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Medical

COMMUNITY HEALTH MANAGEMENT

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This instruction implements AFD 44-1, *Medical Operations*, and provides guidance for the organization and delivery of community based, prevention focused, healthcare. It implements various publications of Department of Defense (DoD) recognized professional medical organizations, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), and appropriate health and safety agencies. This instruction applies to all personnel assigned to or working in Air Force Medical Treatment Facilities (MTF) and Aeromedical Evacuation units, including Reserve and Guard personnel during their active duty periods, civilian, contract, volunteer personnel and trainees. Submit all supplements to this Air Force Instruction (AFI) to AFMOA/SGOC for approval. Send comments and suggested improvements on AF Form 847, **Recommendation for Change of Publication**, through channels, to AFMOA/SGOC, 110 Luke Avenue, Suite 400, Bolling AFB DC 20332-7050.

SUMMARY OF REVISIONS

This instruction represents a major revision of AFI 44-102, previously known as *Patient Care and Management of Clinical Services*. This AFI facilitates the incorporation of principles of managed care and community health management into everyday practice. It also includes the Surgeon General's guidance on the use of anorectic drug therapy and the management of healthcare workers infected with Hepatitis B. **NOTE:** In accordance with the Objective Medical Group (OMG) the designation of MFC (Medical Facility Commander) has been replaced by the use of MDG/CC (Medical Group Commander). Nonetheless, the guidance contained in this AFI still applies to commanders of facilities that are not large enough to merit a group designation.

Chapter 1—MANAGING PATIENT TREATMENT AND CLINICAL SERVICES	9
Section 1A Areas of Responsibility	9
1.1. Purpose.	9

1.2. Responsibilities. 9

Section 1B Organization and Functions 9

1.3. Overview. 9

Section 1C Managed Healthcare 10

1.4. Managed Care. 10

1.5. TRICARE. 10

Section 1D Population Health Management 10

1.6. Epidemiologic Assessments. 10

1.7. Clinical Practice Guidelines (CPGs): 11

1.8. Critical Pathways. 11

1.9. Case Management. 11

1.10. Discharge Planning. 11

1.11. Health Promotion/Disease Prevention. 12

1.12. Patient/Staff Education. 12

Section 1E Emergency Services 13

1.13. Emergency Services. 13

1.14. Emergency Resuscitation Training. 13

1.15. Requirements for Advanced Life Support Training. 13

Table 1.1. CURRENT ACLS CERTIFICATION + REQUIRED. 14

Table 1.2. ACLS TRAINING + REQUIRED. 14

Table 1.3. CURRENT PALS CERTIFICATION + REQUIRED. 15

Table 1.4. PALS TRAINING + REQUIRED. 15

Table 1.5. CURRENT NRC CERTIFICATION + REQUIRED. 16

Table 1.6. NRC TRAINING + REQUIRED. 16

1.16. Pediatric Advanced Life Support (PALS). 17

1.17. Neonatal Resuscitation Course (NRC). 17

1.18. Coordination of Nonmedical Basic Life Support (BLS) Training. 17

1.19. Automated External Defibrillation (AED). 17

Section 1F Primary Care and Aerospace Medicine 18

1.20. Provisions for Care. 18

AFI44-102 1 JULY 1998	3
1.21. Ambulance Services.	18
1.22. Local MTF Policies and Procedures.	18
Section 1G Medicine and Surgery	19
1.23. Organization.	19
Section 1H Performing Surgical Procedures	19
1.24. Qualified Assistants.	19
1.25. Cosmetic Surgery.	19
1.26. Ambulatory Procedure Visits.	19
1.27. Refractive Surgery.	19
Section 1I Organs or Tissue Donation for Transplantation or Research	20
1.28. Organ and Tissue Procurement Planning.	20
1.29. Requesting Permission.	20
Section 1J Anesthesia Policy, Practice, and Services	20
1.30. Responsibilities.	20
1.31. Certified Registered Nurse Anesthetists (CRNA).	21
1.32. Managing Controlled Substances on the Anesthesia Service.	21
1.33. Using AF Form 579, Controlled Substances Register, and SF 517, Clinical Record - Anesthesia.	22
1.34. Processing and Completing Records.	22
1.35. Conscious Sedation.	23
Section 1K Central Supply Service (CSS)	24
1.36. The Operating Room (OR) Supervisor:	24
1.37. Functions of CSS Personnel:	24
1.38. Requesting, Issuing, and Returning Central Supply Items.	24
Section 1L Clinical Laboratory and Anatomic Pathology Services	25
1.39. General Guidance.	25
1.40. Laboratory Services.	25
1.41. Blood Donor Centers (BDC).	25
1.42. Anatomic Pathology Services.	25
Section 1M Radiology and Radiologic Services	26
1.43. Radiologists.	26

1.44. Technicians.	26
1.45. When Early Interpretation is Required.	26
1.46. Completion of Reports.	26
1.47. Film Loaning and Transfer.	26
1.48. Contract Employees' X-Ray Films.	27
1.49. Radiation Safety Surveys.	27
1.50. Records of Calibrations.	27
Section 1N Pharmacy Services	27
1.51. Organization.	27
1.52. Policies and Procedures.	28
1.53. The Pharmacy and Therapeutics Function.	29
1.54. The Pharmacy.	30
1.55. Drug Inventory.	30
1.56. Inventorying Controlled Drugs.	30
1.57. Accountability of Controlled Substances.	31
1.58. Securing Drugs.	31
1.59. Writing Prescriptions.	31
1.60. Packaging Prescriptions.	32
1.61. Labeling Prescriptions.	32
1.62. Refilling Prescriptions.	32
1.63. Mailing Medications.	33
1.64. Inpatient Pharmacy Services.	33
1.65. Sterile Product Preparation.	33
1.66. Bulk Compounding.	33
Section 1O Optometry Service	34
1.67. Policies and Procedures.	34
1.68. Using Therapeutic Agents.	34
1.69. Contact Lens Services.	34
1.70. Documentation of Optometry Services.	34
Section 1P Occupational Medicine	35
1.71. Work Related Illness and Injuries.	35

1.72. Care of DoD Civilians Injured or Ill in the Line of Duty.	35
Section 1Q Occupational and Physical Therapy Services	35
1.73. Chief of Occupational and/or Physical Therapy.	35
1.74. Requests for Occupational and/or Physical Therapy.	35
1.75. Documentation.	36
Section 1R Continuity of Care for Mental Health Patients	36
1.76. Initial Evaluations.	36
1.77. Evacuation and Hospitalization.	36
1.78. Nonmilitary Patients Returning to the United States.	36
Section 1S Administrative Procedures Pertaining to Diagnostic Test Results	37
1.79. MTF Requirements for Tracking Test Results.	37
Section 1T Electrocardiography	37
1.80. Responsibilities.	37
Section 1U Patient Transfers	37
1.81. Required Attendants.	37
Section 1V Departmental Staff Procedures	37
1.82. Title of Doctor.	37
1.83. Name Tags.	38
Section 1W Commercial Insurance Company Physical Examinations	38
1.84. Completion of Forms.	38
Section 1X Using Chaperones	38
1.85. Actions Necessary to Implement Air Force Policy in AFPD 44-1, Medical Operations	38
Section 1Y Medical Personnel Rest Standards	38
1.86. Policy on Rest Standards:	39
Section 1Z Reportable Diseases and Conditions	39
1.87. What and How To Report.	39
Section 1AA Off-Duty Employment	39
1.88. To Whom This Applies.	39
1.89. The MDG/CC Responsibilities.	39

1.90. Requirements. 39

1.91. Types of Services Which Can be Provided as Off-Duty Employment. 40

1.92. Requirements and Restrictions for Off Duty Employment. 40

1.93. Request Processing. 41

Chapter 2— HEALTHCARE FOR SPECIAL AND HIGH RISK POPULATIONS 43

Section 2A Pseudofolliculitis Barbae 43

 2.1. MTF Written Guidance for the Program. 43

Section 2B Acquired Immune Deficiency Syndrome (AIDS) 43

 2.2. Infected Healthcare Workers. 43

 2.3. HIV-Infected Patient Referral. 43

Section 2C Hepatitis B Infected Healthcare Workers 43

 2.4. Hepatitis B Infected Healthcare Workers. 43

Section 2D Allergy Treatment 44

 2.5. Responsibilities. 44

 2.6. Training for AIT Personnel. 44

Section 2E Family Planning 44

 2.7. Family Planning Services Provided. 44

 2.8. Sterilization. 45

 2.9. Contraceptive Services. 45

 2.10. Induced Abortion. 45

Section 2F Medical Care Related To Pregnancy 46

 2.11. Standards. 46

 2.12. High Risk Pregnancy Care. 46

 2.13. Epidural Anesthesia for Delivery. 46

 2.14. Use of Oxytocic Drugs in Pregnancy. 46

 2.15. Restrictions for USAF Military Personnel During Pregnancy. 47

 2.16. Chemical Warfare Defense Ensemble (CWDE). 47

 2.17. Assignment Curtailment In Isolated or Remote Areas. 48

 2.18. Weight and Fitness Compliance. 48

 2.19. Illness During the Prenatal Period. 48

AFI44-102 1 JULY 1998	7
2.20. Evaluation of Pregnant Civilian Employees.	48
Section 2G Other Women’s Health Issues	49
2.21. Annual Health Maintenance Examinations.	49
2.22. Mammograms.	49
2.23. Gynecological Services.	50
Section 2H Newborn Care	50
2.24. Inborn Diseases in Newborn Infants.	50
2.25. Newborn and Intensive Care Nurseries.	50
Section 2I Medical Nutrition Therapy	50
2.26. Medical Nutrition Therapy.	50
Section 2J The Weight Management Program	51
2.27. Medical Evaluation of USAF Personnel Entering the Weight Management	51
2.28. Use of Anorectic Drugs.	51
Section 2K Medical Conditions Existing Prior to Service (EPTS)	51
2.29. Correction of Defects.	51
Section 2L Using Clinical Hypnosis	52
2.30. Provider Privileges.	52
2.31. Restrictions.	52
Section 2M Formal Sex Therapy	52
2.32. Clinician Requirements.	52
Section 2N Medicolegal Matters	52
2.33. Medical Law Consultants (MLC).	52
2.34. Healthcare Provider and Patient Privileged Communications.	52
2.35. Biological Specimens in Administrative or Judicial Proceedings.	53
2.36. Reporting Serious Incidents.	54
Section 2O Informed Consent	54
2.37. MDG/CC Responsibilities.	54
2.38. Resolving Questionable Issues.	54
2.39. Informed Consent Documentation.	54
2.40. Informed Consent for Certain Immunizations.	55

Section 2P Treating Minors 55

 2.41. General Guidelines. 55

 2.42. Treating Minors in CONUS. 55

 2.43. Treating Minors Overseas 55

Section 2Q Hearing Aids 55

 2.44. Diagnostic Hearing Centers (DHC). 55

 2.45. Accessories, Spare Parts, Batteries. 56

 2.46. Repair of Defective Hearing Aids. 57

 2.47. Return of Unserviceable Hearing Aids. 57

 2.48. Replacement Hearing Aids. 57

 2.49. Accountability of Hearing Aids. 57

Section 2R Forms Prescribed 58

 2.50. Forms Prescribed. 58

Attachment 1— GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION 59

Chapter 1

MANAGING PATIENT TREATMENT AND CLINICAL SERVICES

Section IA—Areas of Responsibility

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

1.2. Responsibilities.

1.2.1. The Air Force Surgeon General:

1.2.1.1. Monitors the implementation of these instructions throughout the Air Force.

1.2.2. Command Surgeons (MAJCOM/SG or equivalent):

1.2.2.1. Ensure that commands implement these instructions and recommend any additions, deletions, and amendments.

1.2.3. Medical Group Commanders (MDG/CC):

1.2.3.1. Comply with these instructions and ensure personnel under their authority observe them.

Section IB—Organization and Functions

1.3. Overview.

1.3.1. The MTF Organizational Plan. Will be organized in accordance with the Objective Medical Group (OMG), and includes the office of the Chief, Medical Staff, and clinical services necessary to perform the wing/installation medical services mission. Commanders and supervisors in the chain of command subordinate to MDG/CC control conditions of employment including place, time and means of work, and 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 defined in AFI 44-119, *Clinical Performance Improvement*. The MDG/CC has ultimate responsibility for, and authority over professional standards and clinical performance.

1.3.2. Chief, Medical Staff.

1.3.2.1. Is a Medical Corps officer, maintains regular privileges in their specialty, and is an active medical staff member.

1.3.2.2. Coordinates the Medical Planning for Disaster Casualty Control incorporating those items in the Medical Emergency Set Ambulance.

1.3.2.3. Is responsible for the conduct of professional clinical peer review functions that define clinical standards of care (AFI 44-119, *Clinical Performance Improvement*), and advises MDG/CC about actions required in relation to the clinical performance and professional conduct of privileged providers.

1.3.3. The Assistant Chief of Medical Staff:

1.3.3.1. May be a privileged provider of any corps in the AFMS.

1.3.4. Chief Nurse Executive.

1.3.4.1. Each MTF will have a qualified Nurse Corps officer designated as the Chief Nurse Executive.

1.3.4.2. The Chief Nurse Executive has primary oversight of the clinical nursing activities of non-privileged providers throughout the organization, and will collaborate with other clinical disciplines in the development of an organizational plan for the delivery of nursing care.

1.3.4.3. The Chief Nurse Executive ensures that all nursing personnel are competent to perform their assigned responsibilities, IAW AFI 46-102, *Nursing Care*.

1.3.5. Privileged Providers.

1.3.5.1. Privileged healthcare providers assume complete responsibility for evaluating their patients' medical or dental problems and for prescribing an individualized therapeutic program, within the scope of their clinical privileges.

1.3.5.2. When on call, privileged providers will maintain contact with the MTF. Providers should not rely on the exclusive use of a "pager" or "beeper."

1.3.5.3. A provider fully privileged for a scope of care appropriate to the unit must be assigned responsibility for the care of each admitted patient.

1.3.5.4. A provider will see and evaluate his/her designated inpatients at least once each day. **EXCEPTION:** Patients on holding or self-care units need not see a provider every day, unless new or adverse symptoms develop.

1.3.5.5. A physician will see and evaluate patients in the Coronary Care Unit (CCU), Intensive Care Unit (ICU), or in the Special Care Unit (SCU) at least twice each day.

Section 1C—Managed Healthcare

1.4. Managed Care.

1.4.1. The Air Force Medical Service is part of a managed care system that strives to provide the highest possible quality healthcare at the least resource cost (best value healthcare), through an effective partnership with Military Health System (MHS) beneficiaries that emphasizes satisfaction for our patients and other customers.

1.5. TRICARE.

1.5.1. The TRICARE Policy Guidelines promulgated by the Office of the Assistant Secretary of Defense/Health Affairs (OASD/HA) will be implemented by all MTF's.

Section 1D—Population Health Management

1.6. Epidemiologic Assessments.

1.6.1. Epidemiological Assessments analyze the observed frequencies of past events in populations to predict the risks and prevalence of disease, dysfunction and injury of enrolled beneficiaries and beneficiary groups. Results of such assessments will be used to assess and allocate resources to meet the healthcare needs of the served populations. Providers and managers of healthcare delivery pro-

cesses must utilize these resources in the most efficient and cost-effective manner to achieve the AFMS goals of delivering best value healthcare.

1.6.2. The MDG/CC will establish an ongoing process to assess the health status of their beneficiaries using the Health Enrollment Assessment Review (HEAR).

1.7. Clinical Practice Guidelines (CPGs):

1.7.1. Clinical Practice Guidelines (CPGs) are recommendations for the optimal sequence of actions or decisions (strategies) to solve clinical problems. They are established in order to optimize the delivery of healthcare throughout the medical service and are central to the implementation of total disease management.

1.7.1.1. MTF's will incorporate the use of evidence based clinical practice guidelines into clinical practice for high volume, high cost, high risk, and/or problem prone areas. Guidelines (ex. asthma management) from nationally recognized professional/scientific organizations are well suited for this purpose, and may be modified for local use.

1.8. Critical Pathways.

1.8.1. Critical Pathways are complementary to CPGs and represent detailed, multi-disciplinary plans for translating healthcare strategies into effective actions tailored to the needs of individuals or a population. Critical Pathways are designed to enhance provider proficiency/efficiency, improve clinical outcomes, and reduce cost.

1.8.1.1. MTF's will develop or adapt, and implement critical pathways for the most prevalent, costly, and/or problem prone services required by their served community.

1.8.1.2. Critical Pathways will be used as benchmarks for evaluating and improving some aspects of organizational performance.

1.9. Case Management.

1.9.1. Each MTF will develop plans to ensure a case management approach for those patients/families with extensive and/or complex needs.

1.9.1.1. Case managers coordinate healthcare services across an entire spectrum of disease and dysfunction that may impact an individual, from evaluation and diagnosis through multi-modality treatment and into rehabilitation. Case management seeks to prevent or lessen the potential adverse impact of future events through an emphasis on preventive strategies and to optimize patient functioning while preserving resources.

1.10. Discharge Planning.

1.10.1. Each MTF will establish a formal program to identify and solve post-hospital needs in accordance with Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) guidelines.

1.10.1.1. Discharge planning will be conducted by both inpatient and ambulatory surgery facilities to the extent appropriate for each patient.

1.10.2. The Chief, Medical Staff.

1.10.2.1. Monitors discharge planning activities by overseeing the utilization review process.

1.10.2.2. Ensures that the staff understand their role in discharge planning.

1.10.2.3. Evaluates the effectiveness of the discharge planning process.

1.10.3. Primary responsibility for discharge planning lies with the healthcare provider(s) who approve discharge plans for the patients under their care.

1.11. Health Promotion/Disease Prevention.

1.11.1. Each MTF will establish a multidisciplinary Prevention Committee IAW AFI 48-105, *Surveillance, Prevention, and Control of Diseases and Conditions of Public Health or Military Significance*.

1.11.1.1. Integral activities and oversight will include:

1.11.1.1.1. Implementing the Put Prevention into Practice (PIIP) Program IAW Air Force Pamphlet 44-155, *Clinical Preventive Services*.

1.11.1.1.2. Establishing and fostering the effective utilization of community based Health and Wellness Centers (HAWCS).

1.11.1.1.3. Ensuring that Health Promotion Activities are conducted IAW AFI 40-101, *Health Promotion Program*.

1.11.1.1.4. Ensuring that Preventive Health Assessment (PHA), and the Health Enrollment Assessment Review (HEAR) programs are conducted IAW the most current edition of AFI 48-123, *Medical Examinations and Standards*.

1.12. Patient/Staff Education.

1.12.1. Patient Education. Patient education will be provided at all levels of the healthcare continuum, in an effort to promote healthy behaviors and to involve the patient in appropriate care decisions.

1.12.1.1. Patient oriented education may use individualized teaching, group meetings, support groups, or any other media form, and should, whenever possible, be culturally sensitive, age and gender appropriate.

1.12.2. Staff Education. MTF Commanders will foster environments that encourage continual staff development and educational enhancement. MTF Commanders are responsible for ensuring that all personnel under their command have appropriate training and preparation for their functions. Examples include HAZMAT training and universal precautions for housekeeping personnel.

1.12.2.1. Utilization Management (UM) reviews will be incorporated into educational and process improvement modalities.

1.12.2.2. Specific guidelines governing Continued Health Education (CHE) for officers are outlined in AFI 41-117, *Medical Service Officer Education*. Guidelines pertaining to Medical Technician training are reviewed in the *Career Field Education and Training Plan*.

*Section 1E—Emergency Services***1.13. Emergency Services.** (Refer also to **Section 1F**, paragraph **1.20**.)

1.13.1. Each MTF must have a written plan describing how medical emergencies will be handled for patients in the locality of the MTF.

1.13.2. Provisions for, and care rendered will be in compliance with relevant Health Services Inspection (HSI) and JCAHO guidelines.

1.14. Emergency Resuscitation Training.

1.14.1. Each MDG/CC will designate an Emergency Resuscitation training coordinator in writing.

1.14.2. Personnel may register or re-register with either the American Heart Association (AHA) or the American Red Cross (ARC).

1.14.3. Requirements for personnel (Including Civilians and Contractors) involved in direct patient care:

1.14.3.1. Must maintain current registration in either the AHA Basic Life Support (BLS) Course C or the ARC CPR/BLS Course.

1.14.4. Requirements for personnel (Including Civilians and Contractors) who are not involved in direct patient care, but are working in patient care areas:

1.14.4.1. Must maintain current registration in either the AHA BLS Course A or ARC Adult CPR Course (Race for Life).

1.14.5. Non-medical civilian volunteers or contractors who are not involved in direct patient care, or who do not work in patient care areas may receive a waiver of their CPR/BLS requirement at the discretion of the local MDG/CC.

NOTE:

AHA registration through the Military Training Network may be given for a two year registration period.

1.15. Requirements for Advanced Life Support Training.

1.15.1. Requirements for Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), and Neonatal Resuscitation Course (NRC) training are as noted in tables 1.1 through 1.6. **NOTE:** The term “**certification**” refers to the successful demonstration of written and cognitive skills, either in a standard ACLS/PALS/NRC course, or the equivalent. The term ACLS/PALS/NRC “**training**” refers to participation in a standard ACLS/PALS/NRC course or the equivalent; although successful completion of the course is expected, certification is not critical to the fulfillment of this requirement.

Table 1.1. CURRENT ACLS CERTIFICATION + REQUIRED.

	SCU ICU CCU	OR	ER or Ur- gent Care*	OBSTETRI- CAL UNIT	RECOV- ERY ROOM	MOD	GENER- AL ANES.	IV SED.	COMMUNI- TY HEALTH CENTER
PHYSI- CIAN	X	X	X	X	X	X	X	X	X
PHYSI- CIAN ASSIS- TANT	X	X	X	X	X				X
DENTIST	X	X	X		X		X	X	
PODIA- TRIST		X						X	
CRNA		X					X	X	
MIDWIFE				X					
NURSE	X		X		X				

+ *The term “certification” refers to the successful demonstration of written and cognitive skills, either in a standard ACLS course, or the equivalent. However, certification is not equivalent to, or a guarantee of, competency in specific skills.*

Certification should be re-affirmed every two years.

** To include individuals involved in ambulance transport/services*

Table 1.2. ACLS TRAINING + REQUIRED: (to be accomplished on a biennial basis).

	SCU ICU CCU	OR	ER or Ur- gent Care*	OBSTETRI- CAL UNIT	RECOV- ERY ROOM	MOD	GENER- AL ANES.	IV SED.	COMMUNITY HEALTH CEN- TER
NURSE		X		X				X	

+ *The term “ACLS training” refers to participation in a standard ACLS course or the equivalent; although successful completion of the course is expected, it is not critical to the fulfillment of this requirement.*

** To include individuals involved in ambulance transport/services*

Table 1.3. CURRENT PALS CERTIFICATION + REQUIRED.

	SCU ICU CCU	OR	ER or Ur- gent Care*	OBSTETRI- CAL UNIT	RECOV- ERY ROOM	MOD	GENER- AL ANES.	PEDIAT- RIC IV SE- DATION+ +	COMMUNI- TY HEALTH CENTER
PEDIATRI- CIAN			X					X	X

	SCU ICU CCU	OR	ER or Ur- gent Care*	OBSTETRI- CAL UNIT	RECOV- ERY ROOM	MOD	GENER- AL ANES.	PEDIAT- RIC IV SE- DATION+ +	COMMUNI- TY HEALTH CENTER
ANY PRIV- ILEGED PROVIDER								X	X+++

+ As noted above, certification requires successful completion of ACLS/PALS/NRC course work--or the equivalent; Training implies completion of a ACLS/PALS/NRC course (or equivalent), but does not necessarily require that one successfully "pass the course."

++ To include I.M. and oral pediatric dental sedation

+++ If a pediatrician is not assigned to the Community Health Center (CHC)

*To include individuals involved in ambulance transport/services

Table 1.4. PALS TRAINING⁺ REQUIRED: (biennial training).

	SCU ICU CCU	OR	ER or Ur- gent Care*	OBSTETRI- CAL UNIT	RECOV- ERY ROOM	MOD	GENER- ALANES.	IV SED.	COMMUNI- TY HEALTH CENTER
PEDIAT- RIC NURSE PRACTI- TIONER			X					X	X

+Training implies completion of a ACLS/PALS/NRC course (or equivalent), but does not necessarily require that one successfully "pass the course." Practical familiarization is the goal in this regard.

* To include individuals involved in ambulance transport/services

Table 1.5. CURRENT NRC CERTIFICATION⁺ REQUIRED.

	SCU ICU CCU	OR	ER or Ur- gent Care*	OBSTETRI- CAL UNIT	RECOV- ERY ROOM	MOD	GENER- ALANES	IV SED.	COMMUNI- TY HEALTH CENTER
PHYSI- CIAN				X					
MIDWIFE				X					

+As noted above, certification requires successful completion of ACLS/PALS/NRC course work--or the equivalent

* To include individuals involved in ambulance transport/services

Table 1.6. NRC TRAINING + REQUIRED: (biennial training).

	SCU ICU CCU	OR	ER or Ur- gent Care*	OBSTETRI- CAL UNIT	RECOV- ERY ROOM	MOD	GENER- AL ANES.	IV SED.	COMMUNI- TY HEALTH CENTER
NURSE				X					

+As noted above, certification requires successful completion of ACLS/PALS/NRC course work--or the equivalent; Training implies completion of a ACLS/PALS/NRC course (or equivalent), but does not necessarily require that one successfully "pass the course." Practical familiarization is the goal in this regard.

* To include individuals involved in ambulance transport/services

1.15.2. Every 6 months, the MTF credentials function will review the records of personnel (military, civilian, and contract) who have not received the requisite level of certification or who have failed to maintain their prescribed level of certification/training. In such cases, appropriate privileging action may be required IAW AFI 44-119, *Clinical Performance Improvement*.

1.15.3. Individuals with sufficient experience in managing cardiopulmonary arrest situations independently may request a letter of exemption from MDG/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 credential file (PCF).

1.15.3.1. The MDG/CC may, in select situations, **waive** the requirement for periodic advanced life support training. Such situations may apply to civilian contractors who work limited hours, in settings in which adequate emergency back-up and interventional life support measures are assured. Basic life support training will continue to be required for all personnel involved in direct patient care.

1.15.4. Technicians who work in critical care, emergency, and/or ambulatory surgery areas are encouraged to complete ACLS training. **NOTE:** Although encouraged, advanced life support training of technicians does not equate to the granting of privileges to manage a cardiac emergency.

1.15.5. Labor and delivery room nurses must be trained in both ACLS and NRC. Operating Room nurses must be trained in ACLS. As noted, these individuals do not have to pass the course or take a written examination. However, they should be afforded the opportunity to be certified if they choose to do so.

1.15.5.1. Required life support training will be accomplished within 6 months of this publication update, or within 6 months of assignment to the areas noted above, whichever is later. The local MTF may grant a one-time extension of 6 additional months.

1.15.5.2. Retraining will occur every 2 years.

1.16. Pediatric Advanced Life Support (PALS).

1.16.1. PALS certification is required for all pediatricians, and for those individuals administering pediatric I.V. sedation.

1.16.1.1. PALS certification is also required for dentists who administer pediatric I.M. or oral sedation

1.16.2. PALS training is required for all pediatric nurse practitioners. PALS training is also recommended for all full time E.R. staff.

1.16.3. Privileged providers and nurses with duties exclusively in pediatric or neonatal areas may substitute PALS for the ACLS requirement.

1.17. Neonatal Resuscitation Course (NRC).

1.17.1. Privileged providers with delivery room duties complete NRC and ACLS certification.

1.18. Coordination of Nonmedical Basic Life Support (BLS) Training.

1.18.1. The MDG/CC designates an individual to coordinate BLS provider/instructor training for DoD affiliated, area organizations that are otherwise unable to provide this training. Organizations requesting this training provide funding and course materials.

1.19. Automated External Defibrillation (AED).

1.19.1. MTFs should provide AED services.

1.19.2. Required AED Training:

1.19.2.1. Emergency Service Departments ensure that all personnel involved in providing this service are trained using the AED Chapter in the ACLS manual.

1.19.2.2. Training on the adult AED is required for ER staff directly involved in patient care, and is highly encouraged for all other personnel. *NOTE:* 4NOX1'S/4FOXI'S involved in ambulance operations as primary or secondary responders, and 4NOX1's assigned to nursing units with AED's will be retrained on the adult automated external defibrillator every 90 days.

1.19.2.3. Refresher training will be accomplished every one to two years for all other personnel.

Section 1F—Primary Care and Aerospace Medicine

1.20. Provisions for Care.

1.20.1. Utilizes the concept of a Primary Care Manager (PCM) to provide general preventive, diagnostic and therapeutic care for patients.

1.20.2. Provides occupational health and direct operational support services, as specified in AFI 48-101, *The Aerospace Medicine Program*, AFI 48-123, *Medical Examinations and Standards*, and in AFI 44-102, *Community Health Management*, section 1.70.

1.20.3. If the MTF provides the following services, they will be organizationally aligned IAW the Objective Medical Group (OMG):

Immunizations.

Emergency Services. **EXCEPTION:** In medical centers, this function is organized as a separate department of emergency medicine. When a MTF is unable to staff the emergency department 24 hours a day, personnel must publicize alternate sources of care.

1.21. Ambulance Services.

1.21.1. The ambulance service responds to all emergency calls within the defined response area, during normal duty hours and to aircraft emergencies after duty hours. Aerospace medicine will respond to aircraft or flight-line emergencies during normal duty hours; the use of additional emergency support will be based on the severity of the incident and/or local policy. Two-way voice communication, with a physician, must be maintained during all ambulance responses.

1.21.2. The MDG/CC will establish procedures for after-hours response to flightline emergencies appropriate for the local flying mission and in coordination with the Fire Chief. The MDG/CC must ensure that the leadership of flying units are aware of after-hours flightline response plans for medical emergencies. If civilian emergency medical services are to be involved in primary flightline response, they must be trained in flightline traffic and safety procedures.

1.21.3. Aerospace medicine personnel must be available after-hours to supplement flightline response within a response time established by the MDG/CC. Aerospace medicine personnel will respond to any inflight physiologic incident or flight mishap.

1.21.4. In either case, the MDG/CC will ensure that the level of care meets or exceeds the community standard.

1.22. Local MTF Policies and Procedures.

1.22.1. The MDG/CC ensures:

1.22.1.1. Competent emergency and ambulance services, including medical care are available to addresses the specific problems of aircraft accidents, flight-line emergencies, and Broken Arrow incidents.

1.22.1.2. Proper attention to training, assigning, and controlling medical responses to emergency situations.

1.22.2. The MDG/CC ensures operational safety in the use of ambulances and appoints an individual as the vehicle control officer or Noncommissioned Officer in Charge.

Section IG—Medicine and Surgery

1.23. Organization.

1.23.1. The MDG/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 *Objective Medical Group Implementation Guide*.

Section IH—Performing Surgical Procedures

1.24. Qualified Assistants.

1.24.1. The operating surgeon ensures a qualified first assistant is present for surgical procedures with a high risk of mortality or significant morbidity. **NOTE:** Qualified nurses, PA's, or technicians may function as a second or third assistant or as first assistant for lesser operations.

1.25. Cosmetic Surgery.

1.25.1. MTFs with graduate medical education programs in plastic surgery; ear, nose, and throat (ENT); ophthalmology; dermatology; and oral surgery, or with assigned staff in these subspecialties may perform cosmetic surgery for eligible beneficiaries.

1.25.2. Surgeons may not perform surgical procedures designed to produce weight loss on active-duty personnel.

1.25.3. The MDG/CC establishes a prepayment schedule for nonactive-duty patients and a tracking system for all cosmetic procedures, IAW the annual publication of the DoD *Medical Reimbursement Rates and Procedures* document.

1.26. Ambulatory Procedure Visits.

1.26.1. Each MTF will establish a list of authorized procedures which may be accomplished in an ambulatory setting, IAW DoD Instruction 6025.8, *Ambulatory Procedure Visit*.

1.27. Refractive Surgery.

1.27.1. Performance of refractive surgery, to include photorefractive keratectomy, radial keratotomy, and related procedures, is prohibited in all Air Force Medical Facilities, except by fellowship trained corneal surgeons in direct support of the Wilford Hall Medical Center Ophthalmology Training Program.

1.27.2. Radial keratotomy will not be performed by Air Force Medical facilities on active duty, reserve or guard personnel of any branch of service.

1.27.3. Active duty, guard, or reserve personnel who undergo refractive surgery must undergo a Medical Evaluation Board (MEB), and may be disqualified for continued duty.

Section II—Organs or Tissue Donation for Transplantation or Research

1.28. Organ and Tissue Procurement Planning.

1.28.1. In accordance with DoD Directive 6465.3, dated 16 March 1995, all inpatient facilities must:

1.28.1.1. Establish an organ and tissue procurement plan, which is IAW AFI 40-403, *Clinical Investigation & Human Test Subjects in the Medical Service*, and 32 CFR 219.

1.28.1.2. Contact the nearest military transplant center (MTC) to establish a memorandum of agreement (MOA) or memorandum of understanding (MOU) for organ transplant services.

1.28.2. If the transplant center cannot service the facility, the MTF establishes a contract or MOA with a local organ procurement agency (OPA).

1.28.3. Facilities may obtain assistance from HQ AFMSA/SGSL in negotiating agreements with local OPAs.

1.28.4. 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.

1.28.5. DoD bills its retrieval costs to civilian OPAs or non-DoD transplant recipients for organs and tissues transferred to civilian OPAs.

1.29. Requesting Permission.

1.29.1. The DoD encourages, while avoiding coercion, all personnel covered under the DoD health-care system to donate tissues and organs.

1.29.2. When an active duty member wishes to be a living organ or tissue donor, the MDG/CC ensures that the member has the permission of his or her commander, and can be expected to remain physically qualified for worldwide duty after the donation.

1.29.3. Donations made by active duty personnel must be approved by the Surgeon General of the members parent service.

Section 1J—Anesthesia Policy, Practice, and Services

1.30. Responsibilities.

1.30.1. The Chief Consultant to the Air Force Surgeon General for Anesthesiology Working Through HQ AFMOA/SGOC:

1.30.1.1. Provides guidance for the MTF's anesthesia services.

1.30.1.2. Participates in the selection of Regional/MAJCOM consultants.

1.30.2. The Regional Consultants. Establish and monitor the anesthesia services for each MTF within their region.

1.30.3. The Medical Group Commander. Designates a physician responsible for clinical oversight of MTF anesthesia services.

1.30.4. The Chief of Anesthesia. Schedules daily anesthesia services, and is a privileged anesthesia provider.

1.30.4.1. Ensures that assignments consider the patient's condition and requirements and are coordinated with the Operating Room Director and the designated surgeons.

1.30.4.2. Ensures that personnel develop fail-safe mechanisms to trace controlled drugs which are used in providing anesthesia services.

1.30.4.3. The anesthesia section provides all anesthesia services required. **EXCEPTION:** Local anesthesia for minor surgery or procedures, and/or conscious sedation performed by providers privileged for same, under appropriate circumstances (see paragraph 1.35.).

1.31. Certified Registered Nurse Anesthetists (CRNA). *See also AFI 44-119, Clinical Performance Improvement, for Scope of Practice Issues.*

1.31.1. Appropriately privileged CRNA's may routinely administer anesthesia to:

1.31.1.1. Children 2 years old and older.

1.31.1.2. Patients in American Society of Anesthesiology (ASA) classification II or lower risk.

1.31.2. CRNA's assigned to MTF's will consult with an anesthesiologist before providing care to children under the age of 2 years or to patients in an ASA physical status classification III or higher. This consultation may be verbal or electronic and must be documented in the patient's record. This also applies if the consulting anesthesiologist is not assigned to the same MTF.

1.31.3. There will be a backup provider (float) available in the event of an emergency. The backup provider can be another anesthesia provider or another physician capable of immediately diagnosing and treating a medical emergency.

1.32. Managing Controlled Substances on the Anesthesia Service.

1.32.1. The Anesthesia Service:

1.32.1.1. May keep no more than a 1-week supply of controlled substances.

1.32.1.2. Must keep controlled substances in a double-locked cabinet.

1.32.2. The chief of the anesthesia service appoints an anesthesia officer as the OIC for controlled substances in anesthesia.

1.32.3. A CRNA or anesthesiologist carries the keys to the controlled-substances cabinet during duty hours.

1.32.4. The senior on-call anesthetist or anesthesiologist carries the keys after duty hours.

1.32.5. The anesthetist carries keys for double-locked boxes installed on anesthesia carts.

1.32.6. Personnel must never leave the day's supply of controlled substances unattended on anesthesia carts.

1.32.7. The senior anesthetist or designated representative and another officer who is not an anesthetist takes a daily inventory of controlled substances.

1.32.8. Personnel address appropriate controlled substance dosages as part of the monthly anesthesia audit.

1.33. Using AF Form 579, Controlled Substances Register, and SF 517, Clinical Record - Anesthesia.

1.33.1. All medical personnel utilizing controlled substances:

1.33.1.1. Keep AF Form 579 for each controlled substance stocked by the anesthesia service.

1.33.1.2. Sign out daily controlled substances by the ampule, vial, or syringe.

1.33.1.3. Sign back into stock any unused or unopened vial, syringe, or ampule using the "received" column on AF Form 579.

1.33.1.4. Show all controlled substances administered to a patient in two places on the SF 517. Measure these substances by milliliter (ml) or milligrams (mg) as appropriate.

1.33.1.5. Show incremental doses of controlled substances on the front of SF 517 and enter the time given.

1.33.1.6. Enter a summary of all controlled substances administered to a patient and partial unit dosages wasted on the anesthesia record or any other local form. The case anesthesia personnel must sign this summary entry. If personnel waste, drop, or contaminate partial unit doses, a nurse or physician must co-sign the summary entry.

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

1.33.3. Report incorrect balances and unaccountable substances to the Pharmacy Officer and the Chief of Surgery or the Chief Medical Staff. Promptly file AF Form 765, **Medical Treatment Facility Incident Statement**. Also complete AF Form 85, **Inventory Adjustment Voucher**, to correct the inventory.

1.33.4. Availability of Anesthetics. Anesthesia personnel:

1.33.4.1. Must have induction agents such as sodium pentothal, etomidate, and methohexital immediately available.

1.33.4.2. Control these drugs according to guidelines outlined in Section N, Pharmacy services.

1.33.4.3. During the elective surgical schedule, stock all anesthesia carts with adequate supplies of an induction agent.

1.33.4.4. Stock emergency and obstetrical anesthesia carts with adequate supplies ready for use at all times. Stock additional supplies along with other anesthesia drugs in a controlled area, work-room, and/or refrigerator. **NOTE:** Although personnel must keep an accurate record of incremental doses of drugs administered on SF 517, they need not record this class of drug on AF Form 579 under usual circumstances.

1.34. Processing and Completing Records.

1.34.1. The Anesthesiologist or the CRNA (the latter with the concurrence of the physician who countersigned the preoperative assessment) will:

1.34.1.1. Establish an anesthetic plan and will record their findings on the SF 517, **Clinical Record-Anesthesia**.

1.34.1.2. Writes preoperative orders for the patient on the AF Form 3066, **Doctor's Order**.

1.34.1.3. Accompany the patient from the procedure room to the Post Anesthesia Care Unit (PACU).

1.34.1.4. Promptly complete the anesthesia record at the end of each procedure.

1.34.2. Procedures performed by anesthesia providers not requiring an anesthesia record should be documented in the medical record.

1.34.3. The PACU nurse records all pertinent information regarding the patient's recovery from anesthesia. Local policy will define the parameters to be used when determining whether to transfer/discharge a patient.

1.34.3.1. The physiological parameters at the time of 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.

1.34.4. The unit nurse receiving the patient makes an entry on the patient's chart.

1.35. Conscious Sedation.

1.35.1. Conscious sedation is defined by the use of pharmacologic and/or nonpharmacologic modalities to produce a state of minimally depressed consciousness. Such a state will not interfere with a patient's ability to independently and continuously maintain a patent airway, and to appropriately respond to physical stimulation and/or verbal commands.

1.35.2. Facilities must develop institutional protocols for use of conscious sedation in all patient care settings. **NOTE:** The Chief of Anesthesia ensures procedures are standardized throughout the MTF, regardless of where the sedation is administered.

1.35.3. Appropriately privileged providers determine the selection and use of conscious intravenous (IV) sedation.

1.35.4. Medical personnel must monitor consciously sedated patients and prepare for emergencies by having:

1.35.4.1. The help of a qualified assistant. A qualified assistant is defined as one who meets the following requirements:

Current Basic Life Support certification (ACLS certification is recommended, but not required).

Familiarity with the cardiovascular and respiratory side effects of the agents used.

Medical Technicians will also complete QTP 4NOX1-1 Module 11, *Medication Administration*.

1.35.4.2. An emergency notification system.

1.35.4.3. Monitoring equipment (to include monitoring of blood pressure, cardiac rhythm, and oxygen saturation).

1.35.4.4. Resuscitative equipment and medications readily available.

1.35.5. A privileged provider, or a qualified registered nurse may infuse IV medication.

1.35.6. A technician may administer supplemental doses only with a waiver from MAJCOM, documented training, and the direct visual supervision of a privileged provider.

Section 1K—Central Supply Service (CSS)

1.36. The Operating Room (OR) Supervisor:

1.36.1. Oversees the CSS. **EXCEPTION:** In facilities where there is no OR, the Chief Nurse delegates responsibility for the CSS.

1.36.2. Works closely with the Chief of the Surgical Service and Director, Dental Services to develop CSS policies and procedures. **NOTE:** In facilities using the central processing and distribution system (CPD), the Operating Room supervisor assumes responsibility for central supply services.

1.36.3. Collaborates with Dental Services to combine centralized processing of patient care equipment and supplies.

1.37. Functions of CSS Personnel:

1.37.1. Provide a central sterilizing supply service for medical equipment and supplies required for patient care.

1.37.2. Process and distribute supplies to and from using units.

1.37.3. Establish written operating policies and procedures.

- 1.37.4. Publish a list of all available items and classify it according to local policy.
- 1.37.5. Maintain specialized medical equipment used in patient care areas.
- 1.37.6. Use DD Form 1150, **Request for Issue and Turn In**, as a central sterile supply issue record, or a preprinted list of available items. If using locally preprinted forms, fill out only one copy.

1.38. Requesting, Issuing, and Returning Central Supply Items. (Refer also to AFPAM 41-215, *Central Supply Services*)

- 1.38.1. Unit personnel prepare DD Form 1150 or the preprinted form and submit it to CSS using local policy.
- 1.38.2. Central supply picks up and delivers items according to a published schedule and/or facility policy. Emergency service may vary with each facility.
- 1.38.3. The central supply technician fills requests for supplies, noting available items in stock.
- 1.38.4. CSS personnel file DD Form 1150 in central sterile supply according to local policy.
- 1.38.5. Central supply cleans and sterilizes items according to manufacturer's recommendations and the facility's written policies.
- 1.38.6. Unit personnel wipe or rinse blood, as appropriate, from instruments when they finish using them.
- 1.38.7. The central supply technician verifies the return of all nondisposable items.
- 1.38.8. The sterility of a packaged item is event related and depends on the quality of the packaging material, storage conditions, and amount of handling to which the item is subject. Sterilized items that bear a time related expiration date should be returned to CSS for reprocessing before expiration and/or at any point in which the package integrity is in question.
- 1.38.9. Refer to local procedures for destroying disposable syringes and needles.

Section 1L—Clinical Laboratory and Anatomic Pathology Services

1.39. General Guidance.

- 1.39.1. Each MTF follows DoD standards of laboratory practice defined in the DoD *Clinical Laboratory Improvement Program (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, JCAHO, or other accreditation program approved by OASD(HA).
- 1.39.2. Each MTF prepares a laboratory guide with:
 - 1.39.2.1. A list of specific examinations and services it provides.
 - 1.39.2.2. Specific instructions covering the submission of specimens and requests.

1.40. Laboratory Services.

1.40.1. The MDG/CC designates a Chief, 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 may assume the additional duty of Chief, Laboratory Services.

1.40.2. The MDG/CC designates a Medical Director, who in most cases, will be a pathologist. **EXCEPTION:** The MDG/CC appoints a staff physician trained IAW DoD Clinical Laboratory Improvement Program (DoD CLIP) requirements as medical director in situations in which there is no assigned pathologist.

1.41. Blood Donor Centers (BDC).

1.41.1. The laboratory chief ensures the blood bank or donor center operates under a trained and experienced staff and compatibility testing procedures adequately safeguard the intended recipient.

1.41.2. The operation conforms to military directives and the Good Manufacturing Practices (GMP) published by the Department of Health and Human Services and guidance from the Armed Services Blood Program Office (ASBPO).

1.41.3. Patients, or their guardians, in the case of minors, who expect to receive blood (based on the guidance in the Maximum Surgical Blood Ordering Schedules) or blood-product transfusions must complete AF Form 1225, **Informed Consent for Blood Transfusion**. This form describes some of the common risks associated with transfusions and the alternative of a predeposit autologous blood program.

1.42. Anatomic Pathology Services.

1.42.1. Air Force medical facilities should seek cytologic services through Air Force or DoD cytology centers.

1.42.2. The MDG/CC coordinates with the Armed Forces Institute of Pathology (AFIP) on the use of contracted commercial laboratories for cytopathology services.

1.42.3. All histopathology or cytopathology cases performed by a contracted civilian pathology service and requiring a second opinion are forwarded to the Armed Forces Institute of Pathology, Bldg. 54, 16th Street N.W., Washington DC 20306-6000.

1.42.4. Cytology centers help MTFs develop quality improvement standards for referring cytopathology specimens to commercial laboratories.

Section 1M—Radiology and Radiologic Services

1.43. Radiologists.

1.43.1. Only physicians decide when to use intravenous contrast media for patients undergoing a diagnostic contrast x-ray examination.

1.44. Technicians.

1.44.1. Must complete a locally developed, formal, documented, skill-verification training program before administering intravenous contrast media.

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

1.45. When Early Interpretation is Required.

1.45.1. The requesting provider enters the notation "Wet Reading" in the top border of SF 519B, **Radiologic Consultation Request/Report**. If electronic entry is used, the request will be annotated "Wet Reading."

1.45.2. The radiologist providing the interpretation contacts the referring provider by telephone, electronically, in person, or by handwritten memorandum.

1.45.3. Radiologists:

1.45.3.1. Must contact the referring provider as soon as possible when they find serious abnormalities.

1.45.3.2. Document early notification on the final radiological report, SF 519B, to include the person notified, the date, time, and method of notification.

1.46. Completion of Reports.

1.46.1. Radiologists complete typed reports within 2 workdays (from completion of the examination) in facilities with full-time military or civilian radiologists. **EXCEPTION:** In all other facilities, executive management ensure radiologists' reports are typed and completed as quickly as possible.

1.47. Film Loaning and Transfer.

1.47.1. Films, or copies of the original films, may be temporarily or permanently loaned to another military facility.

1.47.2. Personnel at the originating facility maintain AF Form 614, **Charge Out Record**, in place of the original film file envelope. **NOTE:** Electronic chargeout of record is an acceptable alternative.

1.47.3. If the file is permanently transferred to another medical facility, personnel retire the original envelope or AF Form 614, with the film files for that year. **NOTE:** In most instances, personnel send out film only when the receiving MTF asks for it.

1.47.4. Films may be hand-carried by the patient by order of the attending practitioner.

1.47.5. Patients may hand-carry mammography films, have them sent to a new facility, or request that they be forwarded after the patient's arrival at a new facility.

1.48. Contract Employees' X-Ray Films.

1.48.1. X-rays taken of contract employees during their termination examinations become part of the employees' employment records, as stated in the employment agreement.

1.49. Radiation Safety Surveys.

1.49.1. Facilities must perform and maintain documentation of radiation safety surveys according to:

Title 10 and 21 CFR.

JCAHO.

The Nuclear Regulatory Commission.
USAF Radioactive Materials permits
Applicable Air Force policy.

1.50. Records of Calibrations.

1.50.1. Keep calibrations of all diagnostic x-ray machines, nuclear medicine gamma cameras, uptake probes, dose calibrators, and radiotherapy devices and sources in accordance with established standards.

Section 1N—Pharmacy Services

1.51. Organization.

1.51.1. The MDG/CC ensures that the pharmacy operates under the supervision of a pharmacist in accordance with federal laws, Air Force policy, and accepted standards of practice as defined by:

JCAHO.

The American Society of Health-Systems Pharmacists (ASHP).

The American Pharmaceutical Association (APhA).

EXCEPTION: A designated medical corps officer may supervise a pharmacy as a "pharmacy officer" when a pharmacist is not available.

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

1.52. Policies and Procedures.

1.52.1. Pharmacies develop policies and procedures which provide:

1.52.1.1. Pharmaceutical care consistent with medical staff and patient needs.

1.52.1.2. Security measures to prevent the loss of pharmacy stock and unauthorized entry into the pharmacy.

1.52.1.3. A perpetual inventory of Schedule II, III, IV and V drugs.

1.52.2. Pharmacists and appropriately trained pharmacy technicians offer to counsel patients regarding drug therapy in general, and their newly prescribed medications in particular.

1.52.3. Pharmacies procure, dispense, recommend, or use only drugs approved by the FDA.

EXCEPTION: Pharmacies may dispense approved investigational drugs used in a clinical investigation project using guidelines in AFI 40-403, *Clinical Investigation and Human Test Subjects in the Medical Service*.

1.52.3.1. The pharmacy is the sole 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) to a patient, for self-administration, during the course of a patient visit.

- 1.52.3.2. Pharmacists review all pharmaceutical orders occurring after-hours and ensure that the dispensed medications are included in the automated patient profile.
- 1.52.3.3. Providers note the medication dispensed and any medications administered during the treatment on the patients' SF 600, **Health Record Chronological Record of Medical Care**, or SF 603, **Health Record-Dental**.
- 1.52.4. The Pharmacy Flight Commander or Element Chief supervises drug storage and preparation areas throughout the MTF.
- 1.52.5. Pharmacies fill prescriptions or bulk-drug requests upon receipt of a prescription or bulk drug request.
- 1.52.6. Pharmacies and prescribing providers must use formulary drugs.
- 1.52.7. Pharmacies may fill prescriptions written by DoD providers for brand-name drugs with an FDA approved generic equivalent when available.
- 1.52.8. Pharmacies must fill 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 in order to fill civilian prescriptions.
- 1.52.9. Pharmacies honor prescriptions from:
- 1.52.9.1. Privileged providers of the Uniformed Services, as described in AFI 44-119, *Management of Clinical Performance Improvement*, and their civilian counterparts. Providers who are not employees of the United States government must be duly licensed by the jurisdiction in which the MTF is located.
 - 1.52.9.2. Veterinarians of the Uniformed Services.
 - 1.52.9.3. Privileged providers of consulting referral military facilities.
- 1.52.10. The pharmacy maintains a current AF Form 2383, **Prescriber Information**, for all assigned providers authorized to write prescriptions.
- 1.52.11. Pharmacies may provide drugs not included in the formulary on a one-time basis, with MDG/CC approval. **NOTE:** Before pharmacies purchase the drug for stock, the Pharmacy and Therapeutics Function evaluates it for possible addition to the formulary.
- 1.52.12. Prescriptions from referral facilities for medications not on the formulary are dealt with as above. Referral facilities must provide patients with at least a 60-day supply of medication when they are undergoing long-term therapy.
- 1.52.13. The local MTF arranges for or provides drugs to treat conditions such as immunodeficiency diseases, transplants, and other rare conditions. **NOTE:** In situations in which the cost to the MTF (excluding Medical Centers) exceeds \$6000 per patient per year, the Air Force High Dollar Drug Program at Wright-Patterson AFB should be utilized.
- 1.52.14. Pharmacies need not honor prescriptions from nonreferral military medical facilities for drugs not on the formulary.
- 1.52.15. 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 should be accomplished using disease management guidelines developed cooperatively between members of the medical staff and the pharmacy.

1.52.16. 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, or alterations.

1.53. The Pharmacy and Therapeutics Function.

1.53.1. This medical staff function must meet at least 4 times a year. It must have at least six members:

Two physicians.

One dentist.

One pharmacist.

The chief of medical logistics management.

One nurse.

1.53.2. Other interested personnel whose attendance can improve operations should be included.

1.53.3. Functions:

1.53.3.1. Reviews policies, acquisition, and use of drugs within the MTF and at remote sites for Independent Duty Medical Technicians (IDMT's).

1.53.3.2. Reviews medication errors.

1.53.3.3. Reviews adverse reactions to drugs.

1.53.3.4. Evaluates clinical data on new drugs and preparations requested for MTF use.

1.53.4. Providers request new drugs by submitting DD Form 2081, **New Drug Request**.

1.54. The Pharmacy.

1.54.1. Develops and maintains a formulary that lists drugs and pharmaceutical preparations approved for use by the Pharmacy and Therapeutics Function, and/or by the Pharmacoeconomic Center basic core list.

1.54.1.1. Includes policies and procedures adopted by the Pharmacy and Therapeutics Function and approved by the MTF commander.

1.54.2. Publishes a revised formulary annually.

1.54.2.1. Accounts for all AF Forms 579, **Controlled Substances Register**.

1.54.2.1.1. Issues a new, serially numbered AF Form 579 to the inpatient unit or clinic as needed.

1.54.2.1.2. Brings forward the balance and serial number from the previous sheet.

1.54.2.1.3. Accepts and maintains all completed forms.

1.54.2.1.4. Initiates a new series of forms each calendar year after collecting all incomplete forms from the previous year.

1.54.2.1.5. Uses automated methods to account for AF Forms 579 whenever possible.

1.55. Drug Inventory.

1.55.1. The MTF:

1.55.1.1. Maintains controlled substances according to state and federal regulations.

1.55.1.2. Must conduct a complete and accurate inventory of all controlled substances every 2 years on 1 May (or the first duty day following) of odd-numbered years.

1.55.2. Inventory Schedule II drugs separately from Schedule III, IV, and V drugs.

1.55.3. The pharmacy maintains the files of inpatient unit and clinic inventories.

1.55.4. Facilities inventory newly controlled substances on the published effective date. Thereafter, include each substance in the biennial inventory.

1.56. Inventorying Controlled Drugs.

1.56.1. The MDG/CC appoints a disinterested officer, a member of one of the top three NCO grades, or a civilian of comparable grade to inventory the Schedule II controlled drugs at least monthly. Personnel conduct the inventory in the facility's pharmacy, and in all other locations in which Schedule II controlled substances are maintained.

1.56.2. Inventory personnel adjust shortages and overages on AF Form 85, **Inventory Adjustment Voucher**.

1.56.3. Inventory officers record the balance on each AF Form 582, **Pharmacy Stock Record**, or automated product (spreadsheet, data base or work processing reports) and AF Form 579, including the date of inspection, action taken, and signature.

1.57. Accountability of Controlled Substances.

1.57.1. 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:

1.57.1.1. Ethyl alcohol.

1.57.1.2. Alcoholic beverages used for medicinal purposes (wine, whiskey, beer, etc.)

1.57.1.3. Other drugs designated for control by the MTF Pharmacy and Therapeutics Committee.

1.58. Securing Drugs.

1.58.1. 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 secured areas. With the exception of authorized pharmacy personnel, only licensed clinical staff may be authorized access to controlled substances storage areas.

1.58.2. In the pharmacy, personnel store Schedule II, III, IV, and V controlled drugs in either a vault or a safe.

1.58.3. Schedule II drugs must be stored in a substantial double-locked cabinet in patient care areas outside the pharmacy.

1.59. Writing Prescriptions.

1.59.1. Authorized Providers Must:

1.59.1.1. Write prescriptions in ink on AF Form 781, **Multiple Item Prescription**, if not using the physician order entry function of the Composite Healthcare System (CHCS).

1.59.1.2. Write no more than 3 prescriptions on AF Form 781.

1.59.1.3. Draw a line through unused blocks.

1.59.1.4. Separate prescriptions for drugs listed in Schedule II from those in Schedules III, IV, and V.

1.59.1.5. Not prescribe noncontrolled drugs on the same form as controlled drugs.

1.59.1.6. Review patient identification data for completeness.

1.59.1.7. Write out the patient's full name.

1.59.1.8. Use their prescriber name stamp on all prescriptions.

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

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

1.59.4. The prescribing provider signs prescriptions or documents them via the CHCS electronic signature and dates them on the day of issue. Prescriptions must show:

1.59.4.1. The full name and address of the patient.

1.59.4.2. The name, address and Drug Enforcement Administration (DEA) registration number of the provider. **EXCEPTIONS:** Military and civil service providers show their Social Security Numbers and their branch of service or agency instead of a DEA registry number. Non-US physicians and dentists assigned to overseas facilities use medical or dental license numbers instead of a DEA number.

1.59.4.3. The prescribed amounts of controlled substances will be spelled out, in addition to the written numeral amount; unless the provider is using the physician order entry function of CHCS.

1.60. Packaging Prescriptions.

1.60.1. 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).

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

1.60.3. Prepackaged medications dispensed by a physician, dentist, physician assistant, or nurse practitioner directly to the patient do not require prescriptions. Note the prescribed treatment on the patient's SF 600, **Health Record-Chronological Record of Medical Care**, or SF 603, **Health Record-Dental**.

1.61. Labeling Prescriptions.

1.61.1. Only pharmacy personnel are authorized to label and transfer medications to different containers.

1.61.2. Prepare a label for each prescription and fasten it securely to the container before dispensing. The label must conform to the requirements stated in the *Food, Drug, and Cosmetic Act*, Sections 502 and 503 or 21 U.S.C. Sections 352 and 353. Give the patient additional information when necessary to ensure that they use and store the drugs properly.

1.62. Refilling Prescriptions.

1.62.1. The provider authorizes a pharmacy to refill certain prescriptions by giving refill information on the original prescription.

1.62.2. Pharmacies may not refill prescriptions for drugs listed in Schedule II. Pharmacies may not refill prescriptions for drugs listed in Schedules III, IV, and V more than 6 months after the date of issue or more than 5 times total.

1.62.3. Pharmacies normally honor prescription refills only if they have the original prescription on file. Pharmacists may request transfer of an original prescription provided that the validity of the prescription (e.g. refills are available, 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, the facility, and the date transferred. Consider the prescription on file when MTF's share a computerized prescription record database.

1.63. Mailing Medications.

1.63.1. Routine mailing of prescriptions to eligible beneficiaries, by MTF pharmacies is not authorized.

1.63.1.1. Prescriptions may be mailed to patients in an emergency or when personal hardship keeps them from leaving their homes. Follow postal service regulations for mailing controlled substances.

1.63.2. Encourage patients requesting mail order pharmacy services to enroll in TRICARE PRIME and to use the contract National Mail Order Pharmacy program.

1.64. Inpatient Pharmacy Services.

1.64.1. The Pharmacy Flight Commander or Element Chief:

1.64.1.1. Determines the extent of services.

1.64.1.2. Ensures that a pharmacist reviews all inpatient medication orders.

1.64.2. Unit Dose Drug Distribution.

1.64.2.1. Pharmacies use the unit dose system to the maximum extent possible. This system provides inpatient drugs under a direct copy of AF Form 3066, **Doctor's Orders**. Keep a patient medication profile on AF Form 3069, **Medication Administration Record**, or an automated product.

1.65. Sterile Product Preparation.

1.65.1. A pharmacist supervises the preparation of intravenous admixtures by pharmacy staff and ensures personnel preparing admixtures outside of the pharmacy are trained to follow the American Society of Health-System Pharmacists (ASHP) guidelines for the preparation of sterile products.

1.65.2. A pharmacist ensures sterile products prepared by other than pharmacy personnel follow appropriate standards.

1.66. Bulk Compounding.

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

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

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

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

1.66.1.4. AF Form 781, **Multiple Item Prescription**, to account for all controlled drugs used in compounding.

Section 10—Optometry Service

1.67. Policies and Procedures.

1.67.1. Optometrists:

1.67.1.1. Ensure vision, optical and eye health readiness of forces.

1.67.1.2. Support the flying mission through examining and treating the eyes and vision of aircrew members and by prescribing spectacles, contact lenses, and other optical devices.

1.68. Using Therapeutic Agents.

1.68.1. Optometrists may prescribe drugs for topical ocular therapy and systemic management of ocular disorders, within the scope of practice of their clinical privileges.

1.69. Contact Lens Services.

1.69.1. Aviator Contact Lens Program has priority over all other contact lens services.

1.69.2. For individuals with medical conditions that require contact lenses optometrists may prescribe and issue contact lenses at government expense.

1.69.3. The MDG/CC determines whether to provide cosmetic or elective contact lenses when, for example, unique military or special duty requirements exist.

1.69.4. Patients pay for lenses ordered for cosmetic or elective reasons.

1.70. Documentation of Optometry Services. Use:

AF Form 781, **Multiple Item Prescription**, when prescribing therapeutic agents.

AF Form 1721, **Spectacle Prescription**, to provide patients with a prescription that civilian spectacle suppliers may fill.

AF Form 1722, **Optometric Examination Record**, DD Form 741, **Eye Consultation**, or an overprinted SF 600, **Health Record -Chronological Record of Medical Care**, for routine eye examinations.

DD Form 771, **Eyewear Prescription**, when Spectacle Request Transmission System (SRTS) is not available.

SF 88, **Report of Medical Examination**, for physicals.

SF 513, **Consultation Sheet**, for referrals when CHCS does not provide a source for referral.

SF 600, **Health Record-Chronological Record of Medical Care**, for follow-up and urgent care visits.

DD Form 2351, **Medical Examination Review Board (DODMERB) Report of Medical Examination**, for USAF Academy, Reserve Officer Training Corps (ROTC), and Uniformed Services University of the Health Sciences (USUHS) applicants.

Section 1P—Occupational Medicine**1.71. Work Related Illness and Injuries.**

1.71.1. Effective prevention of work related illnesses and injuries begins with all medical providers developing a working knowledge of the major occupational activities taking place at their assigned installation(s). All inprocessing medical providers must receive a briefing on the major industrial activities at their base. Particular discussion should focus on how medical illnesses and injuries can arise from these activities, and how medical providers can play a role in identifying and preventing these occurrences. Work places which have experienced occupational illnesses or injuries should receive special focus.

1.71.2. Medical providers must identify and report all suspected or confirmed occupationally related illnesses and injuries to the facility's Public Health Office. Medical providers should also consult with the Public Health Office in order to effect appropriate preventive measures.

1.71.3. Whenever a military member is placed on quarters due to a work related circumstance, a brief summary of the circumstance should be annotated on the quarter's form. A copy of this form should then be forwarded to Public Health for further action. Refer also to AFI 48-123, *Medical Examination & Standards*.

1.72. Care of DoD Civilians Injured or Ill in the Line of Duty.

1.72.1. Eligible DoD employees who become ill or who are injured in the line of duty, may choose to obtain care from the military health system or from their private healthcare provider. Their care in medical treatment facilities is authorized and discussed in AFH 41-114, *Military Health Services System (MHSS) Matrix*.

Section 1Q—Occupational and Physical Therapy Services**1.73. Chief of Occupational and/or Physical Therapy.**

1.73.1. A certified, privileged occupational therapist must be assigned to a facility with an occupational therapy service. A licensed, privileged physical therapist must be assigned to a facility with a physical therapy service.

1.74. Requests for Occupational and/or Physical Therapy.

1.74.1. The following personnel may request service on an SF 513, **Medical Record - Consultation Sheet**, or on a AF Form 1535, **Physical Therapy Consultation**. **NOTE:** Occupational Therapy may also accept consultations written on this form.

Medical officers.

Dental officers.

Other privileged providers.

Other uniformed services providers.

Civilian physicians and dentists.

1.75. Documentation.

1.75.1. Occupational Therapy. Document patient evaluation, treatment plan, and goals on SF 513 or AF Form 1535, **Physical Therapy Consultation**. Document patient treatment on either the SF 509, SF 600. Document patient visits on the AF Form 1412, **Occupational Therapy Treatment Record**.

1.75.2. Physical Therapy: Document patient evaluation, treatment plan, and goals on SF 513 or the AF 1535, document patient treatment on the SF 509, SF 600, AF Form 1535, or AF Form 1536, **Physical Therapy Consultation, Continuation Sheet**.

Section 1R—Continuity of Care for Mental Health Patients**1.76. Initial Evaluations.**

1.76.1. Mental Health clinics must ensure that referred patients who fail to keep their initial mental health appointments are contacted and rescheduled if appropriate, as soon as possible. The referring provider must also be notified whenever a patient fails to keep their initial appointment. **NOTE:** This requirement does not apply to self-referred patients.

1.76.2. Each facility must develop a mechanism to track “high risk” patients. This tracking system should be designed to prevent these patients from canceling appointments, or failing to keep appointments, without speaking directly to a provider. Such individuals may be particularly well suited for case management.

1.76.3. Both Family Advocacy and Mental Health will ensure that individuals known to be at high risk for lethal or dangerous behavior are identified to appropriate on-call providers and emergency room staff. Patient confidentiality will be maintained.

1.77. Evacuation and Hospitalization.

1.77.1. US military commanders in foreign countries may evacuate or hospitalize beneficiaries without their consent only when the laws of the host country grant them this authority.

1.78. Nonmilitary Patients Returning to the United States.

1.78.1. Department of Health and Human Services (DHHS) may provide care for nonmilitary patients, including alien dependents of United States (US) citizens, when they return to the United States (Public Law 86-571, 42 United States Code [U.S.C.]1313).

1.78.2. DHHS may intervene when patients are not releasable to their next of kin and no longer qualify for military hospitalization.

1.78.3. DHHS acts upon requests of the Department of State (*45 Code of Federal Regulations [CFR] 211, 212*).

1.78.4. Overseas commanders must ask local US diplomatic representatives to make arrangements through the Department of State with DHHS for patients returning to the United States. **NOTE:** These instructions do not limit the authority to detain emergency medical cases temporarily pending compliance with the laws of the host government.

*Section IS—Administrative Procedures Pertaining to Diagnostic Test Results***1.79. MTF Requirements for Tracking Test Results.**

1.79.1. MTFs must:

1.79.1.1. Implement procedures for tracking diagnostic tests to ensure timely return to providers.

1.79.1.2. Define standards for the timely completion of each phase of process.

1.79.1.3. Assign responsibility for monitoring designated functions.

1.79.1.4. Develop and promulgate provider and patient responsibilities.

1.79.1.5. Implement procedures for locating patients and notifying them of test outcomes.

*Section IT—Electrocardiography***1.80. Responsibilities.**

1.80.1. Medical personnel perform electrocardiograms (ECG) so that the required number of tracings can be prepared, either as originals or by a suitable reproduction process which provides clear, legible, non-fading records.

1.80.2. MTFs keep an original electrocardiogram file as a permanent part of the medical record and send an additional original or a copy to the clinic or physician requesting the ECG.

1.80.3. MTF's without permanently assigned Cardiology support should develop a MOU with an appropriate civilian (or military) facility in order to ensure that fax consultation may be obtained in cases in which expert ECG interpretation is needed. This is especially critical for MTF's which provide emergency and /or critical care services.

*Section IU—Patient Transfers***1.81. Required Attendants.**

1.81.1. MTFs establish written guidelines for assigning medical attendants during emergency transfers.

1.81.1.1. A physician designates the required skill level of attendants in each instance.

*Section IV—Departmental Staff Procedures***1.82. Title of Doctor.**

1.82.1. Address medical service personnel with doctoral degrees as "Doctor" in connection with the performance of their duties. **NOTE:** In official communications, address officers of the AFMS by their military rank.

1.83. Name Tags.

1.83.1. Name tags worn on the Air Force uniform by members of the AFMS must conform to current policies regarding Air Force uniforms. **NOTE:** Optional name tags on hospital work clothing must provide adequate specialty identification of medical personnel.

1.83.1.1. Use the following designations as described:

1.83.1.1.1. Dr. and the last name, for physicians, dentists, and providers possessing doctorate level degrees.

1.83.1.1.2. Grade and last name of individual on the top line and specialty on the bottom line for officers whose grade insignia does not show on work clothing.

1.83.1.1.3. Last name of the individual on the top line and specialty on the bottom line for officers whose grade insignia shows on work clothing. If enlisted personnel must wear such name tags, they are furnished to them without cost to the individual. **NOTE:** Personnel may not wear name tags authorized for optional wear on service or utility uniforms.

Section IW—Commercial Insurance Company Physical Examinations

1.84. Completion of Forms.

1.84.1. Privileged providers may complete commercial insurance company physical examination forms on Air Force beneficiaries. Any reimbursement received (i.e. from the Insurance Company) will be submitted to an appropriate Resource Management Office.

Section IX—Using Chaperones

1.85. Actions Necessary to Implement Air Force Policy in AFD 44-1, Medical Operations.

1.85.1. Each MTF develops local procedures regarding the use of chaperones. At a minimum, these local procedures must contain:

1.85.1.1. Assurance of privacy for examination and treatment.

1.85.1.2. Strict privacy considerations for robing and disrobing.

1.85.1.3. Circumstances for presence of a third party at the request of the patient or provider.

1.85.1.4. Circumstances for presence of a third party during the exposure, examination, or treatment of patient's genitalia, rectum, or female breasts.

1.85.1.5. Communication to the patient of the nature and purpose of the examination or treatment and extent and purpose of disrobing.

1.85.1.6. Education and training requirements for providers and staff on the role of third parties, procedures for identifying and reporting suspected misconduct, and procedures for resolving questions of the use of third parties.

EXCEPTION: During emergencies or life-threatening situations, medical personnel are not required to offer the presence of a third party.

Section IY—Medical Personnel Rest Standards

1.86. Policy on Rest Standards: Each MTF writes policy stating:

- 1.86.1. The minimum number of hours of uninterrupted rest between shifts of providing direct patient care.
- 1.86.2. The maximum number of consecutive hours of direct patient care allowed.
- 1.86.3. The waiver process when those standards must be broken for unusual circumstances.

Section 1Z—Reportable Diseases and Conditions**1.87. What and How To Report.**

- 1.87.1. Providers report diseases and conditions of public health or military significance to the public health section according to AFI 48-105, *Surveillance, Prevention and Control of Diseases and Conditions of Public Health or Military Significance*.
- 1.87.2. Providers report all suspected or confirmed occupational illnesses and injuries (including work related musculoskeletal disorders) to the Public Health or safety office in accordance with AFI 91-204, *Safety Investigations and Reports*.

Section IAA—Off-Duty Employment**1.88. To Whom This Applies.**

- 1.88.1. Medical Corps, Dental Corps, Nurse Corps, Biomedical Sciences Corps, and Medical Service Corps. Also applies to civilian and contract personnel who would be members of the foregoing corps if they were in a commissioned status.
- 1.88.2. Civilian equivalents only need to comply with provisions of Joint Ethics Regulation (JER) concerning off-duty employment. The MDG/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.

1.89. The MDG/CC Responsibilities.

- 1.89.1. Ensures that off-duty commitments, both compensated and uncompensated, do not interfere with the individual's military duties.
- 1.89.2. Denies or terminates off-duty employment if employment interferes with the MTF mission.

1.90. Requirements.

- 1.90.1. All personnel attend a briefing upon arrival at each new duty station, and then annually, on the provisions of this section. Commanders for officers or civilians permanently assigned to another organization but regularly performing duties within an MTF must have a written agreement with the MDG/CC on methods of fulfilling these requirements.
- 1.90.2. Internal review procedures monitor providers' compliance with off-duty employment provisions at least annually.

1.91. Types of Services Which Can be Provided as Off-Duty Employment.

1.91.1. The Air Force encourages healthcare providers to teach, write and publish.

1.91.2. Providers may serve other than DoD beneficiaries only when there is documented community or emergency need. The local professional society writes a statement documenting this need. This document will be filed with other documentation pertaining to a provider's off-duty employment.

1.92. Requirements and Restrictions for Off Duty Employment.

1.92.1. All military personnel on active duty must first obtain the written permission of their commanders.

1.92.2. Squadron Commander's or higher authorities may withdraw permission for personnel to engage in off-duty employment at any time.

1.92.3. Off-duty employment shall not exceed 16 hours per week. **EXCEPTION:** The MDG/CC must approve periods that exceed 16 hours per week. This does not apply to off duty employment performed on official leave.

1.92.4. A period of at least 6 hours rest must elapse between the end of the off-duty employment and the start of the duty period.

1.92.5. Military personnel may not work at a site that is not close enough to allow the provider to return promptly if military duties require it.

1.92.6. For off-duty employment during nonduty hours of normal duty days, providers must be able to return to the MTF within 2 hours by land. Personnel may not travel by air beyond acceptable land travel distances regardless of travel time. For off-duty employment during nonduty days or on official leave, personnel are not restricted by the 2 hour return time to the MTF.

1.92.7. DoD healthcare providers in graduate training programs may not engage in off-duty employment.

1.92.8. DoD 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.

1.92.9. DoD healthcare providers may not provide off duty healthcare service:

1.92.9.1. On military premises.

1.92.9.2. Involving expense to the federal government.

1.92.9.3. Using military equipment, personnel, or supplies.

1.92.10. 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. **EXCEPTION:** Active duty military dentists "moonlighting" in the civilian sector may provide care to individuals enrolled in the TRICARE Family Member Dental plan, IAW Health Affairs Policy # 97-019, dated 10 December 1996.

1.92.11. Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) payments will be disallowed on any claim from a CHAMPUS provider in those instances in which a DoD healthcare provider gives direct healthcare services to a DoD beneficiary.

1.92.12. A ruling by the Assistant Comptroller General to the United States (47 Comptroller General 505, 1 April 1968) prohibits payment by the VA to federally employed providers also engaged in private practice for services rendered persons authorized outpatient medical treatment at VA expense.

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

1.92.14. 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 CHAMPUS or directly from the patient for services provided by a DoD healthcare provider.

1.92.15. Individual healthcare providers on off-duty assignments must comply with local licensing requirements, DEA requirements, and provide their own personal liability coverage. The Air Force is not responsible for the actions of individuals working in off-duty jobs.

1.92.16. DoD healthcare providers apply for annual leave for any off-duty employment obligations that require absence during duty hours.

1.92.17. MDG/CCs must request a yearly statement from all officers of the Medical Service under their command stating:

1.92.17.1. Current off duty employment status

1.92.17.2. Whether current approval for off-duty employment is on file. **NOTE:** The commander responsible for a provider permanently assigned to another MTF enters into an agreement with the MDG/CC to decide how to fulfill this requirement.

1.92.18. Each healthcare provider approved for off-duty employment must:

1.92.18.1. Update the status of off-duty employment within 1 week of any change in that status

1.92.18.2. Submit a monthly summary to the MDG/CC stating the places, dates, and hours of off-duty employment performed. **EXCEPTION:** Personnel on terminal leave need not submit monthly summaries.

1.92.18.3. Submit information for annual survey as described above.

1.92.19. Contracts of civilian DoD healthcare providers must specify the restrictions on off-duty employment.

1.92.20. DoD military healthcare personnel's off-duty employment must not interfere with, or unfairly compete with, local civilian providers in the health professions. **EXCEPTION:** Personnel on terminal leave may compete for jobs with local civilian provides.

1.93. Request Processing.

1.93.1. Healthcare providers requesting permission to work in off-duty positions submit a request to their Squadron or Group Commander for approval. **NOTE:** Medical service personnel assigned or attached to tenant units or performing temporary duty submit their requests to the MDG/CC of the host MTF. Privileged providers must notify their facility credentials monitor.

1.93.2. Applicants describe the civilian position and state they fully understand and comply with Air Force and DoD policies.

1.93.3. The MDG/CC provides a copy of applicable Air Force policy to the prospective off-duty employer when employment is in an area of healthcare and obtains written verification that the employer accepts DoD restrictions on the provider's compensation and availability. **EXCEPTION:** The MDG/CC need not provide this information for personnel on terminal leave.

1.93.4. Individuals considering *locum tenens* in leave status must submit their requests in the prescribed manner. **EXCEPTION:** Does not apply to personnel on terminal leave.

1.93.5. The MTF maintains documentation relating to all healthcare providers' requests.

Chapter 2

HEALTHCARE FOR SPECIAL AND HIGH RISK POPULATIONS

Section 2A—Pseudofolliculitis Barbae

2.1. MTF Written Guidance for the Program.

2.1.1. MTFs develop written policies and procedures for managing personnel with pseudofolliculitis barbae.

2.1.2. Allowable length of facial hair during active inflammation is no longer than one quarter inch or as approved by the installation commander.

Section 2B—Acquired Immune Deficiency Syndrome (AIDS)

2.2. Infected Healthcare Workers.

2.2.1. Healthcare workers infected with the human immunodeficiency virus (HIV) will have their clinical privileges evaluated by the MTF Credentials Function.

2.2.2. The Credentials Function, in cooperation with the Infection Control Committee and the provider's personal physician, will recommend to the MDG/CC, the scope of practice for HIV infected healthcare workers. Clinical privileges will be reassessed on an annual basis, more frequently if the provider's clinical status changes. Any revocation, denial, or limitation of clinical privileges requires reporting to AFMOA/SGOC, and should be conducted IAW AFI 44-119, *Clinical Performance Improvement*.

2.3. HIV-Infected Patient Referral.

2.3.1. Medical personnel must refer Air Force active-duty members with suspected or newly diagnosed HIV infections to the 59th Medical Wing (Wilford Hall Medical Center), Lackland AFB, TX for definitive diagnosis, treatment, and disposition. **NOTE:** Suspicion means that initial testing (ELISA and Western Blot) is positive. See AFI 48-135, *Human Immunodeficiency Virus Program* for additional details.

Section 2C—Hepatitis B Infected Healthcare Workers

2.4. Hepatitis B Infected Healthcare Workers.

2.4.1. All healthcare workers are required to know whether or not they have been infected with hepatitis B IAW current Occupational Safety and Health Administration (OSHA) guidelines.

2.4.2. Healthcare workers who are at risk for transmitting hepatitis B, as manifest by the presence of serum hepatitis B e antigen (HBeAg), or positive hepatitis B DNA, will have their clinical privileges evaluated by the MTF Credentials Function. Recommendations should be referred to the MDG/CC, who will make the final determination on what privileges are granted in light of the provider's health status. Any revocation, denial, or limitation of clinical privileges requires reporting to AFMOA/SGOC, and should be conducted IAW AFI 44-119, *Clinical Performance Improvement*.

2.4.3. The Credentials Function, in cooperation with the Infection Control Committee, will recommend to the MDG/CC, the scope of practice for healthcare workers who are positive for HBeAg or Hepatitis B DNA.

Section 2D—Allergy Treatment

2.5. Responsibilities.

2.5.1. The Chief Consultant to the Air Force Surgeon General for Allergy-Immunology working through AFMOA/SGOC:

2.5.1.1. Organizes MTFs into allergy regions.

2.5.1.2. Designates a regional Allergy-Immunology Consultant.

2.5.2. Regional Consultants:

2.5.2.1. Establish and monitor the allergy services for each MTF within their region.

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

2.5.2.3. Visit local MTFs as needed.

2.5.3. The MDG/CC designates a trained or experienced physician responsible for the MTF allergy clinic.

2.5.4. Regional allergy support facilities provide Allergy Immunotherapy (AIT) extract kits to the supported MTFs.

2.6. Training for AIT Personnel.

2.6.1. OIC and technicians must receive introductory training in clinical allergy. In general, introductory training for technicians will be accomplished at either Walter Reed Army Medical Center or Wilford Hall Medical Center. Introductory physician training will ordinarily be accomplished at either Wilford Hall Medical Center or at a designated regional facility.

2.6.2. Technicians who dose and administer AIT must complete initial allergy specialty training of at least 20 working days duration.

2.6.3. Every 2 years, all personnel must attend refresher training of 5 days duration; in most cases, the refresher training will be conducted at a regional facility.

Section 2E—Family Planning

2.7. Family Planning Services Provided. (See also Section 2P).

2.7.1. MTFs will provide family planning services including contraceptives and sterilization. **NOTE:** Medical personnel who, for moral, ethical, religious, or professional grounds, object to providing family planning services need not perform or assist in such procedures unless their refusal poses life-threatening risks to the patient.

2.8. Sterilization. (See also Section 2P)

2.8.1. 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.

2.8.2. MTFs may perform sterilization procedures or refer the active-duty patient to a civilian or military MTF where the procedure is available.

2.9. Contraceptive Services. (See also Section 2P)

2.9.1. Contraceptive services include counseling, prescribing oral contraceptives, or issuing, inserting, or implanting devices or pharmaceuticals.

2.10. Induced Abortion.

2.10.1. Federal Law prohibits the use of DoD funds to pay for abortions in the Continental United States (CONUS). **EXCEPTION:** When a pregnancy would endanger a woman's life, Air Force medical personnel may induce abortion. The patient's physician and MDG/CC must certify in the medical record that the abortion is medically necessary.

2.10.2. Overseas MTFs may perform prepaid abortions only in cases where the patient is a victim of rape or incest.

2.10.3. Medical personnel who have a personal or moral objection to abortion need not assist in the procedure unless their refusal poses life-threatening risks to the patient. **NOTE:** This applies only to providers directly involved in performing the abortion procedure itself.

2.10.4. All patients (active duty and family members) must pay for the abortion, if permitted, at the current same-day-surgery rate published in *The Federal Register*.

2.10.5. When the patient is an adult or an emancipated minor, only the patient's consent for the abortion is required.

2.10.6. When the patient is a minor, the healthcare provider will obtain a valid consent in one of the following ways:

2.10.6.1. Through judgment by the MDG/CC (or a senior physician designated by the MDG/CC in the event that the MDG/CC is not a physician) that the minor is mature enough and well enough informed to give her own competent consent.

2.10.6.2. If the MDG/CC or senior designated physician decides that the minor is not sufficiently mature to give competent consent, at least one parent or legal guardian must consent to the procedure.

2.10.7. When prepaid abortion services are not available in an MTF, the MDG/CC shall develop other means to assure access for appropriate beneficiaries.

2.10.8. The Air Force will respect host nation laws regarding abortion. The consent procedures described above apply in the absence of controlling host nation laws or legal requirements.

2.10.9. Any complication resulting from an elective abortion procedure will be treated as would any other medical problem/complication.

Section 2F—Medical Care Related To Pregnancy

2.11. Standards.

2.11.1. 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, a MTF may need to develop more specific guidance.

2.11.2. In accordance with the Newborns' and Mothers Health Protection Act, the following standards are invoked:

2.11.2.1. Inpatient maternity care provided in the Air Force Medical System will be available for a minimum of 48 hours following a normal vaginal delivery, and for a minimum of 96 hours following delivery by Cesarean section. No additional approval or authorization is needed for care that falls within these guidelines.

2.11.2.2. The length of post delivery hospital care should involve consideration of maternal and infant health, a psycho-social assessment of the family's ability to care for a newborn infant, and the availability of follow-up care for both mother and infant.

2.11.2.3. 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.

2.11.2.4. 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.

2.12. High Risk Pregnancy Care.

2.12.1. Each MTF providing obstetrical care schedules multidisciplinary conferences to discuss high-risk patients.

2.13. Epidural Anesthesia for Delivery.

2.13.1. MTFs provide the option of epidural anesthesia for normal vaginal deliveries. Options include performing the procedure at the local MTF, referring the patient to local civilian care, and offering aeromedical evacuation to an MTF that has the ability to provide this service.

2.13.2. Prior to initiating epidural anesthesia, a provider privileged in routine obstetrics (obstetrician, family physician, or certified nurse midwife) must personally evaluate the maternal and fetal status, and progress of labor. This provider, or a similarly privileged provider fully familiar with the case, will remain in-hospital to manage the patient's progress.

2.13.3. A physician with cesarean privileges must concur with the plan of management, and both this provider and the facility must be prepared to initiate cesarean section within 30 minutes of the time the decision is made that cesarean section is indicated.

2.14. Use of Oxytocic Drugs in Pregnancy.

2.14.1. Prior to the initiation of an oxytocic agent, a provider privileged in routine obstetrics (obstetrician, family physician, or certified nurse midwife) must personally evaluate the maternal and fetal

status and progress of labor. This provider, or a similarly privileged provider fully familiar with the case, will remain in-hospital to manage the patient's progress.

2.14.1.1. A physician with cesarean section privileges must concur with the plan for using the oxytocic agent, the management of labor, and, along with the facility, must be prepared to initiate cesarean section within 30 minutes of the time the decision is made that cesarean section is indicated.

2.15. Restrictions for USAF Military Personnel During Pregnancy.

2.15.1. Duty Restriction Recommendations.

2.15.1.1. The patient's obstetrical healthcare provider, working with Public Health personnel, Bioenvironmental Engineers (BEE), Flight Medicine, and the patient's supervisor:

2.15.1.1.1. Restricts duty for active duty pregnant personnel based on the patient's work environment and overall medical condition.

2.15.1.1.2. Documents the duty restrictions on AF Form 422, **Physical Profile Serial Report**, and forwards the form to the Physical Exams section. A profile officer in either Flight Medicine or Occupational Medicine will ensure that the occupational hazards affecting pregnancy have been addressed in the restrictions, and that the member's profile is changed to a 4T, potentially disqualifying the member from deployment or a permanent change of station move. See AFI-36-2110, *Assignments*, for details.

2.15.1.1.3. The 4T, profile will remain in effect until the completion of any post-pregnancy convalescent leave. Physical Exams will ensure that the duty restrictions are sent to the member's Military Personnel Flight (MPF) and to the member's unit.

2.15.1.1.4. In all cases, the duty restriction should attempt to balance the patient's medical needs against the right of the military member to fully participate in unit activities.

2.15.1.2. The Air Force Reserve (AFRES) and the Air National Guard (ANG) medical units use (military) public health recommendations along with appropriate Reserve and Guard directives to complete AF Form 422.

2.15.1.3. For Individual Mobilization Augmentees (IMA), the unit of attachment:

2.15.1.3.1. Completes AF Form 422 using base public health procedures.

2.15.1.3.2. Sends a copy of the IMA's AF Form 422 to HQ ARPC/SGS for disposition.

2.16. Chemical Warfare Defense Ensemble (CWDE).

2.16.1. Pregnant Military Members:

2.16.1.1. May not participate in mask confidence training or in any in-chamber training.

2.16.1.2. The physical activities of pregnant military members will be in accordance with the limits/restrictions determined by the patient's healthcare provider. Recommendations of civilian healthcare providers will be reviewed by a military medical provider, who will, in turn, make a final duty recommendation to the military member and her supervisor.

2.16.1.3. Less than 20 weeks gestational age, wear CWDE until it no longer fits or use these ambient temperature guidelines:

2.16.1.3.1. If the temperature is below 70 degrees Fahrenheit, wear the full ensemble.

2.16.1.3.2. If the temperature is greater than 70 degrees Fahrenheit, wear only mask, hood, and helmet. Carry the chemical protective suit. Do not wear or carry the flak vest or web belt.

2.16.1.4. After 20 weeks gestation, must demonstrate proficiency in donning the mask at the beginning of an exercise or training. After completing the proficiency demonstration, carry the mask but do not have to use it. Neither carry nor wear the helmet, flak vest, web belt, or chemical protective suit.

2.17. Assignment Curtailment In Isolated or Remote Areas.

2.17.1. Pregnant members assigned to areas without obstetrical care will have their assignments curtailed by the 24th week of pregnancy or earlier.

2.17.2. If the local medical personnel are not capable of managing the early complications of pregnancy or the pregnancy is complicated, the member's assignment should be immediately curtailed.

2.18. Weight and Fitness Compliance.

2.18.1. Postpartum active-duty women must comply with the Air Force Physical Fitness and Weight Control Program 6 months after delivery or as recommended by their obstetrical provider.

2.19. Illness During the Prenatal Period.

2.19.1. Providers may not recommend convalescent leave during the prenatal period.

2.19.2. Providers authorize normal quarters for up to 72 hours. When the complication is related to the pregnancy, use Quarters-OB (Obstetrical). **NOTE:** There is no duration limitation, but the attending provider must see the patient at least weekly.

2.19.3. Providers place prenatal patients discharged from inpatient status, but medically unable to return to duty, in Subsisting-Elsewhere Status.

2.20. Evaluation of Pregnant Civilian Employees.

2.20.1. When a civilian who is employed by the Air Force presents confirmation of pregnancy to the supervisor, the supervisor directs her to Public Health.

2.20.2. Public Health evaluates workplace risks in conjunction with the BEE, advises the employee of such risks, and reports the risks with recommended techniques for avoiding them to the employee and her supervisor.

2.20.3. Recommendations of civilian healthcare providers pertaining to the limitation of physical activities during pregnancy will be reviewed by a military medical provider, who will, in turn, make a final duty recommendation to the employee and her supervisor.

*Section 2G—Other Women's Health Issues***2.21. Annual Health Maintenance Examinations.**

2.21.1. MTFs must ensure that the capability to administer annual exams exists within the direct- or indirect-care system for all female beneficiaries age 18 years and older and for those under 18 years who are sexually active.

Include at least the following services:

Papanicolaou smear.

Pelvic examination.

Breast examination.

Blood pressure measurement.

Family planning and contraceptive counseling for those desiring this service.

2.21.2. MTFs must report the results of the Papanicolaou smear to the patient within 14 days of testing. **EXCEPTION:** At isolated clinics or overseas locations, report the results within 30 days.

2.21.3. Nationally recognized guidelines, such as those published by the US Preventive Services Task Force, should govern the frequency of selected examinations. In some situations, the privileged provider may determine that a woman does not require a portion of the annual exam. If so, the provider will discuss the basis for that recommendation with the patient and advise her of the time frame for and the content of the next examination.

2.22. Mammograms.

2.22.1. Beginning at age 40, MTFs must perform baseline mammograms for all active-duty women and offer them to all other eligible beneficiaries.

2.22.2. MTFs must provide annual screening mammograms for all AD women over the age of 40 and offer them to all other eligible beneficiaries.

2.22.3. MTFs make a diagnostic mammogram available to a woman at any age who has been identified by her healthcare provider as requiring additional screening as indicated by individual risk factors.

2.22.4. The patient must have a referral from a healthcare provider for a mammogram to ensure test results are tracked and the patient receives appropriate follow-up care.

2.22.5. Radiology Services provides an appointment within 4 weeks of request for baseline or screening mammograms and within 5 duty days for diagnostic mammograms.

2.22.6. Providers notify the patient of results within 14 days for baseline or screening mammograms and 5 duty days for diagnostic mammograms.

2.22.7. Healthcare providers will obtain mammograms only at locations (both direct and indirect care systems) that are accredited by the American College of Radiology or an accrediting body approved by the Department of Health and Human Services (DHHS), IAW 21 CFR 900.

2.22.8. IAW applicable Air Force and/or local instructions:

2.22.8.1. Original mammogram(s) will be released to the patient or an authorized designee upon request.

2.22.8.2. Strict sign out procedures will be instituted and maintained, to ensure MTF accountability.

2.23. Gynecological Services.

2.23.1. MTFs provide or arrange for around-the-clock emergency gynecological services.

2.23.2. A healthcare provider must evaluate patients with urgent gynecological problems within 1 day for an initial evaluation.

2.23.3. MTFs make routine gynecological care available within 4 weeks.

Section 2H—Newborn Care

2.24. Inborn Diseases in Newborn Infants.

2.24.1. MTFs develop written policies and procedures for screening and treatment programs using local state health requirements and the guidelines in the most recent edition of *Guidelines for Perinatal Care*, prepared by the American Academy of Pediatrics and ACOG.

2.25. Newborn and Intensive Care Nurseries.

2.25.1. Refer to the *Guidelines for Perinatal Care* for functional capabilities, physical plant, equipment, and procedures for intensive-care nurseries and transfer plans for newborns.

Section 2I—Medical Nutrition Therapy

2.26. Medical Nutrition Therapy.

2.26.1. Medical Nutrition Therapy (MNT) is an intrinsic component of clinical practice and includes:

Clinical nutrition assessment

Diet modification and counseling

Specialized nutrition therapy

2.26.2. At a minimum, MNT must be considered for patients with the following medical conditions:

Diabetes

Pediatric Failure to Thrive

Dyslipidemia

Hypertension

Malnutrition

High Risk Pregnancy

Renal Disease

Complicated Inflammatory Bowel Disorders

2.26.3. MNT is obtained via referral to Nutritional Medicine, to a Registered Dietitian, or to authorized enlisted staff members who have completed specialized training in dietary therapy.

Section 2J—The Weight Management Program (See also AFPD 40-5, Fitness and Weight Management)

2.27. Medical Evaluation of USAF Personnel Entering the Weight Management Program (WMP).

2.27.1. The Air Force requires a medical evaluation before a patient enters the WMP. The evaluation includes as a minimum:

2.27.1.1. A history and physical examination.

2.27.1.2. A fasting blood glucose.

2.27.1.3. Studies to rule out secondary causes for obesity such as thyroid and/or adrenal cortical dysfunction.

2.28. Use of Anorectic Drugs.

2.28.1. Anorectic drug therapy is not approved for routine use in overweight patients and will not be part of the standard MTF formulary.

2.28.2. Short term use may be considered in carefully selected morbidly obese patients (i.e., patients with a Body Mass Index greater than or equal to 30 kg/m²) with significant comorbid risk factors (hypertension, insulin resistance, and/or severe dyslipidemia). In these situations, drug therapy should be combined with continuous behavioral modification, monthly provider follow-up, dietary counseling, and an appropriate aerobic exercise program. In addition to the screening noted above, these individuals should be evaluated with a complete blood count, a lipid profile, and, if indicated, an overnight dexamethasone suppression test.

2.28.3. Use of anorectic drug therapy must not delay or preclude any administrative action otherwise indicated for active duty members who are either on or entering the weight management program (WMP).

2.28.4. Use of anorectic drugs are medically disqualifying for flying status.

Section 2K—Medical Conditions Existing Prior to Service (EPTS)

2.29. Correction of Defects.

2.29.1. Surgeons may not correct defects that existed before service. **EXCEPTION:** Correct these defects if the performance of military service is likely to aggravate the defects. A medical evaluation board must evaluate the probable result of procedures before surgeons perform them.

2.29.2. Orthognathic procedures may represent an additional exception, particularly if the correction is of a functional, rather than cosmetic nature.

Section 2L—Using Clinical Hypnosis

2.30. Provider Privileges.

2.30.1. Providers may be granted privileges to administer hypnotherapy within their own field if they meet the recommendations and requirements of the American Society of Clinical Hypnosis or the Society for Clinical and Experimental Hypnosis.

2.31. Restrictions.

2.31.1. Practitioners may not use hypnosis on individuals on flying status or engaged in the Sensitive Duty Program.

2.31.2. Practitioners may not use hypnosis or drug-induced interviews on witnesses or victims of crimes, or known subjects of Air Force Office of Special Investigations (AFOSI) investigations. **EXCEPTION:** These subjects may undergo hypnosis or a drug induced interview with full coordination from AFOSI and with the individual's permission prior to the hypnosis.

Section 2M—Formal Sex Therapy

2.32. Clinician Requirements.

2.32.1. Clinicians privileged to provide sex therapy must meet the supervision requirements, or be recognized as a certified sex therapist by the American Association of Sex Educators, Counselors, and Therapists.

Section 2N—Medicolegal Matters

2.33. Medical Law Consultants (MLC).

2.33.1. The MLC advises commanders at medical facilities on all matters other than military justice. (See AFI 51-302, *Medical Law*, for the MLC's responsibilities.) The MLC's Commander ordinarily authorizes temporary duty (TDY) for the MLC to provide consultant visits to each base medical facility within the MLC's geographic area of responsibility at least once each year.

2.33.2. Refer to AFI 44-109, *Mental Health and Military Law*, for specific guidance on issues pertaining to communications between mental health providers and commanders.

2.34. Healthcare Provider and Patient Privileged Communications.

2.34.1. A variety of official military proceedings and investigations may require medical personnel to act as witnesses and otherwise to divulge confidential patient information. Military legal personnel may impound government controlled health record information compiled during medical practice, of individuals subject to the UCMJ, regardless of the patient's consent. **EXCEPTION:** If the Staff Judge Advocate advises otherwise.

2.34.2. Any record may be opened upon the determination of a military or civil court.

2.34.3. Otherwise, medical records may only be released IAW provisions of the Privacy Act (5 USC 522(a)).

2.35. Biological Specimens in Administrative or Judicial Proceedings.

2.35.1. Specimens as Evidence.

2.35.1.1. 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 must cooperate in collecting and presenting such evidence.

2.35.2. Principles Governing Biological Specimens.

2.35.2.1. Medical personnel may take biological specimens according to the Air Force drug testing program.

2.35.2.2. The donor must consent to any medical personnel taking and using biological specimens as evidence.

2.35.2.3. Medical personnel may take blood without the consent of the donor with a search warrant or a search authorization.

2.35.2.4. Medical personnel may take blood without the donor's consent and without a search warrant or search authorization when there is clear indication that evidence of crime will be found and authorities have reason to believe that the delay would result in the destruction of the evidence.

2.35.2.5. Involuntary extraction of blood must be performed in a reasonable fashion by people with appropriate medical qualifications such as:

Physicians

Appropriately privileged providers

Clinical nurses

Designated medical laboratory personnel

Trained Emergency Room medical technicians

2.35.2.6. Military legal and medical personnel must meet the requirements for the nonconsensual taking of blood in order to take biological specimens that require a visual examination of the unclothed body, such as pubic hair samples and dried fluids from the pubic area.

2.35.2.7. The nonconsensual taking of other biological specimens not requiring visual examination of the unclothed body or intrusion into the body, such as fingernail scrapings and hair samples from the head, does not require a search warrant or search authorization. A competent authority may order such nonconsensual takings.

2.35.2.8. Military medical personnel may not take biological specimens solely at the request of and for the use of civilian law enforcement authorities.

2.35.2.9. MDG/CCs develop procedures to ensure that witnesses can identify specimens.

2.35.2.10. MDG/CCs keep specimens either in the exclusive custody of an identifiable person or secured in an identifiable, tamper-proof location from the time personnel collected the specimen to the time it is offered as evidence. MDG/CCs must be able to demonstrate that these precautions were taken.

2.36. Reporting Serious Incidents.

2.36.1. Personnel report incidents involving suspected child abuse, spousal abuse, homicides, suicides, attempted suicide, robbery, aggravated assault, rape, other sex offenses, intentional prescription drug overdose, and narcotic overdose episodes to the Air Force Office of Special Investigations (AFOSI) or other authorities as appropriate.

Section 20—Informed Consent

2.37. MDG/CC Responsibilities.

2.37.1. The MDG/CC or designee at each MTF establishes specific guidance on informed consent, consistent with any relevant state 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 practitioners in the MTF to get answers to specific informed consent questions such as extent of disclosures or whether to use written consent forms.

2.38. Resolving Questionable Issues.

2.38.1. Providers consult the Staff Judge Advocate and the area MLC to determine any peculiar legal standards on informed consent.

2.38.2. Providers obtain information concerning consent and disclosure practices from local medical institutions as well as from state or national professional organizations.

2.38.3. The treating provider is ultimately responsible for assuring that informed consent is obtained.

2.39. Informed Consent Documentation.

2.39.1. The attending provider documents informed consent on SF 522, **Medical Record--Request for Administration of Anesthesia** (or other locally required form), or on AF Form 1225, **Informed Consent for Blood Transfusion**. The provider also makes a handwritten entry in the medical or dental record noting the date and time of counseling, and documents that:

2.39.1.1. The patient and the privileged provider discussed the disease process.

2.39.1.2. The provider explained the nature and purpose of the proposed procedures, its anticipated risks, benefits, and alternative treatments with their risks and benefits.

2.39.1.3. The patient indicated that he or she understands these matters and consents to the procedure.

NOTE:

Dental informed consent is IAW AFI 47-101, *Managing Air Force Dental Services*.

2.39.2. Attending providers must write descriptions of procedures they will perform on SF 522, in layperson's terms.

2.39.3. In cases involving the administration of anesthesia, the anesthesia provider must make a separate, handwritten entry documenting communication with, and consent of, the patient concerning the planned anesthesia.

2.40. Informed Consent for Certain Immunizations.

2.40.1. Medical personnel use information and consent forms published by the Centers for Disease Control and Prevention to document informed consent for immunizations when given to persons other than active-duty personnel. Place the consent forms in the outpatient medical record, which must include, at minimum, information on the lot or batch number of the manufacturer.

Section 2P—Treating Minors**2.41. General Guidelines.**

2.41.1. In all instances where MTFs provide care to minors without parental consent, personnel must make every effort to encourage the patient to tell the parents. Each MTF develops written policies and procedures on this subject.

2.42. Treating Minors in CONUS.

2.42.1. MDG/CCs comply with the local state laws governing consent for medical treatment of minors.

2.43. Treating Minors Overseas.

2.43.1. MDG/CCs outside the United States work within the general principles of American law in treating minors and provide without parental consent:

2.43.1.1. Reproductive counseling and care for pregnancy and pregnancy related conditions.

2.43.1.2. Counseling for drug and alcohol abuse.

2.43.1.3. Counseling and treatment for sexually transmitted diseases and medical conditions where there is imminent threat to life or limb.

2.43.1.4. Contraceptive counseling and treatment.

2.43.1.5. Counseling or treatment following rape.

Section 2Q—Hearing Aids**2.44. Diagnostic Hearing Centers (DHC).**

2.44.1. The Air Force provides hearing aids, replacement parts, accessories, batteries, and repair services at no cost to active duty members of the Uniformed Services at diagnostic hearing centers. Retired members of the Uniformed Services may, on a space available basis, obtain hearing aids at no cost if MTF resources permit. If resources do not permit, the Retiree Hearing Aid Purchase Program (RHAPP) may be used, if available, at the MTF.

2.44.2. Only DHCs are authorized to purchase, prescribe, fit, and issue hearing aids. All DHCs establish a reliable source of hearing aids and hearing aid supplies through GSA contractors or Blanket Purchase Agreements with the Defense Logistics Agency or hearing aid manufacturers on a competitive basis.

2.44.2.1. Active duty members who need binaural amplification, may receive a backup hearing aid when the consulting audiologist approves.

2.44.3. DHCs are located at the following installations:

- Andrews AFB, MD
- Eglin AFB, FL
- Elmendorf AFB, AK
- Fairchild AFB, WA
- Keesler AFB, MS
- Langley AFB, VA
- Lackland AFB, TX
- Lakenheath AB England
- Landshtul AB Germany
- MacDill AFB, FL
- Offutt AFB, NE
- Scott AFB, IL
- Sheppard AFB, TX
- Spanghdalem AB Germany
- Travis AFB, CA
- USAF Academy
- Wright-Patterson AFB, OH

2.44.4. DHCs give active duty members replacement or reissue hearing aids when the member has orders for either mobility status, or a permanent change of station (PCS) to a remote overseas location.

2.44.4.1. The member's MDG/CC:

2.44.4.1.1. Sends the request for an additional hearing aid to the nearest Air Force DHC or to the source that initially tested the member's hearing.

2.44.4.1.2. Includes a copy of the individual's orders with this request, and mailing instructions.

2.44.5. The clinical audiologist bases issuance of monaural or binaural hearing aids on patient's need, audiological test results, and medical evaluation and clearance.

2.45. Accessories, Spare Parts, Batteries.

2.45.1. The Air Force provides accessories based on the type of hearing aid issued. These could include:

2.45.1.1. Earmolds. (one for each ear for which a hearing aid was issued; exceptions can be made by the issuing audiologist).

2.45.1.2. A 60 day supply of batteries. **NOTE:** Issue replacement batteries at no charge to patients for the life of the government-issued hearing aid. MTFs without a DHC, issue batteries

through the pharmacy or medical logistics. Batteries for nongovernment issued hearing aids are not authorized.

2.45.2. DHCs buy spare parts from manufacturers using local-purchase procedures. These parts could include connecting cords, receivers, and rigid tubing.

2.45.3. The DHC prepares a letter for each government-issued hearing aid. It establishes the authority for the recipient to obtain replacement batteries for the life of the hearing aid.

2.46. Repair of Defective Hearing Aids.

2.46.1. Hearing aid repairs are only authorized for government issued hearing aids. While under manufacturer's warranty, the member or DHC returns the hearing aid to the manufacturer, with a letter explaining the malfunctions.

2.46.2. After the manufacturer's warranty expires, the patient returns the broken hearing aid and a copy of the issue letter to a DHC. Include a letter explaining the problem. **NOTE:** The DHC sends the hearing aids to a contract repair facility.

2.46.3. Patients returning a government-issued hearing aid for repair may receive a hearing aid on loan if available. **NOTE:** DHCs may maintain a small stock of loaner hearing aids.

2.46.4. The MDG/CC may authorize rental of a hearing aid from a commercial service if the patient with a non-government issue needs a replacement during the repair period. Use local funds for commercial rentals.

2.46.5. DHCs determine when a hearing aid has undergone an excessive number of repairs. The audiologist determines when replacement is needed.

2.47. Return of Unserviceable Hearing Aids.

2.47.1. Patients return used hearing aids to the local medical logistic activity. The medical logistic activity sends them to the nearest DHC.

2.48. Replacement Hearing Aids.

2.48.1. DHCs replace lost or stolen hearing aids once over a period of 1 year. Exceptions can be made by the issuing audiologist on a case-by-case basis.

2.48.2. A hearing aid has a minimum life span of 5 years. Members may not replace one before 5 years after the date of issue, unless it has an excessive repair record or is no longer appropriate for the hearing loss.

2.49. Accountability of Hearing Aids.

2.49.1. The audiologist.

2.49.1.1. Performs a quarterly inventory of all new hearing aids in stock.

2.49.1.2. Maintains the inventory results in the clinic.

2.49.1.3. Maintains one copy of the letter authorizing issue of the hearing aid to provide an audit trail for issued hearing aids, and/or those obtained under the Retiree Hearing Aid Purchase Program.

Section 2R—Forms Prescribed

2.50. Forms Prescribed. This instruction prescribes the following forms: AF Form 85, **Inventory Adjustment Voucher**, AF Form 422, **Physical Profile Serial Report**, AF Form 579, **Controlled Substances Register**, AF Form 582, **Pharmacy Stock Record**, AF Form 614, **Charge Out Record**, AF Form 765, **Medical Treatment Facility Incident Statement**, AF Form 781, **Multiple Item Prescription**, AF Form 1225, **Informed Consent For Blood Transfusion**, AF Form 1302, **Request and Consent for Sterilization**, AF Form 1412, **Occupational Therapy Treatment Record**, AF Form 1721, **Spectacle Prescription**, AF Form 1722, **Optometric Examination Record**, AF Form 2380, **Pharmacy Manufacturing Control Data**, AF Form 2381, **Pharmacy Master Formula**, AF Form 2382, **Pharmacy Bulk Compounding Chronological Control Log**, AF Form 2383, **Prescriber Information**, AF Form 3066, **Doctor's Orders**, AF Form 3069, **Medication Administration Record**, DD Form 741, **Eye Consultation**, DD Form 771, **Eyewear Prescription**, DD Form 1150, **Request For Issue and Turn In Slip**, DD Form 2081, **New Drug Request**, DD Form 2351, **Medical Examination Review Board (DODMERB) Report of Medical Examination**, SF 88, **Report of Medical Examination**, SF 513, **Medical Records Consultation**, SF 517, **Clinical Record - Anesthesia**, SF 519B, **Medical Record - Radiographic Consultation Request/Report**, SF 522, **Medical Record - Request for Administration of Anesthesia**, SF 600, **Health Record - Chronological Record of Medical Care**, SF 603, **Health Record—Dental**.

CHARLES H. ROADMAN II, Lt General, USAF, MC
Surgeon General

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

Public Law 99-660, Title IV, *The Healthcare Quality Improvement Act of 1986*, 42 United States Code 11131-11152

Title 10 United States Code, *Privacy Act of 1974*, Sections 1102, 1094 and Title 5, United States Code Code of Federal Regulations

OASD(HA) Policy 97-019, 10 Dec 96

DoDD 1010.4, *Military Personnel Drug Abuse Testing Program*

DoDD 6000.10, *Emergency Medical Service*

DoDD 6025.6, *Licensure of DoD Healthcare Providers*

DoDD 6025.7, *Off-Duty Employment by DoD Healthcare Providers*

DoDD 6025.8, *Same Day Surgery*

DoDD 6025.11, *DoD Healthcare Provider Credential Review and Clinical Privileging*

DoDD 6025.13, *DoD Medical Quality Assurance*

DoDD 6025.14, *DoD Participation in the National Practitioner Data Bank*

DoDD 6040.37, *Confidentiality of Medical Quality Assurance (QA) Reports*

DoDD 6465.3, *Organ and Tissue Donation*

DoDI 6025.8, *Ambulatory Procedure Visit*

DoDI 6025.9, *Patient's Bill of Rights and Responsibilities*

Air Force Policy Directive 44-1, *Medical Operations*

Air Force Instruction 36-2110, *Assignments*

Air Force Instruction 40-101, *Health Promotion Program*

Air Force Instruction 40-403, *Clinical Investigation and Human Test Subjects in the Medical Service*

Air Force Instruction 44-109, *Mental Health and Military Law*

Air Force Instruction 41-117, *Medical Service Officer Education*

Air Force Instruction 44-119, *Clinical Performance Improvement*

Air Force Instruction 46-102, *Nursing Care*

Air Force Instruction 47-101, *Managing Air Force Dental Services*

Air Force Instruction 48-101, *The Aerospace Medicine Program*

Air Force Instruction 48-105, *Surveillance, Prevention and Control of Diseases and Conditions of Public Health or Military Significance*

Air Force Instruction 48-123, *Medical Examinations and Standards*

Air Force Instruction 48-135, *Human Immunodeficiency Virus Program*

Air Force Instruction 51-302, *Medical Law*

Air Force Instruction 91-204, *Safety Investigations and Reports*

Air Force Pamphlet 41-215, *Central Supply Service*

Air Force Pamphlet 44-155, *Clinical Preventive Services*

Air Force Handbook 41-114, *Military Health Services System (MHSS) Matrix*

Objective Medical Group Implementation Guide, December 1996

Abbreviations and Acronyms

ACLS—Advanced Cardiac Life Support

ACOG—American College of Obstetricians and Gynecologists

AED—Automated External Defibrillator

AFI—Air Force Instruction

AFMOA/SGOC—Air Force Medical Operations Agency/Clinical Quality Management Division

AFMS—Air Force Medical Service

AFPD—Air Force Policy Directive

AFSC—Air Force Specialty Code

AHA—American Heart Association

AIDS—Acquired Immune Deficiency Syndrome

AIT—allergy immunotherapy

ANG—Air National Guard

APhA—American Pharmaceutical Association

ARC—American Red Cross

ASA—American Society of Anesthesiology

ASBPO—Armed Services Blood Program Office

ASHP—American Society of Health-System Pharmacists

BDC—Blood Donor Center

BEE—Bio-environmental engineering

BLS—Basic Life Support

CHCS—Composite Healthcare System

CCU—Coronary Care Unit

CFR—Code of Federal Regulations

CHAMPUS—Civilian Health and Medical Program of the Uniformed Services

CNM—Certified Nurse Midwife

CONUS—Continental United States

CPD—Central Processing and Distribution System

CPG—clinical practice guideline

CPR—Cardiopulmonary Resuscitation

CRNA—Certified Registered Nurse Anesthetist

CSS—Central Supply Services

CWDE—Chemical Warfare Defense Ensemble

DEA—Drug Enforcement Administration

DHC—Diagnostic Hearing Center

DHHS—Department of Health and Human Services

DoD—Department of Defense

DoDD—Department of Defense Directive

DoDI—Department of Defense Instruction

ECG—electrocardiogram

EMT—Emergency Medical Technician

ENT—Ear, Nose, Throat

EPTS—Existing Prior to Service

GMP—good manufacturing practices

HAWC—Health and Wellness Center

HEAR—Health Enrollment Assessment Review

HIV—Human Immunodeficiency Virus

HQ AFMPC/DPMUN—Air Force Manpower and Personnel Center/Director of Personnel, Medical Utilization, Nursing

HQ AFOSI—Headquarters, Air Force Office of Special Investigations

HQ ARPC/SGS—Headquarters, Air Reserve Personnel Center/SGS

HQ AFRES—Headquarters, Air Force Reserves

HQ AF/SGN—Headquarters, USAF Directorate of Nursing Services

IDMT—Independent Duty Medical Technician

IMA—Individual Mobilization Augmentee

JCAHO—Joint Commission on Accreditation of Healthcare Organizations

MAJCOM/SG—Major Command Surgeon

MEB—Medical Evaluation Board

MESA—Medical Emergency Set Ambulance

MDG/CC—Medical Group Commander

mg—milligram

ml—milliliter

MLC—Medical Law Consultant

MOA—Memorandum of Agreement

MOD—Medical Officer of the Day

MOU—Memorandum of Understanding

MPF—Military Personnel Flight

MTC—Military Transplant Center

MTF—Medical Treatment Facility

NP—Nurse Practitioner

NRC—Neonatal Resuscitation Course

NREMT—National Registry of Emergency Medical Technicians

OASD(HA)—Office of the Assistant Secretary of Defense (Health Affairs)

OB—Obstetrics

OB/GYN—Obstetrics and Gynecology

OIC—Officer in Charge

OPA—Organ Procurement Agency

OR—Operating Room

OSHA—Occupational Safety and Health Administration

PA—Physician Assistant

PALS—Pediatric Advanced Life Support

PCS—Permanent Change of Station

PH—Public Health

PHA—Periodic Health Assessment

QA—Quality Assurance

SCU—Special Care Unit

SDS—Same Day Surgery

STS—Specialty Training Standard

TDY—Temporary Duty

UCMJ—Uniformed Code of Military Justice

USAF—United States Air Force

US—United States

U.S.C.—United States Code

VA—Veterans Administration

WMP—Weight Management Program

Terms

Appropriate Certifying Agency—An agency which certifies healthcare professionals in a specific specialty.

Biological Specimen—A sample from the body.

Broken Arrow Incidents—Incidents involving nuclear weapons.

Case Management—The monitoring, planning, and coordination of treatment of patients with complex conditions.

Civilian Practitioner—Doctors of medicine, osteopathy, dentistry, or podiatry with unlimited license to practice in their specialties, and Optometrists in states where optometrists may prescribe ocular therapeutics.

Clinical Practice Guideline—Clinical practice guidelines are time sequenced guidelines outlining the optimal way to manage a particular condition. Clinical practice guidelines are scientifically derived (evidence based) and are often national in scope.

Conscious Sedation—A minimally depressed level of consciousness that retains the patient's ability to independently and continuously maintain an airway and respond appropriately to physical stimulation and verbal command, produced by a pharmacologic, nonpharmacologic method, or their combination. 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.

Contrast Media—Substances that permit x-ray demonstration of a space, potential space, or 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.

Critical Pathway—Clinical guideline reflect the optimum, multidisciplinary management of a particular condition. Critical pathways are generally consensus (versus evidenced) based..

Healthcare Providers—Military (Active or Reserve component) and civilian personnel (Civil Service and providers working under contractual or similar arrangement) granted privileges to diagnose, initiate, alter, or terminate healthcare treatment regimes within the scope of his or her license, certification, or registration. This category includes physicians, dentists, nurse practitioners, nurse anesthetists, nurse

midwives, podiatrists, optometrists, clinical dieticians, social workers, clinical pharmacists, clinical psychologists, occupational therapists, audiologists, speech pathologists, physicians' assistants, or any other providing direct patient care.

High Risk Of Mortality—Patients in anesthesia classes III to V.

Inborn Diseases—Pertaining to a constitutional characteristic that is inherited or implanted during intrauterine life.

Indirect Care System—Medical care provided outside the Air Force Medical Service.

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 license, experience, competence, ability, health, and judgment. Request is evaluated by credentials function and approved by Medical Group Commander.

Primary Care Manager—Healthcare provider who oversees and coordinates the general preventive, diagnostic and therapeutic care for a particular patient.

Same-Day Surgery—Same day surgery refers to preoperative, surgical, and immediate postoperative care in a healthcare setting for American Society of Anesthesiology Class I and II patients needing relatively simple surgical procedures.

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 - Supervisor does retrospective record review of selected records.

Direct - Supervisor involved in decision-making process either by verbal contact or by being physically present through all or a part of the care.

Qualified Assistant—A physician designated by the Credentials Function of the respective Military Treatment Facility as being qualified to assist with that type of procedure.