UNITED STATES CENTRAL AIR FORCES
(USCENTAF)

DEPLOYED MEDICAL COMMANDERS' HANDBOOK

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United States Central Air Forces (USCENTAF)

Deployed Medical Commanders' Handbook

Operations ENDURING FREEDOM and IRAQI FREEDOM

Purpose

This handbook gives the new deployed medical commander an initial orientation, and ongoing reference, to many of the key issues and situations that may impact his/her command in the AOR. It is not all encompassing, but contains the collective experiences of many who have served as the CFACC/SG (Forward). The original handbook was the masterful effort of Col (Dr) Jim Sammons, CENTAF Surgeon (F), Prince Sultan Air Base, KSA, from June 2002 to May 2003. Col Sammons clearly identified the need for a comprehensive reference for the frequently rotating medical commanders in the AOR. While much of the original text remains, this version contains substantial new material. Much of this material is based on the advice and guidance of the current CENTAF Surgeon, Col (Dr) Tim Jex. Our thanks go to both gentlemen.

Staff Relationships

It helps to understand the working relationship between the CENTAF Forward (F) at Al Udeid AB, Qatar, and CENTAF Rear (R) at Shaw AFB, SC. They are really **one office in two locations**. Office symbols are:

CENTAF/SG = CFACC/SG = CENTAF/SG (R) = CFACC/SG (R) = CENTAF/SG (Shaw) = CFACC/SG (Shaw)

Deputy CENTAF/SG = Deputy CFACC/SG = CENTAF/SG (F) = CFACC/SG (F) = CENTAF SG (Al Udeid) = CFACC/SG (Al Udeid)

Contact Information, CENTAF/SG (F) and (R)

The CENTAF/SG (F) staff consists of the following:

CENTAF/SG	(318) 436-4118	sg@auab.aorcentaf.af.smil.mil sg@auab.aorcentaf.af.mil
CENTAF/SGX	(318) 436-4115	sgx@auab.aorcantaf.af.smil.mil sgx@auab.aorcentaf.af.mil
CENTAF/SGXL	(318) 436-4115	sgxl@auab.aorcentaf.af.smil.mil sgxl@auab.aorcentaf.af.mil
CENTAF/SG PHO	(318) 436-4112	ph@auab.aorcentaf.af.smil.mil ph@auab.aorcentaf.af.mil
CENTAF/SGB	(318) 436-4112	bee@auab.aorcentaf.af.smil.mil bee@auab.aorcentaf.af.mil

Contacting CENTAF/SG (F) after hours

This office is not manned for 24/7 operations. If you need to contact CENTAF(F)/SG after duty hours, or in the rare event that no one answers during duty hours, the JPMRC Cell has agreed to

take any emergency calls for us. JPMRC can be reached at DSN 318-436-4418 or 4107. They have the ability to contact the SG and/or one of the medical planners by phone, pager or runner. Please do not use these numbers during normal duty hours unless it is a true emergency and we cannot be reached in our office.

CENTAF/SG (R), Shaw AFB, SC
CENTAF/SG – (312) 965-4446
CENTAF/SGX – (312) 965-4421/54
CENTAF/SGXL – (312) 965-4373

SIPR web site: http://centaf.auab.aorcentaf.af.smil.mil go to the Site Contents section (left column), select AFFOR Staff, then SG for various useful references.

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Section 1 - Communications, Information Management, & Reporting Instructions

NOTE: All of the contact numbers for the CENTAF/SG (F) offices are at the beginning of this guide.

1.1 Connectivity for new personnel

Communications are obviously essential to our operations. Ensure that you and your staff get unclassified email (**NIPR)** access immediately. You must also have at least one SIPR account for the unit (generally not an issue after the first rotation), which should be checked at least daily. When your replacement arrives, have him/her send CENTAF/SG (F) a message on **BOTH** sides (SIPR and NIPR), so we can ensure currency. Further, ensure you are aware of, and check, your **EMEDS or EMDG/CC** e-mail box.

Please encourage your Logistics, Public Health and Bioenvironmental Engineering staff to send similar SIPR and NIPR emails to their CENTAF (F) functional counterparts so that they can confirm arrival and email addresses.

1.2 After Action Reports (AAR)

Each commander and other key people in your unit (BEE, PHO, Logisticians, etc) should review continuity folders as soon as possible after they arrive. They should make changes as necessary, and review the folder before the end of the rotation for completeness. As commanders, you will be writing an AAR, described in AFI 41-106, paragraph 4.13, and following the format found on the CENTAF/SG SIPR website. It should reflect important operational considerations (not OPR/EPR material for anyone). **Classification of your After Action Report will be SECRET.**

Ensure you review the previous rotation's AAR(s). In your report, try to answer as many of the outstanding issues as possible. Describe actions taken to close or mitigate deficiencies, issues that persist, or changes that have rendered the issue moot. Also, identify new issues, planned actions, and any other info your successor should know to handle the situation. When finished, forward the AAR to CENTAF/SG (F) (not your commander back home, not your MAJCOM, not CENTCOM, or any other office). We will forward it to the appropriate offices. Don't worry…we won't edit your reports or suppress information. This is *your* AAR.
The AAR is your official "legacy"—what you leave behind.

1.3 MEDRED-C Reporting

MEDRED-C reports are meant to convey the important details of operations, to include changes in capabilities, limiting factors (LIMFACs), critical events, etc, to higher headquarters.
Use your "Commanders' Comments" in the daily MEDRED-Cs to pass along this important information...daily. The "Commanders' Comments" is also a tool for you to justify the need to add additional skill sets to the operations by providing a synopsis of care being rendered that is either overwhelming the current staff or you do not have the required staff to deal with these issues (i.e. Life Skills). Make a comment once and remove it after that, do not leave it for several days. If you make a significant comment that is open ended (i.e. a U.S. or HN VIP in the

EMEDS), be sure to close this issue in the MEDRED-C upon final disposition of the case. If you cannot be there to release the MEDRED-C, designate an alternate who can. **Your report is due to this HQ NLT 1300 Zulu…daily…no exceptions. If you lose email connectivity, your report should be provided telephonically to CENTAF/SG (F). Classification of your MEDRED-C will be SECRET.**

Here are some examples of things to include (and NOT include) in the MEDRED-C. Include:

- An unexpected disease cluster occurs: very important.... pass this event along immediately to CENTAF/SG (F) with a phone call (preferable) or e-mail.
- A problem occurs with delivery of services due to supplies, equipment, personnel, etc.
- You opened a new service that continues to see patients, or closed one. Tell us just once...no need to repeat day after day.
- Rotation of personnel out prior to normal rotation (cleared with CENTAF/SG (F) prior)

Do not include:

- John and Mary left, and Sue and Bob replaced them… NOT MEDRED-C material.
- Any unprofessional comments, e.g., "*The **Army** screwed up…**again***!!!! **This** time they…". Please don't put this in the MEDRED-C, but call or e-mail the appropriate CENTAF/SG (F) staff member to discuss the situation.

Personnel at all levels read the MEDRED-Cs, so please don't put inflammatory remarks, personal attacks, etc., in the MEDRED-C and make comments clear and concise. This may provide entertainment for folks at various MAJCOMs and the Air Staff, but will increase our workload at CENTAF/SG (F) tremendously (answering queries from general officers, counterattacks from other branches of the service, etc.). Focus on value-added comments. If it isn't important, don't put it in. If you're not sure whether it's important or not, call the CENTAF/SG (F) staff to discuss.

1.4 CENTAF/SG (F) Notes

This staff will periodically (approximately every few weeks) send our "SG Notes" to EMEDS/EMDG commanders. They are aimed at mentoring, sharing information, providing initial policy or guidance, or just staying in touch. Information in the "SG Notes" should be shared with key staff promptly, providing a common frame of reference. While this guide is aimed at getting everyone off to a common start, it does not include all the information in the notes. Previous editions of "SG Notes" which provide lasting policy or guidance have been incorporated into this update. Recent SG notes will be posted on the CENTAF/SG (F) website until they can be incorporated into this guide.

1.5 Ensuring Continuity during Rotations

This is a **MAJOR** issue. Due to frequent rotations, it is important that each key member of your staff makes contact with his/her incoming replacement (BEE to BEE, PHO to PHO, SGA to SGA, etc.) prior to arrival, and replacements should make contact with their respective CENTAF/SG (F) counterpart at the earliest possible point. Please don't forget to have YOUR replacement touch base with the respective CENTAF/SG (F) counterpart on his/her first day.

1.6 MAJCOM Communications

CENTAF/SG (F), Al Udeid AB, Qatar, is your MAJCOM while you're in the AOR. The SG staff is generally quite experienced in AOR issues and maintains the responsibility and resources to work problems and issues with you. Many of your folks are used to talking with home MAJCOM functional, so there will be a tendency to go to them for help. Please instruct them not to do so. In many cases, CENTCOM and/or CENTAF will have provided specific guidance on issues, which may differ from that at AMC, AFSOC, ACC, etc. While we are not suggesting that you ignore MAJCOM staff inquiries, but ask that you suggest that the inquiry either be re-routed through CENTAF/SG (F) or (Rear), or that you send us a copy of any pertinent correspondence related to business in the CENTAF AOR. (Obviously, don't copy us on strictly "back home" business…that's not our business.)

1.7 CLASSIFICATION OF DOCUMENTATION/INFORMATION

Due to the nature of the wartime/deployment environment, medical personnel will be exposed to classified information. You must ensure this information is safeguarded. We've included this section to help you resolve some of the ambiguity that often occurs when attempting to make classification decisions.

In general, if a document does not warrant classification (email, letter, policy), DON'T CLASSIFY THE DOCUMENT. If, however, a document contains classified information, you must ensure all appropriate procedures are followed (i.e. marking, handling, storage and destruction procedures).

Information is to be classified at one of the three following levels: (1) "Top Secret" shall be applied to information, the unauthorized disclosure of which reasonably could be expected to cause exceptionally grave damage to the national security that the original classification authority is able to identify or describe; (2) "Secret" shall be applied to information, the unauthorized disclosure of which reasonably could be expected to cause serious damage to the national security that the original classification authority is able to identify or describe; (3) "Confidential" shall be applied to information, the unauthorized disclosure of which reasonably could be expected to cause damage to the national security that the original classification authority is able to identify or describe. (EO 12958, Sec. 1.3)

OASD(C3I)/S&ID, Security Classification Guide for OPERATION ENDURING FREEDOM (OEF) and OPERATION NOBEL EAGLE (ONE), dated 28 Mar 02, provides classification direction for OEF and ONE. Table 1 below provides excerpts of classification guidance given specifically for OEF. Although strictly applicable to OEF only, the chart provides useful guidance for you and your staff to make classification determinations on documentation you generate. Table 2 provides additional guidance based on normal CENTAF procedures.

Table 1: Security Classification Examples

Element or Category of Information	Classification
Medical surveillance: when the level of detail is generic	UNCLASS

Medical surveillance: raw numbers reflecting trends and environmental studies	CONF
Medical surveillance: exploitable vulnerabilities such as disease, nonbattle injuries (DNBI) rates	SECRET
Blood reports: when the level of detail is generic and lacks exploitable specifics	UNCLASS
Blood reports: number of units by type, location, trends, etc. that would reflect shortfalls or mission vulnerability	CONF
Blood reports: movement or utilization of blood units (intra-theater)	SECRET
General logistics plans for a brigade (squadron)-size or smaller unit	UNCLASS
General logistics plans for a division (group) or larger unit	CONF
Detailed logistics/sustainment plans or operations revealing vulnerabilities, weaknesses or strengths or based on classified plans or operations **Note: logistics data in and of itself is unclassified. It becomes classified when specifically linked to a unit's mission capability or vulnerability, to a specific operation plan or to a classified geographic location.**	SECRET
Data on stock levels/density, requirements, supply plans, resupply and status	SECRET
Approximate number of tonnage, humanitarian daily rations, sorties or weapon systems	UNCLASS
Anti-Terrorist/Force Protection information, including risk analysis and reasons for recommending a change in FPCON level	Varies based on sensitivity (CONF to TOP SECRET)
Vulnerability of U.S. installations to sabotage or penetration	SECRET
Food and Water Vulnerability Assessments (CENTAF/SG interpretation)	SECRET
Vulnerabilities and readiness of U.S. or allied forces, including personnel, equipment, and supply shortfalls	SECRET

Table 2 – Other Classification Guidance

Single flight information [**particularly the Theater rotator**] that includes specific arrival and/or departure times and dates linked with location (SECRET due to operational security concerns)	SECRET
Inbound/departure dates for individual personnel rotations	UNCLAS
A UTC matched with a beddown location (NOTE: This has been the most frequently compromised info)	SECRET

Section 2 - Combat Operations Issues

2.1 Force Protection Working Group (FPWG)

AFI 10-245 requires establishment of a wing-level Force Protection Working Group (FPWG). The FPWG is a critical component of reducing risks to your installation and personnel. You (or your deputy), your BEE (or BEE tech), and your public health officer (or PH tech) must be members of this group. The latter are key contributors in the areas of food and water vulnerability, medical threats, vector/pest management, field sanitation/hygiene, and environmental risk assessment. These are items that the local AEW or AEG commander needs to know about. While many threats may have been assessed already, conditions and threats change constantly. If you do not have a FPWG on base, please recommend to your commander that he/she form one and make sure your personnel are engaged.

Our recommendation: food and water are critical factors. Think like the enemy... look for vulnerabilities.

2.2 READY Program:

The issue of the appropriateness of "medics" serving as Ready Program augmentees frequently arises in the AOR and CONUS. Serving as a Security Forces augmentee usually entails taking up a weapon and defending the base. CENTAF JA provides the following info on medics carrying weapons:

- Your wing commander **can** assign your personnel to a Ready detail.
- Medical personnel **forfeit** Geneva Convention status while guarding the base, so they should leave Red Cross armbands and Geneva Convention Cards behind.
- You may **not** regain protected status when you go back to your regular duties (a point not clear in the law). The exact dialog is appended, with attachments.

[Reference CENTAF Ready Program Augmentee Guidance]

2.3 Shaving Waivers and NBC Masks

Personnel can and do deploy with shaving waiver. The decision on waivers should be a risk-based decision dependent on the threat of an NBC event. CENTAF policy, *Shaving Waivers and NBC Mask Use* **[BEREF 2.b.]** recommends keeping shaving waivers in effect unless the threat increases to the point where people must carry their masks. At that point, wing leadership should consider rescinding waivers.

AFMOA interim policy change to AFMAN 32-4006, *Gas Mask Quantitative Fit Test (QNFT) Program* **[BEREF 2.e.]** updates QNFT workload distribution and fitting procedures.

2.4 BW/CW

2.4.1 BW/CW Plans

Be sure your BEE and CEX staffs are working with the Force Protection experts on Random Anti-terrorist Measures. Look over the plans, talk through exercises (table tops), and plan base

exercises. It is important to do this every rotation. Ensure that you prioritize time to work these issues...it could save lives and ensure mission accomplishment.

2.4.2 BW/CW Supplies:
You should regularly pulse your loggie about BW/CW antidotes. Level should be 110% of that required to support your population at risk (PAR). Your loggie must submit a BW/CW inventory monthly to CENTAF/SGXL(F) via SIPR at sgxl@auab.aorcentaf.af.smil.mil NLT the 3rd of each month. Identify any shortages/overages to CENTAF/SGXL (F) for guidance/instructions on command cross-leveling. If you see expiration dates upcoming ensure you loggie checks the AFMLO web page for possible expiration date extension. Please order with sufficient lead-time to get in the required supplies. Personnel departing home station are no longer required to deploy with BW/CW antidotes—they will be provided in the AOR if required. If personnel arrive with antidotes, collect the antidotes during medical inprocessing, and add them to your stockpiles. BW/CW materials do not go home with personnel when they redeploy.

2.5 Water Issues

a. Source Identification and Surveillance

AFMAN (I) 48-138, *Sanitary Control and Surveillance of Field Water Supplies*, **[BEREF 3.b.]** provides guidance to assist BE personnel in performing drinking water source identification and surveillance during field operations.

If available, potable water must be provided through distribution systems that must meet minimum water quality criteria provided in the *Overseas Environmental Baseline Guidance Document* (*OEBGD*) and AFMAN (I) 48-138. In addition, potable water should meet EPA standards (***http://www.epa.gov***) whenever possible. If potable water meets *OEBGD* and AFMAN (I) 48-138 standards, but does not meet EPA standards, contact the CENTAF (F) BEE for additional guidance.

Results of routine water sampling must be submitted monthly to the Theater Medical Surveillance Team (TMST) in Bahrain with a courtesy copy to the CENTAF (F) BEE. The *CENTAF Water Surveillance Reporting Policy* **[BEREF 3.c.]** requires notification of CENTAF (F) in the event of any of the following circumstances: (1) immediately if any bottled water has a repeat positive chemical result; (2) within 24 hours of any water system result that exceeds a maximum contaminate level or otherwise represents a potential health threat; and (3) within 3 days of any bottled water declared nonpotable.

b. Bottled Water

CENTAF policy, *Recommended Sampling Frequency for Bottled Water,* **[BEREF 3.a.]** establishes sampling frequencies for bottled water. Currently, all bottled water sources must be on the CENTCOM approved list. Army VETCOM maintains a web site that lists all approved sources for water, ice and food.

Bottled water should be stored upright in shaded, well-ventilated areas. Sunlight can cause breakdown of plastic bottles resulting in leaching of chemicals into the water. While chemical concentrations do not exceed health standards, they do cause taste problems. Whenever possible, maintain storage temperatures between 35°F and 84°F in accordance with good food storage practices, though this is not possible at all locations. Increased temperatures accelerate microbial growth. The increase in microbial growth rates is gradual without abrupt changes.

When bottled water must be stored at temperatures above 84°F, water should be cooled prior to consumption to improve palatability. Non-potable ice may be the only ice available. If so, warn folks not to consume it...just cool their water bottles with it. If people eat non-potable ice, they will eventually learn not to (as our DNBI rates go up temporarily).

Normally, the manufacturer will specify shelf life of bottled water. In general, it is good for one year after the manufacturing date. For water over a year old, additional bacteriological testing by the BEEs should be performed prior to extending shelf life, and testing should be performed at a frequency of every 30 days. Appropriate rotation of bottled water stocks should eliminate any concern about "old" water.

AFI 48-144, Safe Drinking Water Surveillance Program, para 2.8 allows the BEE to approve bottled water sources where no supplier information exists. Be sure to get formal CENTAF(F) BEE concurrence before approving bottled water sources without VETCOM approval.

2.6 Ground-Testing Flight Crews for Medications

CENTAF has approved non-interference ground testing for Go/No-Go Pills, Cipro, and other medications, such as common antibiotics. Non-interference means that you must arrange ground testing so as not to cancel flying. The crew member(s) in question must have adequate non-flying time to complete the required testing, and go through the correct DNIF and Return-To-Fly procedures, without canceling sorties. Different crewmembers may have different requirements. Test as directed by the appropriate parent MAJCOM, based on airframe and crew position requirements. This policy is not intended to require testing beyond MAJCOM-directed requirements.

2.7 Medical Waste Management and Disposal

Medical waste must be segregated from normal waste. Medical waste must be red-bagged (or other identifying means) until final disposal. Used sharps containers need to be placed within rigid, puncture- and leak-proof containers with a closable cover. Consider adding chlorine solution to the sharps containers to kill biological organisms.

At many locations, medical waste disposal procedures are already established. The preferred method for medical waste disposal is establishing a contract through a medical waste facility. Other potential long-term solutions would be: (a) contract for incineration within host

country/AOR; and/or (b) to purchase commercially available medical waste treatment systems to be installed at the units. Army Field Manual (FM) 8-10-14, *Employment of the Combat Support Hospital TTP,* has a field-expedient inclined plane incinerator, which may be used if necessary. Also, note that the Overseas Environmental Baseline Guidance Document (OEBGD) **[BEREF 5.a]** contains requirements for documentation of medical waste disposal (para C.3.20). Ensure that someone in the EMEDS/EMDG is completing this documentation.

Other solutions for medical waste disposal, in order of preference, include:

(a) Off-site treatment/disposal within country;
(b) Off-site treatment/disposal with AOR;
(c) Steam sterilization (autoclave) (DO NOT USE FIELD SURGICAL STERILIZER TO AUTOCLAVE MEDICAL WASTE);
(d) Controlled incineration
(e) Shipment back to CONUS
(e) Direct burial (below scavenging depth of 8 feet). NOTE: Before using the direct burial option, please contact CENTAF/SG (F) BEE for approval.

2.8 Radiation Safety Officer (RSO) Responsibilities

Wing (or equivalent) commanders must appoint your BEE (BEE Tech) in writing as the Site RSO and Unit Permit RSO. The BEE is responsible for all issues involving ionizing and non-ionizing radiation sources, exposure investigations, permit compliance issues, education and training.

CENTAF has a Radioactive Material (RAM) permit issued by the USAF Radioisotope Committee that covers storage and use of Chemical Agent Monitors (CAMs), Automated Chemical Agent Detector/Alarm (ACADA) and Chemical Agent Detectors (M8A1). CENTAF Policy, *RAM Permit Management Program* **[BEREF 4.a.]** provides detailed guidance to BEEs on compliance responsibilities and procedures.

CENTAF RAM Shipment Policy **[BEREF 4.b.]** outlines procedures required to ensure all RAM shipments are made in accordance with strict regulatory requirements. **BEE must document that a receiver is qualified to receive the RAM shipment, complete detailed shipping paperwork, and get documentation that the RAM has been received at the other end.** Compliance with strict shipping procedures has been an issue and special attention must be made to ensure proper procedures are followed in the future.

2.9 Biological Agent Analysis Capabilities

a. Hand-Held Assays (HHAs). HHAs may be available in either your BEE office or at CE Readiness (or both locations). The code key to the HHA is classified; contact the CENTAF BEE if you need a copy.

b. Portal Shield. Your base may have Portal Shield to detect biological agents. The CE readiness office will normally be responsible for the day-to-day operation of this equipment. However, if a positive result ever occurs, the BE office will be involved.

c. The Navy Theater Medical Surveillance Team (TMST) (Bahrain) provides theater biological detection rapid response capabilities. If a biological agent is identified through field-testing with the HHA and/or Portal Shield, the TMST will respond with confirmatory assessment equipment such as the **Ruggedized Advanced Pathogen Identification Device (RAPID).** Request for support must be coordinated through CENTAF and in turn, CENTCOM. Contact information for the TMST is DSN (318) 439-4945. Emergency line is DSN 439-4006/4841/4348.

d. Air Force Biological Augmentation Team (BAT). The only BAT in theater (as of ~ 1 Nov 03) is located at Tallil AB, Iraq. They have the RAPID capability.

2.10 Assessment of Occupational and Environmental Conditions and Exposures

CENTAF Policy for Documentation of Occupational and Environmental Conditions and Exposures **[BEREF 4.c]** establishes procedures for generating a site SF 600 Environmental and Occupational Health Workplace Exposure Data (EOHWED) summary and placing a copy of the document in each member's deployed medical record. The SF 600 summarizes data and associated health risk from a more comprehensive Environmental Health Site Assessment for the deployment site.

The policy standardizes BE industrial hygiene procedures. Procedures for collection, analysis, management and communication of occupational health information are outlined. When necessary, medical units will generate a separate OHWED to document workplace specific occupational exposures not covered in the EOHWED for applicable industrial workers.

CENTAF sites should follow procedures established in the Air Force EHSA Guide **[Atch to BEREF 4.c]** to generate the EHSA for your site.

Section 3 - Personnel Issues

3.1 Management of "Excess" Personnel, and Personnel Rotation (Swap-Out and Overlap)

As a new deployed medical commander, it is vital that you understand these key personnel management policies.

a**. Management of "excess" personnel.** The bed-down situation in the CENTCOM AOR remains dynamic, with changes in planning for site activations, deactivations, and force realignments occurring almost weekly. Please remember that medical personnel assigned to your EMDG/EMEDS are theater assets. As missions and situations change, some personnel may become "excess" to your requirements. Such individuals should be identified to CENTAF/SGX (F) immediately. As sites close (e.g., PSAB) or are realigned, CENTAF/SG (F) planners will evaluate requirements at other locations in the AOR. Excess personnel may be moved to another location for the remainder of their rotation. In some cases, personnel from a closure site may be placed in a holding pattern, (e.g., moved from PSAB to Al Udeid), as we await developments at other locations. Flexibility is the key. It is best for individuals to assume that they will be in the AOR for their entire rotation. **Commanders may NOT authorize early-release (i.e., prior to end of scheduled rotation) of an individual to home station without the express approval of CENTAF/SG (R) (Shaw) via CENTAF/SG (F).** Finally, we ask that both sending and receiving EMDGs/EMEDS commanders keep CENTAF/SG (F) advised on the departure and arrival of personnel, respectively.

b. Personnel rotations

(1) Early/Late arrivals. Personnel must report not later than their DRI. Only deployed commanders have the authority to allow arrival more than 7 days before, or AT ANY TIME after, the DRI. The request must be made in writing from the home unit and approved in writing by the deployed commander (or responsible official). The PRF will forward the request to the appropriate agencies. Approval to arrive before or after the DRI is not a DRI change; if members arrive early, they must serve the normal tour plus the time arrived early.

(2) Date Required In-place (DRI). DRI is the latest date of arrival in the AOR and the day the tour starts. This date is specified on the Deployment Requirements/Manning Document (DRMD) and is transmitted to the Personnel Readiness Unit (PRU) in the deployment tasking. The DRI is treated like a permanent change of station (PCS) Report Not Later Than Date (RNLTD). Only deployed commanders can authorize personnel to arrive more than 7 days early, or AT ANY TIME after the DRI. If transportation is not available to arrive on the required date, back up the travel date to ensure arrival not later than the DRI--arrival on the first rotator after the DRI is not acceptable. The PRU must monitor the status of travel arrangements for personnel traveling to SWA to ensure the arrival date is before the DRI. Changes to this date can only be approved by USCENTAF/CC/CS (EXCEPTION: For medical personnel, this authority has been delegated to CENTAF/SG, currently Col Tim Jex.) Changes will not be considered unless it is to establish and/or maintain a seamless rotation, or there is a change in the mission, equipment or location. In addition, all changes

must fall into the AEF rotation window if an AEF UTC is affected (excludes individual augmentee positions).

You can't get into trouble if you refer to the CENTAF policy that nobody leaves until his or her replacement arrives in person. There always seem to be last minute personnel changes, most noticeable during transition periods. However, please do not go to the AEF Center directly. Work through your local PERSCO and this office to track the "who and when" issues.

(2) Personnel rotation. The CFACC policy on "swap-out" is that no one leaves before his or her replacement arrives on base--not inbound, and not "supposed to be on a plane from Base X", but in the flesh--physically present. If there are positions that are being eliminated, either immediately or before the next rotation, please coordinate with CENTAF/SG (F) to determine release date for currently-assigned .

(3) Overlap. This is your call…to a point. Not every 4N0, for instance, needs a three-day overlap with their replacement. They can probably meet in the terminal, one getting off the plane, and the other get on that same plane. But your key players need to hand over the reins…in person…with a few days overlap. Key personnel are identified on the DRMD as requiring overlap.

Two things will expedite this process: (1) have the continuity book for each key player ready ahead of time; and (2) get down to the core issues.

3.2. USCENTAF/CV Guidance on Changes to Requirements. The attached letter from Brig Gen Peck states that once requirements for a rotation are sent to the AEFC for sourcing, changes must be formally requested by the functional area manager (FAM) at CENTAF (Rear) via CENTAF (F) A1 and SG, and will be personally approved/disapproved by USCENTAF/CV.

[Reference CENTAF/CV FAMS Policy]

3.3 Special Experience Identifiers and Line Remarks

We continue to have issues with manning. If you need personnel with a Special Experience Identifier (SEI) (e.g., an IDMT), or need a "*line remark"* for a particular position (e.g., "must be a 7-Level—no substitutions authorized"), make sure these requirements have been included on the DRMD. Your PERSCO office has the particulars on incoming personnel. Review your manpower requirements when you first take command, and periodically during the deployment. You should request any necessary SEIs or line remarks as soon as possible. Be mindful that CENTAF (R) must approve any changes to the DRMD, and this process takes substantial time and coordination. If a person coming in doesn't meet your requirements, according to the DRMD, then the incumbent must stay until a suitable replacement arrives.

3.4 Decorations and Letters of Evaluation.
Check with your boss and/or PERSCO on local policy on preparing and submitting AF Forms 77a, Letter of Evaluation, and decorations.

3.5 "Ninety-Day Warrior" Syndrome.
There are always a few folks whose replacements don't show up for one reason or another. When that happens, some folks will have to be extended. None of us signed up for a 90-day war when we joined the military. So when bad news comes about extensions, it is up to commanders to lead by example, mentor with wisdom, and demand no more nor less than that which will get the job done safely and effectively. These cases will require additional work, and your local PERSCO and this office will help to resolve those issues where possible. Also, please be aware that no one is guaranteed to be assigned to a single base during his or her rotation. Relocation to meet requirements is always a possibility.

3.6 Policy on Flight Surgeons Flying in the AOR.
The Commander, US Central Command Air Forces (COMUSCENTAF) has reaffirmed that flight surgeons are mission-essential personnel for flying purposes. This policy recognizes the role of the flight surgeon as a member of the aerospace team, responsible for assessment of human weapon system factors with the need to monitor performance, make recommendations, and evaluate reactions of the crews. Flight surgeons that meet the necessary criteria will be eligible for appropriate aircrew decorations under CENTAF guidelines. Aeromedical evacuation (AE) crews are also considered mission essential crewmembers on designated AE missions.

3.7 Personnel Reliability Program (PRP).
While actual PRP duties are rarely performed in the AOR, we do have personnel assigned who are on PRF (particularly Security Forces). Every patient should be asked if they are on PRP when they check in. Treat these patients according to PRP rules, and do make notifications to their PRP monitors back home if they have been treated with narcotics, etc. However, since they are not actively performing PRP duties in the AOR, you can wait until the next duty day (back at home base) to make these notifications to the home base unit PRP monitor. Ensure that the medical record is appropriately annotated, including documentation of the notification (who you called and when). Guidance on the PRP program is available on the ACC Surgeon's website (NIPR).

Section 4 - Clinical Issues

4.1. Immunizations

4.1.1. General

Anthrax, smallpox, and Flu immunization programs are very high visibility and get high-level attention. Neglect them at your peril. Your Public Health Officer is POC for these programs. Vaccinations must be entered into the AFCITA computer database. Current educational materials, policy, and guidance for these programs can be found at www.vaccines.army.mil, and http://chembio.xo.af.pentagon.smil.mil/.

Ensure timely receipt of vaccine (as soon as it clears customs). We risk losing valuable vaccine if the cold chain is not appropriately maintained. Frozen vaccine is as worthless as hot vaccine. Ensure temperature-recording devices are appropriately processed and that you receive confirmation from the shipping depot on validation of temperature control for each shipment.

DoD Public Affairs guidance has prohibited the usual "photo-op" of senior leadership receiving anthrax or smallpox vaccinations.

Personnel arriving in-theater should be current on all required vaccines; however, be prepared to cover those who arrive from their home stations unprotected.

4.1.2. Anthrax Vaccine

Not all countries in the AOR require anthrax vaccine. Locations considered high threat areas (HTAs) for anthrax are listed at http://chembio.xo.af.pentagon.smil.mil/bio-anthrax.shtml. If your country is not on the HTA list, personnel should not start/restart the anthrax series to come to your location. However, personnel who have started/restarted the anthrax series since Jul 02 must remain current while at your location, which will require you to maintain a certain level of anthrax vaccine in stock.

4.1.3. Smallpox Vaccine

All locations within the AOR (as well as a few others), are considered HTA for smallpox and all personnel assigned will be screened for contraindications and either (1) vaccinated against smallpox or (2) medically exempted. Exemption criteria can be found at www.vaccines.army.mil, and http://chembio.xo.af.pentagon.smil.mil/, under Smallpox, Clinical Policy. **All who deploy to a HTA are to have their smallpox vaccination prior to entering the AOR.**

Complete USCENTAF reporting instructions can be found at the AEF Center website at https://aefcenter.acc.af..mil/ under Deploying Airmen, Deployment Requirements, CENTAF, CENTAF Reporting Instructions.

4.1.4. Flu Vaccine

Each fall the DoD Influenza Vaccination Program rolls around and great efforts are taken to ensure 100% coverage of all troops to protect them from one of the world's oldest and deadliest health threats. This year, with global concerns over the potential recurrence of SARS, the Flu shot program promises to be an even bigger DoD priority…pleases work to ensure command

awareness and emphasis for compliance. Your POC for the Flu program is your unit PH Officer.

4.1.5. Flu Vaccine: Vaccine Adverse Events
Information on adverse events to both vaccines is located at www.vaccines.army.mil. All adverse events potentially related to vaccine administration must be evaluated by a provider and reported through VAERS (form downloadable from www.vaccines.army.mil). Include the patient's SSAN and branch of service in the margin at the top of the form (there are no blanks for this information). Completed VAERS forms will be forwarded to AFIOH/RSRH by fax (fist choice, DSN 312-536-6841), scanned e-mail attachment (AFIERA/CC@brooks.af.smil.mil), or surface mail (last choice, AFIOH/RSRH, 2513 Kennedy Circle, Brooks City-Base TX 78235). AFIOH will forward forms to CDC/FDA.

4.1.6. Anthrax/Smallpox Reporting
Two reports are required. They are compiled and reported separately to different headquarters. This is a big deal, and everybody (it seems) looks at these stats…by base.

a. **Monthly** reporting of Anthrax and Smallpox vaccination status from your public health officer to the CENTAF PH officer is required, due NLT COB **the last day of each month** via SIPR. Individual location stats are compiled by CENTAF/SG and sent to higher headquarters for theater reporting.

b. **Monthly** reporting of Anthrax and Smallpox vaccine stock levels, including stock numbers, from your medical logistician to the CENTAF medical logistician is required, NLT the 3rd of each month via NIPR.

4.2 Heat Stress and Water Intake
Dehydration is a year-round concern in the desert and results in heat casualties during summer months. Scores of cases of heat cramps, heat exhaustion and heat stroke have been reported in the AOR. Everyone must be alert for the signs and symptoms of heat illness after prolonged exposure to high temperatures, arid or humid conditions, and exertion outdoors. Work-rest cycles must be enforced.

AFMOA policy **[BEEREF 3.d.]** states that cool water is best for maintaining hydration, but for particularly hot jobs outside, local commanders can obligate funds to purchase sports drinks. If these drinks are dispensed, it is recommended that they be diluted with water to one-half or one-third strength. Regular diets contain adequate amounts of salt, so salt tablets are hardly ever required. **Key point: it is easy to get dehydrated when drinking too little water, but you can also get too much water. Limit intake of water to a maximum of 1½ quarts per hour**, which is a change from references you may have used in the past.

4.3 Global Expeditionary Medical System (GEMS).

4.3.1. GEMS is the CENTAF medical surveillance tool. **Use of GEMS is mandatory.** It

contains four modules:

a. **Patient Encounter Module** (PEM) gathers information on individual patient encounters. It is an electronic medical record, a legal document that is to be used by *providers* to document all outpatient visits and inpatient information. The contractors who developed GEMS are working to improve the system and have made significant strides over the past year, but they're not all the way there yet. If your providers have constructive suggestions for ways to improve GEMS, please have them forward those suggestions to the CENTAF/SG (F) PHO. Also include comments in your unit After Action Report at the end of the rotation.

b. **Theater Epidemiology Module** (TEM) helps your Public Health Officer analyze data on disease patterns.

c. **Theater Occupational Module** (TOM) is the Environmental Baseline Survey (EBS) tool for your bioenvironmental engineer to document environmental risks/exposures.

d. **Public Health Deployment** (PHD) module gives your Public Health Officer a tool for tracking programs in food safety, facility sanitation, and entomology.

4.3.2. GEMS Reporting
Every day your PHO must report the last 7 days' data from the PEM module to CENTAF/SG (F), AFIOH, and TMST via NIPR. Data are analyzed for trends with daily/weekly summary charts posted at the AFIOH secure website https://www.brooks.af.smil.mil/afiera/. These data are reviewed at the highest levels, and if you miss a day somebody will call us asking why. It is important to ensure that your data entry is accurate.

BE offices must send a monthly electronic export of the Industrial Hygiene and EBS export reports to oehs@brooks.af.mil and bee@auab.aorcentaf.af.mil. Send files over the NIPERNET.

4.3.3. GEMS Troubleshooting
Each site should have a designated GEMS Administrator. Usually, this is your MSC or a 4A0X1. They are responsible for performing routine database administration, and are the POC for working with the GEMS Helpdesk in troubleshooting any issues that arise.

The experiences of previous rotations and their after action reports have identified IT failures and training deficiencies as the "big rocks" to be addressed. HQ ACC SSG has aggressively addressed the IT issues through appropriate channels, and has worked to provide just in time training for all administrators tasked to deploy on future rotations.

The GEMS Help Desk should be the first stop for any technical difficulties. They are located at Gunter AFB AL, are open 24/7, and are best reached by phone (DSN 312-596-5771 or Com 877-596-5771). Be sure to ask for Expeditionary Medicine or GEMS help.

General questions on GEMS use and expectations, set-up procedures, QA procedures, and/or reports should be referred to the CENTAF(F) Public Health Officer (PHO). If anyone has difficulty contacting the Helpdesk, or is not getting satisfactory service, this needs to be relayed

to this office as well. Likewise, if the site has difficulties with GEMS and cannot submit their daily reports, the CENTAF(F) PHO must be contacted.

4.4 Malaria prophylaxis

4.4.1 CENTAF Anti-Malarial Policy
As malaria risk within the AOR varies greatly from one location and season to another, local consultation between providers, Public Health, and CE Entomology will continue to be necessary to best determine local anti-malarial needs.

The most current Armed Forces Medical Intelligence Center (AFMIC) data, USCENTCOM guidance, and CENTAF Supplemental guidance should be referenced when determining specific risk areas and periods.

Chloroquine, Mefloquine, and Doxycycline are now all authorized for use as anti-malarials for personnel assigned to malarious areas of Iraq. While all three drugs may be used, Chloroquine should be considered the anti-malarial of choice. Its is preferable due to its greater suitability for prolonged administration, generally better compliance as compared to Doxycycline, and its lower incidence of side effects as compared to Mefloquine. Additionally, Chloroquine is authorized for personnel on flight status.

Mefloquine will remain the antimalarial of choice for all other at-risk areas of the CENTCOM AOR outside Iraq. Doxycycline is the anti-malarial of choice for personnel on flight status in these Chloroquine-resistant areas; however, due to common non-compliance issues, routine use of Doxycycline for malaria prophylaxis of *non-flying* personnel is not recommended.

Terminal prophylaxis (30 mg of primaquine base QD for 2 weeks while still taking chloroquine/mefloquine/doxycycline) is required once personnel leave a malarious area.

4.4.2 Primaquine in G6PD-Deficient Patients:
Primaquine use in G6PD-deficient individuals can lead to adverse outcomes. For those with a 6PD deficiency, prophylax with a standard course of chloroquine, mefloquine or doxycycline, including the 4-week terminal chloroquine, mefloquine or doxycycline after leaving the malarious area, but withhold terminal prophylaxis with primaquine. If they "break through" with *P. vivax* or *P. ovale* later, give primaquine using a modified dosage schedule under careful medical monitoring. For those with African G6PD deficiency, give 3 tablets (45 mg base) weekly for 8 weeks; for those with Mediterranean G6PD deficiency, give 2 tablets (30 mg) weekly for 30 weeks (*Navy Medical Department Pocket Guide to Malaria Prevention and Control*, p 56).

4.5 Leishmaniasis

Leishmaniasis is a serious and sometimes-fatal disease caused by a parasite transmitted to humans by the bites of infected sand flies. In Iraq, the peak season for transmission is from April

to November. Numerous cases of Leishmaniasis occurred in U.S. forces during the opening months of Operation IRAQI FREEDOM.

Public Health (PH) personnel throughout the AOR track sand fly populations, devise control methods, provide disease threat education, and help commanders ensure personnel use appropriate PPM. Medical providers assist by identifying suspect cases and ensuring rapid diagnosis/treatment. An AF medical entomologist is in-theater during the sand fly season co-located with the PH office and AF BAT at Tallil AB. The AF BAT assists the medical entomologist with identification of Leishmaniasis in sand flies, and may, upon CENTAF SG request, provide consult services to other AOR sites.

CENTAF medical units in Iraq should already have an aggressive and comprehensive Leishmaniasis Prevention & Control Program already in place. The degree of emphasis other program components receive, and the specific details on how they can best be applied, will be left for local command determination in consultation with Public Health personnel.

Although there are numerous elements in a comprehensive Leishmaniasis prevention program, the correct and conscientious use of personal protective measures (PPM) and, specifically, the DoD Insect Repellent System, which includes DEET on exposed skin, Permethrin-treated uniforms & bed nets (IDA Kits preferred), and properly worn uniforms, is our best line of defense.

Please ensure your physicians contact the CENTAF SG (F) PH Officer regarding any in-theater suspected cases of Leishmaniasis. The CENTAF SG(F) PH Officer will work with them to refer these individuals to a designated infectious disease consultant, currently located at 332nd EMEDS, Talil AB, Iraq.. Since time to referral is not critical for most cases, they can travel Space A to Tallil (i.e., patients do not need to be sent via Aero Evac.). If they are positive, they are sent directly to WRAMC for confirmation and treatment.

4.6 Blood/urine testing and Rape Kits:

Every MTF in the AOR should have the following kits:

- A combined Blood/Urine toxicology kit for use in drug testing, accident investigation, or command directed testing. The NSN on this kit is 6550-01-111-5053.
- Rape/assault kits. While this kit does not have an NSN, it is available from Surgicot Inc, Part # 711010, UPN H2927110102. There are 4 tests per box and the cost is $128.00 per box.

These products have been coordinated with both the medical and OSI communities. Every base should have 10 blood/urine kits, and at least 2 Rape kits. This should alleviate concerns about samples meeting legal requirements.

4.7 Clinically Inappropriate Personnel in AOR

Real-world examples of personnel who were not clinically appropriate for deployment (all of

whom required evacuation from the theater after arrival) include a member deployed to the AOR on a CPAP machine for sleep apnea; a troop deployed on two antidepressants and one antipsychotic medication who became severely depressed when he ran out of meds at a forward location.; and an individual who reported to the EMEDS for a refill for narcolepsy medication (Dexedrine). Please forward complete information on any service members who have been deployed with inadequate medical screening or inappropriate medical management, including:

- Name, Rank, SSN
- Unit at home station (unit designation; DSN), including MAJCOM
- Deployed unit and location
- All pertinent medical history and treatment

4.8 Routine Patient appointments, or, "Can it reasonably wait"?

We need to keep the needs of the mission in mind and balance it with the medical needs of our patients. We tend to bend over backwards to serve our patients. As a consequence, many of our patients expect the usual special handling, even though "we're not in Kansas anymore".

The following, specific case provides an illustration:

- A patient with a previously abnormal pap was sent for evaluation to Landstuhl. While there, she underwent a LEEP procedure (electrical "coring" of the cervix for diagnosis / therapy). Several thoughts come to mind:

-- If her pap was THAT abnormal, why did she deploy? The result did not come back after she deployed.

-- Why could this not wait 90 or 120 days? Given that the Pap was not suspicious for CA, there was no need to do such evaluation immediately.

4.9 Needle stick exposures.

The first step in managing needle stick exposures is to prevent them in the first place. When that fails, we recommend sending lab tests to US facilities, such as Landstuhl or Brooks, etc. If test results are positive, people can be sent out of the AOR without worrying about the legal implications in the host country. Remember that we don't have Status of Forces Agreements protecting US military personnel from local laws in many countries in the AOR. It may be very difficult to get reliable and timely results from local health departments or host-country labs, and some positive lab results might elicit unwanted official interest.

4.10 Kidney Stones

Because of the tendency for people to get dehydrated, we see far more cases of kidney stones in the AOR than back in the States. This serves as another reminder to us to keep the troops well hydrated.

4.11 Medical Management of Patients Exposed to Depleted Uranium

CENTAF Memo, *AF Medical Service Policy on Operation IRAQI FREEDOM Depleted Uranium (DU) Medical Management* **[BEREF 4.d]** identifies procedures for managing patients potentially exposed to DU. Medical providers should be familiar with this information as

necessary to appropriately identify, evaluate and medically treat patients with potential DU exposure.

4.12 Management of Pregnant Personnel. For Air Force personnel, the guidance in the "AEFC CENTCOM Reporting Guidelines," para 2B, is clear:

> "Women should ensure they are not pregnant prior to departure. Pregnant women will be returned to home station immediately and the home unit will be required to provide a replacement. Pregnant women should be identified with an assignment availability code (DIN ABA) of "81.""
>
> (The complete guidelines can be located at https://aefcenter.acc.af..mil)

For other active duty personnel, specific service policies will apply. Col Bill Gray, 379 EMDG/CC, did some excellent research on ACOG standards for care, and the risks associated with retaining pregnant personnel in the AOR:

> "The academy recommends the initial prenatal visit to include a pelvic exam with Pap smear and genprobe (std screen). The following tests should be done at this time: blood type and Rh determination, antibody screen, HCT/hgb, rubella antibody titer measurement, VDRL, GC, UA, HbsAg, HIV, CSV, and PPD. During the second trimester the following tests should be done to meet standard of care: maternal serum alpha fetoprotein (ideally at 15-18wks), antibody screen for Rh negative women preparatory to RhoGram, ultrasound for dating and fetal anomalies/growth (ideal time is 15-20 wks), amniocentesis for high risk patients, diabetic screen with glucose tolerance test and repeat H&H. We do not have the lab or pathology resources to complete these exams, nor do we have a Doppler to detect fetal heart tones at 10-12 weeks, or u/s to confirm dates. Not only the need for diagnostic evaluations, but also, the lack of Gyn care for ectopics, spontaneous ABs, etc., make it somewhat risky to keep these women in theater."

Generally, pregnant personnel will be returned home as passengers, and will not be regulated as patients. The chief of operations at GPMRC has noted:

"Historically, the GPMRC's policy has been that pregnant women in the first and second trimester with no complications (i.e.. low risk history/good over-all health, etc.) are passengers. Only if there is significant risk to mother and/or fetus was either considered patients. In fact, my recollection of the Bosnian conflict is that it was faster to go duty pax, so newly discovered pregnancies were moved as duty pax AFTER BEING EVALUATED BY A PHYSICIAN AND GIVEN WRITTEN CLEARANCE TO FLY WITHOUT MEDICAL SUPPORT (DOCUMENTED) IN THE PATIENT'S RECORD."

Section 5 - Administration

5.1 Ambulance Markings:
ISSUE: Can the US use the Red Crescent in lieu of, or in addition to, the Red Cross on Ambulances in the AOR?
Short answer: NO!
Longer answer: see attached.

[Reference Ambulance Marking Guidance]

5.2 Care for Host Nation, Local and other Non-U.S. Civilians

What care can we give to HN and TCN personnel? This is a common question after each rotation. Generally, emergency care to preserve life, limb or eyesight can be provided to anyone. For civilian patients, they must generally be referred to host nation, other nation, or non-governmental organization (NGO) care and control as soon medically indicated. Specific guidance from USCENTCOM:

> (U) U.S. forces may provide emergency HSS to individuals from the local population in order to preserve life, limb or eyesight. Also, HSS will be provided to civilians injured as a result of U.S. or coalition actions. This includes emergency transport to coalition medical treatment facilities. Civilian patients will be returned to their National medical authorities and control as soon as medically indicated.

If you admit a civilian patient, please contact the CENTAF/SG (F) medical planner at DSN 318-436-4118, and also include complete details in your next MEDRED-C. We will contact, or direct you to contact, appropriate CENTCOM Surgeon's staff members to begin working transfer/placement to a HN, foreign or NGO hospital/organization. By all means, provide any care necessary for the patient until proper transfer is completed.

5.3 Care for U.S. DoD Civilians, diplomatic personnel, contractor personnel, coalition forces, EPWs, and others.

a. Emergency care. You are authorized to provide emergency care (necessary to preserve life, limb, or eyesight, or to prevent complication of a serious illness) to anyone in need. Generally, this is the only care that will be provided to HN or TCN personnel. Use your good judgment here. Transfer non-authorized personnel to other sources of care as soon as practicable. If you do not have local options, contact the JPMRC for assistance and guidance.

b. U.S. DoD civilians (i.e., Civil Service, GS). Generally, these personnel will be authorized care, particularly if assigned to your installation. U.S. government diplomatic personnel assigned to embassies, consulates, etc., will usually have access through assigned medical staff, or HN resources.

c. Contractor personnel. Col Tim Jex, USCENTAF Surgeon, provides some clear guidance: "Authorized care for contractors is a never-ending issue, but the answer is always the same. The burden is on them to come up with a copy of their contract if they want care from us. Our only viable position is to maintain a fairly hard line on this. We recommend that bases include this issue in their newcomer's orientation so the civilians can start working the issue before they walk through the EMEDS door." Exceptions are made to this policy under the anthrax and smallpox vaccination programs. Contractors providing "mission essential (ME)" duties are authorized vaccination. Your local contracting officer can assist in identifying these individuals.

[Reference Essential Contractor Guidance]

d. Coalition forces. COMUSCENTCOM Plan 1003V, Annex Q, notes that care is provided to coalition forces on a "reimbursable or reciprocal basis". As Col Tim Jex has noted, our British and Australian allies have stood with us from the beginning, and they have provided care to our forces (reciprocity) in many locations. Provide care to these allies on the same basis as our own forces, and don't be concerned with reimbursement. For other nationalities, there is potential for AF medical units throughout the AOR to provide episodes of care to some 15 nations (or more) forming the Multi-National Division (MND) in southern Iraq, and at other locations. Those nations are required to establish "ACQUISITION AND CROSS SERVICING AGREEMENTS (ACSA)" with the United States, and it is possible to seek reimbursement for such care using CC Form 35 (EF), Sep 2000. Ask your local contracting and finance offices for assistance. Use your own good judgment in seeking such reimbursement. Minor episodes of care probably don't warrant the administrative effort.

e. Enemy Prisoners of War (EPW). EPWs are generally provided care on the same basis as U.S. military personnel. Generally, Air Force EMDGs/EMEDS should only take such patients on an emergency basis. The Combined Forces Land Component Commander (CFLCC) has been designed by COMUSCENTCOM as the executive agent for providing HSS to EPWs. If you care for or admit an EPW on an emergency basis, be sure to include comments in your next MEDRED-C, and contact CENTAF/SG (F) telephonically (as you would for any unusual occurrence).

f. Other U.S. citizens/dependents. In some locations, active duty U.S. personnel have married local nationals, and have sought care for these dependents. Infrequently, retired U.S. personnel have sought care from local EMDGs/EMEDS. Generally, these individuals will not be authorized care (except on an emergency basis). These personnel/dependents are usually not command-sponsored, i.e., not in the AOR as a result of official orders.

5.4 Safety Reporting

Make sure your staff works with the local Safety Officer for all standard Ground/Air Safety issues. Ground safety issues (especially sports injuries) can have a significant impact on Disease Non-Battle Injury (DNBI) numbers.

5.5 Reporting Patient Visits
We must all have a common framework of reporting patient visits. Do not report visits to the MTF to fill out the post-deployment surveys as a patient visit. Any visit, which does not include evaluation, diagnosis, and an action plan, is not a reportable visit. This inflates the actual workload and causes a lot of confusion (questions) when one day you report 10 visits, and the next you report 45! As for Coalition partners, count them as if they were US troops. If US troops are seen in Coalition facilities, DO NOT counts them in your MEDRED-C report.

5.6 MDG Effectiveness/Statistics
The 363rd EMDG at PSAB constructed slides every week to track key information (see attached) of interest to the local wing commander. These included patient visits; water analysis; public health issues; GI, respiratory, and injury rates. You may want to produce similar slides for a tabletop briefing for your commander also.

[Reference MDG Standup Example Slides]

5.7 Medical Record Disposition

5.7.1. Outpatient Records. All outpatient records should be placed in the AF Form 2766, Deployed Medical Record, and returned with the re-deploying individual to their home station. All out processing personnel must be directed to go by the records section before redeployment to pick up records, films, etc.

5.7.2 Inpatient Records. According to AFI 41-210, 1 Oct 00, paragraph 2.6:
The deployed MTF maintains inpatient records while deployed. Upon return of the facility to home base, give records to inpatient records section for maintenance as separate record group. Do NOT send inpatient records to patient's home station MTF if different from facility's parent unit. The parent unit will retire records IAW AFMAN 37-139.

Records created by contingency facilities whose management rotates between services or between different AF units, maintain records until management rotates. Upon management rotation, return records to parent unit's inpatient records section for maintenance as separate record group. Do NOT send inpatient records to patient's home station MTF if different from facility's parent unit. Parent unit will retire records IAW AFMAN 37-139.

Records of care for TCNs should be destroyed after two years.

5.8 Paying for Care from Civilian Sources
Short version - there is limited TRICARE in theater. It is generally limited to Permanent Party personnel. If you have any at your base, there should be a mechanism passed to you by your predecessors.
Long version: We have had repeated queries about what to do with troops sent "downtown" for care. Based on guidance from the Contracting and FM experts, when possible, please coordinate

with FM to arrange payment prior to sending someone for civilian care. The member's orders will also provide valuable information. If the member's orders are for OEF/OIF, they should end in ESP code "7C". This will dictate which base fund cite is used to pay the bill. To clarify, the fund cite used will be from **the base**, NOT the member's orders. For those of you who use appropriate host nation facilities on a regular basis, consider establishing contracts for continued usage. Work these issues with your local contracting and FM offices and keep CENTAF/SG (F) informed.

5.9 Shelf Life Extension Program (SLEP)
For drugs that are nearing or past their expiration dates, the manufacturer (via the FDA) will frequently extend the shelf life beyond the current expiration date on the label. Our loggies have notified their counterparts, but you need to be aware of this phenomenon also…especially as it relates to BW/CW antidotes. Remember that in almost every case, a medication on hand, even one beyond its expiration date, is better than nothing. Don't throw anything out until it is replaced. Many expired meds can also be turned in for partial financial credit.

Here is an example of a Shelf Life Extension Program (SLEP) query with Lot number **(9ACX)** for Cipro. Note, item is extended until **31 DEC 03**. Click "**Msgs"** to see the authorization of extension for specific Lot Numbers. If you have any questions, please contact CENTAF/SGXL (F).


FDA Shelf Life Extension Progr...

5.10 Squadron Medical Elements (SMEs)
Each SME belongs to a line commander, usually a deployed flying squadron commander. However, our ability to function at the base level relies on the smooth integration of ALL medical assets into a cohesive network. The EMEDS/EMDG/CC has tactical control over all medical personnel at their base, including SME flight docs/techs. The SGP is responsible for insuring that flight docs/techs meet their SME responsibilities while also sharing in the work at the clinic/hospital. The SGP will manage flying schedules, flight medicine clinic schedules, industrial shop and public health visits, and clinic/hospital schedules for all flight medicine personnel (including SMEs).

5.11 Over-the-Counter (OTC) medication programs
Short version: OTC programs are not authorized by CENTAF/SG.

Because no uniform program exists for all services at all bases, dispensing OTCs at your EMEDS may set a precedent, which would be hard to reverse. It will naturally extend to other bases nearby (if you provide OTCs, *they* will come…). It's a good way to meet your neighbors, but you can exhaust your supplies in short order.

The DoD formally ended OTC medication pick-up programs over 10 years ago.

Fliers, PRP, and Special Operations personnel are restricted as to what OTCs they can take.

5.12. Deployment Health Surveillance

The DoD Deployment Health Surveillance initiative consists of three phases. There are pre-deployment, re-deployment (within the AOR), and post-deployment portions of the process. The re-deployment portions must be completed in-theater.

Every individual must complete the 4-page Post-Deployment Health Assessment questionnaire in theater prior to re-deploying home. This questionnaire is now available in electronic format in AFCITA Plus. The electronic form in AFCITA Plus replaces the need to accomplish this on an original hardcopy questionnaire. Once completed, an electronic copy is automatically sent to the army surveillance activity site. An electronic copy must then simply be printed and placed in the deployed medical record.

Every individual must be provided a SF 600 EOHWED (Environmental and Occupational Health Workplace Exposure Data) form.

Every re-deploying individual must have the opportunity to ask questions of a provider (physician, PA, NP, or IDMT), and that provider must review and sign their Post-Deployment Health Assessment questionnaire. EOHWED should be used to answer environmental exposure-related questions.

All outpatient records (printed from GEMS), the smallpox screening form (if immunized in-theater), the EOHWED, and the completed/signed Post-Deployment Health Assessment questionnaire must be packaged with the DD Form 2766, Deployed Medical Record, for the member to hand carry to Public Health at their home station.

For questions regarding re-deployment processing, or for copies of the most current CENTAF and AF Policy outlining the process, please contact the CENTAF SG (F) PH Officer.

5.13 Purchase of Non-FDA Approved Medications

There are some issues related to the buying of pharmaceuticals from the local economies, as most are not FDA approved. The first issue is to make sure our loggies have complied with AFMAN 23-110 Vol. 5 Chapter 16 and other references.

AFMAN 23-110 Vol. 5

16.3.3. Local Purchase is not authorized for: drugs that do not meet the definition of approved drugs in AFI 44-102, Community Health Management. For exceptions, see paragraph 16.11. and AFI 40-403, Clinical Investigations in Medical Research Guidance and Procedures.

AFI 44-102
1.52.3. Pharmacies can procure, dispense, recommend, or use only drugs approved by the FDA. Do not buy non-US manufactured, non-FDA approved drugs downtown.

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.

Commanders are in the cross hairs on this issue to some extent. They must keep the force mission capable, and yet follow appropriate guidance. When in doubt, call for assistance.

5.14 Participation by U.S. personnel in humanitarian medical activities
COMUSCENTCOM guidance is quite clear. U.S. personnel will not participate in humanitarian assistance medical activities unless specifically directed to do so by COMUSCENTCOM. Specific references are provided below.

> 2. (U) Humanitarian medical activities such as providing immunization, health screening or outpatient care clinics or "space available" hospitalization for local national civilians is beyond the scope of the health service support mission. These types of humanitarian assistance are not permitted without specific direction of USCINCENT.
>
> (g) (U) Civil Affairs. Unless specifically directed by USCINCCENT, U.S. medical units WILL NOT be involved with direct support to Humanitarian Assistance or Civil Affairs activities.

5.15 REPORTABLE MEDICAL EVENTS
All tri-service reportable events; e.g., leishmaniasis, hepatitis, salmonella, etc., must be submitted to the Army Medical Surveillance Agency (AMSA). Please send reports of these events as they happen to the CENTAF SG (Fwd) Public Health Officer so that they can be validated and forwarded to the Air Force Institute for Operational Health (AFIOH). AFIOH will submit them to AMSA. If you are unclear about what events are reportable, the codes and case definitions may be found in the "Tri-service Reportable Events: Guidelines and Case Definitions" on the AMSA website at http://amsa.army.mil/AMSA/amsa_home.htm.

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7 Oct 03

Atch 1

CENTAF POLICY - BEE REFERENCES [BEREF]
On NIPERNET at URL: https://kx.afms.mil/centafbee

1. Management

a. CENTAF BEE Guidance, Jun 03

2. Medical NBC Defense

a. Protective Equipment for Sampling of Suspicious Packages, Feb 02
b. Guidance for Shaving Waivers and NBC Protective Masks Use, Apr 03
c. Policy Memorandum for Nuclear Biological and Chemical Defense Equipment (NBCDE) Usage in Southwest Asia (SWA) Area of Responsibility (AOR), May 03
d. Chemical Warfare Agent Health Risk Assessment Guidance, Aug 03
e. Gas Mask Quantitative Fit Testing (QNFT) Interim Policy, AFMOA/SG, Jun 02

3. Drinking Water

a. Recommended Sampling Frequency for Bottled Water, Jun 03
b. Interim Policy, AFMAN (I) 48-138 Sanitary Control and Surveillance of Field Water Supplies, Aug 03
c. Water Surveillance Reporting Policy, Aug 03
d. Revised Policy on the Role of Sports Drinks in Prevention of Dehydration and Heat Illness, AFMOA/CC, Aug 01

4. Occupational Health and Radiation

a. Radioactive Material Permit Management Program, May 03
b. Radioactive Material Shipment Policy, Jun 03
c. Policy for Documentation of Occupational and Environmental Conditions and Exposures, 10 Sep 03
d. Policy on IRAQI FREEDOM Depleted Uranium (DU) Medical Management, Aug 03

4. Environmental

a. Overseas Environmental Baseline Guidance Document (OEBGD), Jun 03