MEMORANDUM FOR DISTRIBUTION

FROM: HQ USAF/SG
1780 Air Force Pentagon
Washington, DC 20330-1780

SUBJECT: Air Force Guidance Memorandum to Air Force Instruction 44-173,
Population Health and Medical Management

By Order of the Air Force Surgeon General, this Guidance Memorandum immediately implements changes to Air Force Instruction 44-173, Population Health and Medical Management. Compliance with this memorandum is mandatory. To the extent this direction is inconsistent with other Air Force publications, the information herein prevails, in accordance with Air Force Instruction 33-360, Publications and Forms Management.

This supplement meets the intent for developing policy and guidance in provision or coordination of care of Service members or Veterans as established by Department of Defense Issuance 6010.24, Interagency Complex Care Coordination, dated 14 May 2015. It also incorporates the requirements as outlined in the Memorandum of Understanding between Department of Veterans Affairs and Department of Defense for Interagency Complex Care Coordination Requirements for Service Members and Veterans, dated 29 Jul 2014. Additional revisions include care coordination of beneficiaries post hospitalization and modification to the training required by medical management personnel.

The changed guidance is summarized in the attachment. The memorandum becomes void after one-year has elapsed from the date of this memorandum, or upon publication of an Interim Change or rewrite of the affected publication, whichever is earlier.

MARK A. EDIGER
Lieutenant General, USAF, MC, CFS
Surgeon General

Attachment:
Guidance Changes
(Add) Attachment 3 – CRITERIA AND PROCEDURES

2.8. The Chief of the Medical Staff will:

(Add) 2.8.3.3. Ensure all Interagency Complex Care Coordination policies are consistently followed by all applicable clinical personnel. (T-0)
(Add) 2.8.3.3.4. Ensure that Service members and Veterans requiring complex care coordination have an Interagency Comprehensive Plan as described in Attachment A of the Memorandum of Understanding between Department of Veterans Affairs and Department of Defense for Interagency Complex Care Coordination Requirements for Service Members and Veterans, dated 29 Jul 2014 (Attachment 3). (T-0).
(Add) 2.8.3.3.4.1 Complex care coordination involves assisting the most severely wounded, ill, or injured Service members and Veterans, or those Service members and Veterans with complex circumstances. The Service members and Veterans that meet the criteria for complex care coordination, are expected to have a prolonged recovery or rehabilitation process, and may require access to clinical, social, educational, financial, and other services across various organizations and providers. The objective of the interdisciplinary complex care coordination team model is to establish and optimize the use of the Interagency Comprehensive Plan and the resulting application of care, benefits, and services, including military and community resources, to facilitate and promote the Service Member’s and Veteran’s recovery or return to as high a level of function as achievable.
(Add) 2.8.3.3.5. Ensure that an existing member of the Medical Management Staff is assigned as the Lead Coordinator for each Service Member and Veteran who requires complex care coordination, when applicable. (T-0).
(Add) 2.8.3.3.6. Ensure Lead Coordinator training is accomplished by applicable Medical Management personnel. (T-1).
(Add) 2.8.3.3.7. Ensure a member of the Medical Management staff provides care coordination to include a follow-up visit for all hospitalizations. (T-3).

2.13. The Health Care Integrator will:
(Change) 2.13.4. Register in Joint Knowledge Online and complete required training within two months. (T-1). Required training includes Medical Management Essentials, Fundamentals of Case Management, Fundamentals of Disease Management, Fundamentals of Utilization Management and Lead Coordinator training. Will complete refresher training as updates become available. (T-3).

2.14. The Medical Management Director (or Health Care Integrator in the absence of a stand-alone Medical Management Director) will:
2.15. The Disease Management Nurse will:
(Change) 2.15.4. Register in Joint Knowledge Online and complete required training within two months. Required training includes Medical Management Essentials and Fundamentals of Disease Management. (T-1). Will complete refresher training as updates become available. (T-3).

2.16. The Case Manager will:
(Change) 2.16.2. Register in Joint Knowledge Online and complete required training within two months. Required training includes: Medical Management Essentials, Fundamentals of Case Management, Case Manager Module I, TRICARE Fundamentals, Military Medical Support Office, Veterans Health Initiative: Traumatic Brain Injury for Clinical Case Managers, Post-Traumatic Stress Disorder: ‘What is Post-Traumatic Stress Disorder’ module, Psychological Impacts of Deployment, Clinical Decision Support Tools (Note: All Case Managers will complete Ambulatory Care and Behavioral Health modules; those assigned to an inpatient facility will also complete the Inpatient and Surgical Care modules), Veterans Health Administration overview, Introduction to the Department of Defense Disability Evaluation System for Case Managers, Department of Defense Recovery Care Coordination Program, Lead Coordinator Training and service-specific clinical Case Manager courses as assigned. (T-1). Will complete refresher training as updates become available. (T-3).

(Change) 2.16.5.3. Provide care coordination to include a follow-up visit for all hospitalizations in collaboration with the Primary Care Manager teams. (T-3).

(Change) 2.16.10. Screen all Wounded Ill and Injured for Case Manager Services who meet the following criteria, and will collaborate with Care Management Team to identify a Lead Coordinator. The designation of a Lead Coordinator is designed to simplify the coordination among Care Management Team members and the recovering service member. (T-0).

(Add) 2.16.10.1. When in the Lead Coordinator role, ensure that Service members and Veterans requiring complex care coordination have a checklist/Interagency Comprehensive Plan, and comply with the responsibilities of Lead Coordinator as described in Attachment A of the Memorandum Of Understanding between Department of Veteran Affairs and Department of Defense for Interagency Complex Care Coordination Requirements for Service members and Veterans, dated 29 Jul 2014. (T-0).

2.17. The Discharge Planner will:
2.18. The Utilization Manager will:

(Change) 2.18.2. Register in Joint Knowledge Online and complete required training within two months. Required training includes Medical Management Essentials and Fundamentals of Utilization Management as well as the Department of Defense chosen clinical support tool. (T-1). Will complete refresher training as updates become available. (T-3).
Attachment 3

CRITERIA AND PROCEDURES

1. Criteria for Complex Care Coordination:

   a. The need for complex care coordination is determined by factors including both severity of a wound, illness, or injury that is expected to result in prolonged recovery time, or extensive rehabilitation and complexity of care coordination needs involving health care, benefits, and services, including military, federal, or other governmental or community resources. In addition, Service members and Veterans (Service members and Veterans) in need of complex care coordination have longitudinal care and case management needs that will require an interdisciplinary team approach to achieve optimal recovery.

   Such Service members and Veterans might include, but are not limited to, those with multiple, complex, severe conditions such as polytrauma injuries, spinal cord disorders, blindness, amputations, significant burns, complex wounds, traumatic brain injuries, psychological trauma, or other cognitive, psychological, or emotional disorders. Complex care coordination needs may result from either combat or non-combat situations. Further, due to a serious or catastrophic wound, injury, or illness, it is unlikely to highly unlikely that the Service member will return to duty, and may, or will, be medically separated/retired from the military, or it is unlikely to highly unlikely that a Veteran will return to independent living or employment. Other Service members and Veterans who do not meet above criteria but who may benefit from complex care coordination may be included in this model if resources permit.

   The responsibility for assessment of the need for complex care coordination is made by the attending physician in conjunction with other members of the interdisciplinary Care Management Team, which includes the command representative. This is usually accomplished during the acute/stabilization stage, but may occur at any time during the course of recovery.

   Complex care coordination is a Service Member and Veteran-centered, needs-based system designed to support the recovering Service Member and Veteran and their family or caregiver until the criteria for discontinuation have been met. In most cases, enrollment into complex care coordination should occur as early as possible in the course of a hospitalization. This model is continued as a Service Member and Veteran transitions from an inpatient to outpatient setting, or is applied directly to outpatient Service Member and Veteran meeting the “need” criteria above.

   These Service members and Veterans receive an Interagency Comprehensive Plan that has been prepared and updated by members of the Care Management Team. The primary responsibility for maintaining and communicating the Interagency Comprehensive Plan to the Service Member and Veteran is assigned to the Lead Coordinator.
b. Criteria for Discontinuation of Complex Care Coordination: Complex care coordination and use of the Interagency Comprehensive Plan continues until the Care Management Team reviews and concurs that one of the following end points is reached:

- Service Member and Veteran returns to duty or employment with minimal or no limitations;
- Service Member and Veteran has reached a level of stability making continued formal complex care coordination unnecessary;
- Service Member and Veteran requests discontinuation of services; or
- Service Member and Veteran expires or other conditions make complex care coordination unnecessary.

c. The common operating model that details the roles and responsibilities, milestones and decision points for the management and operation of the complex care coordination model is illustrated and explained in Paragraph 2 and Figures 1 and 2 below.

d. Technology Support: Information technology tools will be leveraged and developed as needed, to share required information that enhances and supports effective complex care coordination between the Parties. Future care, benefits, and services information technology investments by the Parties should address the interagency information sharing needs regarding the Service Member and Veteran population requiring complex care coordination, and support requirements for programs directed by this Memorandum of Understanding.

2. Overview of the Model of Complex Care Coordination:

a. This model establishes a consistent method for complex care coordination capable of providing clinical and non-clinical information and support for recovery and rehabilitation of Service members and Veterans and for their families or caregivers wherever care, benefits, and services may be delivered.

b. The complex care coordination model is Service Member and Veteran-centered, needs-based, and applies to Department of Defense and Department of Veteran Affairs whether care, benefits, and services come from Department of Defense, Department of Veteran Affairs, other government agencies, or the private sector.

c. The complex care coordination model is the foundation for a common set of rules, definitions, tools, and processes shared by all of the professionals supporting and facilitating the recovery of Service members and Veterans across both Departments.

d. The model addresses and supports requirements for an Interagency Comprehensive Plan for Service members and Veterans that support realistic outcomes throughout all stages of recovery through ongoing care (see Figure 2). The Interagency
Comprehensive Plan addresses clinical as well as non-clinical support (e.g. pay, benefits, family support, vocational rehabilitation, information, and resources, including military, federal, or other governmental and community resources). This model supports a Service Member and Veteran’s goals (e.g., to recover or complete rehabilitation and return to duty, employment, school, or other meaningful activities), and, if possible, Service Member and Veteran, their family member(s) and/or caregiver(s) are engaged in the establishment and modification of their Interagency Comprehensive Plan at all stages of care, recovery, and reintegration.

e. When returning to duty or employment is not possible, the primary objective of the model is to facilitate an Interagency Comprehensive Plan to help the Service Member and Veteran reach and maintain the highest achievable level of independence function, life adjustment, and quality of life.

f. This model establishes a requirement to use an Interagency Comprehensive Plan that is initiated timely and updated on an ongoing basis to meet the assessed needs of the Service Member and Veteran as they change. A Service Member and Veteran has one Interagency Comprehensive Plan at any given time, which is updated as needed.

g. The Interagency Comprehensive Plan is tailored to each Service Member and Veteran’s unique needs and addresses the full spectrum of care, benefits, and services needed for optimal recovery and/or rehabilitation and may include life-long continuity of care, if necessary.

h. This model establishes the role of the Lead Coordinator, which is assigned to an existing member of the Care Management Team. The Lead Coordinator serves as the primary point of contact for the Service Member and Veteran who requires complex care coordination and their families or caregivers. The Lead Coordinator has primary responsibility for ensuring the establishment and update of the Service Member and Veteran’s Interagency Comprehensive Plan.

i. Key Points of Model Illustration: Figures 1 and 2 illustrate the critical roles and relationships, which support the Service Member and Veteran-centered model of complex care coordination. This model depiction is not all-inclusive and does not establish a priority list, or create barriers for stakeholder involvement in complex care coordination efforts. However, it does provide for Lead Coordinator direct interaction with the Service Member and Veteran and the rest of the Care Management Team.
Figure 1. Care Management Team

- CCM – Clinical Case Manager
- CR - Command Representative
- JRC – Joint Recovery Consultant
- HCPs – Health Care Provider(s)
- LC – Lead Coordinator (Role of a member of the Care Management Team)
- NCCM – Non-Clinical Case Manager
- SM/V – Service Member/Veteran

Figure 2. Common Operating Model Interagency Complex Care Coordination

Milestones and Transition Timeframes
- T0—Time of admission or identification of need for Care Management Team and Interagency Comprehensive Plan.
- T1—Time of establishment of the Care Management Team, Lead Coordinator, and Interagency Comprehensive Plan.
• M1-Mn—Milestones requiring Care Management Team review and updating of Interagency Comprehensive Plan (e.g. regular periodic meetings, transfer of care to another facility, to include outside or private entities).

• T2-Tn—Major transition points (e.g. entry into the Integrated Disability Evaluation System, Separation from the Service, establishment of stable living arrangements in a community post-separation and ongoing reassessment and complex care coordination).

3. Principles of Complex Care Coordination:

a. The Care Management Team includes clinical case manager(s) and non-clinical case manager(s). A member of the Care Management Team is designated as the Lead Coordinator for each Service Member and Veteran. The composition of the Care Management Team will evolve over time, based on the needs of the Service Member and Veteran, but certain members of the Care Management Team may remain the same, even as care is transferred from one facility to another or the Service Member and Veteran moves from inpatient to outpatient status.

b. Service members and Veterans with catastrophic wounds, illnesses, or injuries, or multiple medical conditions with an expected unstable course of recovery, which require long-term, highly complex care, benefits, and services, may also benefit from the inclusion of a Joint Recovery Consultant as a member of the Care Management Team. The Joint Recovery Consultants provide information about the Departments, community, civilian facility or other governmental agency services; assist and advise about the Interagency Comprehensive Plan; and provide longitudinal consultation services and assistance to the Care Management Team, Service Member and Veteran and family or caregiver. The Joint Recovery Consultant may engage as early as the time of Care Management Team establishment, as reflected in the Interagency Comprehensive Plan, at the discretion of the attending physician, and upon request of the Lead Coordinator.

c. The Joint Recovery Consultant may also provide consultation in less severe cases, as reflected in the Interagency Comprehensive Plan, when requested by the Lead Coordinator.

d. Multiple clinical case managers and non-clinical case managers may be involved in supporting the care of a Service Member and Veteran, and will align their service with the goals, activities, and milestones captured in the Interagency Comprehensive Plan.

e. If the command representative is a non-clinical case manager non-clinical case manager, she or he may continue to serve as the non-clinical case manager when the Service Member and Veteran moves between a Medical Treatment Facility and a Department of Veteran Affairs Medical Center, or a civilian facility.

f. All members of the Care Management Team need not be physically present at the Service Member and Veteran’s location, provided that appropriate participation in Care
Management Team updates and services can be delivered to meet the needs of the Service Member and Veteran, family and caregivers.

g. The Care Management Team for a Service Member and Veteran in need of complex care coordination will be convened as soon as possible, but not to exceed one week following admission to a Military Treatment Facility, or a Department of Veteran Affairs Medical Center. In the case of a Service Member and Veteran being admitted to a civilian facility within the United States, the Care Management Team will be convened no later than one week following notification to Department of Defense or Department of Veteran Affairs personnel of that admission. In cases of transfer between facilities and care teams, the transferring Care Management Team will be convened in advance of transfer to facilitate a warm hand-off to the receiving Lead Coordinator so that care continues without interruption. For outpatients, convening of the Care Management Team will occur within one week of an assessed need for interagency complex care coordination.

4. Responsibilities of Lead Coordinator:

a. Department policy will identify and empower the Lead Coordinator role throughout each stage of recovery for the Service Member and Veteran.

b. The Lead Coordinator is not a separate position, but a role assigned to one of the existing members of the Care Management Team. At the care management team initial meeting, a Lead Coordinator is designated and the interagency comprehensive plan is initiated.

c. The Lead Coordinator may be recommended by mutual agreement of the Care Management Team members, including input from the Service Member and Veteran, family or caregiver, and command representative.

d. The Lead Coordinator is held responsible for carrying out duties within his or her normal supervisory structure. Any disagreement about who serves as Lead Coordinator is resolved by the:

- military treatment facility Commander if the Service Member is receiving care at a Military Treatment Facility;
- Department of Veteran Affairs Medical Center Director if the Service Member and Veteran is receiving care at a Department of Veteran Affairs Medical Center; or
- Command representative or designee if the Service Member is receiving care at a civilian facility.

The command representative is always able to communicate with the Military Treatment Facility Commander or Department of Veteran Affairs Medical Center Director when a Service Member is at a Military Treatment Facility or a Department of Veteran Affairs Medical Center.

e. The identity and contact information for the Lead Coordinator is documented in the
Interagency Comprehensive Plan. The Interagency Comprehensive Plan is maintained by the Lead Coordinator, shared with the Service Member and Veteran and any designated family or caregiver, and appropriately recorded.

f. The Lead Coordinator, in collaboration with other Care Management Team members, ensures that the Service Member and Veteran and any designated family member or caregiver are encouraged to participate in the establishment and modification of the Interagency Comprehensive Plan at every stage in the Service Member and Veteran’s care continuum.

g. The Lead Coordinator serves as the primary point of contact for Service members and Veterans and their families or caregivers for coordination of care, benefits, and services related to the Interagency Comprehensive Plan. However, other members of the Care Management Team may communicate with the Service Member and Veteran. The Lead Coordinator identifies potential conflicts in the Interagency Comprehensive Plan and facilitates resolution within the Care Management Team.

h. The Lead Coordinator communicates with the Service Member and Veteran and family or caregiver on an ongoing basis (in person, when possible), and provides them with contact information for the Lead Coordinator and other members of the Care Management Team. The contact information is updated as changes occur. A Care Management Team contact information sheet is provided to the Service Member and Veteran, family and caregivers.

i. The Lead Coordinator is responsible to update the Care Management Team during the regularly scheduled Care Management Team meeting and make sure the Interagency Comprehensive Plan is updated on a periodic basis to include at least the following milestones: at the time of transfer from one facility to another or to another geographic area; at the time of discharge from inpatient to outpatient status; upon transfer to an outside or private entity, or upon significant change in the Service Member and Veteran’s condition.

j. The Lead Coordinator identifies the need for and facilitates the proper phasing of care, benefits, and services to establish and maintain the Interagency Comprehensive Plan. The Lead Coordinator facilitates communication between members of the Care Management Team about the Service Member and Veteran and milestone progress, risks, and issues related to his or her complex care coordination.

k. The Lead Coordinator has regular communication with the Service Member’s command representative and provides periodic status updates no less than monthly. The non-clinical case manager may be the command representative.

l. When a change in the Lead Coordinator is warranted (e.g., a Service Member and Veteran transfers from one level of care or location which requires a Lead Coordinator change), the hand-off of accountability for care and information about the course of the recovery to date and details of the Interagency Comprehensive Plan is accomplished with person-to-person communication between the transferring and
receiving Lead Coordinators. The current Lead Coordinator provides the next identified Lead Coordinator with a summary of the course of care to date, and a current copy of the Interagency Comprehensive Plan and related tools.

m. For transfers between Department of Defense and Department of Veteran Affairs when a change in the Lead Coordinator is warranted, Lead Coordinator identification and communication is facilitated by existing referral processes, including through the Department of Veteran Affairs Liaison for Healthcare, Veterans Health Administration, Operation ENDURING FREEDOM/Operation IRAQI FREEDOM/Operation NEW DAWN Program Manager, and/or Veterans Health Administration Specialty Program coordinators.

n. The command representative is also included in the transfer discussion and activities for Service members.

o. The transferring Lead Coordinator is responsible for providing the Service Member and Veteran and family or caregiver with information about the receiving Lead Coordinator, inform them of any changes to the Interagency Comprehensive Plan, documenting the hand-off in the Service Member and Veteran’s Interagency Comprehensive Plan, and providing contact information to the Service Member and Veteran and family or caregiver, including the contact information for the new Lead Coordinator.

p. The receiving Lead Coordinator will acknowledge and document transfer of responsibility in the Service Member and Veteran’s health records, review the Interagency Comprehensive Plan, and meet with the Service Member and Veteran and their family or caregiver within one workday of transfer if the Service Member and Veteran is an inpatient; for outpatients, the Lead Coordinator should contact the Service Member and Veteran and their family or caregiver within one week and arrange a meeting as soon as feasible for the Service Member and Veteran.
This publication outlines the requirements and provides guidance for the Air Force Medical Service (AFMS) on Population Health (PopH) concepts and related activities, to include delivery of direct health care activities, Medical Management (MM) concepts and related activities, and community health promotion. The AFMS Population Health and Medical Management Guide (AFMS PopH/MM Guide), located on the Knowledge Exchange (Kx), is an adjunct to this instruction and provides supporting information on the implementation of PopH and MM programs in the AFMS. The Military Treatment Facility (MTF) will implement PopH and MM programs in accordance with (IAW) this instruction. This instruction implements Air Force Policy Directive (AFPD) 10-2, Readiness; AFD 44-1, Medical Operations; Department of Defense Directive (DoDD) 1010.10, Health Promotion and Disease/Injury Prevention; National Defense Authorization Act (NDAA) of FY 2008, Title XVI, Wounded Warrior Matters, Section.1611, Comprehensive Care and Transition Policy; and Department of Defense Instruction (DoDI) 6025.20, Medical Management (MM) Programs in the Direct Care System (DCS) and Remote Areas. It also incorporates guidance and recommendations from the Department of Defense (DoD) TRICARE Management Activity (TMA) Medical Management Guide, 2009, and supports/complements Air Force Instruction (AFI) 10-250, Individual Medical Readiness; AFI 40-101, Health Promotion; AFI 41-210, TRICARE Operations and Patient Administration Functions; AFI 44-102, Medical Care Management; AFI 44-170, Preventive Health Assessment (PHA); and AFI 46-101, Nursing Services and Operations.

This instruction applies to all personnel responsible for Population Health Management (PHM) services assigned to or working in Air Force (AF) MTFs. The term “MTF” will be used broadly in this instruction to identify all component medical facilities, groups, and units. This publication does not apply to the Air National Guard (ANG) or to the Air Force Reserve.
Command (AFRC). The authorities to waive wing/unit level requirements in this publication are identified with a Tier (“T-0, T-1, T-2, T-3”) number following the compliance statement. Requests for waivers to this AFI must be submitted through the chain of command to the appropriate Tier waiver approval authority IAW AFI 33-360, *Publications and Forms Management*, or alternately, to the Publication OPR for non-tiered compliance items.

This publication requires collecting and maintaining information protected by the *Privacy Act of 1974 (Title 5 United States Code, Section 552a)*. Forms affected by the Privacy Act (PA) must have an appropriate PA statement. System of records notice F044 AF SG E, *Medical Record System*, (December 9, 2003, 68 Federal Register 68609) applies. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with AF Manual (AFMAN) 33-363, *Management of Records*, and disposed of in accordance with (IAW) Air Force Records Information Management System (AFRIMS) Records Disposition Schedule. All records should be maintained IAW AFI 41-210, *TRICARE Operations and Patient Administration Functions*.

Comments and suggestions pertaining to this instruction should be routed through the appropriate functional chain of command and forwarded to the Office of Primary Responsibility (OPR) Air Force Medical Operations Agency (AFMOA)/SGHC and SGHL, 2261 Hughes Ave, Suite 153, San Antonio, TX, 78236, or e-mail: [AFMOA.SGHC.WF@us.af.mil](mailto:AFMOA.SGHC.WF@us.af.mil) on AF Form 847, *Recommendation for Change of Publication*. This AFI may be supplemented at any level, but all supplements must be routed to AFMOA/SGHC and SGHL for coordination prior to certification and approval.

**SUMMARY OF CHANGES**

This document has been substantially rewritten and must be completely reviewed. Major changes include: Incorporates and cancels AFI 44-175, *Clinical Medical Management Programs*, creation of AFMOA Population Health Working Group (Pop Health Cell), OPR office symbol change, updated internet links, and major formatting changes.

**Chapter 1—POPULATION HEALTH AND MEDICAL MANAGEMENT**

1.1. Population Health (PopH). ........................................................................................................ 4

Figure 1.1. Population Health Model. .......................................................... 4

1.2. Medical Management (MM). ................................................................................................. 5

Figure 1.2. Population Health Model Encompassing Medical Management. ......................... 5

**Chapter 2—ROLES AND RESPONSIBILITIES**

2.1. The Air Force Surgeon General (AF/SG) will ensure medical resources are planned, programmed, and budgeted to meet PopH requirements. ......................... 6

2.2. The Commander, Air Force Medical Operations Agency (AFMOA/CC) will: .... 6

2.3. The AFMOA Population Health Working Group (PopH Cell) will: ......................... 6

2.4. MAJCOM/Direct Reporting Unit (DRU) SG will: ......................................................... 7
2.5. The MTF Commander (MTF/CC) will: ................................................................. 7
2.6. The MTF Executive Committee will: ................................................................. 9
2.7. The MTF PHWG will: ..................................................................................... 9
2.8. The Chief of the Medical Staff (SGH) will: ..................................................... 10
2.9. The Chief of Aerospace Medicine (SGP) will: .............................................. 11
2.10. The Chief Nurse (SGN) will: ......................................................................... 12
2.11. The Chief Administrator (SGA) will: ............................................................. 12
2.12. The Group Practice Manager (GPM) will: ..................................................... 12
2.13. The Health Care Integrator (HCI) will: ......................................................... 13
2.14. The Medical Management Director (or HCI in the absence of a stand-alone Medical Management Director) will: ................................................................. 14

Table 2.1. Health Insurance Portability and Accountability Act (HIPAA) Taxonomy. ........ 16
2.15. The Disease Management Nurse (DM) will: ............................................... 16
2.16. The Case Manager (CM) will: ....................................................................... 17
2.17. The Discharge Planner (DP) will: ................................................................... 21
2.18. The Utilization Manager (UM) will: ............................................................... 21
2.19. The Provider will: ......................................................................................... 22
2.20. The Team Nurse will: ................................................................................... 23
2.21. The Team Medical Service Technician will: ............................................... 23
2.22. The BSC Senior Clinician will: .................................................................... 24
2.23. The Health Promotion Team will: .................................................................. 24
2.24. The Mental Health (MH) Team will: .............................................................. 24
2.25. The Dental Team will: .................................................................................. 25
2.26. The Information Management/Information Technology (IM/IT) Team will: ...... 25
2.27. The Ancillary Services Teams (Laboratory, Radiology, and Pharmacy) will: ...... 25

Attachment 1—GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION 26
Attachment 2—THE ADJUSTED CLINICAL GROUP (ACG) RESOURCE UTILIZATION BAND (RUB) SYSTEM 32
Chapter 1

POPULATION HEALTH AND MEDICAL MANAGEMENT

1.1. Population Health (PopH).

1.1.1. PopH encompasses the analysis of health outcomes and health determinants in an entire population that drive strategies, policies, and interventions to optimize health.

1.1.2. PopH steps beyond the individual-level focus of mainstream medicine by focusing on the assessment and understanding of a broad range of factors (health determinants) that impact health at a population level. These factors include (but are not limited to) individual behavior, social/physical environment, culture, health literacy, social support networks, resiliency, genetics, lifestyle, and healthcare resource distribution.

1.1.3. The PopH model (Figure 1) depicts the broad scope of PopH and population health management (PHM) across the health continuum encompassing primary, secondary, and tertiary prevention to improve health and performance outcomes.

1.1.4. PHM develops, fosters, and has oversight of strategies, policies and interventions being executed both centrally and locally at the MTF. These efforts positively impact health determinants, shift the health status of the population towards wellness, and improve human performance. This includes, but is not limited to, patient self-care, patient education, care coordination, community-based prevention and wellness activities that decrease premature mortality, reduce morbidity, improve health, and optimize wellness. In the AFMS the term “health care integration” is often used interchangeably with PHM.

Figure 1.1. Population Health Model.
1.2. Medical Management (MM).

1.2.1. MM refers to the planning, coordination, and delivery of appropriate health care services rendered to the ill, injured, or disabled patients and/or their families. MM is multi-faceted and is integrated under the tenets of PopH (Figure 1.2) because of shared goals and objectives. The MM program is delineated within this AFI as a separate entity from PopH in order to clarify roles and responsibilities.

1.2.2. MM addresses the needs of chronically ill and at-risk patients to improve patient outcomes and to promote the efficiency and effectiveness of the healthcare delivery system. This is accomplished through support of PopH, Health Promotion (HP), and Patient-Centered Medical Home (PCMH) activities and includes coordination of efforts to improve health care access and quality of care while simultaneously decreasing cost and variation in care management.

1.2.3. MM is comprised of Disease Management (DM), Utilization Management (UM), and Case Management (CM) which includes the CM function of Discharge Planning (DP). Note: The Wounded, Ill, and Injured (WII) program further delineates case managers into Medical Care Case Managers (MCCM) and Non-Medical Care Managers (NMCM). (T-0).

1.2.4. Figure 1.2 illustrates the broad scope of PopH and MM across the health care delivery system. PopH improvement efforts rely on integration and collaboration among care delivery components and community resources. These synergies lead to improved health and performance outcomes within the population.

Figure 1.2. Population Health Model Encompassing Medical Management.
Chapter 2

ROLES AND RESPONSIBILITIES

2.1. The Air Force Surgeon General (AF/SG) will ensure medical resources are planned, programmed, and budgeted to meet PopH requirements.

2.2. The Commander, Air Force Medical Operations Agency (AFMOA/CC) will:

2.2.1. Serve as OPR for AF PopH and MM efforts.

2.2.2. Provide policy guidance for population-based health care activities within the AFMS.

2.3. The AFMOA Population Health Working Group (PopH Cell) will:

2.3.1. Have AFMOA/CC as oversight body.

2.3.2. Develop, validate, recommend, advocate, and evaluate strategies to optimize the health of AF populations and the healthcare delivery system through a cross-functional forum.

2.3.3. Identify AFMS PopH priorities, standardize processes, develop action plans, and provide tools to help MTFs better manage PopH.

2.3.4. Monitor and analyze elements of PopH initiatives to ensure proper alignment of program activities, adequate resource allocation, and organizational support and training with AFMS strategy.

2.3.5. Improve the efficiency and effectiveness of the AFMS healthcare delivery system in support of PCMH and its PopH efforts.

2.3.6. Coordinate with Defense Health Agency (DHA) Informatics to utilize population-based data sources to assess and address PopH needs.

2.3.7. Be chaired by the PopH Cell Lead who will:

2.3.7.1. Convene meetings at least monthly.

2.3.7.2. Represent AF/SG and PopH Cell at PopH-related functions involving other Department of Defense (DoD) entities, non-DoD Federal agencies, and other organizations.

2.3.8. Include core members or representatives from:

2.3.8.1. PopH Cell Lead.

2.3.8.2. MM Division Chief.

2.3.8.3. Transformation Office (CCO).

2.3.8.4. DHA Informatics, formerly AFMSA/SG6.

2.3.8.5. AFMOA Senior enlisted career field representatives: 4N0X0, 4E0X0, and 4A0X0.

2.3.8.6. Health Care Integrator (HCI) Consultant.

2.3.8.7. Group Practice Manager (GPM) Consultant.
2.3.8.8. Public Health.
2.3.8.9. HP.
2.3.8.10. PopH.
2.3.8.11. Quality.
2.3.8.12. PCMH.
2.3.8.13. Mental Health.
2.3.8.14. SGA.
2.3.8.15. SGB.
2.3.8.16. SGD.
2.3.8.17. SGN.
2.3.8.18. Senior Biomedical Sciences Corps (BSC) Clinician.
2.3.8.19. Ad hoc attendees as needed.

2.4. MAJCOM/Direct Reporting Unit (DRU) SG will:

2.4.1. Support implementation of MTF PopH efforts, initiatives, and interventions in support of AFMS strategy.
2.4.2. Identify barriers to implementing MAJCOM and/or MTF PHM initiatives and report findings to AFMOA PopH Cell.

2.5. The MTF Commander (MTF/CC) will:

2.5.1. Serve as OPR for PopH at the installation level. (T-3).
2.5.2. Monitor and ensure compliance with this instruction within the MTF. (T-1).
2.5.3. Maintain an active and effective MTF-level PopH Working Group (PHWG) that directs, monitors, and evaluates PopH efforts at the installation level. (T-1).
2.5.4. Ensure the MTF strategic plan is reviewed at least annually and incorporates the PopH/MM strategic plan which includes at least one PHM measure and at least two MM measures (T-0) for all facilities. For non-Limited Scope MTFs (LSMTF), the strategic plan will include a minimum of one PHM measure and at least three MM measures, one each from CM, DM, and UM. (T-3).
2.5.5. Document approval of the PopH/MM strategic plan in Executive Committee minutes. (T-3).
2.5.6. In cases where an MTF is designated a LSMTF, the MTF/CC will:

2.5.6.1. Make reasonable efforts to adhere to the requirements of this AFI and identify where resource limitations prevent compliance with any requirement. These limitations must be provided to inspectors in writing prior to or at the beginning of inspection activities. (T-1).
2.5.6.2. Not be expected to perform all PHWG functions, but will perform functions relevant to their beneficiary population with guidance from the host MTF. (T-1).
2.5.7. Appoint the SGH to chair the PHWG. (T-3).

2.5.8. Appoint key MTF personnel (primary and alternate) to serve on the PHWG. (T-2).

2.5.9. Ensure organizational planning, support, dedicated resources, and requisite staff training for efficient and effective PopH and MM programs. (T-0).

2.5.10. Advocate and promote PopH and MM initiatives at installation/wing level. (T-3).

2.5.11. Ensure MTF personnel are oriented and receive annual refresher training on PopH and MM principles and programs. (T-3). These include but are not limited to:

   2.5.11.1. PHM framework (e.g., AFMS 6 Critical Success Factors). (T-3).

   2.5.11.2. MTF PopH/MM strategic plan. (T-3).

   2.5.11.3. Evidence-based practice [e.g., Clinical Practice Guidelines (CPGs), support staff protocols (SSP)]. (T-3).

   2.5.11.4. PopH and MM integration into PCMH operations. (T-3).

2.5.12. Designate a MM Director by appointment letter to establish and oversee MM program activities promoting a targeted, coordinated MM plan for improving access, cost, quality, and readiness. (T-0). This will generally be the HCI unless local circumstances dictate otherwise.

2.5.13. Ensure integration of PopH/MM programs into the PCMH team approach to patient care. (T-0).

2.5.14. Follow the established Direct Care System (DCS) review and appeal process for denial of care determinations based on medical necessity. (T-0).

2.5.15. Incorporate beneficiary complaints regarding non-medical necessity (benefit) determinations within the MTF’s existing grievance process IAW policies regarding patient rights and responsibilities. (T-0).

2.5.16. Ensure the PopH/MM strategic plan selects at least one clinical process each year for improvement through application of CPGs. (T-0).

2.5.17. Demonstrate through MM program outcomes an appropriate balance of healthcare services in the DCS for achieving goals related to access, cost, quality, and readiness. (T-0).

2.5.18. Promote coordinated MM practice within the MTF and with Managed Care Support Contractors (MCSCs) IAW regional policy to ensure uniform and integrated procedures and programs. (T-0).

2.5.19. Ensure role-based access to AFMS-approved systems [e.g., CarePoint Application Portal, Aeromedical Services Information Management System (ASIMS), Composite Health Care System (CHCS), Armed Forces Health Longitudinal Technology Application (AHLTA)] to support healthcare operations. (T-3).

2.5.20. Ensure EFMP-M functions are aligned under the SGH and co-located if possible with MM functions. (T-3).
2.6. The MTF Executive Committee will:

2.6.1. Serve as oversight body for MTF PHWG and hold MTFs accountable to implement PopH/MM strategies and programs that align with AFMS and MTF strategy. (T-1).

2.6.2. Hold LSMTFs accountable to implement PopH/MM strategies and programs that align with AFMS, MTF strategy and are relevant to the needs of their beneficiary population. (T-1).

2.7. The MTF PHWG will:

2.7.1. Develop strategies to address identified PopH needs. (T-1). Will guide primary care clinics, specialty clinics, and ancillary services in the identification, evaluation, and coordination of standardized PHM processes (e.g., patient engagement, team training, integrated community services). (T-1).

2.7.2. Lead cross-functional, multi-disciplinary teams to develop integral approaches and processes to implement PHM initiatives [e.g., CPGs, MiCare secure messaging, AFMOA-approved SSPs, Clinical Preventive Services (CPS), medical in-/out-processing protocols, standardized Tri-Service Workflow AHLTA templates] IAW MTF and AFMS strategy. (T-1).

2.7.3. Ensure PHM initiatives and efforts are evaluated for effectiveness. (T-1).

2.7.4. Include core members and senior level representatives from: (T-1).

2.7.4.1. SGH (chair).

2.7.4.2. Chief Administrator (SGA)

2.7.4.3. Chief of Aerospace Medicine (SGP).

2.7.4.4. Chief Nurse (SGN).

2.7.4.5. Health Care Integrator (HCI).

2.7.4.6. Group Practice Manager (GPM).

2.7.4.7. PCMH Physician Champion.

2.7.4.8. PCMH team Registered Nurse.

2.7.4.9. Dental Officer or senior 4Y0X0.

2.7.4.10. Public Health Officer or senior 4E0X0.

2.7.4.11. Mental Health: Behavioral Health Care Facilitator (BHCF), Internal Behavioral Health Consultant (IBHC), Prevention Specialist (FAP, ADAPT), or senior 4C0X0.

2.7.4.12. HP.

2.7.4.13. Senior PCMH team 4N0X0.

2.7.4.14. MM Director.

2.7.4.15. TRICARE Operations and Patient Administration Flight (TOPA).

2.7.4.16. MTF representative to the Community Action Information Board (CAIB).

2.7.4.17. Ad hoc guests as requested by Chair.
2.7.5. Convene at least nine times per year. (T-1).

2.7.6. Report to the Executive Committee either directly or via Executive Committee of the Medical Staff (ECOMS). (T-1).

2.7.7. Use 1) AFMS 6 Critical Success Factors (CSFs), 2) standardized process improvement methodologies (e.g., 8 Step Process, Observe-Orient- Decide-Act Loop, Plan-Do-Study-Act), and 3) relevant metrics to implement, track, and evaluate the impact and effectiveness of PHM initiatives. (T-1).

2.7.8. Ensure that a defined, collaborative process for medical in-/out-processing exists and standardized AFMOA-approved decision-support tools are used to facilitate and monitor the process. (T-1).

2.7.9. Facilitate and monitor use of Adjusted Clinic Group (ACG) Resource Utilization Band (RUB) and Illness Burden Index (IBI) tools and implementation guidelines to assist in the in-/out-processing of beneficiaries and ensure appropriate Primary Care Manager (PCM) empanelment, stratification, and prioritization of patients for targeted PHM interventions. (T-1).

2.7.10. Collaborate with the installation CAIB/Integrated Delivery System (IDS) to identify and prioritize community needs and to develop, market, and implement community-based health improvement programs that impact those needs. (T-1).

2.8. The Chief of the Medical Staff (SGH) will:

2.8.1. Serve as OPR for oversight of PopH efforts and provide clinical oversight and program design guidance to the MM program. (T-1).

2.8.2. Ensure that MM activities are conducted IAW accepted MM standards (T-0).

2.8.3. Oversee, coordinate, and supervise HCI, DM, UM, and CM activities and may delegate supervision of MM staff to the HCI. (T-1).

2.8.3.1. Lead development of a local policy detailing the duration and the circumstances under which DM nurses may be used to cover PCM team nursing duties. This can be accomplished through discussion and documentation in ECOMS. (T-3).

2.8.3.2. Advocate for DM nurses to spend the majority of their time providing DM services to the greatest extent possible. Will work closely with the SGN and consider all MDG assets to maximize effectiveness of DM programs while supporting mission requirements. (T-3).

2.8.4. Maintain overall responsibility for the clinical quality and integrity of the EFMP-M program IAW AFI 40-701, Medical Support to Family Member Relocation and Exceptional Family Member Program (EFMP). (T-1).

2.8.4.1. Provide direct oversight to appointed Exceptional Family Member Program-Medical (EFMP-M) staff in the completion of EFMP enrollment, FMRC procedures, and care of family members with special needs and may delegate supervision to the HCI. (T-1).

2.8.4.2. Ensure a process exists for direct and frequent coordination between MM staff and EFMP-M staff in support of care coordination and warm hand-offs. (T-1).
2.8.5. Ensure development of a PopH/MM strategic plan and monitor progress toward strategic goals via PHWG. (T-2). Will forward PHWG minutes to MDG/CC via Executive Committee and/or ECOMS meeting. (T-2).

2.8.6. Ensure integration of PHM with other departments and services to optimize healthcare delivery for patients throughout the healthcare continuum. (T-0).

2.8.7. Ensure collaborative processes are in place between the EFMP-M, GPM activities, and PHM programs. (T-0).

2.8.8. Ensure WII patients have the highest priority for timely care by assigning a PCM for medical care, referrals, and CM services. (T-0).

2.8.9. Ensure a PopH quality monitoring and self-inspection program is in place, includes process and outcome measures, and is reported to PHWG. (T-0).

2.8.10. Oversee selection, approval, and implementation of standardized evidence-based SSPs and CPGs via ECOMS. (T-0).

2.8.11. Implement SSPs, in coordination with SGP, SGN, and enlisted Functional Managers, enabling support personnel to order CPS- and CPG-associated tests and medication requests. (T-3).

2.8.12. Champion implementation of AFMOA-approved processes ensuring standardized delivery of clinical services (e.g., evidence-based practice, MiCare secure messaging, medical in-/out-processing, CPS). (T-3).

2.8.13. Ensure use of Tri-Service Work Flow (TSWF) templates and workflow processes to document continuum of care elements and meet DD Form 2766 and DD Form 2882 requirements for AD and non-AD beneficiaries IAW AFI 41-210, TRICARE Operations and Patient Administration Functions. (T-3).

2.8.14. Ensure provider peer review includes elements of PHM (e.g., CPG compliance, CPS) IAW AFI 44-119, Medical Quality Operations, Section 8.6.3.1. (T-3).

2.9. The Chief of Aerospace Medicine (SGP) will:

2.9.1. Integrate aerospace medicine expertise (e.g., public health, environmental influences on health, performance enhancement, health promotion) with PopH strategies and ensure aerospace medicine programs are incorporated into PHM interventions and activities. (T-3).

2.9.2. Represent areas of administration and clinical oversight of Force Health Protection (FHP) programs [e.g., Preventive Health Assessments (PHAs), Deployment Health (DH), Duty Limiting Conditions (DLCs), and Medical Evaluation Boards (MEBs)] to the PHWG. (T-3).

2.9.3. Collaborate with SGH in developing MTF Instructions and standardized SSPs for FHP, HP, CPS, and CPGs that support PHM efforts. (T-3).

2.9.4. Arrange and coordinate FHP briefings and training at appropriate MTF venues including ECOMS, professional staff meetings, and ancillary staff in-service training. (T-3).

2.9.5. Provide FHP, occupational, and preventive medicine expertise and oversight to patient care clinics. (T-3).
2.9.6. Direct epidemiologic surveillance and data analysis in support of installation PHM activities. (T-3).

2.10. The Chief Nurse (SGN) will:

2.10.1. Ensure allocation of adequate nursing staff to support execution of PHM activities. (T-0).

2.10.2. Provide input into PopH/MM strategic plan as needed. (T-3).

2.10.3. Ensure all MTF personnel complete required orientation and recurring training on PopH/PHM activities, theory, purpose, and local processes appropriate to their role(s) and document in individual training record. (T-3).

2.10.4. Ensure MM staff complete required orientation and training appropriate to their role(s) and document in individual training record. (T-0).

2.10.5. Oversee training of nursing personnel on standardized SSPs (as approved by ECOMS or AFMOA). (T-3).

2.10.6. Collaborate with SGH on the training, implementation, and use of TSWF AHLTA templates and standardized workflow processes. (T-3).

2.10.7. Ensure nurse peer review includes PHM elements (e.g., CPG compliance, CPS). (T-3).

2.11. The Chief Administrator (SGA) will:

2.11.1. Provide executive-level leadership integrating business disciplines toward the goal of safe, effective healthcare and achieving PHM objectives and goals. (T-3).

2.11.2. Lead and support business planning, financial planning, performance planning, medical logistics planning, and oversight of beneficiary services related to PHM. (T-3).

2.11.3. Assess available data (in coordination with the SGH, SGN, and SGP) to understand current and future population demands for services in order to effectively develop PHM interventions, and to engage with headquarters organizations in the AFMS corporate planning, programming, budgeting, and execution process. (T-3).

2.12. The Group Practice Manager (GPM) will:

2.12.1. Support and collaborate with providers, HCIs, and clinical/administrative support staff on PopH business process goals to most effectively optimize patient care and MTF clinical processes. (T-2)

2.12.2. Participate in business planning, scheduling, managing access to care, optimizing productivity, coordinating logistics, strategic planning, and monitoring beneficiary satisfaction data for inpatient and outpatient services. (T-2)

2.12.2.1. Perform analysis and provide a business perspective for assigned clinical product lines. (T-2)

2.12.2.2. Analyze and present key management indicators (e.g., access-to-care, manpower planning, demand and capacity analysis). (T-2)

2.12.2.3. Use available data sources (in coordination with the HCI, UM, and MEPRS Manager) to analyze population demands, facilitate programs to effectively manage
utilization of resources and patient utilization of appointments, as well as investigate any suspected inconsistencies between databases. (T-1)

2.12.2.4. Partner with HCI, PCM teams, and other staff members to ensure MiCare secure messaging capabilities and utilization are maximized. (T-2)

2.13. The Health Care Integrator (HCI) will:

2.13.1. Be a graduate from a baccalaureate (BSN) program in nursing accredited by a national nursing agency that is recognized by the US Department of Education; he/she will hold and maintain an active, current, valid, and unrestricted license to practice nursing as a Registered Nurse (RN) in any US state or jurisdiction. (T-1)

2.13.2. Lead PHM initiatives and integration within the MTF and champion PopH efforts across community networks. (T-1).

2.13.3. Attend the Health Care Integrator Orientation formal training course no earlier than 30 days after, and no later than 4 months after, assuming the HCI role. (T-1). Will acquire access to needed data sources and gain familiarity with the MTF’s enrolled population and the PopH and MM programs prior to attending the course. (T-1).


2.13.5. Use the AFMS 6 CSFs as a collaborative framework of practice to oversee all MTF PHM activities and effectively measure, report, trend, and evaluate the health status of enrolled population. (T-1). Note: The AFMS 6 CSFs are similar to the key MHS PopH process elements found in the DoD TMA Medical Management Guide.

2.13.6. Integrate MM, FHP, HP, and CPS processes throughout the continuum of care through leadership, collaborative partnerships with stakeholders, and direct supervision as assigned. (T-3).

2.13.7. Partner with stakeholders (e.g., patients, PCM teams, DM, CM, UM, ancillary services, HP, and community partners) in process improvements to address care gaps, streamline processes, and manage high-risk populations. (T-2).

2.13.8. Measure process and outcome goals to validate effectiveness of programs and the care delivery system. (T-2).

2.13.9. Support the effective implementation and utilization of ECOMS-adopted CPGs across the care continuum to affect the health and health care utilization behaviors of the enrolled population. (T-3).

2.13.10. Provide clinical supervision and oversight and ensure appropriate training of the EFMP-M staff as directed by the SGH IAW AFI 40-701, Medical Support to Family Member Relocation and Exceptional Family Member Program (EFMP). (T-2).

2.13.11. Facilitate the PHWG meeting as directed by the SGH, attend the monthly MTF MM team meeting, and promote PopH initiatives addressed at the CAIB and IDS. (T-2).
2.13.12. Support the effective implementation of AF policy on medical in-/out-processing by facilitating deployment, training, and utilization of standardized AFMOA-approved medical in-/out-processing protocols and tools, to include use of non-count MEPRS code ELAB for all medical in-/out-processing documentation in AHLTA. (T-2).

2.13.12.1. Ensure the ACG RUB/IBI acuity classification is used to assess incoming patients for the appropriate level of care, to proactively balance provider panels, and to identify high-risk or high-acuity candidates for targeted PHM interventions (see Attachment 2 of this instruction). (T-3).

2.13.12.2. Inprocessing. Coordinate with clinic leadership to ensure clinic staff at the gaining base review medical out-processing documentation (AHLTA medical in-/out-processing TSWF) when medically in-processing new patients to ensure continuity of care and proper follow-up and handoff. (T-3).

2.13.12.3. Outprocessing. Ensure appropriate evaluation and documentation of patient needs (AHLTA medical in-/out-processing TSWF) during out-processing for appropriate enrollment, follow-up, and care coordination at the gaining base. (T-1).

2.13.13. Partner with GPMs to collect and analyze PopH data and manage demand and capacity proactively. (T-3).

2.13.14. Support PCM teams and MM staff in identifying training and resource requirements to most effectively support PHWG efforts. (T-3).

2.13.15. Use available tools [e.g., CarePoint Application Portal, Web-based Health Assessment (Web HA), ASIMS, Biometric Data Quality Assurance Service (BDQAS)] and metrics [e.g., HEDIS, Medical Home Performance Index (MHPI), Access to Care] to assess health status/health care use behaviors of enrolled population, stratify high-risk groups, identify care gaps, plan and implement process improvements to address gaps, and trend/measure impact of PHM interventions across the care spectrum (see PopH Model, Figure 1.2 of this instruction). (T-1).

2.13.16. Facilitate use of the CarePoint Application Portal platform and MiCare secure messaging capabilities by the PCM teams to provide proactive care to patients and self-evaluation and goal monitoring by the PCM teams. (T-1).

2.13.17. Communicate PHM goals and current goal status to PCM teams and stakeholders. (T-3).

2.13.18. Document HCI-related activities using the EBDA MEPRS clinic (T-3).

2.14. The Medical Management Director (or HCI in the absence of a stand-alone Medical Management Director) will:

2.14.1. Partner with MTF SGH, HCI, and GPM to deploy PHM strategies that enhance patient care coordination and communication. (T-3).

2.14.2. Design, plan, develop, implement, and direct the MM program (in collaboration with the SGH, MM team, and other stakeholders). (T-1).

2.14.2.1. Plan and coordinate the work of MM with all departments and services. (T-2).
2.14.2.2. Assist in the development and coordination of major MM policy applications in
the MTF and the interpretation of DoD, AFMS, MCSC, and national accreditation
policies and instructions in consonance with mission objectives. (T-1).

2.14.2.3. Incorporate MM principles into an annual, interdisciplinary PopH/MM
strategic plan in support of the MTF business plan, PHWG efforts, and PCMH team
operations. (T-2).

2.14.3. Ensure use of evidence-based, ECOMS-approved guidelines from DoD, federal, and
civilian professional organizations in the conduct of MM activities. (T-3).

2.14.4. Conduct a MM meeting at least monthly with SGH, HCI, CM, UM, DM, and Special
Needs Coordinator to discuss progress toward MM goals (e.g., from the PopH/MM strategic
plan, ongoing process improvement initiatives), complex patient cases, status of referrals to
appropriate level of care, and lessons learned. (T-1). Will include the Recovery Care
Coordinator as needed IAW Health Insurance Portability and Accountability Act (HIPAA)
rules. (T-0).

2.14.5. Provide clinical supervision and oversight of DM, UM, CM, and DP personnel and
their programs as directed by the SGH. (T-2).

2.14.6. Register in MHS Learn and complete required training within two months. (T-1).
Required training includes: Medical Management Essentials, Fundamentals of Case
Management, Fundamentals of Disease Management, and Fundamentals of Utilization
Management. Will complete refresher training as updates become available. (T-3).

2.14.7. Provide or facilitate training to MM staff on data management and utilization for
effective MM program activities. (T-3).

2.14.8. Ensure MM staff obtain role-based access to, and training in the use of appropriate
medical documentation and tracking systems, [e.g., CHCS, AHLTA, Essentris, ASIMS,
CarePoint Application Portal, Military Health System Population Health Portal (MHSPHP),
CarePoint Healthcare Application Suite (CHAS)]. (T-1).

2.14.9. Ensure MM staff is trained on documentation requirements and medical coding
procedures as appropriate for role. (T-3).

2.14.10. Ensure MM staff provide correct information on existing AFMS MM personnel
rosters and perform a monthly review for accuracy. (T-3).

2.14.11. Ensure collaborative communication processes exist amongst members of the MM
team and between the MM team and the PCM teams. (T-0).

2.14.12. Ensure at least a quarterly peer review of a minimum of 5% of encounters (but no
less than 15 encounters) for CMs, DPs, and DMs is conducted to evaluate appropriate use of
resources, timely assessments and interventions, and compliance with clinical and
administrative standards. (T-2).

2.14.13. Ensure peer review includes review of appropriate coding practices for workload
data capture. Results will be reviewed in the Nurse Executive Function. (T-3).

2.14.14. Ensure that man-hours worked are documented by MM staff in the Defense
Medical Human Resources System – internet (DMHRSi) using appropriate Medical Expense
and Performance Reporting System (MEPRS) workload accounting system codes. (T-0).
2.14.15. Ensure medical care documentation by MM staff is completed in AHLTA using the appropriate MEPRS and clinic code. (T-0).
   2.14.15.1. MEPRS and clinic code for DMs will be ELAD. (T-0).
   2.14.15.2. MEPRS and clinic code for UMs will be ELAU. (T-0).
   2.14.15.3. MEPRS and clinic code for CMs will be ELAN. (T-0).
   2.14.15.4. MEPRS and clinic code for medical in-/out-processing activities will be ELAB. (T-0).

2.14.16. Ensure medical care documentation by MM staff is completed in AHLTA using the appropriate provider specialty codes for CMs. (T-0). See Table 2.1 of this instruction for the only two codes approved for use to document CM activities. It is important to ensure that neither provider specialty codes 600 (Nurse, General Duty) nor 703 [Social Worker (providing therapy)] are used for case managers. (T-0).

<table>
<thead>
<tr>
<th>HIPAA Taxonomy</th>
<th>Description</th>
<th>CHCS Provider Specialty Code</th>
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<tr>
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<td>613</td>
</tr>
<tr>
<td>1041C0700X</td>
<td>Social Worker Case Manager</td>
<td>714</td>
</tr>
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</table>

2.15. The Disease Management Nurse (DM) will:

2.15.1. Be a graduate from an associate or baccalaureate degree program in nursing accredited by a national nursing agency that is recognized by the US Department of Education; he/she will hold and maintain an active, current, valid, and unrestricted license to practice nursing as a Registered Nurse in any US state or jurisdiction. (T-1).

2.15.2. Develop and execute appropriate multi-disciplinary DM activities in collaboration with SGH, SGN, HCI, MM Director, BHCF, CM, UM, and PCM teams in support of PopH and PHM initiatives. (T-2).

2.15.3. Support medical in-/out-processing screening efforts to identify “at-risk” individuals for enrollment into DM or CM. (T-3).

2.15.4. Register in MHS Learn and complete required training within two months. Required training includes: Medical Management Essentials and Fundamentals of Disease Management. (T-1). Will complete refresher training as updates become available. (T-3).

2.15.5. Attend Disease Manager formal training course if eligible, no earlier than 30 days after, and no later than 4 months after, assuming the DM role. (T-1). DMs hired prior to inception of the DM course will attend the course at the earliest opportunity. (T-3). Will acquire access to needed data sources and gain familiarity with the MTF’s enrolled population and MM programs prior to attending the course. (T-1).

2.15.6. Develop and evaluate the annual DM plan for inclusion in the PopH/MM strategic plan in collaboration with stakeholders (e.g., SGH, HCI, GPM, SGN, MM team). (T-0).
2.15.7. Use available data sources to identify, assess, and prioritize the needs of targeted subsets of beneficiaries for specific DM programs. Will ensure preventive care is included in DM plan of care. (T-1).

2.15.8. Proactively implement DM services for populations with chronic conditions, collaborate with beneficiaries in formulating patient-centered goals, and educate individuals and groups based on ECOMS-adopted CPGs. (T-0).

2.15.9. Document DM-related care provided using the ELAD MEPRS clinic for all face-to-face, telephonic, or secure message interactions. (T-0). Coding should include International Classification of Diseases (ICD), Evaluation and Management (E&M), and DM-specific Healthcare Common Procedure Coding System (HCPCS) codes. (T-0). These encounters must be completed and signed within 72 hours. (T-0).

2.15.10. Track and report to PHWG DM-related data, process and outcome measures, identified opportunities for improvement, and status of process improvement programs. (T-1).

2.15.11. Communicate and collaborate with other members of the healthcare team and MCSC MM staff as needed to ensure continuity of care for patients with chronic illness. (T-0).

2.15.12. Track and report health care outcomes of individual patients with chronic conditions to PCM teams. (T-3).

2.15.13. Provide a warm handoff (person-to-person verbal communication providing continuity of care and a seamless transfer of information) of patients in transition to other levels or places of care by providing pertinent information to the receiving health care provider (e.g., patient self-management status at graduation from the DM program to primary care team, or transfer to CM for more intensive services); document warm handoff in AHLTA. (T-1).

2.15.14. Participate in MM, PHWG, and care coordination meetings as assigned. (T-0).

2.15.15. Conduct DM staff peer reviews, using AFMOA-approved peer review form, as assigned. (T-3).

2.16. The Case Manager (CM) will:

2.16.1. Be either a licensed registered nurse or a licensed clinical social worker, graduated from a program that is accredited by a nationally recognized accreditation agency recognized by the US Department of Education, and must hold an active, valid, current, and unrestricted license to practice nursing as a Registered Nurse or social work as a Licensed Clinical Social Worker in any US state or jurisdiction. Each will utilize the appropriate provider specialty codes discussed in paragraph 2.14.16 of this instruction. (T-0).

2.16.2. Register in MHS Learn and MCG On Demand and complete required training within two months. Required training includes: Medical Management Essentials, Fundamentals of Case Management, CM Module I, TRICARE Fundamentals, Military Medical Support Office, Veterans Health Initiative: Traumatic Brain Injury for Clinical Case Managers, Post-Traumatic Stress Disorder (PTSD): ‘What is PTSD’ module, Psychological Impacts of Deployment, Clinical Decision Support Tools (Note: All CMs will complete Ambulatory Care and Behavioral Health modules; those assigned to an inpatient facility will also...
complete the Inpatient and Surgical Care modules), Veterans Health Administration overview, Introduction to the DoD Disability Evaluation System for Case Managers, DoD Recovery Care Coordination Program, and service-specific clinical CM courses as assigned. (T-1). Will complete refresher training as updates become available. (T-3).

2.16.3. Develop the annual CM plan for inclusion in the PopH/MM strategic plan in collaboration with stakeholders (e.g., SGH, HCI, GPM, SGN, MM team). (T-0).

2.16.4. Provide CM services to beneficiaries who meet eligibility criteria. Will direct questions regarding patient eligibility for care to the Health Benefits office and the SGH. (T-0).

2.16.5. Provide care coordination for enrolled beneficiaries requiring special assistance (e.g., children, elderly, EFMP-M, WII) including discharge planning as needed, throughout the continuum of care. (T-0).

2.16.5.1. Coordinate with PCM teams to provide care coordination services according to CM case load and acuity. (T-0). When CM caseload dictates, PCM teams may be required to retain responsibility for low acuity care coordination.

2.16.5.2. Coordinate care with other MTF MM staff as needed. (T-0).

2.16.5.3. Provide CM services for MH treatment to MTF MH Clinic patients only as outlined in AFI 44-172, Mental Health. (T-1). MH CM for MH patients is provided by MH staff except in special and very limited circumstances. In cases where MH patients have medical issues that require specialty care and/or medical CM, the medical CM will co-manage the patient with the MH CM. (T-1).

2.16.6. Actively participate in MM meetings. (T-0).

2.16.7. Obtain written consent to provide CM services from the patient or legal guardian prior to acting on the patient’s behalf. (T-0). If unable to obtain due to patient inability to be physically present, will document verbal consent in AHLTA and will obtain a written consent at the first opportunity. Will file the consent in the patient’s medical record. (T-0).

2.16.8. Document care provided in the medical record using the ELAN MEPRS clinic for all face-to-face, telephonic, or secure message interactions using the current version of the TSWF alternate input method (AIM) form for CM. (T-0). This requirement does not apply to primary care team nurses performing occasional case management as part of their regular assigned duties. (T-0).

2.16.8.1. Generate, complete, and sign within 72 hours an AHLTA encounter for each patient contact. (T-0). Will complete an encounter note for all patients continuing in CM services at least once per calendar month. (T-0).

2.16.8.2. Use appropriate international classification of disease (ICD) diagnosis codes, evaluation and management (E&M) codes, T1016 procedure codes, and acuity G codes. (T-0). Will assign the applicable deployment-related diagnosis as the secondary diagnosis if the patient is a wounded warrior or in CM for a deployment-related problem. (T-0).

2.16.9. Complete review of CM request/referral within one business day using CM AHLTA template. (T-1). Will document that CM referral was received and reviewed. (T-1).
2.16.9.1. For patients being considered for CM:

2.16.9.1.1. Complete a full health and psychosocial assessment within three business days including, but not limited to, demographic information, medical history, vocational information, health status, current/projected resource utilization, psychological status, community/social support systems, health risk assessment, home/environment assessment, and patient’s health goals, determining whether patient meets CM criteria.  (T-0).

2.16.9.1.2. For those meeting CM criteria, complete an initial care plan within five business days and a comprehensive multidisciplinary care plan within 30 days of the initial assessment.  (T-1).

2.16.9.1.3. The comprehensive care plan must include, but is not limited to, objectives, goals, and actions designed to meet the assessed needs for healthcare, safety, and attainment of patient’s health goals are agreed to by the CM and the patient and documented in the medical record.  (T-0).

2.16.9.1.4. Complete a multidisciplinary care plan for patients determined to require care coordination for more than 30 days, thereby meeting criteria for CM.  (T-3).

2.16.9.2. For patients not meeting criteria for CM, will refer patients back to the originator of the referral with suggested alternatives.  (T-1).

2.16.10. Screen all WII for CM services who meet the following criteria:  (T-0).

2.16.10.1. Category (CAT) 1.

2.16.10.1.1. Has a mild injury or illness.

2.16.10.1.2. Is expected to return to duty within a time specified by his or her Military Department.

2.16.10.1.3. Receives short-term inpatient medical treatment or outpatient medical treatment and/or rehabilitation.

2.16.10.2. CAT 2.

2.16.10.2.1. Has a serious injury or illness.

2.16.10.2.2. Is unlikely to return to duty within a time specified by his or her Military Department.

2.16.10.2.3. May be medically separated from the military.

2.16.10.3. CAT 3.

2.16.10.3.1. Has a severe or catastrophic injury or illness.

2.16.10.3.2. Is highly unlikely to return to duty.

2.16.10.3.3. Will most likely be medically separated from the military.

2.16.11. Screen all beneficiaries, including WII, for CM services once identified with the following criteria:  (T-0).

2.16.11.1. Patient demands referrals from multiple medical providers.
2.16.11.2. Catastrophic illnesses or injuries.
2.16.11.3. Multiple chronic or terminal illnesses.
2.16.11.4. Complex medical problems/dual diagnosis (medical and psychiatric).
2.16.11.5. Lack of family/social support.
2.16.11.7. Multiple visits to the Emergency Department.
2.16.11.8. Transplant, high risk, or high cost.
2.16.11.9. Special interest.
2.16.11.10. Functional/physical deterioration.
2.16.11.11. Frequent utilization of health care resources and services.
2.16.11.13. HIV/AIDS.
2.16.11.15. Substance abuse.
2.16.11.16. Requires extensive coordination of resources and services.

2.16.12. Act as patient advocate and liaison with other DoD and community agencies in coordinating services and will provide timely patient status updates to PCM and other clinicians as needed. (T-0).

2.16.13. Conduct a warm handoff (person-to-person verbal communication providing continuity of care and a seamless transfer of information) to another CM, non-clinical care manager, health care provider, MCSC CM, the Recovery Care Coordinator (RCC), and/or Federal Recovery Coordinator (FRC) when there is a transfer of care to other levels or places of care (another medical facility, agency, or a Veterans Administration facility) for additional treatment and follow-up. (T-1).

2.16.13.1. Obtain beneficiary’s authorization to release Protected Health Information prior to conducting a warm handoff to a non-covered entity such as a Recovery Care Coordinator (RCC), non-clinical care manager, or a Federal Recovery Coordinator (FRC). (T-0).

2.16.13.2. Coordinate transfer of information with the MCSC CMs when patients require care, in whole or in part, outside of the DCS. (T-0).

2.16.13.3. Document a transfer report in the patient’s medical record which will include a written plan encompassing the elements crucial to the smooth transition of the patient to a new site of care, i.e., medical/nursing care requirements, social and physical needs, services required, follow-up, and durable medical equipment. (T-0). Will document the handoff including the diagnosis or medical condition that prompted the need for CM services, a summary of the patient’s current medical status, date of transfer, reason for transfer, mode of transfer, and accepting CM and physician. (T-0).
2.16.13.4. Discuss with CAT 2 and 3 patients the option for self-referral to the RCC and recommend that the medical provider submit a referral to the RCC on behalf of the patient. (T-0).

2.16.13.5. During transition of care, provide patient an electronic or hard-copy CM care plan and any official paperwork pertinent to his/her medical condition and personnel status. (T-3).

2.16.14. After receiving written patient consent, consult with WII member’s chain of command and medical team to validate his/her needs and participate in housing inspections as required. (T-0). Will not conduct the inspection, but will schedule it to accommodate the member's needs, appointments, and physical limitations. (T-0). Will provide insight and recommendations to the housing inspector on pertinent medical and special physical requirements so that the housing being provided is safe, accessible, and facilitates the care and recovery of the member. (T-0).

2.16.15. Participate in PHWG, DAWG, and care coordination meetings as assigned. (T-0).

2.16.16. Conduct nursing peer reviews as assigned. (T-3).

2.17. The Discharge Planner (DP) will:

2.17.1. Be either a licensed registered nurse or a licensed clinical social worker, graduated from a program that is accredited by a nationally recognized accreditation agency recognized by the US Department of Education, and must hold an active, valid, current, and unrestricted license to practice nursing as a Registered Nurse or social work as a Licensed Clinical Social Worker in any US state or jurisdiction. Each will utilize the appropriate provider specialty codes discussed in 2.14.16. (T-0).

2.17.2. Develop and execute discharge planning activities for the MTF. (T-1).

2.17.3. Complete the same training as CMs as specified in 2.16.2. (T-1). Will complete refresher training as updates become available. (T-3).

2.17.4. Follow guidelines IAW DoD TMA Medical Management Guide and the general CM guidelines previously noted. (T-0).

2.17.5. Follow approved discharge planning decision support tool/criteria (e.g., MCG Care Guidelines). (T-3).

2.17.6. Conduct nursing peer reviews as assigned. (T-3).

2.18. The Utilization Manager (UM) will:

2.18.1. Be a graduate from an associate or baccalaureate degree program in nursing accredited by a national nursing agency that is recognized by the US Department of Education. He/she will hold and maintain an active, current, valid, and unrestricted license to practice nursing as a Registered Nurse in any US state or jurisdiction. (T-0).

2.18.2. Register in MHS Learn and MCG On Demand and complete required training within two months. Required training includes: Medical Management Essentials and Fundamentals of Utilization Management as well as MCG Learning Management System training on the MCG clinical support tool. (T-1). Will complete refresher training as updates become available. (T-3).
2.18.3. Develop the annual UM plan for inclusion in the PopH/MM strategic plan in collaboration with stakeholders (e.g., SGH, HCI, GPM, SGN, MM team) (T-0).

2.18.4. Use data-driven processes to prospectively and retrospectively identify indicators of ineffective or inefficient delivery of care including, but not limited to, high-cost, high-volume, or problem-prone diagnoses, procedures, and services, and high utilization rates for services (e.g., pharmacy, Emergency Department, and outpatient visits). (T-1).

2.18.4.1. Make recommendations for cost containment or process improvements. (T-0).

2.18.4.2. Gather necessary information, determine the medical necessity of services ordered or rendered, and determine appropriateness of certain levels of care IAW approved decision support tool. (T-0).

2.18.4.3. Follow the established DCS review and appeal process for denial of care determinations based on medical necessity. (T-0).

2.18.5. Perform data analysis and report to SGH on a regular basis per the UM strategic plan and MTF/PHWG requirements. (T-1). Will report negative trends requiring immediate attention to the SGH as needed. (T-1).

2.18.6. Educate MTF staff on the clinical referral process and the tools available to determine appropriate level of care to achieve optimal patient outcomes. (T-3).

2.18.7. Report any identified quality of care issues to the SGH and/or Quality Manager IAW MTF policy. (T-3).

2.18.8. Conduct inpatient length of stay reviews and report negative trends to SGH as needed. (T-3).

2.18.9. Evaluate clinical practice patterns and trends and provide SGH and clinical areas with feedback. (T-0). Will provide orientation and training to the clinical staff as required. (T-0).

2.18.10. Identify and refer potential cases to DM, CM, DP, and DAWG as appropriate. (T-0).

2.18.11. Use MEPRS and clinic code ELAU when documenting in AHLTA. (T-0).

2.18.12. Participate in MM, PHWG, and care coordination meetings as assigned. (T-0).

2.18.13. Conduct nursing peer reviews as assigned. (T-3).

2.19. The Provider will:

2.19.1. Oversee and champion all PHM efforts and process improvements within their PCM teams. (T-2).

2.19.2. Integrate PHM strategies into clinical workflow (e.g., MiCare secure messaging, huddles, TSWF, SSPs). (T-3).

2.19.3. Ensure electronic DD Form 2766, Adult Preventive and Chronic Care Flowsheet/DD Form 2766C, Vaccine Administration Record, is updated during annual PHA, pre-/post-deployment (including Deployment Health Related Assessments (DHRA)), and prior to PCS for military personnel. (T-1).
2.19.4. Champion efforts to enhance the health and well-being of beneficiaries by identifying and documenting health risks (e.g., tobacco use, sedentary lifestyle, obesity) and providing evidence-based interventions to mitigate these risks. (T-3).

2.19.5. Ensure patients receive CPS according to the USPSTF *Guide to Clinical Preventive Services*. (T-3). When recommendations from specialty organizations (e.g., American College of Obstetrics and Gynecology, American Urologic Society, Advisory Committee for Immunization Practices) differ from USPSTF recommendations, they may be considered for use per local policy. (T-3).

2.19.6. Implement AFMOA/ECOMS-approved SSP and CPG protocols as appropriate for the population. (T-3).

2.19.7. Measure compliance with CPG protocols via peer review process. (T-3).

2.19.8. Ensure use of TSWF Core templates by clinical support staff to document and track continuum-of-care elements such as allergies, current medications, supplement use, active medical conditions, surgeries, hospitalizations, family history, social history (e.g., tobacco use, physical activity, alcohol use), objective health measures (e.g., height, weight, blood pressure), and currency of CPS at each visit. (T-3).

2.19.9. Actively encourage patients to enroll in the MiCare secure messaging system. (T-3). Will use MiCare secure messaging as the primary option for patient/team communication. (T-3).

2.20. The Team Nurse will:

2.20.1. Collaborate with HCI, MM staff, and care team in planning and implementing PHM strategies. (T-3).

2.20.2. Identify and prioritize high-risk patients for care coordination or referral to the MM team for complex care management. (T-3).

2.20.3. Lead patient education efforts by using evidenced-based guidelines and teaching resources designed to help patients manage and improve their health. (T-3).

2.20.4. Integrate PHM strategies into clinical workflow (e.g., MiCare secure messaging, huddles, TSWF, SSPs). (T-3).

2.20.5. Support the effective implementation of AF policy on medical in-/out-processing by using standardized AFMOA-approved medical in-/out-processing protocols and tools, to include use of non-count MEPRS code ELAB for all medical in-/out-processing documentation in AHLTA. (T-3).

2.20.6. Actively encourage patients to enroll in the MiCare secure messaging system. (T-3). Will use MiCare secure messaging as the primary option for patient/team communication. (T-3).

2.21. The Team Medical Service Technician will:

2.21.1. Perform within scope of practice IAW CFETP when using AFMOA/ECOMS-approved SSPs. (T-3).

2.21.2. Integrate PHM strategies into clinical workflow (e.g., MiCare secure messaging, huddles, TSWF, SSPs). (T-3).
2.21.3. Use TSWF Core templates to document and track continuum-of-care elements such as allergies, current medications, supplement use, active medical conditions, surgeries, hospitalizations, family history, social history (e.g., tobacco use, physical activity, alcohol use), objective health measures (e.g., height, weight, blood pressure), and currency of CPS at each visit using the copy-forward methodology as appropriate. (T-3).

2.21.4. Ensure electronic DD Form 2766/DD Form 2766Cs are updated during annual PHA, pre-/post-deployment (including DHRA), and prior to PCS for military personnel IAW AFI 41-210. (T-3).

2.21.5. Support the effective implementation of AF policy on medical in-/out-processing by using standardized AFMOA-approved medical in-/out-processing protocols and tools, to include use of non-count MEPRS code ELAB for all medical in-/out-processing documentation in AHLTA. (T-3).

2.21.6. Actively encourage patients to enroll in the MiCare secure messaging system. (T-3). Will use MiCare secure messaging as the primary option for patient/team communication. (T-3).

2.22. **The BSC Senior Clinician will:**

2.22.1. Solicit input for PHM initiatives from BSC clinicians. (T-3).

2.22.2. Disseminate relevant PHM initiatives to appropriate BSC clinicians for implementation. (T-3).

2.23. **The Health Promotion Team will:**

2.23.1. Provide support to PCM teams on HP strategies that engage, empower, and facilitate populations and individuals to make choices that improve health. (T-3).

2.23.2. Identify, develop, implement, and evaluate community-based HP activities in collaboration with the PHWG in support of PopH needs. (T-3).

2.23.3. Serve as consultant to community agencies and commanders on policy, social, and environmental factors that affect PopH. (T-3).

2.24. **The Mental Health (MH) Team will:**

2.24.1. Participate in the PHWG and provide mental/behavioral health expertise as it relates to PopH needs/strategies. (T-3).

2.24.2. Support PCM teams with integrating MH services with PCMH and educate them on the care coordination/support roles of the IBHC and BHCF (if these positions are staffed at MTF). (T-3).

2.24.3. Promote and advocate community-based efforts to raise awareness of mental/behavioral health services and programs. (T-3).

2.24.4. Partner with HP and aerospace medicine to identify and trend mental and behavioral health needs of population using evidence-based social or behavioral health assessments [e.g., Web HA, DHRA, DoD Health Related Behaviors Survey of AD Military Personnel, Community Needs Assessments]. (T-3).
2.24.5. Collaborate with community support networks that provide programs to improve comprehensive airmen fitness and community wellbeing. (T-3).

2.24.6. Facilitate and advocate periodic and ongoing training for PCM teams on behavior change methods and motivational techniques that help empower patients to choose behaviors that improve health (e.g., tobacco cessation, weight loss, improved care management). (T-3).

2.25. The Dental Team will:

2.25.1. Provide updates and guidance to PHWG related to dental readiness posture, dental caries rates, and fluoride recommendations. (T-3).

2.25.2. Provide guidance and educational support to enhance population dental health (e.g., caries prevention, mouth guard use, tobacco use). (T-3).

2.26. The Information Management/Information Technology (IM/IT) Team will:

2.26.1. Provide IM/IT support to facilitate PHM efforts. (T-3).

2.26.2. Ensure staff members have appropriate role-based access to and availability of technology used in support of PHM (e.g., ASIMS, CHCS, AHLTA, TSWF templates, MiCare secure messaging, AudioNotes, AudioCommunicator, MHSPHP, Web HA). (T-3).

2.27. The Ancillary Services Teams (Laboratory, Radiology, and Pharmacy) will:

2.27.1. Support MTF use of standardized processes to implement AFMOA/ECOMS-approved SSPs (e.g., lab/radiology protocols, medication renewal processes). (T-3).

2.27.2. Support CPS outreach efforts (e.g., patient notification for screening labs, radiologic procedures). (T-3).

THOMAS W. TRAVIS, Lt Gen, USAF, MC, CFS
Air Force Surgeon General
Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References
Public Law 104-191, Health Insurance Portability and Accountability Act of 1996 (HIPAA)
DoD Population Health Improvement Plan and Guide, 2001
National Defense Authorization Act (NDAA) of FY 2008, Title XVI, Wounded Warrior Matters, Section.1611, Comprehensive Care and Transition Policy
DoDD 1010.10, Health Promotion and Disease/Injury Prevention, 22 August 2003
DoD 6025.18-R, DoD Health Information Privacy Regulation, 24 Jan 2003
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Deputy Secretary of Defense Memorandum, DoD Housing Inspection Standards for Medical Hold and Holdover Personnel, 18 September 2007
AFPD 10-2, Readiness, 6 November 2012
AFPD 44-1, Medical Operations, 1 September 1999
AFI 10-203, Duty Limiting Conditions, 15 January 2013
AFI 10-250, Individual Medical Readiness, 16 April 2014
AFI 40-101, Health Promotion, 17 December 2009
AFI 40-701, Medical Support to Family Member Relocation and Exceptional Family Member Program (EFMP), 15 February 2012
AFI 41-210, TRICARE Operations and Patient Administration Functions, 6 June 2012
AFI 44-102, Medical Care Management, 20 January 2012
AFI 44-119, Medical Quality Operations, 16 August 2011
AFI 44-170, Preventive Health Assessment, 22 February 2012
AFI 44-172, Mental Health, 14 March 2011
AFI 46-101, Nursing Services and Operations, 28 October 2011
AFI 47-101, Managing Air Force Dental Services, 20 February 2014
AFI 48-101, Aerospace Medicine Enterprise, 19 October 2011
AFI 48-123, Medical Examinations and Standards, 5 November 2013
AFMAN 33-363, Management of Records, 1 March 2008


Prescribed Forms

None

Adopted Forms

DD Form 2766, Adult Preventive and Chronic Care Flowsheet
DD Form 2882, Pediatric and Adolescent Preventive and Chronic Care Flowsheet
Tri-Service Work Flow (TSWF) Core templates
AF Form 847, Recommendation for Change of Publication

Abbreviations and Acronyms

AAAHC—Accreditation Association for Ambulatory Health Care
ACG—Adjusted Clinical Group
AD—Active Duty
ADAPT—Alcohol Drug Addiction Prevention and Treatment
AE—Aeromedical Evacuation
AF—Air Force
AFCITA—Air Force Complete Immunization Tracking Application
AFI—Air Force Instruction
AFMAN—Air Force Manual
AFMOA—Air Force Medical Operations Agency
AFMSA—Air Force Medical Support Agency
AFMS—Air Force Medical Service
AFPAM—Air Force Pamphlet
AFPD—Air Force Policy Directive
AHLTA—Armed Forces Health Longitudinal Technology Application
AHRQ—Agency for Healthcare Research and Quality
AIM—Alternate Input Method (AHLTA template)
ANG—Air National Guard
ASIMS—Aeromedical Services Information Management System
BHCF—Behavioral Health Care Facilitator
BHOP—Behavioral Health Optimization Program
CAIB—Community Action Information Board
CAT—Category
CC—Commander
CFETP—Career Field Education and Training Plan
CHCS—Composite Health Care System
CM—Case Management; Case Manager
CMSA—Case Management Society of America
CPG—Clinical Practice Guideline
CPS—Clinical Preventive Services
CPT—Current Procedural Terminology
CPT—Current Procedural Terminology
DAWG—Deployment Availability Working Group
DCS—Direct Care System
DH—Deployment Health
DHRA—Deployment Health Related Assessments
DHA—Defense Health Agency
DLC—Duty Limiting Conditions
DM—Disease Management; Disease Manager
DMHRSi—Defense Medical Human Resource System - internet
DoD—Department of Defense
DoDD—Department of Defense Directive
DoDI—Department of Defense Instruction
DP—Discharge Planning; Discharge Planner
DRU—Direct Reporting Unit
ECOMS—Executive Committee of the Medical Staff
EFMP-M—Exceptional Family Member Program-Medical
eHIP—electronic Health Initiative Projects
FAP—Family Advocacy Program
FHP—Force Health Protection
FSS—Force Support Squadron
FTAC—First Term Airman Center
GPM—Group Practice Manager
HCI—Health Care Integrator
HEDIS—Healthcare Effectiveness Data and Information Set
HP—Health Promotion
IAW—in accordance with
IBHC—Internal Behavioral Health Consultant
IBI—Illness Burden Index
ICD—International Classification of Diseases
IDS—Integrated Delivery System
IM—Information Management
IMR—Individual Medical Readiness
IT—Information Technology
Kx—Air Force Medical Service Knowledge Exchange
LSMTF—Limited Scope Medical Treatment Facility
MAJCOM—Major Command
MCCM—Medical Care Case Manager
MCG—MCG Care Guidelines
MCSC—Managed Care Support Contractor
MDG/CC—Medical Group Commander
MEB—Medical Evaluation Board
MEPRS—Medical Expense Performance Reporting System
MH—Mental Health
MHS—Military Health System
MHSPHP—Military Health Service Population Health Portal
MM—Medical Management
MTF—Military Treatment Facility
NDAA—National Defense Authorization Act
NMCM—Non-Medical Care Managers
OPR—Office of Primary Responsibility
PA—Privacy Act
PCM—Primary Care Manager
PCMH—Patient Centered Medical Home
PCS—Permanent Change of Station
PopH—Population Health
PHA—Preventive Health Assessment
PHM—Population Health Management
PHWG—Population Health Working Group
RCC—Recovery Care Coordinator
RUB—Resource Utilization Band
SG—Surgeon General
SGA—Chief Administrator
SGB—Chief of Biomedical Science Core Executive
SGD—Chief of Dentistry
SGH—Chief of the Medical Staff
SGN—Chief Nurse
SGP—Chief of Aerospace Medicine
SQ—Squadron
SSP—Support Staff Protocol
TA—Team Aerospace
TJC—The Joint Commission
TOPA—TRICARE Operations and Patient Administration
TMA—TRICARE Management Activity
TSWF—Tri-service Work Flow (AHLTA template)
UBU—Unified Biostatistical Utility
UR—Utilization Review
UM—Utilization Management
URAC—Utilization Review Accreditation Commission
USPSTF—United States Preventive Services Task Force
VA—Veteran Affairs
Web HA—Web Health Assessment
WII—Wounded, Ill, and Injured

Terms

**Armed Forces Health Longitudinal Technology Application (AHLTA)**—Electronic medical health record used for documentation of outpatient care.

**Care Coordination**—Care coordination uses a broader social service model that considers a patient’s psychosocial context (e.g., housing needs, income, and social supports). It is a process used to assist individuals in gaining access to medical, social, educational, and other services from different organizations and providers and coordinate the continuum of care for those beneficiaries whose needs exceed routine discharge planning but who do not meet requirements for long term CM.

**Case Management**—Collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual’s and family’s comprehensive health needs through communication and available resources to promote quality cost-effective outcomes. (CMSA, 2002)

**Essentris**—MHS inpatient electronic documentation system.

**Exceptional Family Member Program**—Works with other civilian and military agencies to provide comprehensive and coordinated medical, educational, housing, community support, and personnel services to families with special needs. EFMP ensures sponsors are assigned to those areas where the specialized medical and educational needs of the family member can be met.

**MCG Care Guidelines**—Guidelines that set standardized criteria used in MM programs, such as UM and DP. The Guidelines are used in conjunction with the healthcare professional’s clinical judgment and define the assessment and treatment modalities that should occur at the primary care level prior to referral for specialty care.

**Population Health Working Group**—A multidisciplinary group that identifies and develops population health priorities and programs. The PHWG monitors and evaluates population health status, processes, and outcomes to improve beneficiary health and the efficiency and effectiveness of the healthcare delivery system.

**Primary Care Manager**—A healthcare provider who oversees and coordinates the general preventive, diagnostic, and therapeutic care for a particular patient.
Attachment 2

THE ADJUSTED CLINICAL GROUP (ACG) RESOURCE UTILIZATION BAND (RUB) SYSTEM

A2.1. The Adjusted Clinical Group (ACG) Resource Utilization Band (RUB) system is an established, systematic approach for identifying high-risk or complex patients that was adopted by the AFMS. All AF MTFs will utilize the ACG RUB system in the assessment incoming patients for the appropriate level of care, to proactively balance provider panels, and to identify high-risk or high-acuity candidates for targeted PHM interventions.

A2.1.1. ACG Definition: A series of mutually exclusive health status categories defined by morbidity, age, and sex. They are based on the premise that the level of resources necessary for delivering appropriate healthcare to a population is correlated with the illness burden of that population. Over time, each person develops numerous conditions. Based on the pattern of these morbidities, the ACG approach assigns each individual to a single ACG category. Thus, an ACG captures the specific clustering of morbidities experienced by a person over a given period of time, such as a year. Individuals assigned to the same ACG category are expected to require similar levels of healthcare.

A2.1.2. RUB definition: RUBs are classes into which ACG groups are broken down based on the patient’s age, gender, morbidity and resource utilization over a 12-month period. The six classes are:

- 0 No or Only Invalid Dx
- 1 Healthy Users
- 2 Low
- 3 Moderate
- 4 High
- 5 Very High

A2.1.3. ACG Goal: To allow healthcare providers, health plans, and public sector agencies to describe a population’s past healthcare utilization and costs to predict future needs. It provides a standardized system to allow Health Care Integrators, Disease Managers, Case Managers, Utilization Managers, Group Practice Managers, and providers to more effectively identify and manage high-risk patients.

A2.1.4. Prerequisites: Individuals assigned to review the current ACG RUB for their empanelment must have a CarePoint/ MHSPHP account and complete the training for patient-level data access. Training information is available in the announcements section of the MHSPHP.

A2.2. Recommended ACG RUB for MTF providers – This is an example of how the ACG RUBs can be divided among providers based on skill level:

A2.2.1. ACG RUB 1-3: May be assigned to any level provider in primary care clinics.

A2.2.2. ACG RUB 4: X percentage may be assigned to Nurse Practitioners (NP) or Physician Assistants (PA) as determined by the Medical Director based on such factors as overall provider experience, credentials, and clinical expertise.

A2.2.3. ACG RUB 5: Requires Medical Director review before assigning to NPs or PAs. Review will be documented in Population Health Working Group minutes and forwarded to Executive Committee of the Medical Staff (ECOMS). Clinical review, conducted semi-
annually, should be documented and maintained in provider activity folder. Clinical review for new providers will be accomplished after one year.

EXAMPLE: Chart of sample RUB percentages for different level providers and clinics.

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>% RUB 0</th>
<th>% RUB 1</th>
<th>% RUB 2</th>
<th>% RUB 3</th>
<th>% RUB 4</th>
<th>% RUB 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Medicine</td>
<td>1-3%</td>
<td>1-5%</td>
<td>1-10%</td>
<td>40-60%</td>
<td>20-30%</td>
<td>15-20%</td>
</tr>
<tr>
<td>Family Medicine Physician</td>
<td>5-10%</td>
<td>5-20%</td>
<td>10-20%</td>
<td>30-60%</td>
<td>5-15%</td>
<td>1-5%</td>
</tr>
<tr>
<td>Family Medicine NP or PA</td>
<td>5-10%</td>
<td>5-20%</td>
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<td>Pediatrics Physician</td>
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<tr>
<td>Pediatrics NP or PA</td>
<td>5-30%*</td>
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<tr>
<td>Flight Medicine</td>
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</tr>
</tbody>
</table>

Note: * There will be higher numbers of RUB 0 in Pediatrics as data must be collected consecutively for 11 months before an ACG RUB will be generated.

A2.3. ACG Utilization Process for AF MTFs:

A2.3.1. PCM Team Current Empanelment

A2.3.1.1. In CarePoint/MHSPHP select the Patient Management tab from the menu. Then select the Other Lists from the drop down menu to the left. Select all enrollees-ACG.

A2.3.1.2. Filter by provider name, make individual lists for each provider, and then export to Excel.

A2.3.1.3. Result: List of each provider and their current empanelment sorted by ACG RUB (Very High [5] to No or Only Invalid Dx [0]).

A2.3.1.4. SGH will develop an MTF guideline/policy on the case mix (number/percentage of empanelled patients each provider may have in each ACG RUB score) that can be assigned to each provider.

A2.3.2. Empanelment of incoming patients new to military healthcare (newborn, new spouse, and new recruit/cadet/accession)

A2.3.2.1. The HCI or other RN identifies risk level of incoming patients.

A2.3.2.1.1. Gathers baseline data using current MTF-specific screening form at Right Start (MTF in-processing orientation) and highlights patients with acute or chronic care needs

A2.3.2.1.2. Makes recommendation to MTF designee for PCM empanelment (most often Managed Care Support Contractor [MCSC]) regarding level of provider care needed according to conditions noted.

A2.3.2.1.3. MTF designee for PCM empanelment assigns incoming patients to PCM.
A2.3.3. For incoming patients with documented medical history in military healthcare system:

A2.3.3.1. Current state: Follows above process as designated for patients new to military healthcare.

A2.3.3.2. Interim state: The HCI or other RN reviews incoming patient’s record in AHLTA for the ACG RUB result found on the out-processing note written by previous base; the HCI or other RN then recommends empanelment assignment to MTF designee for PCM empanelment.

A2.3.3.3. Future/final state: The HCI or other RN reviews incoming patient’s record in CarePoint MHSPHP for the ACG RUB result; the HCI or other RN then recommends empanelment assignment to MTF designee for PCM empanelment.

A2.3.4. Maintenance of PCM Empanelment

A2.3.4.1. MTF designee with MHSPHP access prepares quarterly Provider ACG RUB empanelment distribution report for review and empanelment adjustments by GPM, UM, and/or SGH per MTF policy as needed for turn-over of providers/beneficiaries, to achieve patient safety.

A2.3.4.2. MTF designee with MHSPHP (most often Medical Management staff) access prepares quarterly Provider ACG RUB empanelment distribution report for review and empanelment adjustments by GPM, UM, or SGH per MTF policy.