual assault took place. (T-0, DoDI 6495.02)

11.5. Medical Response for Sexual Assault Victims.

11.5.1. The following information is supplemental to U.S. Department of Justice, Office on Violence Against Women, *"A National Protocol for Sexual Assault Medical Forensic Examinations, Adults/Adolescents,"* April 2013; Department of Defense Instruction (DoDI) 6495.02, *Sexual Assault Prevention and Response (SAPR) Program Procedures*; and AFPD 90-60, *Sexual Assault Prevention and Response (SAPR) Program* and its supporting instructions. These resources are available on line at <https://www.ncjrs.gov/pdffiles1/ovw/241903.pdf>, <http://www.sapr.mil/>, and <http://www.e-publishing.af.mil/>. These resources must be reviewed and used as the foundation to the execution of all of aspects of medical response to sexual assault victims.

11.5.2. Program Oversight.

11.5.2.1. The MDOS/CC will provide executive oversight for the MTF Sexual Assault Prevention and Response Program and report program status to the MDG/CC on a recurring basis. (T-3)

11.5.2.2. The MDOS/CC will appoint a healthcare provider as an official, additional duty, to be the point of contact concerning Sexual Assault Prevention and Response Program policy and care. (T-0, DoDI 6495.02)

11.5.3. Medical Response Planning.

11.5.3.1. Each MTF must have a written plan describing the medical response for sexual assault victims. (T-1)

11.5.3.2. At a minimum the plan will:

11.5.3.2.1. Identify appropriate local resources for the performance of quality, victim-centered sexual assault forensic examination IAW Department of Justice references in paragraph 11.5.1. of this instruction. (T-1)

11.5.3.2.2. Establish the sexual assault nurse examiner role as described in paragraph 11.5.5. of this instruction. (T-0, NDAA 2014, Section 1725)

11.5.3.2.3. Establish procedures for quality, victim/survivor-centered medical forensic care to address concerns, minimize trauma, and promote healing. (T-0, DoDI 6495.02)

11.5.3.2.4. Include collaboration with the SARC and FAP on the following;

11.5.3.2.4.1. Procedure for SARC notification regarding every report of sexual assault EXCEPT those covered by paragraph 11.4.3. of this instruction. (T-0, DoDI 6495.02)

11.5.3.2.4.2. Procedures for FAP notification regarding sexual assaults described in paragraph 11.4.3. of this instruction. (T-0, DoDD 6400.1)

11.5.3.2.4.3. Ongoing training for healthcare personnel on the roles and responsibilities of the SARC (T-0, DoDI 6495.02) and FAP. (T-1)

11.5.3.2.4.4. Local policies and procedures, the availability of sexual assault and domestic abuse victim advocacy resources and the potential impact of State and local laws governing sexual assault. (T-0, DoDI 6495.02)

11.5.3.3. The plan should be gender-responsive, culturally sensitive and recovery-oriented. (T-0, DoDI 6495.02)

11.5.3.4. The plan will establish protocols describing the provision, documentation and follow up of medical and mental health care for a victim of sexual assault. Components of the protocols will include testing, prophylactic treatment options, and follow-up care for possible exposure to human immunodeficiency virus (HIV) and other sexually transmitted infections (STI). When gender appropriate, patients will be assessed for the risk of pregnancy and options for emergency contraception. Procedures for emergency contraception are discussed in paragraph 8.4.6. of this instruction. (T-0, DoDI 6495.02)

11.5.3.5. At many MTFs victim Sexual Assault Forensic Examinations (SAFE) are not provided in-house, because it is in the best interest of the victim to be referred to a center of excellence for the highest standard of care. MTFs that do not provide victim SAFE in-house must have a MOU/MOA with a local medical facility that includes the specific provision for victim SAFE to be performed by an appropriate provider, trained registered nurse or health care provider. (T-0, DoDI 6495.02)

11.5.3.5.1. MTFs will initially and upon renewal verify that the local facilities they have an MOU/MOA with meet the standards for forensic exams of sexual assault victims set forth by the Department of Justice reference in paragraph 11.5.1. of this instruction. (T-0, DoDI 6495.02)

11.5.3.6. Timely medical response to a sexual assault victim is essential. The MTF will appropriately triage patients on presentation as emergencies and make every effort to minimize the time until actual SAFE. (T-0, DoDI 6495.02)

11.5.3.7. An adequate supply of Sexual Assault Forensic Examination kits will be maintained at each location that provides SAFE. (T-0, DoDI 6495.02)

11.5.4. Confidentiality and Documentation.

11.5.4.1. Sexual Assault victim confidentiality must be maintained. Only non-personally identifiable information (non-PII) is releasable under Restricted Reporting. Exceptions to this policy are found in DoDI 6495.02, enclosure 4, and include allowance for the disclosure of the minimum information necessary for fitness for duty and disability determinations. PRP notifications must be managed IAW DoDI 6495.02 enclosure 4. Identifying sexual assault as the source of the injury and/or duty limitations is not appropriate. The SARC or FAP is responsible for reporting non-PII to the installation commander. Consult the MLC or servicing staff judge advocate if there are questions regarding releasable information under Restricted Reporting. (T-0, DoDI 6495.02)

11.5.4.2. Medical and mental health record documentation under restricted reporting must have special protection to avoid unauthorized release of information. (T-0, DoDI 6495.02)

11.5.4.2.1. The following wording in bold type should be placed in each notation in the electronic or paper records: **“Restricted from disclosure unless and until determined to be releasable by the MTF Commander or designee. Do not release without specific patient authorization or as specifically authorized by DoD or AF policy.”** (T-1)

11.5.4.2.2. Electronic records in AHLTA must also be secured via a —break the glass‡ function (sensitive box checked) in addition to the notation in paragraph 11.5.4.2.1. of this instruction. (T-1)

11.5.4.3. Documentation in the medical and mental health record must follow a standard approach of addressing acute complaints, gathering pertinent historical data, describing findings, and documenting treatment and follow-up care. Providers must ensure the documentation includes information regarding the physical and emotional injuries resulting from the assault. The level of detail should be sufficient to provide continuity of care. (T-1)

11.5.4.4. Forensic examination documentation must remain with the evidence kit and copies of evidence kit documentation should not be included in the medical record. (T-0, DoDI 6495.02)

11.5.5. Performing SAFE in AF MTFs;

11.5.5.1. MTFs that provide SAFE in-house must ensure sexual assault forensic examiners have access to and are familiar with all guidance referenced in paragraph 11.5.1. of this instruction in addition to meeting all training requirements. (T-1)

11.5.5.2. MTFs with a full service, 24 hour Emergency Department must have at least one, appropriately trained, sexual assault nurse examiner. (T-0, NDAA 2014, Section 1725)

11.5.5.2.1. In addition to the requirement in paragraph 11.5.5.2. of this instruction, on-call schedules to cover 24 hour Emergency Department operations may be augmented by other appropriately trained, qualified, privileged providers. Minimum training requirements are listed below in paragraph 11.5.6. of this instruction. (T-1)

11.5.5.3. In MTFs and Clinics that do not provide full, 24 hour, Emergency Department services, an appropriately trained sexual assault nurse examiner must be made available to a patient of the facility. (T-0, NDAA 2014, Section 1725)

11.5.5.3.1. Sexual assault nurse examiners at these facilities will be the primary medical POC for victims who receive their SAFE and treatment via MOU with local community facilities. They will facilitate any follow up care and specialty care needs ensuring that local MOUs meet the medical needs of victims who may require forensic exams. (T-1)

11.5.6. Qualifications and Training Requirements.

11.5.6.1. MTFs must ensure assigned providers and staff are appropriately trained to respond to sexual assaults. (T-0, DoDI 6495.02)

11.5.6.2. Each MTF will require all personnel to take AFMS SAPR First Responder Training for Health Care Personnel on an annual basis. The on-line pathway to this training is: ADLS, ADLS Gateway, Med+Learn, Course List, USAFSAM-General. MTFs can monitor the course training data through ADLS or MRDSS. AFMS SAPR First Responder Training for Health Care Personnel is in addition to all other Sexual Assault Prevention and Response training. (T-0, DoDI 6495.02)

11.5.6.3. In addition to all other Sexual Assault training requirements, those AF MTF personnel who perform SAFE will meet the following initial and refresher training requirements:

11.5.6.3.1. Minimum initial training requirement for those AF MTF personnel who perform SAFE is attendance at a 40 hour forensic sexual assault examination training course and five accurately preformed case/mock exams reviewed by a competent SA examiner. (T-1)

11.5.6.3.2. To meet annual refresher requirements, those AF MTF personnel who preform SAFE must accurately complete five cases/mock exams a year as reviewed by a competent SA examiner. The initial training outlined above may also be used to fulfill annual refresher training needs. (T-1)

11.5.6.3.3. Those AF MTF personnel who perform SAFE must repeat initial training every five years. (T-1)

11.5.6.3.4. Documentation of training and competency assessment will be completed prior to performance of SAFEs in MTFs. (T-1)

11.5.7. Deployed Environment.

11.5.7.1. Each Expeditionary Medical Support (EMEDS) facility must have a written plan describing medical response for Armed Forces sexual assault victims. (T-0, DoDI 6495.02)

11.5.7.1.1. The written plan will establish protocols for providing and documenting medical care. (T-1)

11.5.7.2. Medical documentation of restricted reporting will have special protection in IAW paragraph 11.5.4. of this instruction. (T-1)

11.5.7.3. EMEDS/CCs will designate a SA examiner to be the primary POC for conducting SAFE. If the EMEDS does not have a trained SA examiner, in-place training will occur. The "Sexual Assault: Forensic and Clinical Management" DVD ordered through the EMEDS Theater Medical Logistics may be used for this purpose. Training will be documented in the SA examiner's deployed credential or competency folder as appropriate. (T-1)

11.5.7.4. Sexual assault victims who exceed the local EMEDS capabilities will be transported to the appropriate level of care IAW established aeromedical evacuation standards. (T-1)

11.5.7.5. The deployed SA examiner will review procedures with the SARC and AFOSI, or comparable offices, upon designation. (T-1)

11.6. Forensic Examination of Alleged Perpetrators. The technical information listed in paragraph 11.5.1. of this instruction regarding medical forensic exams of victims can be applied to the non-treatment oriented forensic exam of an alleged perpetrator.

11.6.1. At deployed and non-deployed MTFs that provide victim SAFE in-house, the MTF will also perform alleged perpetrator exams. The medical response plan for victims will be appended if necessary to include any MTF specific information regarding alleged perpetrator

exams. Providers who perform alleged perpetrator exams must be trained IAW paragraph 11.5.6. of this instruction. (T-1)

11.6.2. At MTFs that do not provide victim SAFE in-house, the MTF and line installation commander will partner in developing, executing and maintaining a joint line/medical MOU/MOA that includes provisions for alleged perpetrator exams. Since Defense Health Program funds cannot pay for alleged perpetrator exams, line leaders will insert provisions in the joint line/medical MOU/MOA outlining how responsible line leadership will fund these exams. Wing agencies (SARC, JA, and AFOSI) provide needed expertise and will assist in the development, execution and maintenance of the joint MOU/MOA. (T-1)

Chapter 12

ASSISTIVE TECHNOLOGY (AT) AND COMPUTER/ELECTRONIC ACCOMMODATIONS PROGRAM (CAP)

12.1. CAP. The CAP affects individuals with disabilities that impact the use of information technology and/or job performance.

12.2. MTFs with Occupational Therapy (OT). MTF/CCs at facilities that provide OT services must designate a CAP representative to assist in the coordination of this program. (T-2)

12.2.1. MTF/CCs at facilities that provide OT services can utilize the Medical Group Instruction (MGI) template on the OT Kx site.

12.3. MTFs without OT. MTFs that do not provide Occupational Therapy services are not required to appoint a CAP representative; however, the SGH should have access to the template MGI for referral purposes.

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CFS
Surgeon General

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

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SF 519B, *Medical Record-Radiographic Consultation Request/Report*
SF 600, *Health Record-Chronological Record of Medical Care*
SF 603, *Health Record-Dental*
SF 858, *Emergency Care and Treatment*

Abbreviations and Acronyms

AAAHC—Accreditation Association for Ambulatory Health Care
AAP— American Academy of Pediatrics
ACLS— Advanced Cardiac Life Support
ACOG— American College of Obstetricians and Gynecologists
ACR— American College of Radiology
AED— Automated External Defibrillators
AFMOA— Air Force Medical Operations Agency
A/I— Allergy/Immunizations
ASIMS— Aeromedical Service Information Management System
BLS— Basic Life Support
CAP— College of American Pathologists
CLIP— Clinical Laboratory Improvement Program
CRNA— Certified Registered Nurse Anesthetist
FDA— Food and Drug Administration
HA— Health Affairs
HIPAA— Health Insurance Portability and Accountability Act
HIV— Human Immunodeficiency Virus
IBT— Immunization Back-up Technician
IDMT— Independent Duty Medical Technicians
LSMTF— Limited Scope Medical Treatment Facilities
MLC— Medical Law Consultants
NRP— Neonatal Resuscitation Program
PALS— Pediatric Advanced Life Support
PCM— Primary Care Manager
PCMH— Patient-Centered Medical Home
P&T— Pharmacy and Therapeutics

SAE— Sexual Assault Exams

SANE— Sexual Assault Nurse Examiner

SARC— Sexual Assault Response Coordinator

SEI— Special Experience Identifier

TJC—the Joint Commission

VBAC— Vaginal Birth after Cesarean Section

Terms

Biological Specimen—a sample from the body.

Concussion—also known as mild traumatic brain injury. The diagnosis of concussion is made when two conditions are met: 1) an injury event must have occurred AND 2) the individual must have experienced alteration of consciousness lasting less than 24 hours OR loss of consciousness lasting less than 30 minutes OR memory loss after the event (post-traumatic amnesia) lasting less than 24 hours. In addition, neuroimaging (if performed) must be normal. In the absence of documentation, both conditions are based on self-report information.

Contrast Media—substances that permit radiographic demonstration of a space, a potential space or an organ.

Controlled Substances—drugs so designated by the Attorney General because of demonstrated or potential abuse. Five schedules are used to classify controlled substances by potential for abuse.

Cosmetic Surgery—surgery performed only to improve physical appearance.

Credentials—the documents that constitute evidence of training, licensure, experience and expertise of a provider.

Deployed—all troop movement of Active Component and Reserve Component personnel resulting from a Joint Chiefs of Staff/unified command deployment for over 30 consecutive days or greater to a location outside the United States that does not have a permanent military treatment facility (funded by the Defense Health Program).

Healthcare Providers—Military (Active or Reserve component) and civilian personnel (Civil Service and other providers working under contractual or similar arrangement) granted privileges to diagnose medical conditions and initiate, alter or terminate healthcare treatment regimens within the scope of his or her license, certification or registration. This category includes physicians, dentists, nurse providers, nurse anesthetists, nurse midwives, podiatrists, optometrists, clinical dieticians, social workers, clinical pharmacists, clinical psychologists, occupational therapists, physical therapists, audiologists, speech pathologists, physician assistants or any other professional providing direct patient care.

Inborn Diseases—pertaining to a constitutional characteristic that is inherited or implanted during intrauterine life.

Mild Traumatic Brain Injury (mTBI)—See definition under concussion.

Moderate Sedation—a minimally depressed level of consciousness that allows the patient to retain the ability to independently and continuously maintain an airway and respond

appropriately to physical stimulation and verbal command, produced by a pharmacologic method, non-pharmacologic method or a combination of the two. Sedating procedures, which would result in the loss of protective reflexes for a significant percentage of a group of patients, are not considered conscious sedation.

Occupational illness—Any abnormal condition or disorder, other than one resulting from an occupational injury, caused by exposure to factors associated with employment. It includes acute and chronic illnesses or diseases that may be caused by inhalation, absorption, ingestion, or direct contact. See the Department of Labor, Bureau of Labor Statistics, Occupational Injury and Illness Classification Manual for further details.

Occupational injury—Any injury such as a cut, fracture, sprain, amputation, etc., which results from a work-related event or from a single instantaneous exposure in the work environment.

Privileges (clinical)—permission to provide medical and other patient care services in the granting institution within defined limits based on the individual's education, professional licensure, experience, competence, ability, health and judgment. Request is evaluated by the credentials function and approved by the MTF/CC.

Primary Care Manager—healthcare provider who oversees and coordinates the general preventive, diagnostic and therapeutic care for a particular patient.

Purchased Care System—medical care provided outside the Military Health System.

Restricted Reporting—A process used by a service member to report or disclose that he or she is the victim of a sexual assault to specified officials on a requested confidential basis. Under these circumstances, the victim's report and any details provided to the SARC, Healthcare Personnel, or a VA will not be reported to law enforcement to initiate an official investigation unless the victim consents or an established exception is exercised under DoDD 6495.01.

Sexual Assault—*(The following definition for sexual assault has been directed by DoD and is for training and educational purposes only. This definition does not affect in any way the definition of any offense under the Uniform Code of Military Justice. Commanders are encouraged to consult with their Staff Judge Advocate for complete understanding of this definition in relation to the UCMJ.)* Sexual assault is defined as intentional sexual contact, characterized by use of force, threats, intimidation, abuse of authority, or when the victim does not or cannot consent. Sexual assault includes rape, forcible sodomy (oral or anal sex), and other unwanted sexual contact that is aggravated, abusive, or wrongful (to include unwanted and inappropriate sexual contact), or attempts to commit these acts.

Sexual Assault Forensic Examination (SAFE)—Medicolegal examination under circumstances and controlled procedures to ensure the physical examination process, and the collection, handling, analysis, testing, and safekeeping of any bodily specimens, meet the requirements necessary for use as evidence in criminal proceedings.

Sexual Assault Nurse Examiner (SANE)—Registered nurses who receive specialized education and fulfill clinical requirements to perform sexual assault examinations.

Sexual Assault Response Coordinator (SARC)—An Air Force civilian employee or Air Force officer reporting to the Wing Vice Commander (WG/CV) who serves as the commander's central point of contact at installation level or within a geographic area to ensure appropriate care is coordinated and provided to victims of sexual assault and tracks the services provided to a

victim from the initial report through final disposition and resolution. Ensures the implementation of prevention programs, to include sexual assault awareness, prevention and response training.

Special Care Unit—any type of critical care unit with a dedicated nursing staff and administrative support.

Supervision—process of reviewing, observing and accepting responsibility for assigned personnel. Indirect supervision is where the supervisor does a retrospective record review of selected records. Direct supervision requires the supervisor to be involved in decision-making processes either by verbal contact or by being physically present through all or part of the care.

Qualified Assistant—a provider designated by the Credentials Function of the Military Treatment Facility as being qualified to assist with a particular type of procedure.

Attachment 2

UNINTENDED RETAINED FOREIGN OBJECTS DURING VAGINAL DELIVERY ALGORITHM

Figure A2.1. Unintended Retained Foreign Objects During Vaginal Delivery Algorithm

