As part of my duties as the AF/SG8, I am the SG rep to the AF Board, a team of MAJCOM and HAF GOs and SESs who help build the AF POM and AF Budget. Periodically, the Board is honored to travel to various bases to see our operational AF first hand—to hear from the young men and women who are saddled with the task of applying scarce resources and capability apportioned to them through our POM and Budget processes. We recently returned from a quick trip to Langley, Davis-Monthan, Beale, Nellis, and Creech (with a stop off at the AF Academy) where we were able to see our fellow AF warriors working their tails off in the Joint and AF fight. It was very inspirational to see and hear how they are doing our Nation proud as they take the fight to the enemy and rescue our injured from the battlefields in distant lands—all the while putting their lives on the line day in and day out. It reminded me how blessed I am to be a member of the AF team...it re-energized me for the challenges that lie ahead. There is still so much more to accomplish in the short time I have left as a member of the active force.

Speaking of POMs, I hope you had input into our AFMS POM efforts through the call for investment opportunities...if you did not, you are missing out on a great opportunity to positively impact our mission and future, and to further develop your skills and knowledge of strategic resourcing and prioritization processes. Don’t be disappointed if your idea doesn’t make the final resourcing cut...the journey can be as rewarding as the outcome in terms of your development as an MSC.

It was great to see and visit with many of you at the MSC Awards Dinner and AF Day in Chicago. Congratulations to all those recognized as nominees and award winners—you represent all MSCs and I know you realize how much all of your teammates contributed to your recognition. We also rolled out the MSC Strategic Plan, and we now have an excellent roadmap to get some very important things done during the next few years. As we make progress in meeting our objectives, we will be sure and share those successes across the MSC “fleet” so all can be informed. I’m very serious about our goals and encourage you to study the goals and objectives—the objectives will continue to “morph” as the goal champions and their teams work through them. If a particular goal sends chills up and down your spine, contact the goal champion and volunteer for their team. You might as well help to build your future, right? Check out the MSC website for the Strat Plan and Goal Champions.

I start a rigorous travel schedule shortly. I’m looking forward to seeing you as I travel to USAFE, IES, the Med Readiness Symposium, W-P, New Colonel’s orientation, etc., etc. Visiting with you is definitely the highlight of my role as Corps Chief.

See you soon!
So glad that spring is finally here and winter (and all that snow) is finally over with!

We had a wonderful time with the annual Air Force MSC Awards dinner held in conjunction with the American College of Healthcare Executives Congress on Healthcare Leadership in Chicago last month.

Thanks to our MSC Force Development fellow, Maj Gigi Simko, and her small but mighty team of helpers, the evening went smoothly and a good time was had by all. Maj Craig Keyes did a fabulous job as emcee since our very own Associate Corps Director, Lt Col Greg Cullison, is currently deployed to Afghanistan. Everyone enjoyed the newly featured “Spirit Videos” produced by the MAJCOMs and/or their MTFs; the Lakenheath team who represented USAFE walked away with the “Oscar” with their Monty Python-themed search for the “Medical Home.” It was a pleasure to celebrate with all the honorees, including the AF Annual Award winners, the AF ACHE Regent award winners, and all our generous sponsors without whose support such a first-class event would not be possible. I echo Gen Miller in congratulating all our outstanding award nominees and winners!

Our Air Force Day program featured our Air Force Surgeon General, Lt Gen Bruce Green, as the keynote speaker. He emphasized the AFMS imperatives and how critical the contributions of our professional administrators (MSCs!) play in successfully achieving our objectives. We were also honored by having retired Brigadier General Don Wagner provide us a very insightful and personal reflection of his long career as a healthcare administrator in both the military as well as in the private sector. As the 2008 ACHE Lifetime Service Award winner, he is the second AF MSC to have been bestowed with this honor…retired Col Don Good had also been similarly honored for his ACHE contributions during his career as an AF MSC as well as in academia while serving on the faculty of George Washington University’s Health Service Management program. General Wagner’s remarks were creatively presented in a format very similar to Bravo’s “Inside the Actor’s Studio” format, with BGen Miller asking him the questions and Gen Wagner responding in a thoughtful and spontaneous manner. We only regret not having recorded it for those who missed it…otherwise we could have posted it on YouTube! The third and final presentation focused on our updated MSC Strategic Plan, which, as Gen Miller mentioned, everyone can access on the MSC Knowledge Exchange website. More importantly, we very much encourage as many people as possible to volunteer to help work on the strategic plan objectives…simply look up the goal you are most interested in, and contact the Goal Champion for that goal.

My final shout out this quarter is to all of you out there deployed around the world…we missed seeing your faces in Chicago but know that you are doing great things supporting OEF, OIF and many other important missions. I’ve heard from a lot of you, and am so proud of what you are doing for our country, our Air Force, and our families. Continue the great work and come back safe!

Recent or Upcoming MSC Retirements
Thank you for your service - best wishes for a successful future

COL LINNES CHESTER
COL GARY FORTHMAN
COL DIANE REESE
COL BRIAN “HOOSIER” RIGGS
LT COL CHARLES CHAPDELAINE
LT COL SEAN MURPHY
LT COL JUDITH SCHULIK
MAJ ROBERT ENGLE

COL LINDA EATON
COL THOMAS HAINES
COL ROBERT RENNIE
COL LYNDASY STAUFFER
LT COL REGINA JULIAN
LT COL DAWN ROWE
MAJ ALBERT DUFFIELD

If we have missed someone, please let us know. We are not routinely notified by the personnel system and rely on informal channels including retirement letter requests. To request a letter from the Corps Chief, please go to https://kx.afms.mil/msc.
Greetings from Afghanistan! I am having the deployment of a lifetime in Kabul as a member of a Medical Embedded Training Team, working with the Afghan National Police (ANP) Office of the Surgeon General and ANP medical leaders around the country. I fell in on an existing USAF team in late October (actually Halloween night—Trick or Treat!) Then a Navy team of medics that I was with for Combat Skills Training at Ft Polk arrived and displaced most of the Air Force members of the team. So I have had the pleasure of working with two different teams of professionals, and the experience has been incredible.

We are finding that Afghanistan is a country of contrasts. The situation in Kabul does not reflect the realities in other parts of the country. This is true geographically, socio-economically, ethnically, and certainly true in terms of ANP medical infrastructure and development. Here in Kabul, we work mainly with the doctors, nurses, and administrative staff at the 200-bed ANP Central Hospital (ANPH). This hospital has come a long way in the last few years, and we believe its Executive Staff can effectively manage the facility on a day-to-day basis. They only need our help periodically as they address significant problems. Most of the problems are due to logistics and involve the rather robust bureaucratic inertia that has developed within the Afghan government, the vestigial remains of the Soviet era here in Kabul.

On several trips outside of Kabul, I have seen areas of the country where there is no ANP medical system to speak of, not even first aid-trained members of the force. It is well reported by the media that the ANP is several years behind the Afghan National Army, in terms of staffing, resources, and training. ANP Combat Support and Combat Services Support, including medical care and logistical processes have also lagged behind the ANA’s. But progress is being made on all fronts. ANP Basic Training is ramping up in several sites around the country, enabling the force to grow to the desired end-strength as quickly and responsibly as possible, in order to protect and defend Afghan citizens from insurgents and criminals. Likewise, physicians and nurses are being recruited, and medical facilities are being built to give the ANP the proper level of medical support that it requires, both in the cities and in the rural police districts.

I will be completing the deployment in April, and I consider myself fortunate to have been able to travel throughout Afghanistan and to meet the people and learn of their history and culture. It makes me more grateful than ever to be an American. I am proud of the job the Air Force Medical Service is doing as part of the joint and coalition forces to help rebuild Afghanistan after three decades of war and oppression. I urge any of you to take the opportunity to deploy to Afghanistan in an advisory role. This will be among the most memorable experiences of my career.

From the Associate Corps Director

LT COL GREGORY CULLISON

From the Editor

Maj Gigi Simko, Fellow, MSC Force Structure Management

Happy Spring—hope you’re beating seasonal allergies and enjoying the warmer weather!

Keep those articles and photos coming. You’ll see in the next few pages I get plenty about deployment. Our peers are doing tremendous work in remote locations.

We’d also like to hear how people are doing at home station. Remember the newsletter when you implement a best practice or process improvement or simply have a lesson learned to share.

Only three more TDYs remaining in my fellowship. The call for applications for AY 2011 fellowships, EWIs and AFITs will be out by the end of May. I encourage everyone to apply. I never expected this one to turn out spectacularly. When else would I be expected to arrange an awards dinner to rival the Oscars, conferences for senior leaders and junior personnel, tours, too many luncheons and dinners to count, not to mention the opportunities to be a fly on the wall (Capt Palumbo’s article at the end of the issue talks about this). The best part has been the people... It was a pleasure to finally meet many of you in Chicago last month. Exchanging e-mails and talking on the phone is no substitute for personal interaction. A huge THANKS goes out to Capt Wendy Moreno, Capt Joe Sanchez, Capt Statwell Sinclair, Maj Dave Gill and Maj Pam Townsend-Atkins who helped me orchestrate the AF Activities held in conjunction with ACHE Congress. My wedding was easier to plan, but they kept me sane.

As I get ready to give my ice breaker speech, I want to put in a plug for self-improvement. I recently joined a local Toastmasters chapter. I figured this would be a good way to improve my oral communications skills, especially extemporaneous speaking. Whatever aspect of yourself you decide to improve, tackle it full on. Make a commitment to lifelong learning.

Thank you for everything you do every day. If you need anything, feel free to call or e-mail anytime. Take care. - Gigi
Medical Teams Render Aid after Afghanistan Avalanches

MSC officers from all over Bagram Air Field, Afghanistan, rallied to help the victims of this natural disaster. Close to 300 Afghan Nationals were off-loaded and triaged at the passenger terminal, a couple of miles from the hospital. For complete article, visit http://www.defense.gov/news/newsarticle.aspx?id=57929.

Expeditionary Medical Support (EMEDS): What Planners Need to Know

Maj Joseph Lyons

What you already know:
EMEDS was designed using Air Force-minded doctrine. It is flexible (modular), rapidly deployable (mobile), and easily fits in the back of Air Force aircraft (small footprint). Those are the Line of the Air Force requirements levied on Air Force medical planners. When planning medical requirements, we planners use Population at Risk (PAR) factors (not bed count). Because EMEDS travels on aircraft, it is “always” (doctrine) positioned near an airfield, so we utilize air evacuation as a standard practice. The combination of PAR and Aeromedical Evacuation helps EMEDS maintain the smallest possible footprint necessary to meet mission requirements.

What you need to know:
1. The footprint is not that small, when you consider the Base Operating Support (BOS) requirements for operating an EMEDS.
2. PAR differs based on missions (Combat Support (CS), Humanitarian Relief Operations (HUMRO), and Defense Support to Civil Authorities (DSCA)).
3. Aeromedical evacuation authorization differs based on missions (CS, HUMRO, DSCA).

An EMEDS +10 (10 beds) deploys on 17 aircraft pallets and sets up in 6 Alaskan Shelter tents. Those are relatively small footprints in terms of pallet positions and ground space requirements. What’s missing? Did you bring a 100k generator and plan for 150 gallons of diesel fuel per day? Was there a 10k all-terrain forklift available at the airfield when EMEDS arrived? Did you secure an ambulance or at least some vehicles for patient movement? Where are the medics sleeping, eating, freshening up, etc? Security? Re-supply plan? There is a significant BOS requirement to be added to the footprint and must be planned for.

PAR on a CS mission counts for healthy Airman (and other base personnel). The same PAR can’t be used for either HUMRO or DSCA missions. If EMEDS deploys to aid an ill and injured indigenous population, then planners must consider additional medical requirements. The type of response can change your PAR planning. Women in their third trimester of pregnancy have a significant chance of going into premature labor during hurricanes and typhoons. Did you plan additional supplies and personnel? Diapers, incubators, or infant formula are not on the EMEDS allowance standards, nor are pediatricians and OB providers (unless you pulled the UTC for OB/Gyn and Peds). You need to know what the mission you’re supporting is and what additional planning factors to consider before you deploy.

Aeromedical evacuation also varies based on mission. The US doesn’t usually air evacuate indigenous patients. Where would we take them? We have to plan for either ground transportation, other nation air support, or at the very least, some additional holding requirements for HUMRO missions. For DSCA missions, we do air evacuate US civilians. During Hurricane Katrina relief operations in New Orleans, we evacuated thousands of US citizens. You need to be prepared to adjust your plan according to your mission requirements.

EMEDS is a great capability. It is modular, mobile and small(ish). Planners need to know what factors impact mission requirements and adjust plans accordingly.

Footnote: I said that we “don’t usually air evacuate indigenous patients,” during HUMRO missions, but we certainly did air evacuate a large number of patients during rescue operations in Haiti. An important point to consider though is what is the repatriation plan for all those patients now in Florida’s (and other states’) hospitals?
Deployment Tea  Maj Pamela Townsend-Atkins

In December 2009, I returned from a six month deployment where I learned many life and leadership lessons, some of which came in the metaphor of tea. During this awesome deployment experience, I embraced and enjoyed every opportunity. I had the honor of serving as the Deputy to the Air Force Forces Surgeon, and Medical Planner, AF-CENT, Combined Air Operation Center, Al Udeid Air Base. My responsibilities included attending joint planning conferences, facility assessments, and manpower alignment, at the tactical, operational and strategic level.

As I think back on “my best day ever” during this deployment, I think about the 2009 Dubai Air Show. The Emiratis hosted this huge event, where an estimated 20,000 people attended and billions were spent buying commercial and fighter aircraft during this Air Show. The Emiratis had 500+ medics and emergency management personnel trained and standing by specifically to support the event. This team was equipped with everything from one man motorcycles, to several mass casualty response buses. The Emirati Medical Team was a great group of people; it was an honor to work with them. Their medical capability was impressive, but their ability to “drink tea” was even more impressive. In Dubai, I learned that there is an art to drinking tea; very different from what we might expect.

Our American idea of drinking tea is to heat the water, throw the tea bag in the cup, pour the hot water, drink it hot and get back to business. What I learned during the Dubai Air Show was much different quite refreshing. These life and leadership lessons we can all apply to our own taste.

First, you must be invited in to do business; you can’t just invite yourself. Just because you think you have all the answers, that doesn’t make you the best in the class. Second, you should be humble enough to wait, listen, and learn. Wisdom treasures instructions, knows when to speak, how to speak succinctly, and at the appropriate moment. Third, have an understanding of what the essence of the entire situation holds, not just your tiny vision of your concerns in a bubble. Wisdom and understanding is what opens the doors of communication. Until the door of understanding is opened, no effective business can be conducted. This understanding requires one to look beyond the culture and see the human. We all have different styles, shapes, colors, tastes, beliefs, traditions, and desires, but we are all human. Don’t be so quick to judge; take the time to get to know the person (where are they from? what their family is like?). Discover the flavor of their tea.

Finally, drinking tea is about establishing “trust and understanding” to work a common issue. This common issue is what we like to call “the mission.” Sometimes, it is not about your project, your idea, your presentation, or your great work. It’s about listening, learning, laughing, and the creativity of the entire team.

Drinking tea in that part of the world is what creates change over time and friendships for a lifetime. The decisions you make today will impact the views of someone tomorrow. This is why drinking tea is a slow, conscious, deliberate, and thorough process. I believe how we “drink tea” today, sets the table for our future leaders tomorrow. Today, you control the “potency” of your tea; with your words, attitude, understanding, flexibility, and willingness to communicate. How you choose to drink your tea, and what flavor you prefer is up to you. May your journey be victorious on your quest to find the finest tea leadership has to offer.

Question: Does experience gained before a member attends HSA count towards the 12-month requirement for the award of the 3 skill level? There seems to be some confusion in the field on this amongst the Services.

Col Lew: No. The 41A1 AFSC is awarded upon graduation from the HSA course. The time hack for 41A3 AFSC begins the day an MSC officer is awarded the 41A1 AFSC and Corps badge—upon graduation from HSA. For award of AFSC 41A3, in addition to the successful completion of HSA, officers must have at least 12 months experience in one of the MSC core functions and the approval of their unit’s senior ranking MSC.

Did you know?

A true professional, tremendous mentor, coach and friend, CMSgt (r) Clarence L. “Henry” Harrison, 62, died on Saturday, 24 April 2010. He served as a 906XO for 30 years and retired from the United States Air Force in 1996, after which he worked at Humana Military as manager of documentation services. In lieu of flowers, donations can be made to J. Graham Brown Cancer Center.
Biometrics in Afghanistan

1st Lt Andrew Severt

What is Biometrics? Webster’s defines it as the measurement and analysis of unique physical or behavioral characteristics (such as fingerprint or voice patterns) especially as a means of verifying personal identity. For the Government of the Islamic Republic of Afghanistan (GIRoA), it’s the development of a host nation Biometrics Program, a strategic priority for the Afghan National Security Forces (ANSF), and a key contributor to counterinsurgency and anti-corruption efforts.

Why is a Medical Service Corps (MSC) officer advising the ANSF in the development of their Biometrics program? Did the shortest straw get pulled? Actually, I think this is what they mean by “opportunities to excel” outside of the MSC. Each Biometrics team member provides a unique skill-set to this mission and our role is vital to the success of the ANSF. Becoming a Subject Matter Expert on the Jump Kit is an important first step. We’re all required to learn as much as possible about the system, especially how to conduct a good enrollment and what to look for to prevent someone else from doing a bad enrollment. Becoming familiar with all the data fields and the differences between a civil and criminal enrollment, along with a deceased enrollment is critical. My main focus is to create, implement, and advise Logistics Standard Operating Procedures for the Ministry of Interior (MoI) Biometrics Department. A few necessary requirements are vehicle maintenance, mission planning, acquiring weapons and uniforms, inventory management, facilities management/security, and fuels. Although we (US Military) see the importance of maintenance and management, getting our Afghan counterparts to understand is another issue in itself. Advising is very challenging in this environment. Getting an Afghan to make your idea their idea is paramount. Praise must soon follow to keep them motivated to move onto the next project. Keep in mind building a trusting relationship with an Afghan comes first, which can take a considerable amount of time and many cups of chai. Once accomplished, then, and only then can work begin to progress. I’ll be more than elated if only one of my projects is completed during my tenure, and remains successful long after my departure.

All Biometrics enrollments are administered solely by Afghans on Afghans using the Cross Match Guardian R Jump Kit. A Jump Kit contains a durable ten-print live-scan device, mug shot camera, iris scanner, and global positioning system (GPS) to log date, time and exact location of enrollment. An enrollment consists of a collection of fingerprints (slaps and rolls), iris scans, facial images (front and profile) and enrollment data. Data is uploaded into the Afghan-Automated Biometric Identification System (A-ABIS), which came on-line in late 2009, and is critical in identifying known persons of interest attempting to infiltrate the ANSF. Technology is in place to transfer Biometrics records from A-ABIS to Department of Defense (DoD) Biometrics. Additionally, there’s a Memorandum of Understanding under development between GIRoA and the US to permit data sharing. The NATO Training Mission-Afghanistan/Combined Security Transition Command-Afghanistan (NTM-A/CSTC-A) is enabling the development of a sustainable GIRoA Biometrics Program through training, advising and equipping the ANSF. The Minister of Defense (MoD) and Minister of Interior (MoI) have directed 100% Biometric collection on all members of the ANSF. Current Afghan Biometrics operations are focused on Afghan National Police (ANP) Personnel Asset Inventory (PAI), Afghan National Detention Facility (ANDF), and Kabul Military Training Center (KMTC). Although this program is in its infancy it has posted many successes in a very short period of time. Biometrics collection was initially set up in Afghanistan by the Federal Bureau of Investigation (FBI), and has been progressing steadily since 2007 with the hope of aiding the GIRoA in its anti-corruption efforts. Today, a large amount of the progress is being made by Afghans. The Biometrics Division of the ANSF graduated 20 new fingerprint examiners on 4 March 2010, tripling the size of the examination team. These specialists are responsible for inputting over 88,000 backlogged records gathered by more than 130 ANP collectors positioned throughout the country. At last count, 121,000 Biometrics records have been collected, with new records being added daily. One of the benefits the MoI expects to realize is the elimination of insurgents from the ANP.

If you’re a Logistics trained MSC, the majority of these programs come to you as second nature. However, advising is probably new territory; it’s not like giving feedbacks and writing performance reports on your staff. Even if you’re not tasked to deploy as an advisor, or don’t know what you’ll be doing until arriving in country, like me; stay awake during all the necessary readiness training (I didn’t think I would be convoys on an almost daily basis to fulfill my mission, but I am). Also, do yourself a favor, educate yourself on the culture, learn some of the language, and by all means have fun!

NOTE: 1st Lt Severt is assigned to the 30 MDSS, Vandenberg AFB, CA and is currently deployed to NATO Training Mission-Afghanistan/Combined Security Transition Command-Afghanistan, Combined Joint Directorate of Intelligence, Biometrics Team (NTM-A/CSTC-A, CJ2, Biometrics Team).
I arrived at FOB Vulcan on 21 Jul 09. My mission was to educate and train the 5th Kandak Afghan National Army (ANA) medics on Healthcare Administration. When I arrived, I met the rest of the Embedded Training Team (ETT) I would be working with. However, they were preparing to redeploy back to the states in less than a month. We were supposed to have 16 members on the team possessing a variety of different backgrounds (e.g. intelligence, logistics, medical, communications, etc), but there were only nine members besides myself. I was fortunate because there was a Navy Corpsman mentoring the ANA medics on the clinical aspects of healthcare. So, I could expect some foundation to be in place and hoped there would be some continuity built into the medical piece that I would be taking over. The FOB was split in two parts separated by HESCO barriers; the ANA was on one side and the Coalition Forces (Americans and Polish) on the other. The following day, we went to the ANA side with our interpreter and I was introduced to my counterparts. There were roughly 350 soldiers assigned to the 5th Kandak that fell under our purview and approximately 70 of them were medics.

The Corpsman back-briefed me on the challenges he had experienced during his tour. He told me the ANA medics didn’t have a clinic to work out of, their supply chain from the Regional Depot was badly broken and they didn’t have the necessary supplies they needed to support their functions as medics. Prior to coming to Afghanistan, I did some research on the Afghan’s morbidity and mortality rate. The average life span of an Afghan male was late 40’s to early 50’s, so one of my goals was to implement a preventative healthcare program within the ANA, similar to the one we use in the USAF. After hearing the Corpsman’s initial brief, I could see that the preventative healthcare program would have to be put on hold, so we could focus on getting the ANA clinic up and running.

I clearly recalled a senior AF mentor, who completed two tours in Afghanistan, telling me not to come over and try to change the world because it would just frustrate me. She told me to pick a few rudimentary projects and focus on accomplishing them. After my initial visit with the Afghans, I could totally relate to what she was saying. So instead of trying to change the world, I thought of a few simple ways to help. First, I wanted to try to get a clinic built for them so they had a proper place to work. Next, I would pursue the broken logistics chain, so they would have medical equipment and supplies to work with. Once that was accomplished, if time permitted, I would try to help them develop some administrative organizational flow to their day-to-day working environment (e.g. develop a patient check-in process, medical records, give some prevention classes, develop an exercise and evaluation program, etc.).

The following day, during our regular morning staff meeting, the Team Chief told us we had several convoy missions coming up in the next couple weeks, starting with a two-day reconstruction convoy mission to Moqrur. I was not expecting to do many convoys because I was told my mission here was to mentor and advise ANA medics. During our staff meeting the following day, I asked the Team Chief how often we did these convoy missions and he replied, “a couple times a week.” He told me it wasn’t our primary mission, but one of the mentors on our team was an engineer and he had to do periodic checks on construction contracts in the eastern province. The small number of personnel on our team and the theater policy, requiring a minimum of three American vehicles to roll in a convoy, didn’t leave us much choice. I was somewhat distraught, not because I was concerned about going outside the wire, but because I only had 179 deployment days to work with the ANA. Figuring the three weeks it took me to in-process and get to my permanent FOB, conducting convoy missions two or three times a week and two weeks for out-processing was only going to give me approximately 14 weeks to accomplish the things I wanted to get accomplished with my ANA medics. I was coming to realize more and more why my senior AF mentor told me to only pick a couple areas to focus on.

The following day, I talked to the Corpsman about putting in for a CERP project for a clinic. He told me that he had already done so, but the Kandak was supposed to be moving down the road about 8 km next year and the US wasn’t going to sink a ton of money into a clinic that would be vacant in 12 months. So, apparently they approved the CERP project, but they won’t build the clinic until the Kandak moves. So, I asked the Team Chief if we could use title 10 or title 22 money to build them a B-Hut that they could at least work out of until they move. There are very stringent rules with title 10 and title 22 funding. The funds are only authorized to be used for specific materials, projects and resources and both have funding ceilings that can not be exceeded. The Team Chief and our Funds Officer crunched the numbers and said they would be able to fund the outside structure, but couldn’t fund the rest. I told them that I was pretty good with a hammer, so if they could build us the structure, I would take care of the inside of the clinic. So they built us a Clinic. The Corpsman and I developed the floor plan that fit the budget and an Afghan carpenter came in and built the structure in about four days. When he completed the roof, I got a team of medics together and gave them a crash course on carpentry. We installed a supply closet, built shelves in the Pharmacy, in the sick call and trauma rooms and also in the supply closet. We built waiting room benches, desks in the offices and several other small self-help projects. I made sure we got a sink with running water to employ an infection control plan because hand sanitation over here was not practiced very well at all. I thought to myself, we did pretty well for only being here for a couple weeks.

The five Navy members on our team redeployed right after the clinic was completed,
so we only had the four of us AF members remaining. I became the Team Chief for the remaining three months of my deployment and unfortunately it didn’t appear as if we were going to get backfills for any of the 12 positions we had vacant. Therefore, we had to double up on responsibilities. I had two of my Logistics Airmen that were working with the S-4 shop, start mentoring the personnel and admin staff. I had my Commo Officer work with the Intel shop and I mentored the Kandak Commander, the Executive Officer and the medics. We continued to function, but never seemed to have enough time to get everything done we wanted to accomplish.

My next big project with the medics was their medical supply logistics chain. This one was a little more difficult to work because we were in the middle of nowhere. Our DSN lines did not work very well, we didn’t have NIPRNet and our SIPRNet wasn’t working very well, so we had to go with the old cell phone. I contacted one of the ETT mentors over at FOB Lightning, which was where the Regional Supply Depot was located. I told him what my concerns were and that I was having problems getting the kinks worked out. I told him we were preparing to open our clinic, but the supplies we had on hand wouldn’t last very long. He told me he would contact the Regional Depot and try to help us fix the problem.

While we waited on the supply issue to get resolved, I conducted some leadership engagements with my ANA counterparts. I got to know them pretty well through my leadership engagements. I found out that they didn’t really share the same views on safety, prevention, clinical or administrative healthcare that we did in the United States. The medic’s healthcare skills in my Kandak were antiquated to say the least. They had very little understanding of how to run a garrison clinic, they didn’t have medical records or create documentation on the patients to develop a medical history, they had no appointment booking or scheduling processes in place and no concept or very little when it came to infection control. This was literally worlds apart from the healthcare I was accustomed to.

I thought of a few things I could do to help them develop the foundation for a medical infrastructure. First, thing I wanted to do was provide them with an automated system. There were six computers that were distributed to the Kandak and the majority of them weren’t being used because the individuals they were assigned to didn’t know how to use them. So, I explained my vision to the Kandak Commander and he liked it. So, a couple days later one of the computers was transferred to the medical company. The next thing we needed to do was get the inventory issue under control. Once the inventory issue was under control and we opened the clinic for business, I wanted to develop a Preventative Healthcare Assessment (PHA) program by conducting healthcare surveys and performing annual physicals on all the soldiers in the Kandak, which would help me reach my primary goal in the first place (effecting the Afghan’s morbidity and mortality rate). I also wanted to create a generic electronic medical record (EMR) so the doctor could record and track the patient’s medical history. In my mind, the PHA program in itself would have a huge impact on the ANA’s morbidity and mortality rate for the simple fact that it would facilitate the identification of soldiers with life-threatening diseases at a much earlier stage. If identified early enough, the providers would be afforded the opportunity to conduct surgery or use pharmaceutical intervention to either slow or control the process or cure the disease itself, which would in effect save or at least extend the lives of the ANA soldiers. The EMR would be portable, so if a soldier got moved to another Kandak in a different region, the clinic could burn a copy of his record onto a CD and let him take it to the gaining Kandak. This would prevent repetitive patient work-ups on the gaining unit’s clinic.

Fixing the supply chain, creating a couple databases, developing a couple electronic documents, setting up a rudimentary electronic medical record system, developing and growing a preventative healthcare program all sounded pretty easy in theory, but each simple project became a huge undertaking. For instance, the way the supply chain is supposed to work here in Afghanistan is that the Company is supposed to fill out a Ministry of Defense form 14 (MOD-14, request for supplies) and send it to the Kandak S-4 (Supply Shop) to fill the order. If the Kandak doesn’t have the item, they push the MOD-14 to the Brigade S-4. If the Brigade S-4 doesn’t have the item, then they push the MOD-14 to the Regional Depot. If the Regional Depot doesn’t have the item, they push it to the National Depot. Our FOB is closer to the National Depot than it is to the Regional Depot. So the Brigade and the Corp Surgeon decided to do a hand shake agreement to skip the Regional Depot and go straight to the National Depot, which is not following policy. This was never conveyed to my Kandak medical staff. So, they never knew who they needed to follow-up with on outstanding orders. We assumed, since our medics weren’t told about this hand-shake agreement, the folks running the National Depot probably didn’t know either because when we forwarded our MOD-14’s with the National Depot, it seemed as if the staff there would sit on our orders forever. Perhaps, it appeared as if we weren’t following protocol. Oftentimes, if our orders were filled, it took us much longer getting them filled through the National Depot than it would if we would have followed the initial protocol, routing them through the Regional Depot. However, in discussing this issue with the ANA Corps Surgeon General, his task was that he made the deal with the Regional and the National Depot and that is the way he wanted it to work. Obviously, there are a lot of political issues that are out of our control. Even though there are more efficient ways to do business, it is their country, their systems and we have to let them make their own deci-
Little by Little (cont’d)

Prior to opening the clinic for business, we placed all the supplies in the clinic in their respective places and were preparing to conduct an initial inventory of everything on hand, which wasn’t much. They had about 400 line items. I figured this would take us four hours to a whole day tops, a pretty simple process. I had developed an electronic inventory and ordering sheet and had my interpreter, translate it into Dari (local Afghan language) for the ANA medics. We installed it on their computer as a template, so they could use it in the future. I explained to my counterpart, that he would have to conduct a monthly inventory, so he really needed to identify and appoint a primary and alternate medic as supply officers. We had 13 pre-packed boxes in all, which consisted of approximately 90% of their inventory. The U.S. provided these kits as initial issue to the new ANA clinics that were standing up. There were two four drawer boxes filled with supplies that made up the sick call kits and 11 other boxes that made up the trauma sets. We started on the sick call kits and to my amazement, these pre-packed kits had a lot of supplies in them. We only got through three drawers on the first day. This was another one of those unexpected hurdles we had to cross. I found out that day that my ANA counterpart they referred to as doctor was not really a medical doctor, but a nurse. He went through nursing school, but the ANA were so short on doctors for them to learn, that they would want to intimidate by the computer, but I assured them that I would make this stuff so easy for them to learn, that they would want to play on the computer all day. When my counterpart turned the computer on, I felt a huge sigh of relief because at least he knew how to turn it on. The computer lessons went well. We started with some very basic skills, like how to use the mouse, single and double clicking to execute commands and we eventually got into building and naming files, creating sub-directories and databases. He seemed to be overwhelmed at first, but when I gave him the mouse and had him physically create files and records on his own, you could tell he was quite proud of himself. He would get frustrated when he would make a mistake, but he was very determined to get it right. I told him the more practice he put into it, the better and quicker he would learn it. We spent about 30 minutes a day on computer lessons and he picked it up pretty quickly.

About a week later we procured a list of all the soldiers in the Kandak and we started populating the electronic medical records database with individual EMRs. Instead of re-inventing the wheel, I had my Flight Chief from the states send me a couple forms we used back home. One was an old Preventative Health Assessment (PHA) questionnaire and the other was a standard form 600 (Chronological Medical Records Form). I modified the questions on the PHA questionnaire to relate to the Afghan culture. Our plan was to print out the PHA questionnaire, hand one out to every soldier in the Kandak, have them fill them out and turn them in when they came in for their annual physicals. However, once again, we had a major challenge. As I thought through the process, I completely forgot that 70% of the soldiers in the Kandak couldn’t read or write. So how were they supposed to fill out the PHA questionnaire? I had to switch gears a bit. Instead of handing out hard copies of the questionnaires, I decided that it would be much easier to put a literate medic behind a patient administration desk in the waiting room. As the patient showed up for their appointment, the medic at the check-in desk would take them back, pull up the electronic PHA questionnaire template on the computer, ask the patient the questions, and fill the electronic form out for the patient. The medic would then save the PHA form in the patient’s electronic medical record file, take the vitals, record them in the electronic medical record (EMR) and walk the patient over to the treatment room. Prior to my counterpart examining the patient, he would pull up the patients EMR and review the patient’s electronic PHA questionnaire to identify any issues that he should address with the patient while performing the annual physical.

Our goal was to start seeing patients one week after the clinic was completed, so even though we hadn’t completed the inventory we had to start multi-tasking because we were running out of time. I decided to start building our electronic forms and databases, thinking this would be less challenging than the inventory. Little did I know, the majority of the medics in the Kandak had never seen a computer, let alone worked on one. So, instead of getting straight to the forms and databases, I had to provide them with some basic computer classes. Of course, they were a little tense and somewhat intimidated by the computer, but I assured them that I would make this stuff so easy for them to learn, that they would want to play on the computer all day. When my counterpart turned the computer on, I felt a huge sigh of relief because at least he knew how to turn it on. The computer lessons went well. We started with some very basic skills, like how to use the mouse, single and double clicking to execute commands and we eventually got into building and naming files, creating sub-directories and databases. He seemed to be overwhelmed at first, but when I gave him the mouse and had him physically create files and records on his own, you could tell he was quite proud of himself. He would get frustrated when he would make a mistake, but he was very determined to get it right. I told him the more practice he put into it, the better and quicker he would learn it. We spent about 30 minutes a day on computer lessons and he picked it up pretty quickly.

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When done reviewing the patient’s medical records, he would go into the treatment room and give the patient his annual check-up. Once he finished with the patient’s exam, he would provide the patient with any necessary follow-up appointments or scripts, release the patient, go back into his office and document his exam findings on the patient’s EMR. This check-up will be conducted annually to track and monitor the soldier’s health over an extended period of time.

With that said, I developed the electronic PHA questionnaire as a Microsoft Office Word form. We were able to protect the documents so the technicians wouldn’t accidentally erase them and not be able to fix them. We also placed drop down boxes in the answer columns on the PHA questionnaire to ease the workload on the Patient Administration Technicians because they couldn’t type very well either. We ended up building the EMR database, which consisted of 368 records. Each record contained a blank PHA questionnaire and an excel workbook with three blank chronological medical record worksheets for the provider to track the patient’s history. I had my interpreter translate all of these procedures on scheduling, sick call procedures, routine and established appointment procedures, physical and PHA procedures and daily hard drive back-up procedures. I had my interpreter translate all of these procedures into Dari and we printed them out and made an OI binder for them. We also transferred the soft copies to the ANA clinic computer for future modifications.

Before long, my counterpart had a couple patient follow-up visits. He was impressed with the EMRs because he was able to pull the patients’ medical records up and see why he made follow-up appointments for them, without needing to ask patients why they were returning. One patient was quite impressed because my counterpart went into the room and asked him how his ingrown toe nail was doing without the soldier saying anything to him. I am only speculating, but I got the impression that the soldier felt like my counterpart cared about him and his condition because he knew exactly what was wrong without asking. My counterpart told me after the visit that he was glad that he recorded, in the record, what he did to the patient during the first visit, because he forgot why he scheduled the patient for a follow-up appointment. He told me that the patient thought that he was a very smart doctor because his first visit was five days ago and he has seen several patients since then. He came back today and didn’t even ask him what was wrong...he remembered.
**Small by Small (cont’d)**

Little did the patient know that my counterpart really didn’t remember...he just pulled it up on the computer. It was really nice to see the impact of these programs. A major difference in the program we set-up over here is that we only see active duty Afghan soldiers, which is much different than a garrison clinic in the states where we see active duty, dependents and retirees. In an active duty only clinic open access is the standard of care because the soldiers know that if they report to the clinic, they are going to be seen that day. When we first opened, we had 15 to 25 patients a day for about the first month because garrison healthcare was new to the soldiers and they wanted to experience it. Most of these soldiers have never seen a doctor in their lives let alone had an appointment to receive a check-up. The majority of them have all had their initial physicals so they aren’t as inquisitive about healthcare as they were initially. Since our opening, the soldiers have grown accustomed to getting treatment when they need it. Our patient load has dropped drastically and is steady at around 5 to 7 patients a day, which prevents us from having appointment issues. However, it has increased slightly over the last month due to the cold and flu season, but only by a couple patients a day.

My counterpart has now been seeing patients for nearly three months. He’s implemented some of his own processes to the existing set-up that we started together and they are working out very well. He and his staff have seen up to 25 patients in a day and his speed has picked up considerably. We’ve even conducted a few minor surgeries (e.g. removing shrapnel from limbs with topical anesthetic). There have been no glitches that we are aware of with the forms, the EMRs nor the questionnaires. My counterpart has had to refer several patients over to the Brigade based on the answers they provided on the PHA questionnaire and his physical assessment. He’s identified patients with gall stones, kidney stones, lymphoma, cysts, several kinds of skin rashes and a few unknown infections/diseases and has referred them to the Brigade for more extensive care. By identifying these issues early, he has enhanced or possibly even saved the lives of these soldiers.

When I started these processes my goals were very simple, build a clinic and teach these ANA medics how to see patients. We built a program that was very simple. The processes within the program are efficient and effective and very easy for the soldiers to learn. As it turned out these processes gained a lot of notoriety from the Center for the Army’s Lessons Learned (CALL). An officer came down to Ghazni and wrote a story about the program we developed and had it published in the Army CALL newsletter. He also sent the story to the Combined Security Transition Command-Afghanistan (CSTC-A) Surgeon General. The Surgeon General reviewed the documents that were sent to him and liked what he saw so much that he wants to standardize our program and implement it at all ANA FOBs throughout the Afghan theater.

In conclusion, this experience has reinforced a few old adages. Never take what you have for granted and never take others for granted. It’s not good to assume (ASS out of U and ME) anything. There is always someone in this world better off than you and there is always someone worse off. Regardless of where we fall in that spectrum, we have joined the service to help resolve problems, spread diplomacy throughout the world and try to make things a little easier for everyone. This has truly been an extraordinary and worthwhile experience for me and I would highly encourage anyone that is stuck behind a desk in an administrative role for the Department of Defense to volunteer to come to a foreign country and share their knowledge and experiences with some less fortunate people.

**Brigadier General Michael W. Miller** opened the Air Force Reserve (AFR) Medical Service Corps (MSC) Development Team (DT) meeting 25 January 2010 at the Air Reserve Personnel Center (ARPC), Denver CO. He addressed the DT members on a variety of issues within the Air Force Medical Service and the Corps. General Miller discussed the work being accomplished to update the Active Duty (AD) MSC Strategic Plan and the benefit in linking that effort with the AFR MSC strategic planning. He advised the DT that recent changes in time in service for AD MSC accessions were implemented to address the current loss of personnel in the ranks of Major/Lt Colonel. On a side note, there is no time in service cap for accessions into the AFR MSC. Additionally, General Miller acknowledged that Reserve Component MSC officers had taken Joint Expeditionary Tasking deployments for some AD MSCs, thus allowing personnel reinvestment. He also spoke of deployment participation opportunities and the “All In” philosophy. General Miller encouraged everyone to look at current processes in the workplace and use continuous process improvement. Last, and most importantly, General Miller shared his Guiding Principles of Service, Leadership and Relevancy.

**To access the 4AO Newsletter, visit https://kx.afms.mil/chiefscorner**
Reserve MSCs Publish First “Strategic Plan”
Col Teri Mueller, USAFR

At the last AMSUS meeting in November 2009, Reserve MSC Leadership debuted the first-ever Reserve MSC Strategic Plan. The plan was written and finalized in 2009 and is the culmination of efforts by Reserve MSC senior leadership over a series of meetings throughout last year. Its purpose is to provide strategic direction for the corps and summarizes the new Reserve MSC vision, mission, and core values. The principle parts of the plan are:

VISION: “The Air Force Reserve Medical Service Corps...leading, training and inspiring healthcare professionals around the globe!”

MISSION: “Our mission is to support military medical service delivery, medical planning, force readiness, mission generation, theater medical operations and global patient movement. As competent and inspirational leaders, Reserve MSCs embrace the full spectrum of deployed and in-garrison medical operations, mentor medical professionals to their full potential and instill in our Airmen an expeditionary warrior spirit.”

CORE VALUES:
INTEGRITY FIRST
- Credibility is the cornerstone of all we do
- Responsibility for all resources under our charge
- Transparency in our processes
- Accountability for our actions

SERVICE BEFORE SELF
- Inspirational leadership
- Commitment to the mission
- Taking care of our people
- Readiness to serve anytime, anywhere

EXCELLENCE IN ALL WE DO
- Professional competence
- Inclusive decision-making
- A culture of innovation
- Adaptability to a changing environment
- Peacetime core competencies, establishing a 4½ day course for newly accessed MSCs, formulating peacetime core competencies, establishing a reading list, obtaining final approval for RSV training course, and incorporating Reserve content into the HSA course.

GOALS:
1. Enhance Communication: Promote cohesion and unit of effort by ensuring timely and comprehensive information to all Reserve MSCs. Things being worked include consolidating information on available positions, publicizing leadership educational programs, enhancing the annual AMSUS social event, and re-establishing a Society awards program at AMSUS each year. Goal Champion Leader: Col Deb Esque
2. Promote MSC Force Development: Provide a structure for the work force and a guide for career development. Key areas making progress in this goal include publishing a Reserve MSC Force Development Guide, assessing force structure and position vacancies, developing a process to fill MSC vacancies in units, championing awareness for AGR positions, attaining 95% ODP currency for the corps, increasing O-6 promotion opportunities, determining rules of engagement for IMA MSCs, and establishing Reserve MSC Functional Area Advisors for career subsets. Goal Champion Leader: Col Norma Bressi
3. Nurture Core Competencies: Guide the development of special skills and professional attributes all Reserve MSCs must attain. Projects underway in this last goal include offering a periodic Reserve Healthcare Administrators conference, establishing a 4½ day course for newly accessed MSCs, formulating peacetime core competencies, establishing a reading list, obtaining final approval for RSV training course, and incorporating Reserve content into the HSA course.

21 MDG Receives Highest Inspection Score in AF

Members of the 21st Medical Group cheered with excitement...as the Air Force Inspection Agency medical team chief announced they had received the highest inspection score in more than 150 Air Force medical group inspections spanning six years. For complete article, visit http://www.sg.af.mil/news/story.asp?id=123196514.
With the historic graduation of Class 10-B, the first-ever all-Guard/Reserve Health Services Administration class, we are pleased to announce that HSA has successfully completed the transition to our new four-week format. The course content is now validated by AETC, and we have a full year of lessons learned to guide even more improvements. This marks the execution of a major objective from the 2007 MSC Strategic Plan and represents the culmination of over three years of work by the HSA staff and the Senior MSC Council to transform HSA from an orientation for new accessions to a center of ongoing learning for MSCs at every stage of their career.

New accessions now spend four to six weeks at their duty station prior to HSA orienting to the Air Force and the MTF. Further, they complete a data collection project for use in hands-on classroom analysis that provides context and ensures a visit to each MSC functional area. Finally, we spend four weeks teaching them what it means to be an MSC and fostering the technical and analytical skills that every MSC should have at their disposal. We have shed the old stove-piped functional approach and now focus on “what every MSC needs to know”, core competencies like written and oral communications, critical analysis, strategic planning, self-inspection, process improvement, mentorship and leadership.

The changes to HSA are dramatic, but arguably the greatest change is the development of functional orientation courses, not just for HSA students but also for MSCs already in the field. We provide comprehensive just-in-time instruction for all MSCs entering new jobs, not just new accessions. This represents a philosophical shift in that we extend our support throughout your career rather than trying to teach you every detail in your first six months. We believe that this hands-on training with subject matter experts is an awesome opportunity as MSCs move into new and increasingly challenging roles, and we are excited to announce that orientation courses in every functional area are available before MSCs rotate this summer. For course dates, points of contact and enrollment instructions visit our webpage at https://kx.afms.mil/hsa.

We at the schoolhouse are absolutely committed to this Corps-changing initiative. Our goal is to deliver a better-prepared MSC for every mission, and as always, we appreciate your support. For more information call Maj Chess Martin at DSN 736-6969.

Training Opportunities at HSA Maj Chess Martin

Defense Medical Readiness Training Institute Homeland Security Medical Professionals Course Seattle, WA 13-18 June 2010

- Identify key components that build the foundation for an effective medical response to an all-hazards incident.
- Identify processes that ensure a comprehensive national medical response system is brought together.
- Coordinate all necessary response assets quickly and effectively to an all-hazards incident.

Speakers include FEMA, FBI, USPHS, DHS, DHHS, US NORTHCOM, USDVA, private industry leaders and various military agencies, local and state government. Continuing Education: AMA PRA/CME Cat I; CNE; Cat II non-ACHE (30-40 credits). HLSMPC is open to DoD Active Duty/Reserve/Guard, US Public Health Service and US Coast Guard medical department officers and invited local, state, and federal healthcare professionals and emergency managers to include Public Health Emergency Officers. For more information, contact SrA Corrin Dowers, HLSMPC Course Coordinator, at DSN 421-0128 or corrin.dowers@us.army.mil.

What is MyODP?

MyODP is the new Career Field Manager User Guide. It provides the Total Force a standardized presentation of content for education, training and experience opportunities populated by Air Staff, Air Reserve Component and Career Field Managers. You can access it at https://w20.afpc.randolph.af.mil/MyXDP or on the AF Portal, lower left. Your feedback is very important. Please send all comments to Major Pamela Townsend-Atkins at pamela.townsend-atkins@pentagon.af.mil.
Have you ever said, “I’d love to be a fly on the wall when...”? As I write this article, I am about to complete my MSC Education and Utilization Branch Fellowship at the Air Force Personnel Center (AFPC). During the last year, I have had the opportunity to observe an MSC accession board, Squadron Officer School (SOS) selection board, two Development Team (DT) meetings, along with assisting in making over 300 assignments. The DT membership includes our Corps Chief, Corps Director, MAJCOM SAs, Associate Corp Chiefs, and AFPC/DPAMS. During these DTs, I have witnessed numerous discussions regarding the assignment and utilization of our CGO and FGO MSCs. I’ve also witnessed Squadron Command/SGA/AES DO screening and matching, PME “in residence” selection, Developmental Education (AFIT, EWI and Fellowship) program matches, a specialty match board and career vectoring to over 400 officers. Bottom line, I have had a chance to be a “fly on the wall” while these senior leaders have discussed the careers of many MSCs and their future impact to our corps. I wanted to take this opportunity to share some of my observations during this last year.

- Do a GREAT job in your current position. I know this is obvious and you probably hear it all of the time, but it is absolutely the most important thing you can do to help yourself. Remember the first day of HSA when you were told, “your reputation begins today”. Your daily attitude and approach to your current position has a significant impact on your success in the Medical Service Corps. One should always remember that once the “negative reputation bell” has rung, it may be difficult to “un-ring” it. Find a way to make things work!
- Career progression is an absolute must. It is hard to understand why folks self-eliminate from desired opportunities. Career progression factors are not secrets. PME and graduate level education currency, Board Certification, progression in jobs/levels are very important. These items are not just “boxes that get checked”. They are significant Air Force officer professional development opportunities, and are there for very good reason. MSC promotion rates are currently amongst the highest in the Air Force. MSCs who “take the initiative” have ample career progression opportunities. Ensuring you remain competitive is certainly within your own control.
- Your record MUST be accurate. I must admit, it amazed me the number of inaccurate records presented to the boards. Take that extra step and ensure your record is accurate. According to the Air Force, your record and its accuracy is your responsibility. In addition to reviewing your SURF and e-Record (ARMS, ADP, etc) you can call the AFPC records section and conduct an over the phone records review. Our office is certainly available to help you through this process as well. I have not seen an inaccurate record go unnoticed in any of the boards I observed.
- Not all the senior MSCs progressed along the exact same path. If you contact your MSC Assignments Team for advice, we will often refer to the “right” opportunity for you. This advice is founded from a thorough review of your record, SURF, and your ADP. Our career counseling is primarily based on ensuring you are most competitive for that next job, ultimately leading to future SGA and Squadron Command opportunities later in your career. As you compare the diverse paths of our MSC senior leaders, you will see there is no “silver bullet” in getting promoted throughout one’s career. All have very diverse backgrounds and possess various levels of specialty experience. If you find yourself off the traditional MSC path, first, you need to ensure you do a great job in your current position. This will only help open doors for future opportunities. Second, make intentional decisions to get as close to the traditional path as possible. Remain engaged with our office as we will do our best to facilitate those decisions, placing you in professionally appropriate positions, in an effort to make you most competitive down the road.

If you have taken the time to read this entire article, you have probably asked “that’s it?”. The answer is simply “Yes”. I realize I haven’t presented anything in this article that you haven’t already heard. As I reflect on my last year, that very point is what was most refreshing about my opportunity to be a “fly on the wall” during my fellowship and observe our senior leaders in action. Bottom line, the advice we’ve been given since the beginning of our careers is absolutely true. Our leaders are objective in their evaluations, and use the whole person concept at every opportunity. The greatest advice I can give you is to perform in your current job to the best of your abilities. Do it well, with a great attitude, and ensure you continue your career progression. Continue to trust our senior leaders as they are deliberately developing the future of our Corps. You will undoubtedly be mentored, and coached along the way…embrace it!

The MSC Strategic Plan was unveiled during ACHE AF Day and is now posted on at https://kx.afms.mil/msc