



PH Shop Talk

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UPDATE

Our world has changed since my last newsletter. Many of our people have been taking on extra tasks dealing with everything from increased deployments to responding to anthrax threats. We are all busy. It has become more difficult to keep current on all of the events and the multitude of information coming out from various sources (CDC, FDA, USAF, ARMY etc). I will try to get back to a monthly newsletter. However, I rely on you all to share information with me. Without it, my newsletters will not have the information that you need. There are many projects being worked to help you accomplish your job in the field (for example...a Food and Water Security Guide, improvements to our deployment surveillance process and an updated PIMR guidance). I will attempt to keep you updated on the important projects being worked at the USAF level. Stay tuned...more updates coming.

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Consolidating Administrative Functions of PIMR

By Col Deneice Van Hook

I recently took a trip to Hawaii, and found one of the things I enjoyed most of all was "Boogey Boarding". This is a toned down version of surfing, that even the more "mature" generation can master.. but it is not as easy as it might look. There is a split second of timing when you recognize the perfect wave, start paddling, catch it at the cusp, and ride it joyously to shore. If you don't recognize the wave, or you start paddling too late, you will miss the crest and get stuck watching the more seasoned enjoy the ride. One other scenario is when you pick the wrong wave, misjudge your timing, and end up grinding your face into the shells on the bottom of the beach.

This is a lot like life these days. We live in an ocean of constant change. Only those among us with the ability to look to the horizon, see the wave coming, and start paddling in the right direction early enough will enjoy the ride and not end up picking shells out of our teeth.

Public Health folks have been pretty good at catching waves...let's face it, over the last 20 years we've changed our name alone four times, and even our basic mission has undergone several changes and updates. Most recently we've beefed up and strapped on the mission of epidemiology, and although it's still early in the ride, we are firmly on top of the wave and have made some significant progress toward the beach.

Well folks...there is another wave on the horizon...and this one has all the markings of a real thriller. Your leadership has determined that this one is worth a strong paddling and we are well on our way.

We have long recognized that the administration of medical readiness requirements for our military members has been somewhat disjointed with several areas having responsibility for various pieces of this pie. PES, providers, flight surgeons, patient administration, and others have all had a piece. Public health personnel have been responsible for medical intel and immunization oversight and have also assumed responsibility for deployment surveillance...conducting pre-deployment screening, tracking post deployment...all with no increase in our manning. With the advent of Preventive Health Assessment and Individual Medical Readiness (PIMR), many public health offices have also become involved with this program...again with no additional manpower. This approach to managing the health of our force has been difficult and fragmented at best.

To complicate the issue even more, two additional factors are combining to make this worse. First is the full implementation of Primary Care Optimization. As the clinical aspects of occupational health, preventive health, and patient management shift from PES and flight medicine to the PCM teams, it becomes increasingly complicated to provide ade-

quate oversight and ensure people get the right exams at the right time. It also complicates the interface with line units who will no longer have a central location to access the system.

The second factor which is making force health management more difficult is that in October of 2002, the 4F AFSC ceases to exist. They will become either 4N's or 4E's. The merger portion to 4N has been planned for several years and is intended to fix several things, including decreasing the number of medical AFSCs, and enhancing the clinical skills of the 4F (soon to be 4N) community. We (the AFMS) still need a trained cadre of individuals to grow up understanding the technical aspects of medical standards. As I am sure you are aware of by now...the resolution we will implement to address this complicated problem is to build a new function under the public health umbrella...called force health management. Thus we will finally bring together a variety of fragmented pieces under one roof. Many of these functions we are already working with (OH, deployment processing etc), while many others will be entirely new to us (primarily medical standards and Quality Control of physical examination paperwork).

The rest of this newsletter is devoted to describing what this new function will do. We ARE NOT transferring PES to public health...we are building a new function to better serve the needs of our members, line commanders and our PCM teams. You all have risen to many challenges in the past...I know you are capable to meet this one head on and succeed. Press on!

PIMR Oversight

As part of the new mission we are taking on, the administrative oversight of the PHA and Individual Medical Readiness (PIMR) program is a critical process to the line commanders. This program tells commanders if their troops are medically ready to deploy and to perform their jobs. The AFMS is pushing the performance of the PHA process out to the Primary Care Management (PCM) teams. This could create a problem for the line units...having to deal with several PCM teams to determine if their people are medically ready to deploy. Right now... who owns printing out the rosters for commanders? Who prints out the rosters for the PCM teams telling them who needs a PHA? There needs to be a central oversight area to ensure the program is operating correctly. There should be one "belly button" for line units to ad-

dress PIMR related issues within the medical group. We are a good match for the administrative portion of this mission. However, we will not be involved with the clinical execution of the program (except for performing audiograms). We will print the rosters for each PCM team telling them who needs a PHA and who needs what item taken care of before a deployment. We will tell them who from their enrolled population is IMR RED and what needs to be done to get them to GREEN status. We will work primarily with the 4A and 4N members on the team to help them manage their populations. This will be important for notional deployment taskings as well as mass deployments. We will help work with units to ensure they show up for their appointments. We will get with the First Sergeants and Command-

ers when there are problems with no show appointments. We will have to work closely with PCM teams to ensure they have adequate appointments available for all the necessary medical requirements to be completed. This will be especially important with units who have large numbers of personnel in IMR RED. We will be the liaison between the units and the Medical Group to help devise a plan to get numbers to IMR GREEN. We will have visibility if a member is on a profile, if they have had occupational exposures that would cause limitations in their job, if they are IMR RED, or GREEN and if there are medical standard issues concerning their health. The importance of one section having visibility of the medical status of the deployment population on the installation should now become much clearer.

Occupational Health Examination Oversight

The administrative oversight of the Occupational Health Examination Program is similar to the administrative oversight to the PIMR Program. Actually the OH Exam (OHE) program is a subset or part of the PIMR program for the active duty population. However, the significance of the OHE is that it is OSHA driven and has requirements that are covered within the United States Public Law. If base personnel are not appropriately being followed medically for their potential occupational exposures in their workplace, the base can be fined and responsible personnel can get into very serious trouble. It is imperative that the Medical Group appropriately administer the Occupational Health Examination Pro-

gram. This includes performing the audiograms within the specified time frames. We believe that it will be easier and more efficient for our office to take on the administrative oversight of this program. It is an extension of the PIMR program. However, there are also civilians working in hazardous shops on base who are not enrolled to a PCM team at our facilities. The medical group must ensure these folks receive the required occupational health examinations at appropriate intervals and that the necessary follow-ups are carried out. Again, the clinical portions of the examinations (except audiograms) must be performed by an assigned PCM team (locally determined based on

numbers enrolled and available capacity). This can be within Primary Care or in the Flight Medicine area. Non-enrolled patients will be assigned to teams based on capacity. We will perform the quality control check of the examination paperwork (at the end of the process). We will be the liaison between the units and the different PCM teams and try hard to ensure a smooth process.

Audiograms

There was a problem associated with the 4N-4F merger plan when it came to performing audiograms...the 4N's had signed up to perform this function, however, the training associated with this job was becoming a nightmare to manage. The 4N career field is the largest within the AFMS. How do we manage the training and certification of a large group of people who intrinsically rotate through many sections throughout their career (to

keep current on their clinical skills)? 4N's would receive training and then rotate through other sections and may not rotate back to audiograms for many years (requiring others to get certified and those in the first group not receiving re-certification) resulting in much higher training costs. Our leadership felt this function was better managed by a smaller career field and since the training is good for 5 years, the smaller career field would most likely get better use of that training with fewer personnel rotations (more time spent performing audiograms than 4Ns resulting in lower overall costs). Public Health will ensure this function is

done. Since audiograms can be accomplished anytime (at the required intervals), we can schedule them by blocks (shops) and ensure the results are available for their PHA or OHE. We will also ensure scheduling for any needed follow-up for any abnormal audiograms. Since we have been involved with the follow-up of abnormal audiograms for years, taking on the actual audiograms (with the associated manpower) is not that significant AF wide. Also, locations where this process works well (AFMC logistics bases) will remain unchanged. Working together, we can make this transition a success! We have the best people doing it!

Deployment Processing

Part of the plan to consolidate the Force Health Management function is to place most of the administrative portions of the deployment processing under one section. That section is Public Health. We are already involved with significant portions of the program...so we will be adding some tasks to our plate...with added manpower and the addition of a new In-Place UTC (under development). For deployments with adequate advanced notice...we will pull a PIMR roster and ensure each PCM team has a list of the status of those enrolled to their team. This list will show what they need to do to get their folks medically ready to deploy (shots, etc). If there are any medical conditions known that would preclude them from deploying a profile could be accomplished (by a PCM team) and a replacement deployer can be found. Remember, it is the PCM provider

who determines that a member is not medically ready to deploy. PH would provide medical intelligence, preventive medicine briefings, have members complete questionnaires (pre and post...as required), provide rosters to PCM teams and line units, assist PCM teams with record reviews (for medical standard related issues) and refer identified problems to proper PCM teams for resolution. We would also track surveillance for pre, during and post deployments (with available systems...GEMS, LEADERS, ESSENCE etc). We would be the single point of contact for both line units and PCM teams for the medical por-

tion of the deployment process. We produce personnel status reports (PIMR including immunizations) for deployable units, we identify the immunizations needed for the deployed location and provide input to local immunizations policy. However, we DO NOT provide any clinical or programmatic oversight to the immunizations function. That is provided by a 4N TSgt or above and an immunizations/allergy trained credentialed provider.

There is a UTC (In-Place Generational) under development that will stand up when the base stands up a processing line. It's job is to medically process the rest of the base's mobility population when called upon. There will be 4E, 4N (immunizations), provider, administrative, logistic, and other necessary support provided as needed. Stay tuned for further details on this new UTC development.

Medical Standard and Profiles Management

A major portion of the realignment of Force Health Management tasks is the management and expertise of medical standards and profiles. PH will become the central warehouse of experience for the medical group. The administrative management of these programs will be done by PH and the clinical execution of these programs will be done by the PCM teams. This means every PCM team and health care provider should have a basic knowledge on the medical standards (when to ask questions like

whether some condition is disqualifying or not). They will get formal training in their courses as they are revised. We will provide continuing training for PCM teams and other health care members on these processes. It is important to have a group of people that have grown up through their career knowing medical standards and profile management. PH will process profiles using PIMR software...and ensure each profile is quality checked before it goes to the line units and to the personnel system. We will be the point of contact for line

units and PCM teams who have questions concerning medical standards (cross training, etc). However, if a physical examination must be completed on a person desiring cross-training...these exams must be accomplished by the members PCM team. When the PCM team is done with the paperwork...we will QC it and send it on it's way to the approving authority. We will also track these packages through the system and ensure folks receive an answer for medical qualification (either for cross training or for remaining in their job).

HSI Involvement

With the changes looming between now and next October 2002, there will have to be detailed guidance and policy changes to accompany the transition. Part of this change will include updating the way the HSI looks at each base. We would like to separate out the potential write-ups on the Inspection checklist into those write-ups associated with the clinical side (PHA appointment accessibility, proper fol-

low-up and adequate clinical examinations etc) and those associated with the administrative oversight of it (proper notification to PCO teams and line units of requirements and personnel needing assessments etc) and those write-ups associated with leadership (people not coming in for their appointments). We will try to change the metrics to reflect these divisions. The overall PIMR rate is actually a wing or installation rate and not necessarily a medical group rate (unless there is inadequate access for personnel to get it accomplished etc).

This area will be discussed at length between AFIA and AFMOA. I am sure there will be some modifications to the checklist based on new policy distributed to the field. If you have suggestions for improvements to this area please feel free to forward them up through the chain to AFMOA or myself for evaluation and potential implementation. Input from you all who are working where the rubber meets the road and actually performing the work...is extremely valuable when we address changes to the Inspection checklist. Your opinion does count! Stay tuned for updates!

USAF PUBLIC HEALTH



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[http://wwwsam.brooks.af.mil/eh/.](http://wwwsam.brooks.af.mil/eh/)

A Public Health Family Publication

THE NEW 4E

PUBLIC HEALTH FLIGHT



The Manpower Technician Support: Requirements

	Approx Auth
FM PCO / 1500 enrollees	
One 4A	102
Two 4Fs for PCO	204
Two 4Fs for Operational Support	204
SME 4Fs	241
PES	
One 4F per 1000 active duty	430

(+/- HQ/MAJCOM and Additions / Deletions)

Integrity - Service - Excellence

Final Thoughts– Let’s Welcome Our New Family Members

You know...if you put yourself in the shoes of our 4F brethren, you would see people who have been stretched very thin between trying to keep up their clinical skills and having to learn administrative tasks amidst manpower shortages. Then they were told that they were going to merge with the 4N’s and 4A’s. They were also told that they were going to be swallowed up by the two larger career fields...and have to give up their identity they have enjoyed and been very proud of for a long time. They would have to rotate through all of the sections that traditional 4N’s and 4A’s receive training on. That meant they would no longer be a part of Team Aerospace (unless they are lucky enough to stay in Flight Medicine for a period of time...but eventually they

will have to rotate out). They will not even be able to keep any portion of their name or part of their traditional identity. With the change in direction that a sizable portion of the 4F’s are to go...now to 4E...I am sensitive to their plight. I am also sensitive to the fact that Public Health has gone through many changes (names in particular) over the past several years. Since there is a significant number of 4F’s who will be coming to the 4E side of the house (still in Team Aerospace and still on the operational side of the AF)... I propose that we build a new combined mission...and NOT just swallow up those folks who have been through the psychological grinder. I propose we build a new Public Health Flight. One flight with two houses (so to speak). One named Community Health Management and the other being called Force Health Management. The UTCs for community health protection (PAM, MGRL, etc) will be staffed out of the Community Health Management side and the newly to-

be-formed In-Place Generational UTC (to process the rest of the base out the door) will be staffed from the Force Health Management side. I believe it is important to be sensitive to those 4F’s who will become part of our family. We should welcome them with open arms and help them learn our job and I am sure they will help us learn theirs. Changing our structure and naming the new element Force Health Management, is a small way that we can send a message to our new family members...that we care about them and we welcome them into our newly remodeled home. Once these folks are identified, we need to help them make a smooth transition. Please tell me what you think about this idea...I welcome your thoughts!