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SECRETARY OF THE AIR FORCE**

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Medical

**AIR FORCE MEDICAL HOME
CLINICAL OPERATIONS**

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This instruction implements Air Force (AF) Policy Directive 44-1, *Medical Operations*. It provides guidance and procedures on Primary Care Operations for Air and United States Space Force Medical Homes. This instruction applies to all United States Space Force, Regular AF and civilian employees who provide primary care services to beneficiaries in Air Force and United States Space Force Medical Treatment Facilities (MTFs). This instruction does not apply to Air Force Reserve Medical Units, Air National Guard Medical Groups, or Aeromedical Evacuation Squadrons. This Instruction requires the collection and or maintenance of information protected by the Privacy Act of 1974 authorized by Department of Defense Instruction (DODI) 5400.11, *DoD Privacy and Civil Liberties Programs*. The applicable SORN(s) [F001 MRB A DoD Physical Disability Board of Review (PDBR) Records, F036 AF A1 I Air Force Fitness Program, F044 AF SG D Automated Medical/Dental Record System, F044 AF SG G Nursing Service Records, F044 AF SG T Suicide Event Surveillance System (SESS), F044 AF SG U Special Needs and Educational and Developmental Intervention Services (EIDS), F044 F SG E Electronic Medical Records System] are available at:

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SUMMARY OF CHANGES

This document has been substantially revised and needs to be completely reviewed. Major changes include updating Defense Health Agency (DHA) publications, updating roles and responsibilities, changes to squadron naming conventions, updates to enrollment numbers and appointment decrements, and tiering that identifies waiver authorities for unit level compliance.

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Chapter 1

PROGRAM OVERVIEW

1.1. Air Force medical homes (AFMH) are patient-centered medical homes (PCMH) within the United States Air and Space Forces. The PCMH is best described as a model or philosophy of primary care with the following core principles: personal provider, team-based care, whole person orientation, coordinated, comprehensive, and integrated care, quality and safety, enhanced access and payment reform. In addition, medical homes consistently measure and seek to improve performance within these core principles through innovation and continuous quality improvement initiatives.

1.2. AFMH clinical operations refers to the health care delivered in Air and Space Forces primary care clinics. All family medicine, pediatrics, adolescent medicine, internal medicine, primary care, flight medicine, and operational medicine clinics (including associated graduate medical education where applicable) will practice the principles of PCMH in their daily operations. Hereafter in this instruction, these clinics will be identified as AFMH.

1.2.1. Some primary care clinics within the Air Force Medical Service will not be expected to fully function as an AFMH. These clinics are considered nontraditional primary care clinics and include cadet clinics, trainee health clinics, some operational clinics, and clinics at remote or unaccompanied locations. These clinics are expected to fully embrace the tenets of AFMH; however, because of how these clinics are organized and staffed, certain requirements are not always achievable.

1.2.2. Where these nontraditional primary care clinics cannot meet the expectations of this guidance, they are expected to submit waivers through the appropriate level and process. Examples include expectations for patient continuity, staff continuity, and training requirements, among others.

Chapter 2

ROLES AND RESPONSIBILITIES

Section 2A—General Roles and Responsibilities

2.1. Air Force Surgeon General (AF/SG).

2.1.1. The AF/SG will monitor compliance in accordance with Defense Health Agency (DHA)-Procedural Instruction (PI) 6025.11, *Processes and Standards for Primary Care Empanelment and Capacity in Medical Treatment Facilities (MTFs)* and DHA-Interim Procedural Memorandum (IPM) 18-001, *Standard Appointing Processes, Procedures, Hours of Operation, Productivity, Performance Measures and Appointment Types in Primary, Specialty, and Behavioral Health Care in Medical Treatment Facilities (MTFs)* and this instruction. **(T-0)**.

2.1.2. The AF/SG will serve as the office of primary responsibility (OPR) for AFMH operations.

2.1.3. The AF/SG should ensure guidance is in place for AFMH operations.

2.2. Major Command Surgeon (MAJCOM/SG).

2.2.1. The MAJCOM/SG should coordinate with Air Force Medical Readiness Agency (AFMRA) staff on readiness requirements, changes to readiness requirements, and taskings for their respective AFMHs.

2.2.2. The MAJCOM/SG should monitor Military Treatment Facilities (MTFs) within their command on AFMH operational and readiness performance to facilitate process improvement.

2.2.3. The MAJCOM/SG should ensure alignment of Regular Air and Space Force active component clinical personnel with opportunities to maintain clinical currency for their respective unit type code (UTC) assignments.

2.2.4. The MAJCOM/SG should monitor high reliability and overall culture change metrics as agreed upon with their MTFs.

Section 2B—MTF Guidance and Procedures

2.3. MTF Commanders/Directors.

2.3.1. MTF commanders/directors will comply with the standards and processes in accordance with DHA-PI 6025.11, DHA-IPM 18-001, and this instruction. **(T-0)**.

2.3.2. MTF commanders/directors will serve as the OPR for execution of AFMH practices at the MTF level and will be responsible for overall AFMH outcomes measures and metrics for their facility. **(T-0)**.

2.3.3. MTF commanders/directors will ensure appropriate material resources that are allocated by DHA for AFMH operations are utilized for those operations. **(T-0)**.

2.3.4. MTF commanders/directors will ensure that AFMH personnel are assigned to AFMH positions where they are earned and remain in place for no less than two years. **(T-0)**.

2.3.5. MTF commanders/directors will provide oversight of placement of AFMH staff within the MTF; if necessary, will approve any “matrixing” of staff assigned against an AFMH authorization into other duties and ensure these decisions are documented in the appropriate committee minutes. **(T-1)**.

2.3.6. MTF commanders/directors will ensure that required executive leader staff attend the AFMH Executive Leadership Seminar and complete the review of the DHA Center for Excellence in MultiMedia videos. **(T-1)**.

2.3.7. MTF commanders/directors will ensure that AFMH expanded team members are trained appropriately in AFMH foundations, including the AFMH Operations Course and review of the Center for Excellence in MultiMedia videos. **(T-1)**.

2.3.8. MTF commanders/directors will be accountable for overall access in their MTF, by ensuring an optimal supply of appointments in accordance with DHA-IPM 18-001 by: **(T-0)**.

2.3.8.1. Ensuring maximal appointment utilization through frequent template management.

2.3.8.2. Evaluating staff capacity, patient demand, and mission requirement interrelationships.

2.3.8.3. Ensuring clinic staff are appropriately trained and work at the maximum ability of their skill set and training to maintain clinical currency.

2.3.8.4. Ensuring the provision of appropriate facilities, resources, and staffing to assure successful AFMH efforts.

2.3.8.5. Ensuring clinic staff are appropriately trained in current high reliability frameworks or platforms.

2.3.9. MTF commanders/directors will be the preliminary approval authority for appointment standards deviation from the DHA- IPM 18-001 for AFMH Clinics, and will ensure any deviation is documented in executive committee minutes. **(T-0)**.

2.3.10. MTF commanders/directors will ensure standardized DHA medical home position descriptions are utilized in the MTF. **(T-0)**.

2.3.11. MTF commanders/directors should ensure the Group Practice Manager (GPM), Health Care Integrator (HCI)/Population Health Lead, and Medical Management (MM) personnel fully support the AFMH Clinics.

2.4. Medical Operations Squadron, HealthCare Operations Squadron, Operational Medical Readiness Squadron, and Aeromedical Dental Squadron Commanders.

2.4.1. Squadron commanders will comply with the standards and processes in DHA-PI 6025.11 and this instruction. **(T-0)**.

2.4.2. Squadron commanders are expected to be responsible for the execution of AFMH clinic operations within their respective squadrons, to include staffing, implementing and sustaining processes, medical home performance metrics, and outcomes for the beneficiaries enrolled to their respective squadrons.

2.4.3. Squadron commanders will ensure AFMH teams accomplish daily huddles using a standardized huddle tool to improve communication amongst team members, including a

review of the day's scheduled patients, identification of proactive and preventive tasks to be accomplished, and addressing administrative tasks, manning issues, and identification of potential process improvement activities. **(T-2)**.

2.4.4. Squadron commanders will ensure AFMH clinics in their squadrons provide the appropriate number of appointments on their schedules in accordance with DHA-IPM, 18-001. **(T-0)**.

2.4.5. Squadron commanders are expected to ensure that AFMH clinic staff, to include the flight commander/officer in charge (OIC) and flight chief/non-commissioned officer in charge (NCOIC), actively work on AFMH teams in their Air Force specialty code (AFSC) role as a primary duty.

2.4.6. Squadron commanders should direct flight commander/OIC and flight chief/NCOIC, Health Services Management Technician (4A) and Aerospace Medical Services Technician (4N) functional managers to defer non-mission essential administrative supervisory duties in lieu of patient care duties during times of high demand or decreased staffing.

2.4.7. Squadron commanders should minimize meetings involving AFMH clinic personnel during patient care hours. When ad hoc meetings during patient care hours are identified after the appointment schedule is published, the meeting should be scheduled during planned administrative time and approval by the medical group commander/director or designated representative is expected to be obtained.

2.4.8. Squadron commanders should provide support for readiness training for AFMH teams by ensuring time is placed into clinic schedules.

2.5. MTF Chief of the Medical Staff (SGH).

2.5.1. The SGH will comply with the standards and processes in DHA-PI 6025.11 and this instruction. **(T-0)**.

2.5.2. The SGH is expected to provide clinical leadership and guidance of AFMH operations including program development, execution, monitoring, and evaluation.

2.5.3. The SGH is expected to maintain general oversight of provider templates and schedules in the AFMHs, in conjunction with squadron commanders, flight commanders/OICs, flight chiefs/NCOICs, and the GPM to provide appropriate appointment availability.

2.5.4. The SGH should ensure provider team panels in those non-active component enrolled clinics are acuity-based, leveled, and matched to individual provider capabilities to provide quality, safe patient care.

2.5.5. The SGH is expected to ensure care coordination meetings at the team level are convened and attended on a regular basis by all appropriate staff. Care coordination meetings should include appropriate MM staff members and be held outside of normal patient care hours. These meetings should be used to discuss specific patients and their health care needs.

2.5.6. The SGH will ensure timely adoption, training, and use of evidence-based Clinical Practice Guidelines (CPGs) within the MTF in accordance with DHA-PI 6025.19, *Population Health, Operation, and Integration across the Military Health System (MHS)*, and Air Force Instruction (AFI) 44-173, *Population Health*. **(T-0)**.

2.5.7. The SGH will require use of asynchronous communication (secure messaging) within all AFMHs. **(T-0)**.

2.5.8. The SGH should review primary care manager (PCM)-level performance metrics with individual teams and clinic-level performance metrics with entire AFMH clinic staff at least quarterly.

2.5.9. The SGH is expected to ensure AFMH performance metrics are tracked and presented to MTF leadership on a monthly basis in collaboration with the GPM.

2.5.10. The SGH should ensure new providers receive the appropriate supervision, mentorship and guidance to allow for a safe and successful transition to full clinical practice, using the “AFMH Consolidated Ramp-up Checklist” as the guidance to accomplish this.

2.5.11. The SGH should ensure AFMH metrics are available for MTF staff, patients, and visitors to review if requested.

2.5.12. The SGH is expected to ensure all AFMH provider staff maintain their licensure and understand their scope of practice, role, and utilize provided tools as directed in this instruction.

2.6. MTF Chief of Aerospace Medicine (SGP).

2.6.1. The SGP will comply with the standards and processes in DHA-PI 6025.11 and this instruction. **(T-0)**.

2.6.2. The SGP will provide MTF-wide leadership and oversight of operational medical capabilities within AFMH including program development, execution, monitoring, and evaluation in accordance with AFI 48-101, *Aerospace Medicine Enterprise*. **(T-1)**.

2.6.3. The SGP should facilitate flight medicine continuity of care and clinic staffing in collaboration with squadron commanders, SGH, and appropriate functionals.

2.6.4. The SGP will advise the SGH about building clinic empanelment based on operational and occupational risk in accordance with Air Force Manual (AFMAN) 48-149, *Flight and Operational Medicine Program (FOMP)* and DHA-PI 6025.11. **(T-0)**.

2.6.5. The SGP is expected to oversee, in conjunction with squadron commanders, SGH, and clinic flight commanders, development of mission-essential task list and activities for line support for clinical teams. The SGP is ultimately responsible for military mission requirements and sustainment of processes in relation to healthcare.

2.6.6. The SGP should ensure accomplishment of flight medicine care coordination meetings (1041 meeting) at the team level on a regular basis to include appropriate MM and enhanced access personnel.

2.6.7. The SGP will implement Tri-Service Periodic Health Assessment (PHA) in accordance with DODI 6200.06, *Periodic Health Assessment (PHA) Program* and DHA-PI, 6200.06, *Periodic Health Assessment (PHA) Program*. **(T-0)**. The SGP is expected to ensure initial and updated training is accomplished as required.

2.6.8. The SGP will act as office of primary responsibility for implementation of Base Operational Medical Clinic processes in all evolving iterations in accordance with AFMAN 48-149. **(T-2)**.

2.7. Medical Group Chief Nurse Executive.

2.7.1. The MTF chief nurse will comply with the standards and processes in DHA-PI 6025.11, DHA-IPM 18-001, and this instruction. **(T-0)**.

2.7.2. The MTF chief nurse will collaborate with squadron commanders, flight commanders/OICs, flight chiefs/NCOICs and senior 4N functional manager for the orientation, training and allocation of nursing and medical technician resources in accordance with this instruction and AFI 46-101, *Nursing Services and Operations*. **(T-1)**.

2.7.3. The MTF chief nurse is expected to work with squadron commanders, flight commanders/OICs, flight chiefs/NCOICs, 4N/4A functional managers, and resource management office to routinely update the unit manpower document and unit personnel management roster to accurately reflect current manning and duty location of all nurses and medical technicians in support of the AFMH structure.

2.7.4. The MTF chief nurse should ensure all AFMH nursing staff maintain their licensure or certification and understand their scope of practice, role, and utilize provided tools as directed in this instruction.

2.8. Medical Group Administrator.

2.8.1. The Medical Group Administrator will comply with the standards and processes in DHA-PI 6025.11, DHA-IPM 18-001, and this instruction. **(T-0)**.

2.8.2. The Medical Group Administrator is expected to be responsible, in coordination with the squadron commanders, for the facilities, resources, and staffing in support of AFMH operations.

2.8.3. The Medical Group Administrator should lead and track civilian General Schedule and contracting efforts in conjunction with appropriate squadron commanders for hiring of qualified clinic staff supporting AFMH clinics.

2.8.4. The Medical Group Administrator should facilitate effective communication and coordination of MTF patient care activities with TRICARE regional contractor in support of AFMH team processes (examples include discharge planning, referral tracking, empanelment rules, and network urgent care availability).

2.8.5. The Medical Group Administrator is expected to work with resource management office to accurately reflect current authorizations, assigned manning, and location of clinic staff in support of AFMH clinic structure on the unit manning document and unit personnel management roster.

2.9. Aerospace Medical Services Technician (4N) Functional Manager.

2.9.1. The 4N functional manager will comply with the standards and processes in DHA-PI 6025.11, DHA-IPM 18-001, and this instruction. **(T-0)**. The 4N functional manager should advise commanders on the preferred placement and movement of personnel to optimize both mission completion and personnel development, and facilitate commander-approved personnel employment actions.

2.9.2. The 4N functional manager is expected to establish and maintain two year continuity of 4N (medical technician or civilian equivalent) staff in support of AFMH clinics. If a 4N is out of the duty section for an extended period of time (such as deployment or honor guard), the 4N

functional manager should work to keep the integrity of the AFMH team by not counting the time away as part of the time assigned to the clinic. However, if the assigned time must be reduced below two years, the 4N functional manager should coordinate through the duty section commander, squadron commander, and chief nurse.

2.9.3. The 4N functional manager should ensure appropriate skill level balancing at the clinic level.

2.9.4. The 4N functional manager should provide clinical leadership and mentorship to 4N (or civilian equivalent) staff members of AFMH teams and participate in clinical operations when possible in accordance with 4N's scope of care.

2.9.5. The 4N functional manager should develop a training plan for all staff using the 4N career field education and training plan (CFETP) and their specific roles.

2.9.6. The 4N functional manager will ensure compliance with 4N (or civilian equivalent) peer review process and report peer review outcomes to executive leadership in accordance with AFI 46-101. **(T-1)**.

2.9.7. The 4N functional manager should coordinate any scope of practice waivers as needed.

2.9.8. The 4N functional manager should balance UTC assignments for 4N staff.

2.10. Health Services Management Technician (4A) Functional Manager.

2.10.1. The 4A functional manager will comply with the standards and processes in DHA-PI 6025.11, DHA-IPM 18-001, and this instruction. **(T-0)**.

2.10.2. The 4A functional manager should establish and maintain continuity of 4A (health administration technician or civilian equivalent) staff in support of AFMH teams on both daily and long term basis. The 4A functional manager is expected to advise commanders on the preferred placement and movement of personnel to optimize both mission completion and personnel development, and facilitate commander-approved personnel employment actions.

2.10.3. The 4A functional manager should provide clinical administrative leadership and mentorship to 4A (or civilian equivalent) members of the AFMHs.

2.10.4. The 4A functional manager should develop a training plan for all staff on the 4A CFETP and their specific roles.

2.10.5. The 4A functional manager should ensure 4A works to the full level of their CFETP and are not default front desk receptionists to the exclusion of their other duties.

2.10.6. The 4A functional manager should balance UTC assignments for 4A staff.

2.11. Flight Commander/Officer in Charge (OIC), AFMH clinic.

2.11.1. The flight commander/OIC will comply with the standards and processes in DHA-PI 6025.11, DHA-IPM 18-001, and this instruction. **(T-0)**.

2.11.2. The flight commander/OIC is expected to implement AFMH operations within their flight.

2.11.3. The flight commander/OIC will function in their primary AFSC role as directed in DHA-PI 6025.11, Appendix D, as this position is not a separate authorization. **(T-0)**.

2.11.4. If the flight commander is a provider, decrements to their empanelment will be in accordance with DHA-PI 6025.11. **(T-0)**. If the flight commander is a nurse, consider assigning to a smaller primary care team to ensure that direct patient care and support to the team is continued even in the flight commander role, and direct patient care contribution should mimic the percentage of time required by a flight commander who is a provider.

2.11.5. The flight commander/OIC should coordinate with appropriate personnel to ensure clinic staff assignment and alignment.

2.11.6. The flight commander/OIC should ensure appropriate administrative and clinical documentation is completed, to include:

2.11.6.1. Orientation, training, and supervision of clinic staff to include attendance at the Air Force Medical Home Operations Course and completion of the DHA Center for Excellence in MultiMedia videos. In conjunction with clinic medical director and clinic NCOIC, ensure all clinic staff complete DHA PCMH orientation program using prescribed documents and new provider ramp-up process as needed. **(T-0)**.

2.11.6.2. Outpatient encounters are coded and closed, in accordance with DHA-IPM 18-016, *Medical Coding of the DoD Health Records*. **(T-0)**.

2.11.6.3. End of day processing is completed at the end of each duty day.

2.11.6.4. Defense Medical Human Resource System internet (DMHRSi) and Medical Expense and Personnel Reporting System (MEPRS) coding is completed at the end of each month.

2.11.7. The flight commander/OIC will ensure clinic utilizes DHA, AFMRA, or locally-approved clinical support staff protocols (CSSPs) in accordance with DHA-IPM 18-001. **(T-0)**.

2.11.8. The flight commander/OIC is expected to ensure AFMH staff respond to secure messaging requests within one business day and complete the message in a timely manner.

2.11.9. The flight commander/OIC will collaborate with appropriate leadership for approval to adjust appointment ratio (number of face-to-face appointments versus virtual appointments) per provider per full week, in accordance with DHA-IPM 18-001. **(T-0)**.

2.11.10. The flight commander/OIC should brief specified clinic and team metrics on a quarterly basis with all assigned clinic staff.

2.11.11. The flight commander/OIC will observe huddles and ensure all staff on PCM teams accomplish daily and weekly huddles utilizing standardized huddle scripts and tools to improve efficiency, comprehensiveness and communication amongst team members. (T-2). The daily huddle should cover at the minimum: review of scheduled patient list, tasks to be accomplished for the day and week, opportunities for improvement, administrative tasks to complete, and manning issues. The weekly huddle should cover a quick overview of patients scheduled for the next week, upcoming manning and staffing issues, and any pre-scheduled interruptions to patient care (such as readiness exercises, holidays, etc.).

2.11.12. The flight commander/OIC should ensure clinic exam rooms are standardized.

2.11.13. The flight commander/OIC should provide oversight of peer review process and additional duties assigned to staff.

2.11.14. The flight commander/OIC should delegate additional duties to clinic staff as needed to maintain clinic functions and mission.

2.11.15. The flight commander/OIC is expected to perform initial review and routine updating of booking protocols.

2.12. Flight Chief/Non-Commissioned Officer In Charge (NCOIC), AFMH Clinic.

2.12.1. The flight chief/NCOIC will comply with the standards and processes outlined in DHA-PI 6025.11, DHA-IPM 18-001, and this instruction. (T-0).

2.12.2. This position is not a separate authorization. Consider assigning to a smaller primary care team to ensure that direct patient care and support to the team is continued, even in the flight chief role. The flight chief's direct patient care contribution will mimic the percentage of time required by a flight commander who is a provider or nurse. (T-3). Each clinic will have only one clinic flight chief/NCOIC assigned. (T-3).

2.12.3. The flight chief/NCOIC should train staff on, and ensure appropriate use of, enhanced access tools such as:

2.12.3.1. Patient secure messaging tools, and

2.12.3.2. CarePoint® portal application suite tools to include the huddle tool, the health maintenance registry, and others that are deemed appropriate for that specific clinic, and

2.12.3.3. DHA, AFMRA, and locally-approved CSSPs, and

2.12.3.4. Electronic health record workflow forms, and

2.12.3.5. MTF adopted CPGs.

2.12.4. In conjunction with clinic medical director and clinic OIC, the flight chief/NCOIC will ensure all clinic staff complete DHA PCMH orientation program using prescribed documents and new provider ramp-up process as needed. (T-3).

2.12.5. The flight chief/NCOIC should ensure non-clinical duties are not assigned to enlisted staff during patient care hours on a routine or recurring basis.

2.12.6. The flight chief/NCOIC should delegate additional duties to enlisted (or civilian equivalent) clinic staff, as needed to maintain clinic functions and mission.

2.12.7. The flight chief/NCOIC is expected to ensure enlisted clinic staff (or civilian equivalent) complete their monthly DMHRSi and MEPRS coding.

2.12.8. The flight chief/NCOIC should designate daily staffing assignments to ensure adequate patient care activities.

2.12.9. The flight chief/NCOIC will participate in, observe, and ensure all staff on PCM teams accomplish daily and weekly huddles to improve communication amongst team members. (T-2).

2.13. Group Practice Manager (GPM).

2.13.1. The GPM will comply with the standards and processes in DHA-PI 6025.11, DHA-IPM 18-001, and this instruction. (T-0).

2.13.2. The GPM is expected to work in conjunction with providers, clinic, and squadron leadership on initial development and ongoing modification of provider templates and schedules, to provide an adequate supply of appointments through management of templates, schedules, appointing procedures and utilization of access enhancing tools (such as TRICARE Online or MHS GENESIS®).

2.13.3. The GPM should ensure all beneficiaries enrolled in TRICARE Prime and empaneled to the MTF are assigned to a PCM by name. GPMs, in coordination with the HCI, should ensure appropriate PCM assignment based on age ranges set in the PCM's privileges and equitably distribute workload across the AFMH teams in accordance with DHA-PI 6025.11.

2.13.4. The GPM should provide data on historic and projected needs as part of demand analysis.

2.13.5. The GPM should collaborate with and advise AFMH clinic leadership on space, information systems and other logistical requirements needed to successfully accomplish AFMH operations.

2.13.6. The GPM should utilize DHA, Air Force Medical Service, and AFMH tools and checklists to evaluate all opportunities to address MTF access needs.

2.13.7. The GPM should understand business rules and booking protocols for use of appointments within the MTF and referrals to the civilian network to manage patient demand.

2.13.8. The GPM will coordinate business rules and changes with TRICARE Operations and Patient Administration and MTF executive leadership, in accordance with AFI 44-176, *Access to the Care Continuum*. (T-1).

2.13.9. The GPM will ensure booking protocols are kept current and provided to all staff who book appointments in accordance with DHA-IPM 18-001. (T-0).

2.13.10. The GPM should assist medical director and flight commander in standardizing processes, exam rooms, workflows and other clinical process improvement (CPI) activities.

2.13.11. The GPM should train office managers on template and schedule maintenance duties.

2.13.12. The GPM should assist with the quadruple aim performance plan process and development.

2.14. The Health Care Integrator (HCI)/Population Health Lead.

2.14.1. The HCI/population health lead will comply with the standards and processes in DHA-PI 6025.11, DHA-PI 6025.19, DHA-IPM 18-001, and this instruction. (T-0).

2.14.2. The HCI/population health lead should support appropriate acuity or squadron-based enrollment in coordination with clinical leadership, PCM teams, GPM, SGH, and TRICARE regional contractor.

2.14.3. The HCI/population health lead is expected to assist AFMH teams by identifying individuals and populations of patients at risk for chronic, complex, and co-morbid conditions and provide actionable data from various sources for use by the team.

2.14.4. The HCI/population health lead should analyze population data for trends and provide recommendations for development of comprehensive population health programs in support of AFMH operations.

2.14.5. The HCI/population health lead should direct, in coordination with the AFMH team leader(s), flight commander, and SGH, as appropriate, disease management (DM), case management (CM), and utilization management (UM) nurse responsibilities for individual patient care and interaction in support of the PCM teams to which the patient is empaneled.

2.14.6. The HCI/population health lead should assist AFMH staff to initiate CarePoint® portal accounts, and provide training so they understand how to utilize these tools to evaluate care provided to their patients.

2.14.7. The HCI/population health lead should coordinate with the SGH-designated provider champion to facilitate training on, and implementation of, new CPGs within the MTF.

2.14.8. The HCI/population health lead should facilitate annual review and update of currently used CPGs.

2.14.9. The HCI/population health lead should assess and identify gaps in population health practices and facilitate CPI events to enhance care to the MTF beneficiaries.

2.15. Disease Management (DM) Nurse.

2.15.1. The DM nurse will comply with the standards and processes in DHA-PI 6025.11, DHA-PI 6025.19, DHA-IPM 18-001, and this instruction. **(T-0)**.

2.15.2. The DM nurse will develop and execute DM activities in collaboration with HCI, PCM teams, chief nurse, and SGH, in accordance with DHA-PI 6025.19 and AFI 44-102, *Medical Care Management*. **(T-1)**.

2.15.3. The DM nurse should identify patients who may benefit from DM programs and notify AFMH team members so that appropriate DM referral can be completed for initiation of DM services.

2.15.4. The DM nurse is expected to provide services to identified DM patients, establish DM registries, develop and execute individualized DM interventions (care plans) in conjunction with the patient and family in accordance with accepted standards and guidelines. The DM nurse should provide the patient and family a copy of this individualized care plan.

2.15.5. The DM nurse is expected to document patient specific DM goals, DM interventions, progress, and education in patient's electronic health record (EHR).

2.15.6. The DM nurse should provide AFMH staff training on DM programs and CPG implementation and maintenance.

2.15.7. The DM nurse should collaborate with the PCM team staff members on DM activities. The DM nurse is expected to maintain a current registry of patients to whom services are provided. The DM nurse should coordinate with the PCM team staff members about patients moving into DM care (into the registries), and graduating from primary DM care back to the team (off the registries) and document such in an EHR note.

2.15.8. The DM nurse should provide routine updates and outcome metrics on AFMH patients enrolled in DM programs to PCM team members. This includes identifying treatment goals in accordance with national guidelines.

2.15.9. The DM nurse should educate AFMH staff on DM nurse role.

2.15.10. The DM nurse will attend and participate in AFMH team huddles, care coordination, population health, and transition of care meetings. **(T-2)**.

2.15.11. The DM nurse should coordinate with medical director and PCMs to develop criteria on when the DM nurse should be present during a patient encounter within the AFMH clinic.

2.16. Case Management (CM) Nurse.

2.16.1. The CM nurse will comply with the standards and processes in DHA-PI 6025.11, DHA-PI 6025.19, DHA-IPM 18-001, DHA-IPM 19-004, *Utilization of the Case Management (CM) Registry (Active and Screening) for Military Health System (MHS) Beneficiaries*, and this instruction. **(T-0)**.

2.16.2. The CM nurse will identify individuals with chronic, catastrophic, complex, high utilization, high-risk, or high-cost health issues who would benefit from CM services and notify PCM teams, in accordance with DHA-PI 6025.19 and AFI 44-173. **(T-0)**.

2.16.3. The CM nurse should provide CM and/or care coordination to these patients and develop and execute an individualized multi-disciplinary care plan in conjunction with patient and family in accordance with accepted standards. The CM nurse should provide the patient and family a copy of this individualized care plan.

2.16.4. The CM nurse is expected to document CM interventions, care coordination, and outcomes in patient's EHR and maintain a registry of all patients receiving CM services.

2.16.5. The CM nurse should provide AFMH staff training on CM programs.

2.16.6. The CM nurse is expected to collaborate with PCM teams on CM activities. The CM nurse is expected to maintain a current registry of patients to whom CM services are being provided. The CM nurse should coordinate with the PCM team staff members about patients moving into CM care (into the registries), and graduating from primary CM care back to the team (off the registries) and document such in an EHR note

2.16.7. The CM nurse should provide routine updates and outcome metrics on AFMH patients enrolled in CM programs to PCM teams.

2.16.8. The CM nurse will provide care coordination guidance and mentoring to AFMH staff who provide these services for their empaneled patients.

2.16.9. The CM nurse should educate AFMH staff on CM nurse role.

2.16.10. The CM nurse will attend and participate in AFMH team huddles, care coordination meetings, population health, and transition of care meetings. **(T-2)**.

2.17. Utilization Management (UM) Nurse.

2.17.1. The UM nurse will comply with the standards and processes in DHA-PI 6025.11, DHA-PI 6025.19, DHA-IPM 18-001, and this instruction. **(T-0)**.

2.17.2. In collaboration with the AFMH teams, HCI/population health lead, GPM, and CM/DM nurses, the UM nurse will determine which measures and processes should be targeted for in-depth review in accordance with DHA-PI 6025.19 and AFI 44-173. **(T-0)** Processes that relate to high-cost, high-volume or problem-prone diagnoses, procedures, services and beneficiaries who have demonstrated high utilization rates should be reviewed by UM nurses.

2.17.3. The UM nurse should educate AFMH Clinic staff on UM role.

2.18. TRICARE Operations and Patient Administration.

2.18.1. The TRICARE operations and patient administration staff will comply with the standards and processes in DHA-PI 6025.11, DHA-IPM 18-001, and this instruction. **(T-0)**.

2.18.2. The TRICARE operations and patient administration staff is expected to provide AFMH clinic PCM teams with a daily list of enrollees admitted to or discharged from military and civilian hospitals and emergency departments. The PCM team nurse is expected to review the list and establish follow-up (telephonically, digitally, virtually or face-to-face) with the patient to assess the current status of health and any additional needs, documenting appropriately in the EHR. PCM team 4A or other team staff should book appointments for those patients who need virtual or face-to-face follow up care.

2.18.3. The TRICARE operations and patient administration staff should work with the MTF executive staff and TRICARE regional contractor as necessary via a specific memorandum of understanding if necessary to ensure timely notification of admissions and pending discharges.

Section 2C—AFMH Clinic Guidance and Procedures

2.19. AFMH Clinic Medical Director.

2.19.1. The AFMH clinic medical director will comply with the standards and processes in DHA-PI 6025.11, DHA-IPM 18-001, and this instruction. **(T-0)**.

2.19.2. The AFMH clinic medical director should be the senior ranking physician identified by their squadron commander in consultation with the SGH or senior corps representative. Criteria for selection will include a candidate's interest and expertise in clinical affairs, as well as the ability to manage the dual interest of patient care and medical staff oversight.

2.19.3. The AFMH clinic medical director will be board certified within their specialty, or equivalently qualified and have at least 1 year of clinical experience. **(T-3)**.

2.19.4. The AFMH clinic medical director should provide general professional guidance for clinic staff, direct clinic's outpatient services, and instruct other health care providers and nonmedical personnel as they pertain to clinical matters.

2.19.5. The AFMH clinic medical director should collaborate with the hospital administrator, GPM and the SGH on administrative and quality operations of the medical services. In general the medical director is considered the subject matter expert on matters regarding the delivery of care within their clinic.

2.19.6. The AFMH clinic medical director is expected to identify the criteria for clinical privileges that are relevant to the care provided in the department and the clinical privileges of each individual in the department.

2.19.6.1. The AFMH clinic medical director should clinically in-process new clinicians in conjunction with the credentials function to include:

2.19.6.1.1. Implement a clinical orientation process, and

2.19.6.1.2. Implement standard DHA/AFMRA approved ramp-up plans (as applicable), and

- 2.19.6.1.3. Ensure staff complete DHA PCMH orientation program using prescribed documents, and
 - 2.19.6.1.4. Develop formal plans of supervision when needed, and
 - 2.19.6.1.5. Identify preceptors or advisors for new clinical staff, to include focused professional practice evaluations.
- 2.19.6.2. The AFMH clinic medical director should evaluate initial and re-appointment applications within their respective services.
- 2.19.7. The AFMH clinic medical director is expected to routinely review the professional performance of all individuals in the department who have delineated clinical privileges to include:
- 2.19.7.1. antibiotic usage,
 - 2.19.7.2. blood utilization,
 - 2.19.7.3. surgical case reviews,
 - 2.19.7.4. timely record completion,
 - 2.19.7.5. interpersonal skills with patients and staff,
 - 2.19.7.6. attendance and participation in required meetings,
 - 2.19.7.7. pharmacy and therapeutic trends,
 - 2.19.7.8. infection control reviews,
 - 2.19.7.9. usage of ancillary services, and
 - 2.19.7.10. morbidity and mortality reviews.
- 2.19.8. The AFMH clinic medical director is expected to oversee department peer review program for credentialed providers and ensures peer review is relevant, current and sustained.
- 2.19.9. The AFMH clinic medical director should conduct routine risk management or potential patient safety concerns and documents and communicates these with the SGH as soon as possible.
- 2.19.10. In conjunction with the flight commander, the GPM, squadron commander and the SGH, the AFMH clinic medical director is expected to ensure clinician templates are adequate to meet the demand of the population served, balanced with other clinical duties (e.g., pain management champion, inpatient rounds, deployments, etc), and follows current DHA guidance, AF guidance and/or local policy regarding decrement to patient care for the credentialed provider staff within the flight. Any decrement for the medical director should be determined by the SGH and squadron commander.
- 2.19.11. The AFMH clinic medical director will direct the development and implementation of departmental CPI programs, patient safety, and professional quality control policies and programs in alignment with DHA high reliability framework or platform in accordance with DHA PM 6025.13, *Clinical Quality Management in the Military Health System, Volume 7: Clinical Quality Improvement. (T-3)*. This includes outcome based peer review as outlined in AFI 44-119, *Medical Quality Operations*.

2.19.12. In conjunction with clinic administrator, the AFMH clinic medical director should help ensure clinically appropriate medical supplies and equipment are available. The AFMH clinic medical director should provide input when new equipment is to be procured or when current equipment is in ill-repair or outdated.

2.19.13. The AFMH clinic medical director is expected to attend functions such as executive committee of the medical staff and squadron or group functions as appropriate in order to serve as the clinic subject matter expert.

2.19.14. The AFMH clinic medical director should provide opportunity for educational activities for the clinical staff using formats such as grand rounds, informal lectures, journal clubs, and mortality and morbidity rounds based on the size, scope, and facilities available.

2.20. Provider Team Lead.

2.20.1. The provider team lead will comply with the standards and processes in DHA-PI 6025.11, DHA-IPM 18-001, and this instruction. **(T-0).**

2.20.2. The provider team lead should be the senior ranking or most experienced provider assigned to that AFMH team. The flight commander, in conjunction with the medical director, may choose to designate an experienced advanced practice provider as the team lead if the advanced practice provider is the most appropriate experienced provider.

2.20.3. The provider team lead will ensure the performance of, and lead, daily team huddles and periodic care coordination meetings to maximize team communication, prioritize patient care, and identify and discuss process improvement opportunities. **(T-2).**

2.20.4. The provider team lead is expected to ensure all providers on the team are responsible for the care of their empaneled patients. When a provider on the team has a short term absence, the other providers on that team are expected to provide coverage for those empaneled patients. Longer term absences, such as deployments, necessitate administrative redistribution of patients to cover the enrolled patients' health care needs in a structured way.

2.20.5. The provider team lead should facilitate appropriate use of enhanced access tools to meet demand of patients empaneled to the team (walk-in or group appointments, virtual appointments, nurse or technician run clinics, utilization of CSSPs).

2.20.6. The provider team lead should ensure team members collaborate with the MM staff to identify, establish, and maintain a list of their high acuity, high risk and disease or case management patients. PCM team staff should review the list on a routine basis, identify any care coordination, preventive services, medication renewals, or referrals or other services that the patient may need. This will better support comprehensiveness, quality, and efficiency in patient care.

2.20.7. The provider team lead should encourage appropriate and full use of team and support team members to include behavioral health consultant, behavioral health care facilitator, medical nutrition therapist, clinical pharmacist, and physical therapy assets.

2.21. AFMH Clinic Provider.

2.21.1. The AFMH clinic provider will comply with the standards and processes in DHA-PI 6025.11, DHA-IPM 18-001, and this instruction. **(T-0).**

2.21.2. The AFMH clinic provider is expected to be responsible for providing care and continuity to the provider's empaneled patients.

2.21.3. The AFMH clinic provider should proactively notify the team lead and flight commander of any planned absences.

2.21.3.1. The AFMH clinic provider is expected to conduct a provider-to-provider hand-off for all complex patients prior to known absences and ensure a surrogate is identified in the EHR system.

2.21.3.2. The AFMH clinic provider should make every effort to accomplish recurring follow-up care for empaneled patients before departure.

2.21.4. The AFMH clinic provider is expected to ensure the team provides care to empaneled patients in a proactive, patient-centered, and evidence-based manner to meet demand including, but not limited to, the use of: online patient portal secure messaging, scheduled appointments, walk-ins, registered nurse or 4N (or civilian equivalent) run clinics, use of CSSPs, clinical pharmacy clinics, physical therapy clinics, phone consults, and virtual visits.

2.21.5. The AFMH clinic provider should be familiar with the CFETP and the capabilities of the 4Ns/4As (and civilian equivalents) assigned to their team, utilize in accordance with the CFETP, and participate in their training with appropriate documentation completed.

2.21.6. The AFMH clinic provider should work directly with appropriate staff to develop strategies to care for their empaneled patients with more complex disease states through huddles and regular scheduled care coordination meetings.

2.21.7. The AFMH clinic provider should participate in entire AFMH team staff training as needed.

2.21.8. The AFMH clinic provider will participate in daily team huddles and team building and training events. **(T-2)**.

2.21.9. The AFMH clinic provider should attend and participate in formal MM, care coordination, or transition of care meetings for their empaneled patients.

2.21.10. The AFMH clinic provider is expected to participate in the peer review process.

2.22. AFMH Clinic Team Nurse.

2.22.1. The AFMH clinic team nurse will comply with the standards and processes in DHA-PI 6025.11, DHA-IPM 18-001, and this instruction. **(T-0)**.

2.22.2. The AFMH clinic team nurse is expected to demonstrate competency of skills for ambulatory practice as directed by the chief nurse. This competency verification should be documented in competency assessment folder or electronic equivalent.

2.22.3. The AFMH clinic team nurse is expected to be responsible for nursing care, counseling, and care coordination provided to PCM team empaneled patients.

2.22.4. The AFMH clinic team nurse should plan and coordinate proactive and preventive care for patients.

- 2.22.4.1. The AFMH clinic team nurse should notify patients of preventive services that are needed (such as mammograms, PHAs, well child visits, immunizations, etc.) on a routine and as needed basis.
- 2.22.4.2. The AFMH clinic team nurse is expected to notify enrolled patients who have chronic diseases and are not followed in DM of required laboratory or diagnostic testing on a routine and as-needed basis.
- 2.22.5. The AFMH clinic team nurse should provide care in accordance with accepted nursing DHA policies, AFIs, MTF policy, CPGs, and CSSPs as directed by the flight commander, medical director, and chief nurse.
- 2.22.6. The AFMH clinic team nurse is expected to obtain, maintain, and routinely utilize access to CarePoint® portal tools for proactive patient management.
- 2.22.7. The AFMH clinic team nurse is expected to utilize Schmitt-Thompson Clinical Content® triage protocols for management of symptom-based telephone calls. Training on these protocols should be documented in the nurse's competency assessment folder or electronic equivalent.
- 2.22.8. The AFMH clinic team nurse should participate in the training of team 4Ns/4As (or civilian equivalent) as appropriate. The AFMH clinic team nurse is expected to have working knowledge of the 4N/4A CFETPs and how to document training.
- 2.22.9. The AFMH clinic team nurse will attend and participate in all team huddles and other team building and team training. **(T-2)**.
- 2.22.10. The AFMH clinic team nurse should attend and participate in MM, care coordination, and transition of care meetings for their empaneled patients.
- 2.22.11. The AFMH clinic team nurse is expected to ensure their team provides care to empaneled patients in a proactive, patient-centered, and evidence-based manner to meet demand including the use of: face-to-face or virtual (telephone or video) scheduled appointments, walk-ins, registered nurse or 4N (or civilian equivalent) run clinics, use of CSSPs, clinical pharmacy and physical therapy clinics, or phone consults.
- 2.22.12. The AFMH clinic team nurse will review inpatient, emergency department, and urgent care center admission and discharge documentation for their team-enrolled patients in accordance with DHA-IPM 18-001, to ascertain follow-up needs. **(T-3)**. If patient needs follow up, the team nurse will contact patient within 72 hours of notification of discharge and schedule appointments for this follow up as necessary, or refer patient for appropriate health care (such as DM, behavioral health, etc.) for disposition. **(T-3)**.
- 2.22.13. The AFMH clinic team nurse should place active component service member patient on 24 hours quarters if warranted using a documented nursing assessment as well as approved nursing protocols.
- 2.22.14. In conjunction with 4Ns (or civilian equivalent), the AFMH clinic team nurse is expected to appropriately scrub patient appointment lists and identify patients who may benefit from virtual appointments.
- 2.22.15. In conjunction with 4Ns (or civilian equivalent), the AFMH clinic team nurse should assess education the patient may benefit from and prepare appropriate patient education

materials prior to the appointment; these may be printed, sent to the patient through secure messaging, or provide the patient with appropriate website information.

2.22.16. The AFMH clinic team nurse is expected to participate in the peer review process.

2.22.17. The AFMH clinic team nurse is expected to review and answer secure messages in accordance with their training and direct messages which are beyond RN scope to the appropriate level of care.

2.22.18. The AFMH clinic team nurse is expected to obtain, maintain, and routinely utilize access to CarePoint® portal tools for proactive patient management.

2.23. AFMH Clinic 4N (or Civilian Equivalent).

2.23.1. The AFMH clinic 4N will comply with the standards and processes in DHA-PI 6025.11, DHA-IPM 18-001, and this instruction. (T-0).

2.23.2. The AFMH clinic 4N is expected to participate in hands-on patient care and counseling as indicated by the specific patient encounter and in accordance with their CFETP and training.

2.23.3. The AFMH clinic 4N should inquire if patient is signed up for online patient portal secure messaging during patient encounter. If patient is not already signed up, encourage patient to do so. Review and answer secure messages in accordance with their CFETP and training. The AFMH clinic 4N should direct messages which are beyond 4N (or civilian equivalent) scope to the appropriate level of care.

2.23.4. The AFMH clinic 4N is expected to assist provider by obtaining and documenting clinical information prior to and during patient encounter.

2.23.5. The AFMH clinic 4N is expected to utilize current version of the tri-service workflow form screening and intake algorithm or MHS GENESIS® power chart.

2.23.6. After training is completed and competency validated and in accordance with the CFETP, the AFMH clinic 4N may perform the following:

2.23.6.1. Review and document patient's subjective and objective information;

2.23.6.2. Assist with and perform procedures;

2.23.6.3. Assist with patient order entry and documentation;

2.23.6.4. Perform medication reconciliation.

2.23.7. Training on the above items should be documented in the Air Force training record or competency assessment folder for civilian staff.

2.23.8. The AFMH clinic 4N should perform, or assist in accomplishing, administrative tasks and functions including, but not limited to, staffing of clinical check-in area, record retrieval, management of equipment and supplies, on an as needed basis.

2.23.9. The AFMH clinic 4N should assist team nurse with functions such as, but not limited to, managing telephone consults and secure messages, contacting patients with normal lab results and other clinical tasks according to the CFETP and CSSPs.

2.23.10. In conjunction with the team nurses, the AFMH clinic 4N is expected to appropriately scrub patient appointment lists and identify patients who may benefit from virtual appointments.

2.23.11. Prior to patient encounter, the AFMH clinic 4N should identify and notify patients of preventive services that are needed (such as mammograms, well child visits, immunizations) on a routine basis.

2.23.12. Prior to patient encounter, the AFMH clinic 4N should identify and notify patients who have chronic diseases and are not followed in DM of required laboratory and/or diagnostic testing on a routine basis, per CPG, CSSP, or locally approved guidance.

2.23.13. The AFMH clinic 4N is expected to have access to, and working knowledge of, and updates as appropriate Aeromedical Services Information Management System (ASIMS), to support force health management.

2.23.14. The AFMH clinic 4N is expected to obtain, maintain, and routinely utilize access to CarePoint® portal tools for proactive patient management.

2.23.15. The AFMH clinic 4N will attend and participate in all team huddles and other team building and team training. **(T-2).**

2.23.16. The AFMH clinic 4N should attend and participate in MM, care coordination, and transition of care meetings.

2.23.17. The AFMH clinic 4N should assist with the check-out process to include, but not limited to, reviewing ASIMS, providing and briefing patients about check out activities (such as pharmacy or laboratory), and directing patients about referral processes.

2.23.18. The AFMH clinic 4N is expected to participate in the peer review process.

2.24. AFMH Clinic 4A Office Manager (or Civilian Equivalent).

2.24.1. The AFMH clinic office manager will comply with the standards and processes in DHA-PI 6025.11, DHA-IPM 18-001, and this instruction. **(T-0).**

2.24.2. The AFMH clinic office manager should assist the GPM in developing, inputting, and maintaining AFMH clinic provider templates and schedules in Composite Health Care System or MHS GENESIS®.

2.24.3. The AFMH clinic office manager should coordinate patient referrals with Referral Management Center (RMC) and PCM team as needed including:

2.24.3.1. The AFMH clinic office manager should assist the patient given a referral by providing briefing on expectations or directing patient to RMC.

2.24.3.2. The AFMH clinic office manager should obtain referral reports from RMC when needed and route to appropriate provider.

2.24.3.3. The AFMH clinic office manager should scan referral reports or results into the electronic health record and notify the provider by telephone consult or per designated electronic health record process.

2.24.3.4. The AFMH clinic office manager should obtain paper copies or route the referral results to the PCM when the PCM is not the ordering provider.

2.24.4. The AFMH clinic office manager is expected to perform end of day processing at the end of clinic each day in line with local MTF guidelines.

2.24.5. The AFMH clinic office manager should order and restock office supplies as required.

2.24.6. The AFMH clinic office manager should coordinate required documentation with appropriate clinical and support functions on behalf of the team.

2.24.7. The AFMH clinic office manager should assist clinical staff in maintenance of preventive health databases for PCM teams, as needed.

2.24.8. The AFMH clinic office manager should contact and schedule patient appointments for AFMH team as directed.

2.24.9. The AFMH clinic office manager should assist resource management office in auditing third party collections forms to provide for maximum MTF reimbursement.

2.24.10. The AFMH clinic office manager should supervise, rate, and train the AFMH clinic front desk personnel.

2.24.11. The AFMH clinic office manager will attend and participate in all daily team huddles and team training. **(T-2)**.

2.24.12. The AFMH clinic office manager should assist with the check-out process to include, but not limited to, reviewing ASIMS and providing and briefing patients about check out activities (such as pharmacy or laboratory).

2.25. AFMH Clinic Front Desk Receptionist.

2.25.1. The AFMH clinic front desk receptionist will comply with the standards and processes in DHA-PI 6025.11, DHA-IPM 18-001, and this instruction. **(T-0)**.

2.25.2. The AFMH clinic front desk receptionist will verify patient identity, eligibility, and demographics in Defense Eligibility Enrollment Reporting Systems (DEERS) following AFMAN 41-210, *Tricare Operations and Patient Administration*. **(T-3)**. The AFMH clinic front desk receptionist should direct patient to update information if it is not current.

2.25.3. The AFMH clinic front desk receptionist is expected to check the patient in and enter patient information into EHR.

2.25.4. The AFMH clinic front desk receptionist is expected to obtain third party collection information and forward to resource management office at close of business daily.

2.25.5. The AFMH clinic front desk receptionist will identify members assigned to sensitive duties programs, flag record, and initiate start of MTF process for care of these patients in accordance with AFMAN 41-210. **(T-3)**.

2.25.6. The AFMH clinic front desk receptionist should identify whether patient is enrolled in online patient portal secure messaging; if not, encourage patient to do so and aid with the flow of secure messages.

2.25.7. The AFMH clinic front desk receptionist is expected to determine from patient if visit is injury-related, and if so, make an injury notification and document accordingly in accordance with local guidance and notify team 4N (or civilian equivalent).

2.25.8. The AFMH clinic front desk receptionist is expected to complete end of day processing.

2.25.9. The AFMH clinic front desk receptionist should assist patient to complete required visit paperwork and provide clinic instructions to patient. The AFMH clinic front desk receptionist should route patient to appropriate location for the visit.

2.25.10. The AFMH clinic front desk receptionist is expected to schedule follow-up visit for patient if required at the end of the appointment.

2.25.11. The AFMH clinic front desk receptionist should track, or assist with tracking, diagnostic testing results. The AFMH clinic front desk receptionist should provide hard copy results or enter telephone consult or message to appropriate staff members.

2.25.12. The AFMH clinic front desk receptionist should train, as appropriate, and assist 4Ns (or civilian equivalent) in the proper completion and maintenance of outpatient medical records.

2.25.13. The AFMH clinic front desk receptionist should perform other patient administrative functions consistent with the 4A skill set as appropriate to the AFMH clinic setting.

2.25.14. The AFMH clinic front desk receptionist is expected to assist with the check-out process to include, but not limited to, inputting quarters slips into ASIMS and briefing patients about check out activities (such as pharmacy or laboratory).

2.25.15. In the absence of an authorized front desk receptionist position, AFMH clinic enlisted team members should provide coverage for front desk reception duties and should be equitably distributed among all enlisted AFSCs (or civilian equivalent). All staff who work the front desk is expected to complete appropriate customer service training prior to independent duty. All staff should provide a professional and customer-friendly atmosphere in reception area when welcoming patients.

Chapter 3

AFMH DEFINITION, SCOPE, AND PRINCIPLES

3.1. AFMH Definition. The AFMH is a team-based health care delivery model within the MTF or other military facility strategically placed within the local network, which facilitates partnerships between individual patients, their personal provider team, and when appropriate, the patient's family. This model ensures patients have a range of health options and interact with an interdisciplinary team focused on improved health and human performance. By standardizing primary care services and enhancing access and continuity, and the partnership between the patient and family, the PCM and the PCM team is optimized. This partnership focuses on sustaining and enhancing readiness and health in enrolled patients as well as optimal efficient delivery of comprehensive health care services, based on the needs of enrolled patients.

3.2. AFMH Scope. AFMH clinical operations refers to the health care delivered in primary care clinics noted in **paragraph 1.2.**

3.3. AFMH Principles. The AFMH model is based on a strong primary care platform including continuous access to a personal provider, a team that is responsible for all of the patients' health care needs, a practice built on the principles of patient-centeredness, and fully leveraged use of health information and communication systems. Efficient, effective, and comprehensive primary care results in better health outcomes as well as improved access, higher quality, lower costs, and increased patient satisfaction. AFMHs have adopted the basic core principles of the Patient-Centered Primary Care Collaborative; however, as part of the military service, AFMHs should remain cognizant of the need to maintain the readiness of empaneled troops and meet mission requirements at all times. An active component service member receives the same level of care based on the universal PCMH principles below, to promote the health, well-being and readiness of active component patients in order to prevent and reverse chronic disease if it exists. Therefore, AFMH core principles display some slight differences from the Patient Centered Primary Care Collaborative as listed below:

3.3.1. Personal Provider - each patient has an ongoing relationship with a personal provider trained to provide continuous and comprehensive care. In the AFMH this provider may be a physician, nurse practitioner, or physician assistant and is called the PCM.

3.3.2. Team-Based Care - the personal provider leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

3.3.3. Whole Person Orientation - care should be a collaborative endeavor between the health care team and the patient and their caregivers and should respect patient values, cultural traditions, language, and socioeconomic conditions. Patients and their caregivers are expected to be an integrated part of the decision making process and determining their treatment plan.

3.3.4. Coordinated, Comprehensive and Integrated Care - the personal provider is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care and across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information

exchange and other means to assure that patients get the indicated care when and where they need and want it.

3.3.5. Quality and Safety – As a high reliability organization, AFMHs are committed to quality and safety at all times.

3.3.5.1. The AFMH team is expected to be an advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by care planning processes driven by a compassionate, robust partnership between providers, patients, and the patients' families.

3.3.5.2. The AFMH team is expected to use evidence-based medicine and clinical decision support tools to guide decision-making.

3.3.5.3. Providers in the AFMH accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement as a journey to provide patients the best primary care possible.

3.3.5.4. Patients and families actively participate in CPI activities and decision-making. AFMHs seek feedback to ensure patients' expectations are being met at the practice level.

3.3.5.5. Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

3.3.5.6. AFMHs go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient-centered services consistent with the medical home model. Currently, the DHA uses The Joint Commission for this PCMH recognition process.

3.3.6. Enhanced Access – care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal provider, and AFMH staff.

3.3.7. Payment Reform (High Value Care) – care provided in AFMHs should achieve outstanding outcomes for patients. This includes being good financial stewards by utilizing resources wisely and considering costs, both to the patient and to the health system, when providing for the care of patients. The value structure should be based on the following framework:

3.3.7.1. Reflect the value of provider and non-provider staff patient-centered care management work that falls outside of the face-to-face visit.

3.3.7.2. Support adoption and use of health information technology for quality improvement.

3.3.7.3. Support provision of enhanced communication access such as virtual encounters, secure electronic messaging, and telephone consultation.

3.3.7.4. Recognize the value of provider work associated with remote monitoring of clinical data using technology.

3.3.7.5. Recognize case mix differences in the patient population being treated within the AFMH.

Chapter 4

PROVIDER-DIRECTED TEAM-BASED CARE

4.1. Primary Care Manager (PCM) or AFMH Provider.

4.1.1. The PCM is expected to be responsible for providing all routine, non-emergent, and urgent health care. A referral should be generated for a patient to see a specialist if the PCM is unable to provide that care.

4.1.2. The PCM should ensure ghost panels (i.e., panels of patients not empaneled to a provider) are not utilized. During PCM transitions, empaneled patients will continue to be assigned to the outgoing PCM until the new PCM arrives in accordance with DHA-PI 6025.11. **(T-0)**.

4.1.3. For clinics that have no active component service members assigned, PCM empanelment should be acuity-balanced and matched to the assigned provider's capabilities to ensure the safety of patients and quality of care provided.

4.1.4. The PCM is expected to assume primary responsibility for all of the care each empaneled patient needs, otherwise known as "patient ownership". This is not to say that the PCM team has to provide all of the care, but that they need to oversee all of the care of their empaneled patients.

4.1.5. The PCM is expected to proactively meet the patient's needs as soon as possible, in the most efficient way for the patient: via virtual or telephone visits, traditional face-to-face visits, secure messaging, telephone consults, or another method such as CSSPs, or nurse or clinical pharmacist protocols.

4.1.6. The PCM will ensure a "one visit/one problem" policy, in which a patient is only allowed to discuss one health concern during the appointment, is not implemented in accordance with DHA-IPM 18-001. **(T-0)**. Patients will be allowed to identify multiple medical concerns they may have in one appointment slot, however, the provider may determine which medical concerns are most clinically urgent to be addressed during the appointment time.

4.1.7. The PCM is expected to be responsible for integrating and coordinating beneficiary care delivered inside the MTF and in the network, reviewing results for any care the beneficiary receives outside of the enrolled clinic, and providing follow-up on any identified health issues or recommendations made by specialists.

4.1.8. The PCM should use the latest health information technology and evidence-based medical approaches, as well as maintain updated electronic personal health records.

4.1.9. The PCM should conduct regular check-ups with patients proactively to address current and future causes of disease, and initiate treatment or prevention measures before costly, last-minute emergency procedures are required.

4.1.10. The PCM is expected to adhere to evidence-based care and Department of Defense/Veterans Health Administration CPGs.

4.2. AFMH Clinic Structure:

4.2.1. AFMH teams are made up of three to five PCMs with their support staff. Smaller teams are only authorized in clinics that only have one or two authorized provider positions. These PCM teams will consist of at least one board certified or board eligible physician.

4.2.2. AFMH staff structure in the family medicine, internal medicine, pediatrics, and flight medicine clinics are to be set up to include full-time equivalent (FTE) staffing as indicated in [Table 4.1](#) or current DHA staffing model.

Table 4.1. AFMH Staff Structure.

	Provider	Nurse	4N (or civilian equivalent)	4A (or civilian equivalent)
Family Medicine	1.0 FTE	0.67 FTE	2.0 FTE	.5 FTE
Pediatrics	1.0 FTE	0.67 FTE	2.0 FTE	.5 FTE
Internal Medicine	1.0 FTE	0.67 FTE	2.0 FTE	.5 FTE
Flight Medicine	1.0 FTE	0.50 FTE	2.0 FTE	.5 FTE

4.2.3. Graduate medical education pod model should have one FTE staff provider, one 3rd year resident, one 2nd year resident, one 1st year resident, one FTE registered nurse, two to 2.2 FTE medical technicians (4N or civilian equivalent), one FTE administrative office manager (4A or civilian equivalent).

4.3. Space Requirements:

4.3.1. A minimum of two exam rooms per provider and an office space to accommodate the PCM team. All staff should have mobile laptop capabilities to enable clinic flexibility. Docking stations should be available in office spaces.

4.3.2. All exam rooms within each clinic should be configured in a standard fashion to enable clinic flexibility, maximal use of space by available providers, reliability, and to decrease confusion of new staff during orientation.

4.3.3. Each primary care clinic should have additional space within the confines of the clinic for administrative functions, staff work rooms, treatment rooms, supply rooms, procedure rooms, etc.

4.4. Staff Continuity:

4.4.1. Minimum expectation is that continuity is expected to be maintained between a provider and at least one of the two assigned 4N (or civilian equivalent) for each clinic session.

4.4.2. All AFMH staff will be assigned to the AFMH for a minimum of two years. **(T-3)**. During that time, they should be assigned to the same PCM team unless mission performance would be adversely affected by keeping them in place.

4.5. AFMH Team training:

4.5.1. AFMH staff are expected to attend the appropriate training as required. The four-day Air Force Medical Home Operations Course is required for all staff assigned to AFMH clinics. It should be completed within the first 12 months of being assigned to the clinic. This training need not be repeated unless there is a sustained gap of more than 4 years between AFMH team assignments.

4.5.2. Complete the required DHA PCMH Center for Excellence in MultiMedia videos.

4.5.2.1. Viewing these videos is a one-time requirement that is expected to be accomplished within 90 days of assignment to an AFMH clinic.

4.5.2.2. The following staff are required to view these videos:

4.5.2.2.1. All leaders overseeing an AFMH (to include medical group commander/director, chief nurse, SGH, Chief of Aerospace Medicine, squadron commanders),

4.5.2.2.2. All staff members assigned to an AFMH,

4.5.2.2.3. Behavioral health consultants and behavioral health care facilitators, if applicable,

4.5.2.2.4. GPMs, HCIs, and MM team members.

4.5.2.2.5. Embedded physical therapists and clinical pharmacists.

4.5.3. AFMH initial clinical orientation checklist

4.5.3.1. All AFMH staff will complete the AFMH initial clinical orientation checklist within six weeks of assignment to the clinic. **(T-3)**. This orientation checklist covers information that all AFMH clinic staff need to know before they are released to independent practice. The checklist includes general information sections as well as AFSC-specific sections.

4.5.3.2. AFMH RNs are expected to complete additional checklists as identified by the chief nurse and AF outpatient nursing guidance.

4.5.3.3. 4N (or civilian equivalent) and 4A (or civilian equivalent) are expected to complete additional training as outlined in the CFETP or as directed by their senior 4N and 4A functional managers.

4.5.4. DHA PCMH new provider ramp-up: all newly accessioned or graduated providers will complete the ramp-up using DHA-approved documents. **(T-3)**.

4.5.5. All MTF executive staff members are expected to attend the two-day AFMH Executive Leadership Seminar within the first 12 months of being assigned to the MTF.

4.6. MEPRS and DMHRSi completion:

4.6.1. Accuracy of MEPRS and DMHRSi data is crucial.

4.6.2. AFMH staff are required to use the proper MEPRS code for activities performed outside their primary clinical MEPRS code (such as readiness training or fitness time) and accurately report actual hours for these additional activities, in accordance with DHA-PI 6025.11. **(T-3)**.

Chapter 5

WHOLE PERSON ORIENTATION

5.1. Core Principle of Patient Centeredness.

5.1.1. AFMHs are fully grounded in the core principle of patient centeredness. The Institute of Medicine defines patient-centered care as, “providing care that is respectful of, and responsive to, individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions” as is applicable to meet the standard of medical care.

5.1.2. Patient-centered care should be a collaborative endeavor between the health care team and the patient and their caregivers. The team should understand and respect patient values, cultural traditions, socioeconomic conditions, and respect the patient and family’s wants, needs, and preferences to deliver care that is tailored accordingly.

5.1.3. Patients and their caregivers are expected to be a part of the team and play an active role in the decision-making process and in determining their plan of care and treatment (self-directed goals).

5.1.4. Health literacy is an integral portion of patient-centered care and is defined as the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions. AFMH staff should:

5.1.4.1. Assess the patient’s oral and written communication needs, including the patient’s preferred language or need for translator services and document in the EHR.

5.1.4.2. Provide standardized patient educational material that is appropriate to the general educational level and translated in the patient’s preferred language to the extent it is available.

5.1.4.3. Provide the patient with education in their preferred language to include: the plan of care, self-management, treatment, services, safe and effective use of medications, and nutritional modifications if needed. Discuss pain and pain management, and provide information on the safe use of medical supplies or devices. Document in the EHR.

5.1.4.4. If English is not the primary language for the patient, AFMH staff are expected to obtain interpreter services as needed per local policy.

5.1.5. AFMH staff are expected to evaluate the patient’s understanding of the education provided to them and document in the EHR.

5.1.6. The provider is ultimately responsible for assuring that informed consent is obtained and documented for a procedure.

5.1.7. Special circumstances can occur regarding confidentiality, consent, and treatment of minors in accordance with AFI 44-102 and local policy.

5.1.8. Each AFMH is expected to ensure the chaperone policy is made known and available to all patients, in accordance with AFI 44-102. Posting of the policy in patient exam and treatment areas is recommended.

5.1.9. The patient’s rights and responsibilities will be posted in all primary care areas within the MTF as directed in DHA-PI 6025.10, *Standard Processes, Guidelines, and Responsibilities*

of the DoD Patient Bill of Rights and Responsibilities in the Military Health System (MHS) Military Medical Treatment Facilities (MTFs), Enclosure 3. (T-0).

Chapter 6

COORDINATED, INTEGRATED, AND COMPREHENSIVE CARE

6.1. Coordination and Integration. Care is coordinated and/or integrated across all elements of the complex health care system (such as subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (such as family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to ensure that patients get the indicated care when and where they need it. The goal of coordination is greater efficiency through avoidance of duplication of services, synchronization of services so that they have a maximum impact, and ensuring connection of patients to needed services.

6.2. Focus. Comprehensive care focuses on the whole person and their health. Comprehensive care includes acute, chronic, preventive, and wellness care; behavioral and mental health care; and health promotion. Care is expected to be specifically tailored to meet the needs of each individual patient and family. Care within the primary care setting is delivered by a team rather than a single clinician, so professionals with different skill sets are available to meet the patient's needs. AFMH staff should partner with accredited health and community-based organizations to promote the patient's health and wellness as needed.

6.3. Comprehensive care steps. There are many steps that should happen to ensure comprehensive care is provided to patients. These steps should be started several days prior to the scheduled appointment and completed prior to patient's arrival.

6.3.1. Step 1: Pre-visit preparation. Pre-visit preparation should be used to identify patient health care needs as well as equipment and supplies that may be needed during the visit. Pre-visit preparation includes reviewing the provider's daily schedule for:

6.3.1.1. Patient's chief complaint, so the team can ensure they are able to provide the requested care, or encourage the patient to obtain the appropriate care in another venue if necessary.

6.3.1.2. Determination if the patient's requested care could effectively be met through enhanced access or integrated support services (such as virtual encounter, behavioral health, CSSPs, direct access physical therapy, clinical pharmacist, telephone consults). The patient will need to provide consent to transfer to another offered service prior to cancelling their already scheduled provider appointment.

6.3.1.3. Identify and order any diagnostic testing that needs to be completed prior to the appointment and encourage patient to accomplish the order.

6.3.1.4. Request documentation for any reports or clinical notes needed from the network for the appointment.

6.3.2. Step 2: Pre-populate encounter. Pre-populate the encounter with pertinent information. CarePoint® application portal is a comprehensive tool that can help staff to identify items to pre-populate in the encounter.

6.3.2.1. Update and document any preventive care needs (such as labs, mammograms, colonoscopy) patient is due or overdue using CarePoint® health maintenance registry.

Generate screening order(s) and make a notation to remind the patient of this need during the appointment if not needed sooner.

6.3.2.2. Identify and document any readiness items within the encounter using military medical readiness applications and make a notation to remind the patient of this need during the appointment.

6.3.2.3. Identify any active medications or referrals needing to be renewed and make a notation to alert the provider of this need during the appointment. Authorized team members may pre-order medications and/or referrals ahead of time within the encounter.

6.3.3. Step 3: The primary care team will conduct daily and weekly huddles. **(T-2)**. Daily and weekly huddles maximize communication within the primary care team and the integrated support team, which is crucial to ensuring comprehensive and quality patient care is provided. The MM team should be included in these huddles to perform indicated care coordination activities. However, this does not substitute for formal MM meetings or team care coordination meetings. At a minimum during the daily and weekly huddles, the following should be discussed:

6.3.3.1. Daily huddles be accomplished using a standardized checklist and should include:

6.3.3.1.1. Review of staffing for the day. Identify who is available, team assignments, lunch coverage, administrative coverage (such as meetings and appointments) and enhanced access coverage (such as secure messaging, CSSP clinic, or walk-in clinics).

6.3.3.1.2. Review of scheduled appointments for the day. Review of scheduled patient lists with identification of necessary diagnostic testing required, supplies and equipment that may be needed for the visit, preventive care needs, prescription refills, referral renewals, and any other pertinent items that the patient may need.

6.3.3.1.3. Report any access problems, equipment problems, supply shortages, patient or staff safety issues, and report up the chain of command if unable to resolve at the clinic level.

6.3.3.2. Weekly huddle should be accomplished using a standardized checklist and should include:

6.3.3.2.1. Review of scheduled appointments for the week and begin the pre-visit preparation and pre-populate encounter steps above.

6.3.3.2.2. Review of staffing for the week to alert clinic leadership if coverage is needed. Additionally, review if there will be any disruption to patient care such as readiness exercises or holidays.

6.3.3.2.3. Discussion of what needs to be improved upon from the prior week in regards to clinic management, workflows, or identify items for CPI activities.

6.3.4. Step 4: Front desk standardized check-in process. For face-to-face visits, every AFMH clinic should accomplish a patient appointment check-in in a standardized manner.

6.3.4.1. Front desk check-in should be accomplished in a standardized fashion for all patients using the “standard check-in process”. The process should include:

6.3.4.1.1. Greet every person with courtesy and respect.

- 6.3.4.1.2. Ask patient if on special duty status: personnel reliability program, presidential support program, flying status, and arming use of force. If yes, initiate MTF process for applicable special duty status.
- 6.3.4.1.3. Verify appointment and check patient's full name and date of birth against their military issued identification card, and the scheduled appointment within the EHR or printed schedule (if systems are down). If the identification card has expired, initiate MTF process for expired cards.
- 6.3.4.1.4. Verify and update patient's ten digit phone number and home address.
- 6.3.4.1.5. Verify patient's eligibility via DEERS. If patient fails DEERS check, ask for other proof of eligibility (such as active military orders or line of duty paperwork). If still unable to verify DEERS eligibility, initiate appropriate MTF process.
- 6.3.4.1.6. Verify notice of privacy practices acknowledgment in patient's record. If the form or documentation isn't seen, initiate appropriate MTF process.
- 6.3.4.1.7. Review and update third party insurance for non-active component.
- 6.3.4.1.8. Identify if visit is injury-related and if so, initiate MTF process.
- 6.3.4.1.9. Verify if patient has a patient portal secure message account. If not, provide registration information.
- 6.3.4.1.10. Ensure medication reconciliation has been reviewed, updated with the patient or parent, and any other applicable forms are completed.
- 6.3.4.2. Inform patient of any known delays and when they should notify the front desk if they haven't been called.
- 6.3.5. Step 5: 4N (or civilian equivalent) standardized check-in process:
- 6.3.5.1. Use of the appropriate tri-service workflow form or MHS GENESIS® power chart form in the EHR.
- 6.3.5.2. Vital signs appropriate to the patient's age and chief complaint is expected to be completed and documented in the EHR.
- 6.3.5.3. 4N (or civilian equivalent) is expected to complete further determination of the chief complaint, symptoms, other necessary questions, and potential further diagnostic tests or assessments (such as a monofilament exam) to complete the subjective and objective portions of the note and should document this in the EHR. This determination should include assessment of:
- 6.3.5.3.1. If a patient has more than one medical complaint, AFMH staff should attempt to address as many as are safe to do so in the appointment. A secondary complaint may become the highest priority medical need to be addressed in the appointment. If all medical concerns cannot be addressed in one appointment, the patient should be offered another appointment or venue to be able to take care of these issues.
- 6.3.5.3.2. The 4N (or civilian equivalent) should use standardized assessment tools to include patient health questionnaire-2. If results are positive, then the patient health questionnaire-9 should be completed.

6.3.5.3.3. AFMH clinics should use only MTF-approved and standardized patient education materials and health literacy screening tools.

6.3.5.3.4. 4N or 4A (or civilian equivalents), should review readiness requirements using the military medical readiness applications.

6.3.6. Step 6: Warm hand-off. Once the check-in process is completed and the room is set-up, the 4N (or civilian equivalent) is expected to notify the provider of the patient's readiness to be seen.

6.3.6.1. At minimum, the following information should be relayed to the provider:

6.3.6.1.1. Demographics (such as age, sex, component), and

6.3.6.1.2. Chief complaint, and

6.3.6.1.3. Pertinent history (such as diabetes, hypertension, pregnancy), and

6.3.6.1.4. Provide objective data (such as vital signs, exam findings, pain report, patient health questionnaire), and

6.3.6.1.5. Any medical readiness requirements due, and

6.3.6.1.6. Any preventive services due or overdue, and

6.3.6.1.7. All referrals or medications needing to be renewed.

6.3.6.2. The 4N (or civilian equivalent) should remain in the exam room to participate in the evaluation and documentation of the patient encounter, enter orders on behalf of the provider as directed (except medication orders), and assist as needed.

6.3.7. Step 7: Standardized check-out process. All AFMH clinics should utilize a standardized patient check-out form that will be available (hard copy or electronic) to the patient to identify next steps, additional diagnostic testing that needs to be completed (such as laboratory or pharmacy), and follow up interval.

6.4. Neighborhood. The AFMH team is the central hub of patient information, primary care provision, and care coordination. All care that happens outside of the AFMH clinic is considered part of the neighborhood.

6.4.1. The goal of the neighborhood is to promote integrated, coordinated care throughout the entire health care system, including specialists, subspecialists, and other health care entities who are involved in care of the patient.

6.4.2. AFMH teams and neighborhoods need to effectively communicate, provide safe and timely coordination of care, transitions, or hand-offs, and integrate care practices (such as co-management determinations, effective flow of information) in a bi-directional manner to provide the highest quality care to the patient.

6.5. Hand-Offs. Coordination of patient transfers, permanent change of station, and warm handoffs should occur with high risk, high acuity patients, complex patients, patients enrolled in Exceptional Family Member Program (EFMP) or case management or patients with incomplete treatment episodes (such as newly diagnosed, but patient is moving) whenever possible for continued quality of care.

6.5.1. When such a patient is transferred for care, but will remain empaneled with the current AFMH clinic, the staff, (including PCM team, RMC, MM department, TRICARE Operations and Patient Administration staff) are responsible to provide the new treatment team with information pertinent to the care of the patient (such as medical records and diagnostic test results). This provision includes providers that the patient is referred to for specialty care.

6.5.2. When a change of empanelment at a MTF is known and the patient is high acuity, high risk, complex, enrolled in EFMP or case management or patients who are newly diagnosed, the primary care team is responsible for providing a warm handoff to the new primary care clinic staff. This warm handoff should be completed between appropriate members of the primary care team (team nurse contacts new team nurse and provider contacts provider). When possible, this warm handoff should occur prior to the patient transferring.

6.6. Discharges. Post discharge follow-up should occur at the MTF whenever a patient is discharged from an inpatient stay or emergency department visit. The AFMH team nurse should review referral results, inpatient hospital and emergency department admissions and discharges, and ascertain what follow up care is needed. If a patient is discharged from care for a mental health concern, the team nurse may engage the behavioral health consultant staff. The team nurse may engage the clinical pharmacist for evaluation of medications. The MTF will need to have an established process to ensure the nurse receives this information.

6.6.1. The team nurse is expected to contact patients within 72 hours of receipt of discharge notification or paperwork. The nurse should ensure these patients are scheduled into appointments if requested by the PCM or if the nurse's clinical judgment identifies a need for follow up.

6.6.2. In some instances, a virtual visit may be adequate to address the patient's follow up needs. In this instance, the team nurse is expected to call and schedule the patient into a virtual visit.

6.7. Referrals. The AFMH team staff should be aware of current referral guidelines in accordance with AFI 44-176. The MTF should develop a local process to get pertinent clinical information to the specialist prior to the patient appointment.

6.8. Referral Results. The AFMH team is expected to coordinate retrieval of patient referral results with the MTF RMC. For MTFs still using Armed Forces Health Longitudinal Application, these results should be placed in Health Artifact Image Management System by appropriate personnel and the PCM should be notified of the availability of the results. MTFs using MHS GENESIS® should follow local policy to ensure patient referral results are in the EHR. The PCM is responsible to review the results within 72 hours of notification of receipt and determine if follow up care is required. If follow-up care is required, the PCM team should notify the patient and schedule follow-up.

6.9. Managed Care Support Contractor MM. AFMH patients who receive the majority of their care from network specialty care may be eligible for managed care support contractor CM or DM services.

6.10. Durable Medical Equipment. The MTF should identify a process for obtaining durable medical equipment when a patient requires it.

6.11. Referrals to PCMs. In some instances, a patient will be referred to their empaneled PCM (such as from a dental visit with a high blood pressure recorded). Patients who are referred to the PCM should be scheduled by a team member into a face-to-face or virtual appointment.

6.12. Wounded, Ill and Injured (WII). AFMH staff should be aware of programs that are available for wounded, ill, and injured service members.

6.12.1. Recovery care coordinators and wounded warrior case managers provide a well-coordinated & personalized support team that helps wounded, ill, and injured service members access and navigate the continuum of care. These staff develop recovery plans, interact with the service member's leadership and base-level agencies, and coordinate warm hand-offs with the Department of the Veteran's Affairs.

6.12.2. These staff members also assist the service member transition back to duty or into civilian life, and ensure they receive all the benefits, entitlements, and financial aid for which they are eligible. The primary care team should refer appropriate patients to the recovery care coordinator or wounded warrior case managers in accordance with DAFI 34-1101, *Warrior and Survivor Care* and AFPD 34-11, *Warrior and Survivor Care Services*.

6.13. Special Needs Coordinator (SNC). The SNC oversees and manages the installation EFMP-M program in accordance with AFI 40-701, *Medical Support to Family Member Relocation and Exceptional Family Member Program (EFMP)*. The SNC is an integral member of the overseas clearance process and identifies sponsors and their family members with special needs. Once the sponsors and family members with special needs are identified, the SNC is able to determine the ongoing necessary medical and educational services the family members require. Identifying these requirements allows the SNC to determine support and access to specialized services at the current and projected duty assignment. These efforts are also in place to protect federal rights and entitlements for mobile family members.

Chapter 7

QUALITY AND PATIENT SAFETY

7.1. The MTF Executive Committee. Based upon recommendations of the population health function, the MTF executive committee should identify subsets of enrollees who make the MTF their “medical home” vs. those who are enrolled but obtain their healthcare elsewhere. Quality of care and patient safety should be of the highest priority within AMFH for these “medical home patients” and is a core principle of a PCMH.

7.2. High Reliability Organizations. High reliability organizations consistently produce better than expected outcomes despite operating in the complex and high-risk healthcare environment by applying principles known to lead to high reliability. In accordance with DHA-PM 6025.13, *Clinical Quality Management in the Military Health System, Volume 1: General Clinical Quality Management*, AFMHs should affirm and express a single-minded focus on identifying potential problems and high-risk situations before they lead to a patient safety event. **(T-0)**. The MHS aims for harm prevention and process improvement to become second nature for everyone. The Air Force Medical Service is working toward being a high reliability organization by providing trusted care. The Air Force Medical Service is a continuous learning and improving organization that partners with patients and families in a single-minded focus on safety and zero harm.

7.2.1. AFMH staff are expected to continually strive to identify and problem solve CPI opportunities as part of daily and weekly huddles, and work towards zero harm for their medical home patients.

7.2.2. Additional time may be allotted in provider schedules for process improvement activities, team training, discussion of trusted care principles, etc. and should be done at the flight level during monthly staff meetings.

7.2.3. High reliability organizations work to continually improve the culture of safety and reliability within the medical service. In order to produce quality and safety results reliably, several strategies are required:

7.2.3.1. Consistent utilization and standardization of processes and documentation will assist to increase the reliability and quality of care provided to medical home patients; therefore:

7.2.3.2. All medical home staff should utilize appropriate tri-service workflow forms or MHS GENESIS® equivalent.

7.2.3.3. All exam rooms within each clinic should be standardized.

7.2.3.4. Allowing outside entities to inspect processes within the MTF is part of trusted care in accordance with DHA-PM 6025.13, *Clinical Quality Management in the Military Health System Volume 5: Accreditation and Compliance*. The MTF will undergo inspections according to the DHA as well as higher headquarters, to include, but are not limited to: The Joint Commission and unit effectiveness inspections. **(T-0)**.

Chapter 8

ENHANCED ACCESS

8.1. Enhanced Access. Enhanced access describes a suite of strategies essential to AFMH operations. Access in this context should no longer be considered only a face-to-face appointment with a provider, but rather the entire spectrum of options a MTF PCM team can deliver to provide care to the patient.

8.2. Enhanced Access options. Enhanced access options include, but are not limited to; virtual appointments, secure messaging, RN/4N (or civilian equivalent) run clinics, CSSP use, nurse advice or telephone consults, clinical pharmacist clinics, medical nutrition therapy, physical therapy clinic, primary care behavioral health providers, as well as traditional face-to-face appointments within the AFMH Clinics.

8.3. Traditional face-to-face appointments. Traditional face-to-face appointments are one type of access for patients to obtain needed health care from their PCM Team. These appointments are created by using templates, and these templates should follow DHA-IPM 18-001. **(T-0)**.

8.3.1. Templates are expected to be built in the CHCS until the facility migrates to MHS GENESIS®. After migration, the facility staff are expected to only use MHS GENESIS® to schedule appointments.

8.3.2. Templates for AFMH clinics will follow rules set forth in the DHA-IPM 18-001. **(T-0)**.

8.4. Virtual Appointments. Virtual appointments enhance access by enabling patients to visit a credentialed healthcare provider in a non-face-to-face encounter using a cell phone, video, landline phone or secure messaging to address their healthcare needs. These scheduled patient-provider interactions differ from traditional telephone encounters in that they are for a specified purpose which may involve significant medical evaluation or decision-making, but does not require a physical exam. Virtual appointments may be utilized when face-to-face care is not required to address the patient's needs. If templated, use the "SPEC" appointment type with home care (HC) detail code. They can be used to address things such as PHAs or medication follow-up assessments like titration of dosages. Patients should not be forced into virtual appointments. Guidance for virtual appointments is found in the DHA-IPM 18-001.

8.5. Clinic Hours. Clinics should assess the needs of their population to determine their hours of operation. Tools to assess these needs include call center metrics, patient satisfaction survey results, patient and family partnership councils, wing operational or other needs, local school hours, unused appointments, or other patient feedback. Some clinics may have to extend their duty hours in response to these needs.

8.5.1. This process should be continually evaluated to address patients' appointment time desires while optimizing staff utilization, in accordance with DHA-IPM 18-001.

8.5.2. DHA has released guidance and tools to assist MTF primary care clinics to assess their need to open or continue internal urgent care clinics. All MTFs should utilize these tools and complete a periodic evaluation of the need for these clinics.

8.6. First Call Resolution. AFMHs should still strive for first call resolution with all of their patients by scheduling an appointment, conducting a virtual visit, conducting a telephone consult with the nurse, or other options as they are available.

8.6.1. AFMH staff will never ask a patient to call back later to see if an appointment is available, in accordance with DHA-IPM 18-001. **(T-0)**.

8.6.2. The GPM will maintain template and schedule control and management in accordance with DHA-IPM 18-001. **(T-0)**.

8.7. Booking Protocols. All MTFs should create and regularly update clinical booking protocols. These protocols are used by appointment call centers to properly appoint patients, direct them into clinical support staff protocols or virtual appointments, create nursing telephone triage requests, or direct patients to urgent or emergency care. GPMs are expected to work with office managers, medical directors, and clinic/flight commanders to assemble feedback and be the liaison with the call centers to update the booking protocols in accordance with DHA-IPM 18-001.

8.8. Asynchronous Communication (Secure Messaging). Every MTF should maximize the facility's use of secure messaging as a communication method between the PCM team and the patient. AFMH clinics will use secure messaging in accordance with DHA-IPM 18-001. **(T-0)**. Other clinics may also use secure messaging. Secure messaging may be used within and between the MTF clinics for coordination of care and treatment between providers and clinical staff. Each MTF will assign one primary OIC to be the lead for patient marketing, staff training, and to track monthly metrics. **(T-0)**. Metrics for secure messaging should be tracked monthly to identify and address MTF and provider level registration, utilization and response rates and times.

8.9. CSSP/RN/4N (or civilian equivalent) Run Clinics. CSSPs are nurse or 4N (or civilian equivalent) run, centrally developed protocols to add access and otherwise direct care to the most appropriate personnel (such as normal diagnostic results directed to the team 4N (or civilian equivalent) to provide the patient the results). These clinics are expected to use evidence-based methodology that has been developed by DHA staff, the Department of Defense/Veterans Health Administration CPGs or other nationally-approved protocols. Patients who meet the requirements to utilize these protocols should be identified and scheduled into an appropriate appointment before daily appointments have run out. A locally-developed booking protocol will be required for the appointing center to ensure proper utilization of CSSPs with handoff to the nurse or technician.

8.10. Nurse Advice Line. MTF will utilize the nurse advice line in accordance with DHA-IPM 17-009, *Nurse Advice Line (NAL) Program Operations Guidance*. **(T-0)**.

8.11. Embedded Clinical Pharmacist. The clinical pharmacist provides evidenced-based interventions to patients across a wide variety of health conditions to include, but not limited to; medication therapy management, polypharmacy coordination, transition of care management (post hospital discharge), opioid management assistance (e.g., pain agreements and state lockout programs), and medication and over the counter medication patient education and some ambulatory care (such as upper respiratory infection, cold and flu protocols) in accordance with the 2018 United States Air Force Pharmacy Practice Manual (located at: <https://kx.health.mil/kj/kx2/pharmacy/documents/outpatientpharmacypracticesig/pharmacyhttps>:

[//kx.health.mil/kj/kx2/pharmacy/documents/outpatientpharmacypracticesig/pharmacy practice manual](https://kx.health.mil/kj/kx2/pharmacy/documents/outpatientpharmacypracticesig/pharmacypractice%20manual)).

8.12. Direct Access Physical Therapy. All MTFs with appropriately credentialed physical therapists are expected to establish direct access physical therapy evaluation and treatment programs for empaneled service members as part of the MTF medical home expanded team concept. Booking protocols are needed for the call centers to direct appropriate patients into physical therapy appointments in cases where the patient does not need to see the PCM first.

8.13. Behavioral Health. Behavioral health care will be integrated into AFMHs in accordance with DODI 6490.15, *Integration of Behavioral Health Personnel (BHP) Services Into Patient-Centered Medical Home (PCMH) Primary Care and Other Primary Care Service Settings*, DHA-PM 6025.01, *Primary Care Behavioral Health (PCBH) Standards*, and DHA-PI 6025.27, *Integration of Primary Care Behavioral Health (PCBH) Services into Patient-Centered Medical Home (PCMH) and Other Primary Care Service Settings Within the Military Health System (MHS)*. (T-0).

8.13.1. The behavioral health consultant works as a consultant to the PCMs on behavioral health issues and provides brief interventions to patients across a wide variety of medical, mental health, and behavioral change related health conditions such as chronic diseases, obesity, pain management, sleep disorders, etc.

8.13.2. Behavioral health care facilitators are specially trained registered nurses assigned to primary care clinics who track, monitor, and assist with adherence to behavioral health pharmacological treatment. They primarily work with patients presenting with depression, post-traumatic stress disorder, and generalized anxiety, and provide updates to the PCM team on treatment adherence and progression. The behavioral health care facilitator should collaborate closely with the behavioral health consultant and PCM team to coordinate behavioral health care and provide motivational interviewing to assist patients with basic problem-solving to promote behavioral change where indicated. They can also assist with behavioral health transition care management (post hospital discharge) to arrange follow-up care within required timeframes using MTF and network resources.

Chapter 9

AFMH PERFORMANCE MEASUREMENT

9.1. AFMH measures and metrics. AFMHs should evaluate their ability to provide outstanding outcomes for patients and families by identifying, monitoring, and analyzing metrics on a routine basis. The metrics that encompass the elements of the MHS Quadruple Aim, the Military Health System's ultimate goal of delivering value to all we serve, should be used to evaluate the AFMHs. The following metrics are expected to be used:

- 9.1.1. PCM continuity;
- 9.1.2. Health Enrollment and Data Information Set;
- 9.1.3. Patient satisfaction metrics;
- 9.1.4. Primary care leakage;
- 9.1.5. Staff satisfaction;
- 9.1.6. Third next 24-hour and future appointments and
- 9.1.7. Secure messaging use.

9.2. AFMHs not meeting targeted goals for these metrics should develop and implement strategies to reach them.

9.3. These metrics can be found on the DHA CarePoint® application portal site at <https://carepoint.health.mil>.

Chapter 10

MISSION SUSTAINMENT

10.1. Primary mission. The primary mission of the AFMH is to ensure a medically ready force to meet the readiness mission of the United States Air and Space Forces. The AFMH should do this by ensuring the following are completed:

10.2. Periodic Health Assessment (PHA). All active component and reserve service members will complete an annual PHA in accordance with DODD, 6200.04, *Force Health Protection (FHP)*, DODI 6200.06, DODI 6025.19, *Individual Medical Readiness*, and DHA-PI, 6200.06. (T-0).

10.3. Mental Health Assessment (MHA). An MHA is required annually and will be conducted as part of the annual PHA in accordance with DODI 6200.06, DODI 6025.19, DODD, 6200.04, and DHA-PI 6200-06. (T-0).

10.4. Sensitive Duties Program. The sensitive duties program includes personnel reliability assurance program and presidential support program. AFMH staff will identify members assigned to sensitive duties programs and refer or provide care to these patients in accordance with AFMAN 41-210. (T-2).

10.5. Readiness Training. MTF commanders/directors are expected to ensure and support optimal medical readiness for all Airmen and Guardians to ensure Air and Space Force medics are current, trained, and equipped to deliver trusted care, anywhere in support of the full spectrum of military operations. Time should be allocated in the AFMH schedules to complete readiness training and readiness requirements as directed by mission requirements. This includes, but is not limited to, readiness training days that the entire MTF conducts, readiness team leader training, and other readiness training.

10.6. Deployment Operations. AFMH active component staff may be assigned to a deployment position in accordance with DAFI 10-401, *Operations Planning and Execution* and AFI 10-403, *Deployment Planning and Execution*.

10.6.1. It is preferable that providers assigned to the same AFMH team not be aligned with the potential to deploy at the same time.

10.6.2. 4N and registered nurses may be aligned to deploy at the same time as their assigned provider on their AFMH team. The senior 4N functional manager and chief nurse should ensure skill level balancing for both in-garrison and garrison operations when assigning technicians or nurses to deployment positions.

10.7. Disability Evaluation System (DES) and Integrated Disability Evaluation System (IDES), to include Medical Evaluation Board (MEB) Physical Evaluation Boards (PEB). The purpose of the DES and IDES is to maintain a fit and vital force that can meet mission requirements.

10.7.1. AFMH staff will adhere to AFI 36-3212, *Physical Evaluation for Retention, Retirement, and Separation*. (T-2).

10.7.2. When an AFMH provider identifies a medical defect or condition that may disqualify the member from continued active component service, the AFMH provider will prepare

appropriate documents in accordance with AFI 36-3212, and refer the case to a medical or physical evaluation board. (T-2).

10.8. Separation history and physical exam (SHPE). AFMH staff will conduct SHPEs in accordance with Department of the Air Force Manual (DAFMAN) 48-123, *Medical Examinations and Standards* and DODI 6040.46, *The Separation History and Physical Examination (SHPE) for the DOD Separation Health Assessment (SHA) Program*. (T-2).

DOROTHY A. HOGG
Lieutenant General, USAF, NC
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Attachment 1**GLOSSARY OF REFERENCE AND SUPPORTING INFORMATION*****References***

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- AFPD 44-1, *Medical Operations*, 9 June 2016.
- DODI 5400.11, *DoD Privacy and Civil Liberties Programs*, 29 January 2019.
- AFI 33-322, *Records Management and Information Governance Program*, 23 March 2020.
- DHA-PI 6025.11, *Processes and Standards for Primary Care Empanelment and Capacity in Medical Treatment Facilities (MTFs)*, 9 October 2018.
- DHA-IPM 18-001, *Standard Appointing Processes, Procedures, Hours of Operation, Productivity, Performance Measures and Appointment Types in Primary, Specialty, and Behavioral Health Care in Medical Treatment Facilities (MTFs)*, 4 February 2020.
- DHA-PI 6025.19, *Population Health, Operation, and Integration across the Military Health System (MHS)*, 9 August 2019.
- AFI 44-173, *Population Health*, 10 January 2019.
- AFI 48-101, *Aerospace Medicine Enterprise*, 8 December 2014.
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- DODI 6200.06, *Periodic Health Assessment (PHA) Program*, 8 September 2016.
- DHA-PI 6200.06, *Periodic Health Assessment (PHA) Program*, 9 May 2017.
- AFI 46-101, *Nursing Services and Operations*, 30 January 2015.
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- AFI 44-102, *Medical Care Management*, 17 March 2015.
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AFI 40-701, *Medical Support to Family Member Relocation and Exceptional Family Member Program (EFMP)*, 19 November 2014.

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DODI 6490.15, *Integration of Behavioral Health Personnel (BHP) Services into Patient-Centered Medical Home (PCMH) Primary Care and Other Primary Care Service Settings*, 8 August 2013.

DHA-PM 6025.01, *Primary Care Behavioral Health (PCBH) Standards*, 20 December 2019.

DHA-PI 6025.27, *Integration of Primary Care Behavioral Health (PCBH) Services into Patient-Centered Medical Home (PCMH) and Other Primary Care Service Settings Within the Military Health Service (MHS)*, 18 October 2019.

DODD 6200.04, *Force Health Protection*, 9 October 2004.

DODI 6025.19, *Individual Medical Readiness (IMR)*, 9 June 2014.

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AFI 10-403, *Deployment Planning and Execution*, 17 April 2020.

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DAFMAN 48-123, *Medical Examinations and Standards*, 8 December 2020.

DODI 6040.46, *The Separation History and Physical Examination (SHPE) for the DOD Separation Health Assessment (SHA) Program*, 14 April 2016.

2018 United States Air Force Pharmacy Practice Manual, 11 December 2018.

Prescribed Forms

None

Adopted Forms

AF Form 847, *Recommendation for Change of Publication*

Abbreviations and Acronyms

AF—Air Force

AFI—Air Force Instruction

AFMAN—Air Force Manual

AFMH—Air Force Medical Home

AFMRA—Air Force Medical Readiness Agency

AFSC—Air Force Specialty Code
ASIMS—Aeromedical Services Information Management System
CFETP—Career Field Education and Training Plan
CM—Case Management
CPG—Clinical Practice Guideline
CPI—Clinical Process Improvement
CSSP—Clinical Support Staff Protocols
DAFI—Department of the Air Force Instruction
DAFMAN—Department of the Air Force Manual
DEERS—Defense Enrollment Eligibility Reporting System
DES—Disability Evaluation System
DHA—Defense Health Agency
DHA-IPM—**DHA**—Interim Procedures Memorandum
DHA-PI—**DHA**—Procedural Instruction
DM—Disease Management
DMHRSi—Defense Medical Human Resource System-internet
DODI—Department of Defense Instruction
EFMP—Exceptional Family Member Program
EHR—Electronic Health Record
FTE—Full-Time Equivalent
GPM—Group Practice Manager
HCI—Health Care Integrator
MEPRS—Medical Expense and Performance Reporting System
MHS—Military Health System
MM—Medical Management
MTF—Medical Treatment Facility
NCOIC—Non-Commissioned Officer in Charge
OIC—Officer in Charge
OPR—Office of Primary Responsibility
PCM—Primary Care Manager
PCMH—Primary Care Medical Home
PHA—Periodic Health Assessment

PI—Procedural Instruction

RMC—Referral Management Center

SGH—Chief of the Medical Staff

SGP—Chief of Aerospace Medicine

SNC—Special Needs Coordinator

UM—Utilization Management

UTC—Unit Type Code

4A—Health Services Management Technician

4N—Aerospace Medical Services Technician

Terms

Airmen—collectively refers to uniformed members of the United States Air Force.

Appointment—a scheduled day and time for an individual to be evaluated or treated by a medical provider or other licensed healthcare professional.

Beneficiary—a person eligible for or receiving benefits under an insurance policy or plan, usually health care insurance.

Care coordination—the deliberate organization of patient care activities between two or more participants involved in a patient’s care to facilitate the appropriate delivery of health care services.

Continuity—a long term partnership between two or more individuals

Embedded—firmly affixed to or attached to, typically to a military unit

Evidence-based—practices or programs that are considered effective based on scientific evidence. A model in which empirical evidence is used to make informed decisions.

Expanded—having been enlarged or extended. An expanded team includes staff that are in addition to the primary team.

Guardians—collectively refers to uniformed members of the United States Space Force.

Healthcare providers—military (Active or Reserve component) and civilian personnel (Civil Service and other providers working under contractual or similar arrangement) granted privileges to diagnose medical conditions and initiate, alter or terminate healthcare treatment regimens within the scope of licensure, certification, or registration. This category includes physicians, dentists, nurse providers, nurse anesthetists, nurse midwives, podiatrists, optometrists, clinical dietitians, social workers, clinical pharmacists, clinical psychologists, occupational therapists, physical therapists, audiologists, speech pathologists, physician assistants or any other professional providing direct patient care.

Huddle—the action of a team gathering to strategize. A team collaboration to manage tasks, projects, and activities.

Matrixing—to move personnel from their assigned post, department, or location to a new post, department or location where they were not “earned” or authorized; reassigned.

MHS Quadruple Aim—the ultimate goal for the Military Health System; the MHS Quadruple Aim represents leadership’s commitment to delivering value to all they serve and is aligned with the MHS Strategic goals and value proposition to include: readiness, population health, experience of care, and per capita cost.

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

Patient—Centered Medical Home (PCMH)-a model of patient care that puts the patient at the forefront of care. Provides healthcare that is relationship-based with a whole-person orientation.

Peer review—a process in which medical clinicians review each other’s patient care documentation to make sure that it is thorough, accurate, relevant, and significant.

Provider—a person who provides a healthcare service to a patient, typically identified as a physician, physician assistant, or nurse practitioner.