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Medical

POPULATION HEALTH

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This publication implements Air Force Policy Directive (AFPD) 40-1, *Health Promotion;* AFPD 44-1, *Medical Operations*; AFPD 46-1, *Nursing Services*; AFPD 48-1, *Aerospace Medicine Enterprise*; and Department of Defense Instruction (DoDI) 6025.20, *Medical Management Programs in the Direct Care System (DCS) and Remote Areas*. This publication provides guidance and procedures on population health concepts and related activities, to include delivery of direct healthcare activities, formal medical management, and support of community health promotion, throughout the Air Force Medical Service.

This instruction applies to all personnel assigned to or working in an Air Force military medical treatment facility who share responsibility for the health of the enrolled population. This includes, but is not limited to, those assigned to perform specific population health programmatic functions. This publication does not apply to the Air Force Reserve or Air National Guard. This publication may be supplemented at any level, but all supplements must be routed to the Office of Primary Responsibility (OPR) listed above for coordination prior to certification and approval. Refer recommended changes and questions about this publication to the OPR listed above using the Air Force Form 847, *Recommendation for Change of Publication*; route Air Force Forms 847 from the field through the appropriate chain of command. The authorities to waive wing/unit level requirements in this publication are identified with a Tier ("T-0, T-1, T-2, T-3") number following the compliance statement. See AFI 33-360, *Publications and Forms Management*, for a description of the authorities associated with the Tier numbers. Submit requests for waivers

through the chain of command to the appropriate Tier waiver approval authority, or alternately, to the Publication OPR for non-tiered adherence items.

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SUMMARY OF CHANGES

This document has been substantially revised and must be completely reviewed. Major changes include incorporation of the new Defense Health Agency Population Health Model, addition of complex care coordination, updated internet references, and major formatting changes.

Chapter 1

POPULATION HEALTH OVERVIEW

1.1. Purpose of Population Health

1.1.1. The purpose of population health in the Air Force Medical Service is to improve the health of Air Force Medical Service beneficiaries by assessing determinants of health and defined outcomes for a defined group of people (i.e. population) in order to drive strategies, policies and interventions that maintain and improve those outcomes for the entire population as well as for all subgroups within that population.

1.1.2. Population health steps beyond an individual-level focus of medicine by considering the factors that affect both populations and individuals. These factors include (but are not limited to) individual and group behavior, social and physical environment, culture, health literacy, support networks, resiliency, genetics, lifestyle and healthcare resources.

1.1.3. Population health incorporates the concepts of population health management and medical management for people across the continuum of healthcare needs. This includes needed primary, secondary, and tertiary prevention throughout that continuum.

1.2. Purpose of Medical Management

1.2.1. The medical management of patients is a collaborative effort between Air Force Medical Home, specialty/ancillary services, and military/community stakeholders to ensure the planning, coordination, and delivery of appropriate healthcare services for wounded, ill, or injured service members as well as other beneficiaries.

1.2.2. Medical management is integrated under the tenets of population health because of shared goals and objectives. It addresses the needs of chronically ill patients as well as those deemed to be at increased risk for chronic or disabling conditions or those who may require care beyond routine primary care. The intent is to improve patient outcomes and to promote the efficiency and effectiveness of the healthcare delivery system. This is accomplished through support of population health, health promotion, and Air Force Medical Home activities and includes coordination of efforts to improve healthcare access and quality of care while simultaneously decreasing cost and variation in care management.

1.2.3. The medical management team is staffed by Health Care Integrators, Disease Managers, Utilization Managers, and Case Managers (including discharge planning and complex care coordination).

Chapter 2

ROLES AND RESPONSIBILITIES

2.1. The Air Force Surgeon General.   Ensures medical resources are planned, programmed, and budgeted to meet population health requirements.

2.2. The Commander, Air Force Medical Operations Agency:

2.2.1. Serves as Office of Primary Responsibility for Air Force population health efforts.

2.2.2. Provides policy guidance for Air Force Medical Service population-based healthcare activities.

2.3. The Air Force Medical Operations Agency Population Health Branch:

2.3.1. Provides subject matter expertise to the Air Force Medical Service for population health.

2.3.2. Develops, validates, recommends, advocates and evaluates strategies to optimize the health of Air Force populations and the healthcare delivery system through a cross-functional team.

2.3.3. Identifies and addresses trends in Air Force population health data and leads process improvement coordination.

2.3.4. Monitors, analyzes, and interprets data and communicates the impact of actions and decisions on Air Force Medical Service beneficiary health.

2.4. The Major Command/Direct Reporting Unit Command Surgeon:

2.4.1. Supports implementation of military medical treatment facility population health efforts, initiatives, and interventions in support of Air Force Medical Service's strategy.

2.4.2. Identifies barriers to implementing Major Command and/or military medical treatment facility population health initiatives and report findings to Air Force Medical Operations Agency Population Health Branch.

2.5. The Military Medical Treatment Facility Commander/Director:

2.5.1. Serves as the installation Office of Primary Responsibility for all population health related initiatives. (T-1).

2.5.2. Monitors and ensures adherence with this instruction within the military medical treatment facility. (T-1).

2.5.3. Maintains an active and effective military medical treatment facility-level Population Health Working Group that directs, monitors, and evaluates population health efforts at the installation level. (T-2).

2.5.4. Designates the Chief of Medical Staff (SGH) in writing to chair the Population Health Working Group. (T-3).

2.5.5. Appoints key military medical treatment facility personnel, both primary and alternate, to serve on the Population Health Working Group. (T-3).

2.5.6. Designates a Medical Management Director in writing to establish and oversee the military medical treatment facility's medical management program activities promoting a targeted, coordinated plan for improving access, cost, quality, and readiness. (T-0). This will generally be the Health Care Integrator. (T-3).

2.5.7. Ensures the military medical treatment facility strategic plan incorporates the annual population health plan. (T-2).

2.5.8. Documents review and approval of the population health plan within the Executive Committee minutes. (T-3).

2.5.9. Ensures organizational planning, support, dedicated resources, and requisite staff training for efficient and effective population health programs including medical management. (T-3).

2.5.10. Advocates and promotes population health initiatives at installation/wing level. (T-3).

2.5.11. Ensures military medical treatment facility personnel complete required orientation and receive annual refresher training on population health principles and programs. (T-3).

2.6. The Military Medical Treatment Facility Executive Committee:

2.6.1. Serves as the oversight body for military medical treatment facility's Population Health Working Group and holds the military medical treatment facility accountable to implement population health and medical management programs that align with Air Force Medical Service goals and objectives. (T-3).

2.6.2. Holds Limited Scope Medical Treatment Facilities accountable to implement population health and medical management programs that align with Air Force Medical Service goals and objectives relevant to the needs of their beneficiary population. (T-3).

2.7. Chief of the Medical Staff (SGH):

2.7.1. Has primary responsibility for oversight of population health efforts and provides clinical and program design guidance to the medical management program. (T-3).

2.7.2. Ensures that medical management activities are conducted in accordance with accepted medical management standards [e.g., Case Management Society of America and URAC® (formerly known as Utilization Review Accreditation Commission)]. (T-3).

2.7.3. Oversees, coordinates, and supervises health care integration, case management, disease management, and utilization management activities, but may delegate direct supervision of medical management staff to the Health Care Integrator. (T-3).

2.7.3.1. Ensures all applicable clinical personnel follow all Interagency Care Coordination Committee policies. (T-3).

2.7.3.2. Ensures appropriate management of service members and veterans requiring complex care coordination. (T-3).

2.7.3.3. Appoints a member of the medical management staff (usually the Case Manager) as the Lead Coordinator (see **paragraph 5.2**) for each service member or veteran requiring complex care coordination. (T-3).

2.7.4. Maintains overall responsibility for the clinical quality and program integrity of the Exceptional Family Member Program-Medical (EFMP-M) in accordance with AFI 40-701, *Medical Support to Family Member Relocation and Exceptional Family Member Program (EFMP).* (T-1).

2.7.5. Ensures development of a population health plan in support of the military medical treatment facility strategic plan. (T-3).

2.7.6. Ensures integration of population health management with other departments and services to optimize healthcare delivery for patients throughout the healthcare continuum. (T-3).

2.7.7. Ensures collaborative processes are in place between Exceptional Family Member Program-Medical, Group Practice Manager, and population health management activities and programs. (T-3).

2.7.8. Champions implementation of Air Force Medical Operations Agency-approved processes ensuring standardized delivery of clinical services (e.g., evidence-based practice, TRICARE Online, secure messaging, clinical preventive services, etc.). (T-3).

2.8. The Chief of Aerospace Medicine (SGP):

2.8.1. Integrates aerospace medicine expertise with population health strategies and ensures aerospace medicine programs and activities incorporate and are aligned with population health management interventions and activities. (T-3).

2.8.2. Represents force health protection programs (e.g., Periodic Health Assessments, deployment health, duty limiting conditions, and Medical Evaluation Boards) to the Population Health Working Group. (T-3).

2.8.3. Collaborates with the Chief of Medical Staff in developing military medical treatment facility instructions for force health protection, health promotion, clinical preventive services, and clinical practice guidelines supporting population health management efforts. (T-3).

2.8.4. Directs epidemiologic surveillance and data analysis in support of installation population health activities. (T-3).

2.9. The Biomedical Sciences Corps Executive (SGB):

2.9.1. Solicits input for population health initiatives from Biomedical Sciences Corps personnel. (T-3).

2.9.2. Disseminates relevant population health initiatives to appropriate Biomedical Sciences Corps personnel for implementation. (T-3).

2.10. The Chief Nurse (SGN):

2.10.1. Ensures allocation of adequate nursing staff to support execution of population health activities. (T-3)

2.10.2. Provides input into the population health plan as needed. (T-3).

2.10.3. Ensures all relevant military medical treatment facility personnel complete required orientation and recurring training on population health and medical management activities,

theory, purpose, and local processes appropriate to their role(s) and documents in the individual's training record. (T-3).

2.10.4. Ensures medical management staff complete required orientation and training appropriate to their role(s) and document in the individual's training record. (T-3).

2.10.5. Collaborates with the Chief of Medical Staff on training, implementation, and use of Tri-Service Workflow templates (or their equivalents) and standardized workflow processes. (T-3).

2.10.6. Ensures nurse peer review includes population health management elements (e.g., clinical practice guideline adherence, clinical preventive services). (T-3).

2.11. The Administrator (SGA):

2.11.1. Provides executive-level leadership integrating business principles toward the goal of safe, effective healthcare and achieving population health objectives and goals. (T-3).

2.11.2. Leads and supports business, financial, and performance planning and oversight of beneficiary services related to population health. (T-3).

2.11.3. Assesses available data (in coordination with the Chief of Medical Services, Chief Nurse, and Chief of Aerospace Medicine) to understand current and future population demands for services, in order to effectively develop population health strategy, planning, programming, budgeting, and execution processes. (T-3).

2.12. The Group Practice Manager:

2.12.1. Supports and collaborates with providers, Health Care Integrators, and clinical/administrative support staff on population health business process goals to most effectively optimize patient care and military medical treatment facility clinical processes. (T-3).

2.12.2. Uses available data sources [in coordination with the Health Care Integrator, Utilization Manager, and Medical Expense and Performance Reporting System (MEPRS) manager] to analyze population demands, facilitate programs to effectively manage utilization of resources and patient utilization of appointments, as well as investigate any suspected inconsistencies between databases. (T-3).

2.12.3. Partners with the Health Care Integrator, primary care manager teams, and other staff members to ensure secure messaging capabilities and utilization are maximized. (T-3).

2.13. The Health Care Integrator:

2.13.1. Will be a licensed registered nurse graduated from a baccalaureate of science in nursing program accredited by a national nursing agency and recognized by the United States (US) Department of Education. (T-3). Will hold and maintain an active, current, valid, and unrestricted license to practice as a Registered Nurse in any US state or jurisdiction. (T-3).

2.13.2. Leads population health management initiatives and integration within the military medical treatment facility and champions population health efforts across community networks. (T-3).

2.13.3. Attends the Health Care Integrator formal training course no earlier than 30 days after, and no later than 4 months after, assuming the Health Care Integrator role. (T-3). Acquires

access to needed data sources and gains familiarity with the military medical treatment facility's enrolled population and population health and medical management programs prior to attending the course. (T-3).

2.13.4. Completes all required training, as directed and outlined by the Air Force Medical Operations Agency, within 3 months of assuming Health Care Integrator role. (T-3). Completes refresher training as updates become available. (T-3).

2.13.5. Ensures collaborative communication processes exist between the primary care and medical management teams. (T-3) Collaborates with medical management staff, and primary/specialty care teams to plan and implement population health strategies. (T-3).

2.14. The Medical Management Director:

2.14.1. Collaborates with the Health Care Integrator, medical management staff, and primary/specialty care teams to plan and implement population health strategies. (T-3). Partners with the Health Care Integrator, and Group Practice Manager(s) to deploy population health strategies that enhance patient care coordination and communication. (T-3).

2.14.2. Designs, plans, develops, implements, and directs medical management programs in collaboration with the Chief of Medical Staff and other stakeholders. (T-3).

  2.14.2.1. Plans and coordinates the work of medical management with all departments and services. (T-3).

  2.14.2.2. Assists in the development and coordination of major medical management policy applications in the military medical treatment facility and the interpretation of Department of Defense, Air Force Medical Service, managed care support contractor, and national accreditation policies and instructions in alignment with mission objectives. (T-3).

2.14.3. Provides clinical supervision and oversight of case management, disease management, discharge planning, and utilization management personnel and their programs as directed by the Chief of Medical Staff. (T-3).

2.14.4. Completes all required training within 3 months of assuming Medical Management Director role as instructed and outlined by the Air Force Medical Operations Agency. (T-3). Completes refresher training as updates become available. (T-3).

2.14.5. Ensures all medical management staff complete required training and report, as needed and requested, to local and higher leadership. (T-3).

2.14.6. Provides or facilitates training to medical management staff on data management and utilization for effective medical management program activities. (T-3).

2.14.7. Ensures medical management staff are trained on documentation requirements and medical coding procedures as appropriate for role. (T-3).

2.14.8. Ensures collaborative communication processes exist amongst members of the medical management team and between the medical management and primary care teams. (T-3). Collaborates with the Health Care Integrator, medical management staff, and primary/specialty care teams to plan and implement population health strategies. (T-3).

2.15. The Disease Manager:

2.15.1. Will be a licensed registered nurse graduated from a baccalaureate of science in nursing program accredited by a national nursing agency and recognized by the United States Department of Education. (T-3). Will hold and maintain an active, current, valid, and unrestricted license as a Registered Nurse in any US state or jurisdiction. (T-3). It is highly recommended to obtain certification by a nationally recognized disease management organization.

2.15.2. Develops and executes appropriate multidisciplinary disease management activities in collaboration with the Chief of Medical Staff, Chief Nurse, Health Care Integrator, Medical Management Director, Behavioral Health Care Facilitator, Case Manager, Utilization Manager, and primary care teams in support of population health and population health management initiatives. (T-3).

2.15.3. Completes all required training within 3 months of assuming Disease Manager role as directed and outlined by the Air Force Medical Operations Agency. (T-3). Completes refresher training as updates become available. (T-3).

2.15.4. Attends the disease management formal training course, if eligible, no earlier than 30 days after, and no later than 4 months after, assuming the role. (T-3). Disease Managers hired prior to inception of the disease management course will attend the course at the earliest opportunity. (T-3). Acquires access to needed data sources and gains familiarity with the military medical treatment facility's enrolled population and medical management programs prior to attending the course. (T-3).

2.15.5. Ensures collaborative communication processes exist between the primary care and medical management teams. (T-3). Collaborates with the Health Care Integrator, other medical management staff, and primary/specialty care teams to plan and implement population health strategies. (T-3).

2.16. The Case Manager:

2.16.1. Will be either a licensed registered nurse or a licensed clinical social worker, graduated from an academic program recognized by a national accreditation agency and recognized by the United States Department of Education. (T-3). Will hold an active, valid, current, and unrestricted license as a registered nurse or licensed clinical social worker in any US state or jurisdiction. (T-0). Will utilize Provider Specialty Code 613 (for Registered Nurses) or 714 (for Licensed Clinical Social Workers). (T-0). It is highly recommended each case manager obtain certification by a nationally recognized case management organization.

2.16.2. Completes all required training within 3 months of assuming Case Manager role as directed and outlined by the Air Force Medical Operations Agency. (T-3). Completes refresher training as updates become available. (T-3).

2.16.3. Acts as patient advocate and liaison with other Department of Defense and community agencies in coordinating services and will provide timely patient status updates to primary care managers and other clinicians as needed. (T-3).

2.16.4. Ensures collaborative communication processes exist between the primary care and medical management teams. (T-3). Collaborates with the Health Care Integrator, other medical management staff, and primary/specialty care teams to plan and implement population health strategies. (T-3).

2.17. Discharge Planner (inpatient facilities only):

2.17.1. Will be either a licensed registered nurse or a licensed clinical social worker, graduated from an academic program that is recognized by a national accreditation agency and recognized by the United States Department of Education. (T-3). Will hold an active, valid, current, and unrestricted license as a registered nurse or licensed clinical social worker in any US state or jurisdiction. (T-0). Will utilize Provider Specialty Code 613 (for Registered Nurses) or 714 (for Licensed Clinical Social Workers). (T-0).

2.17.2. Develops and executes discharge planning activities for the military medical treatment facility. (T-1).

2.17.3. Completes all required training as directed and outlined by the Air Force Medical Operations Agency within 3 months of assuming role. (T-3). Completes refresher training as updates become available. (T-3).

2.17.4. Follows approved discharge planning Clinical Decision Support Tool criteria. (T-3).

2.17.5. Conducts nursing peer reviews as assigned. (T-3).

2.17.6. Ensures collaborative communication processes exist between the primary care and medical management teams. (T-3). Collaborates with the Health Care Integrator, other medical management staff, and primary/specialty care teams to plan and implement population health strategies. (T-3).

2.18. Utilization Manager:

2.18.1. Will be a licensed registered nurse graduated from a baccalaureate of science in nursing program accredited by a national agency and recognized by the United States Department of Education. (T-3). Will hold and maintain an active, current, valid, and unrestricted license as a Registered Nurse in any US state or jurisdiction. (T-0).

2.18.2. Completes all required training as directed and outlined by the Air Force Medical Operations Agency within 3 months of assuming role. (T-3). Completes refresher training as updates become available. (T-3).

2.18.3. Develops the annual utilization management plan for inclusion in the population health plan in collaboration with stakeholders (e.g., Chief of Medical Staff, Chief Nurse, Health Care Integrator, Group Practice Manager, medical management team). (T-3).

2.18.4. Uses data-driven processes to prospectively and retrospectively identify indicators of ineffective or inefficient delivery of care including, but not limited to: high-cost, high-volume, or problem-prone diagnoses, procedures, or services, and high utilization rates for services (e.g., pharmacy, emergency department, and outpatient visits). (T-3).

2.18.5. Ensures collaborative communication processes exist between the primary care and medical management teams. (T-3). Collaborates with the Health Care Integrator, other medical management staff, and primary/specialty care teams to plan and implement population health strategies. (T-3).

2.19. Primary Care Team Provider:

2.19.1. Oversees and champions all population health management efforts and process improvements within the clinical team. (T-3).

2.19.2. Integrates population health management strategies into clinical workflow (e.g., secure messaging, team huddles, Tri-Service Workflow templates (or their equivalents), Military Health System Population Health Portal, etc.). (T-3).

2.19.3. Ensures collaborative communication processes exist between the primary care and medical management teams. (T-3)

2.19.4. Ensures patients receive appropriate clinical preventive services. (T-2).

2.19.5. Implements clinical practice guidelines approved by the Air Force Medical Operations Agency and the Executive Committee of the Medical Staff as appropriate for the population. (T-3).

2.20. Primary Care Team Nurse:

2.20.1. Collaborates with the Health Care Integrator, medical management staff, and primary/specialty care teams to plan and implement population health strategies. (T-3).

2.20.2. Identifies and prioritizes high-risk patients for care coordination or referral to the medical management team for complex care management. (T-3).

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

2.21. Primary Care Team Medical Services Technician.   Reviews patient health history for currency of preventive services, within scope of Career Field Education and Training Plan, in accordance with United States Preventive Services Task Force guidelines, and as approved by the Executive Committee of the Medical Staff. (T-3).

2.22. Health Promotion:

2.22.1. Provides support to commanders and the installation on health promotion strategies that engage, empower, and facilitate populations and individuals to make choices that improve health. (T-3).

2.22.2. Partners with key stakeholders to identify and trend preventive health measures. Identifies at risk subpopulations and implements evidence based interventions to optimize population health. (T-3).

2.22.3. Serves as consultant to community agencies and commanders on policy, social, and environmental factors that affect population health. (T-3).

2.22.4. Connects high-risk populations with additional supportive services, as necessary. (T-3).

2.23. Mental Health:

2.23.1. Provides mental/behavioral health expertise to the Population Health Working Group and to primary care teams as it relates to population health needs. (T-3).

2.23.2. Supports primary care teams by integrating mental health services with primary care delivery and by educating primary care teams on the care coordination/support roles of the Internal Behavioral Health Consultant and Behavioral Health Care Facilitator (if these positions are staffed at the military medical treatment facility). (T-3).

2.23.3. Promotes community-based awareness of mental health conditions and services, and encourages active behavioral change across the installation. (T-3).

2.23.4. Partners with Health Promotion to identify and address lifestyle needs of population using evidence-based social or behavioral health assessments (e.g., Web-based Health Assessment, Deployment-Related Health Assessments, Department of Defense Health-Related Behaviors Survey of Active Duty Military Personnel, Community Needs Assessment). (T-3).

2.23.5. Collaborates with community support networks that provide evidence-based programs to improve comprehensive Airmen fitness and community well-being. (T-3).

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

2.23.7. Ensures collaborative communication processes exist between the mental health and medical management teams. (T-3).

2.24. Dental team:

2.24.1. Provides updates and guidance to Population Health Working Group on dental readiness posture, dental caries (i.e. cavities) rates, and fluoride recommendations. (T-3).

2.24.2. Provides guidance, educational support and clinical care to primary care teams and populations on measures to enhance population dental health [e.g., caries (cavities) prevention, mouth guard use, tobacco cessation]. (T-3).

2.25. Ancillary Services teams (e.g., laboratory, radiology, pharmacy):

2.25.1. Support military medical treatment facility use of standardized processes (e.g., lab/radiology protocols, medication refills/renewals) to implement clinical practice guidelines approved by the Air Force Medical Operations Agency and Executive Committee of the Medical Staff. (T-3).

2.25.2. Supports clinical preventive services outreach efforts (e.g., patient notification for cancer screenings, labs, radiologic procedures). (T-3).

Chapter 3

POPULATION HEALTH MANAGEMENT

3.1. The *Air Force Medical Service Population Health and Medical Management Guide*, **located on the Air Force Medical Service Knowledge Exchange, is an adjunct to this instruction and provides supporting information on the implementation of population health and medical management programs within the Air Force Medical Service.**

3.2. Military Medical Treatment Facility Population Health Working Group

3.2.1. The Population Health Working Group is a multidisciplinary team that exists to develop strategies to address the health and health care needs of the population within its area of influence, e.g. military medical treatment facility empanelment.

3.2.2. The Population Health Working Group will be composed of the following members: (T-3)

3.2.2.1. Chief of the Medical Staff (SGH) (chairperson).

3.2.2.2. Administrator (SGA).

3.2.2.3. Chief of Aerospace Medicine (SGP).

3.2.2.4. Chief Nurse (SGN).

3.2.2.5. Health Care Integrator (facilitator).

3.2.2.6. Group Practice Manager.

3.2.2.7. Air Force Medical Home physician champion.

3.2.2.8. Air Force Medical Home registered nurse.

3.2.2.9. Senior 4N0X0 from Air Force Medical Home Team.

3.2.2.10. Dental officer or senior 4Y0X0 from Dental.

3.2.2.11. Public Health Officer or senior 4E0X0 from Public Health.

3.2.2.12. Mental Health representative (may include mental health provider, Behavioral Health Care Facilitator, Internal Behavioral Health Consultant, prevention specialist [e.g., Family Advocacy Program representative, Alcohol and Drug Abuse Prevention and Treatment], or senior 4C0X0).

3.2.2.13. Health Promotion.

3.2.2.14. Medical Management Director.

3.2.2.15. TRICARE Operations and Patient Administration (TOPA) Flight representative.

3.2.2.16. Military medical treatment facility representative to the Community Action Board.

3.2.2.17. Case management, disease management, utilization management, and/or discharge planning personnel as needed.

3.2.2.18. Ad hoc guests as requested by the chairperson.

3.2.3. The Population Health Working Group will:

3.2.3.1. Monitor progress toward population health plan goals and population health goals within the military medical treatment facility strategic plan. (T-3).

3.2.3.2. Guide primary care clinics, specialty clinics, and ancillary services in the identification, evaluation, and coordination of standardized population health management processes (e.g., patient engagement, team training, integrated community services). (T-3).

3.2.3.3. Develop integral approaches and processes to implement population health initiatives [e.g., clinical practice guidelines, secure messaging, clinical preventive services, standardized Tri-Service Workflow templates (or their equivalents)] in accordance with military medical treatment facility and Air Force Medical Service policies. (T-3). The Chief of Medical Staff will oversee selection, approval, and implementation of standardized evidence-based clinical practice guidelines via the Executive Committee of the Medical Staff. (T-3).

3.2.3.4. Ensure population health initiatives and efforts are evaluated for effectiveness. (T-3).

3.2.3.5. Use the Air Force Medical Service's 6 Critical Success Factors or another evidence-based population health framework, standardized process improvement methodology , and relevant metrics to implement, track, and evaluate the impact and effectiveness of population health initiatives. (T-1). If a population-health framework other than 6 Critical Success Factors is used, it must be based on a valid model and designated within the Population Health Working Group charter. (T-1). The 6 Critical Success Factors are:

3.2.3.5.1. Describe the demographics, needs and health status of the enrolled population.

3.2.3.5.2. Appropriately forecast and manage demand capacity.

3.2.3.5.3. Proactively deliver preventive services to the enrolled population.

3.2.3.5.4. Manage medical and disease conditions of the enrolled population.

3.2.3.5.5. Continuously evaluate the population's health status and the delivery system's effectiveness and efficiency for areas of improvement.

3.2.3.5.6. Energize a total community approach to population health.

3.2.3.6. Assess at least annually for the empaneled population the 12 leading health indicators listed in Enclosure 2, paragraph 4e, of Department of Defense Instruction 1010.10, *Health Promotion and Disease Prevention*. (T-1)

3.2.3.7. Facilitate and monitor use of Adjusted Clinical Group Resource Utilization Band (ACG RUB) and Illness Burden Index tools to assist in the proper empanelment of primary care managers, stratification, and prioritization of patients for targeted population health management interventions. (T-3). These tools may be found online at the Health Care Integrator page of the Air Force Medical Service Knowledge Exchange.

3.2.3.8. Collaborate with the installation Community Action Team and Community Action Board to identify and prioritize community needs and develop, market, and implement community-based health improvement programs impacting those needs. (T-3).

3.2.4. The Disease Manager will track disease management-related data, process and outcome measures, identified opportunities for improvement, and status of process improvement programs, and report this information to the Population Health Working Group. (T-3).

3.2.5. The Chief of Medical Staff will ensure a population health quality monitoring and self-inspection program is in place, to include process and outcome measures, and report results to the Population Health Working Group. (T-3).

3.2.6. The Population Health Working Group will convene at a frequency necessary to guide population health initiatives as determined by the Chair, but no less than 6 times per year. (T-3).

3.2.7. The Population Health Working Group will report to the military medical treatment facility Commander/Director via either the Executive Committee or the Executive Committee of the Medical Staff. (T-3).

3.3. Delivery of Population Health Services

3.3.1. The Chief of Medical Staff will:

3.3.1.1. Ensure use of Tri-Service Workflow templates (or their equivalents) and workflow processes to document continuum of care element requirements for patients at all visits in accordance with AFI 41-210. (T-3).

3.3.1.2. Ensure role-based access to Air Force Medical Service-approved systems (e.g., CarePoint Application Portal, Aeromedical Services Information Management System (ASIMS), electronic health record, etc.) to support healthcare operations. (T-3).

3.3.2. Provider peer review will include elements of population health management (e.g., clinical practice guidelines, clinical preventive services) in accordance with AFI 44-119, *Medical Quality Operations*. (T-3).

3.3.3. The Health Care Integrator will:

3.3.3.1. Use the Air Force Medical Service's 6 Critical Success Factors (see **paragraph 3.2.3.5**), or another framework specifically designated in the Population Health Working Group charter, as a collaborative framework of practice to oversee all military medical treatment facility population health activities and to effectively measure, report, trend, and evaluate the health status of the enrolled population. (T-3).

3.3.3.2. Integrate medical management, force health protection, health promotion, and clinical preventive service processes throughout the continuum of care through leadership, collaborative partnerships with stakeholders, and direct supervision as assigned. (T-3).

3.3.3.3. Partner with stakeholders (e.g. patients, primary care manager teams, disease management, case management, utilization management, ancillary services, Health Promotion, and community partners) in process improvement initiatives to address care gaps, to streamline processes and to identify high-risk populations and streamline processes/programs to address population needs. (T-3).

3.3.3.4. Measure process and outcome goals to validate effectiveness of programs and the care delivery system. (T-3).

3.3.3.5. Support the effective implementation and utilization of Executive Committee of the Medical Staff-adopted clinical practice guidelines across the care continuum to affect the health and healthcare utilization behaviors of the enrolled population. (T-3).

3.3.3.6. Facilitate the Population Health Working Group meeting as directed by the Chief of Medical Staff, attend regularly scheduled military medical treatment facility medical management team meetings, and promote population health initiatives addressed at the Community Action Board and Community Action Team. (T-3).

3.3.3.7. Partner with the Group Practice Manager to collect and analyze population health data. Uses information from analyzed results to predict impact on demand. Manages facility's capacity in response to predicted demand. (T-3).

3.3.3.8. Support primary care teams and medical management staff in identifying training and resource requirements to effectively support population health working group efforts. (T-3).

3.3.3.9. Use available tools [e.g., CarePoint application portal, Periodic Health Assessment questionnaire, Aeromedical Services Information Management System (ASIMS), Biometric Data Quality Assurance Service (BDQAS)] and metrics [e.g., Healthcare Effectiveness Data and Information Set (HEDIS®), Access to Care] to assess health status and healthcare use behaviors of the enrolled population, stratify high-risk groups, identify care gaps, plan and implement process improvements to address gaps, and trend/measure the impact of population health interventions across the care spectrum. (T-3)

3.3.3.10. Encourage the use of the CarePoint application portal and secure messaging capabilities by primary care teams in order to provide proactive care to patients and for self-evaluation and goal monitoring. (T-3).

3.3.3.11. Communicate population health goals and current status to primary care teams and stakeholders through various avenues (e.g., Population Health Working Group, medical management team meetings, Nurse Executive Function meetings, team huddles). (T-3).

3.3.3.12. Document Health Care Integrator-related activities using the "EBDA" Medical Expense and Performance Reporting System (MEPRS) code. (T-3).

3.4. Population Health Management by Primary Care Teams

3.4.1. The primary care team will provide to each patient the appropriate clinical preventive services in accordance with United States Preventive Services Task Force guidelines and the Air Force Medical Operations Agency. (T-1). Patient involvement with medical management services will not alter delivery of recommended clinical preventive services except where the clinical condition directly affects the applicability of the recommendation to the patient. (T-1).

3.4.1.1. Preventive services may be rendered in alignment with recommendations from relevant medical specialty-specific professional organizations, but will be subject to review and approval by the Executive Committee of the Medical Staff. (T-3).

3.4.1.2. Any decision not to render preventive care in accordance with accepted guidelines (e.g. patient refusal of recommended screening) must be documented in the patient's medical record and CarePoint registry to include that the patient was informed of the risks of not receiving the recommended preventive service. (T-1).

3.4.2. The primary care team will integrate population health management strategies into clinical workflow. (T-3). Integration can be accomplished using such methods as secure messaging, team huddles, Tri-Service Workflow templates (or their equivalents), and Military Health System Population Health Portal; this list is not all-inclusive.

3.4.3. The primary care team will implement strategies in collaboration with the Health Care Integrator and the medical management team to optimize the health of its empaneled population. (T-3).

3.4.4. At each visit, the primary care team will use Tri-Service Workflow templates (or their equivalents) to document and track continuum of care elements such as allergies, current medications, supplement use, active medical conditions, surgeries, hospitalizations, family history, social history (e.g., tobacco use, physical activity, alcohol use), objective health measures (e.g., height, weight, blood pressure), and currency of clinical preventive services. (T-3).

3.4.5. The primary care team and the Base Operational Medicine Clinic will ensure the electronic DD Form 2766, *Adult Preventive and Chronic Care Flowsheet*, and DD Form 2766C, *Vaccine Administration Record*, are updated during annual Preventive or Periodic Health Assessment (to include all Deployment Health Assessments), pre-/post-deployment, and prior to Permanent Change of Station for military personnel. (T-2).

3.4.6. All members of the primary care team will champion efforts to enhance the health and well-being of empaneled beneficiaries by identifying and documenting health risks (e.g., tobacco use, sedentary lifestyle, obesity) and providing evidence-based interventions to mitigate these risks. (T-3).

3.4.7. Each member of the primary care team shares responsibility to actively encourage patients to enroll in the secure messaging system. (T-3). The primary care team will use secure messaging as the principal means for non-face-to-face communication with patients. (T-3).

3.4.8. If determined necessary by the military medical treatment facility Commander/Director, the Chief of Medical Staff will develop a military medical treatment facility guideline or policy on the case mix (number/percentage of empaneled patients each provider may have in each Adjusted Clinical Group Resource Utilization Band score) that can be assigned to each provider. (T-3).

3.5. Exceptional Family Member Program-Medical (EFMP-M)

3.5.1. The Chief of Medical Staff will provide oversight, either directly or delegated to the Health Care Integrator, to Exceptional Family Member Program-Medical staff in completion of Exceptional Family Member Program enrollment, Family Member Relocation Clearance procedures, and care of family members with special needs. (T-3). In the event of the Chief of Medical Staff's absence, the military medical treatment facility Commander/Director may designate an interim Chief of Medical Staff to provide these duties.

3.5.2. Exceptional Family Member Program – Medical functions should be co-located with medical management functions whenever possible.

Chapter 4

MEDICAL MANAGEMENT

4.1. The Medical Management Director will:

4.1.1. Develop an annual, interdisciplinary population health plan that incorporates medical management principles in support of the military medical treatment facility strategic and business plans, Population Health Working Group efforts, and Air Force Medical Home team operations. (T-3).

4.1.2. Conduct monthly meetings with the Chief of Medical Staff, Health Care Integrator, Case Manager, Disease Manager, Utilization Manager and Special Needs Coordinator to discuss progress towards medical management goals (e.g., from the population health plan, ongoing process improvement initiatives), complex patient cases, status of referrals to appropriate level of care, and lessons learned. (T-3). These meetings will include the Recovery Care Coordinator as needed. (T-3). Inclusion of the Recovery Care Coordinator will be conducted in accordance with Health Insurance Portability and Accountability Act rules. (T-0).

4.2. Medical Management Activities will be conducted using evidence-based guidelines, whenever available, from Department of Defense, federal, and/or civilian professional organizations as approved by the Executive Committee of Medical Staff. (T-3).

4.3. All Medical Management Staff will obtain role-based access to and training in the use of appropriate medical documentation and tracking systems (e. g., electronic health records, Aeromedical Services Information Management System, CarePoint application portal, Military Health System Population Health Portal). (T-3).

4.4. Medical management staff will provide correct information to the medical management roster and training database on the Medical Management portion of the Air Force Medical Service Knowledge Exchange. (T-3).   The Medical Management Director will review the database monthly for accuracy. (T-3).

4.5. Case Managers, Discharge Planners and Disease Managers will conduct standardized peer review at least quarterly to evaluate appropriate use of resources, timely assessments and interventions, and adherence with clinical and administrative standards to include appropriate coding practices for workload. (T-3). Peer review will follow Air Force Nurse Corps Concept of Operations and results will reported to the Nurse Executive Function. (T-3).

4.6. Medical management staff will document hours worked in the Defense Medical Human Resource System – internet (DMHRSi) using appropriate Medical Expense Performance Reporting System (MEPRS) workload accounting system codes. (T-3).

4.7. Medical management staff will document medical care in the electronic health record using the appropriate Medical Expense Performance Reporting System (MEPRS) code (T-0) and using the appropriate Provider Specialty Codes (for case managers). (T-3).

4.8. Disease Management. The Disease Manager:

4.8.1. Develops and evaluates the annual disease management plan for inclusion in the population health plan in collaboration with stakeholders (e.g., Chief of Medical Staff, Chief Nurse, Health Care Integrator, Group Practice Manager, medical management team). (T-3).

4.8.2. Uses available data sources to identify, assess, and prioritize the needs of targeted subsets of beneficiaries for specific disease management programs. (T-3). Ensures preventive care is included in the disease management plan of care. (T-3).

4.8.3. Proactively implements disease management services for populations with chronic conditions, collaborates with patients in formulating patient-centered goals, and educates individuals and groups based on clinical practice guidelines approved by the Executive Committee of the Medical Staff. (T-3).

4.8.4. Documents disease management-related care provided using the ELAD Medical Expense and Performance Reporting System (MEPRS) code for all face-to-face, telephonic, or TRICARE Online Patient Portal Secure Messaging interactions. (T-3). Coding will include current International Classification of Diseases (ICD), Evaluation and Management (E&M), and disease management-specific Healthcare Common Procedure Coding System (HCPCS) codes and the encounters must be completed and signed within 3 business days. (T-0).

4.8.5. Communicates and collaborates with other members of the healthcare team and managed care support contractor's medical management staff as needed to ensure continuity of care for patients with chronic illness. (T-3).

4.8.6. Tracks and reports healthcare outcomes of individual patients with chronic conditions to applicable primary care teams. (T-3).

4.8.7. Provides a direct person-to-person summary (i.e., verbal communication providing continuity of care and a seamless transfer of information) of patients transitioning to other levels or places of care by providing pertinent information to the receiving healthcare provider (e.g., patient self-management status at graduation from the disease management program to primary care team, or transfer to case management for more sensitive services); document direct person-to-person summary in the electronic health record. (T-3).

4.9. Case Management

4.9.1. The Case Manager will develop an annual case management plan for inclusion in the population health plan in collaboration with stakeholders (e.g., Chief of Medical Staff, Chief of Nursing, Health Care Integrator, Group Practice Manager, medical management team). (T-3).

4.9.2. Case management requests/referrals will be completed within one business day using appropriate case management electronic health record template. (T-3).

4.9.3. For patients meeting case management criteria, an initial assessment will be completed within 5 business days, and a comprehensive plan within 30 days of the initial assessment. (T-3). The comprehensive plan must include, but is not limited to, opportunities, interventions, and expected goals/outcomes to be achieved and actions designed to meet the assessed needs for healthcare, safety, and attainment of patient's health goals as agreed to by the case manager and the patient and documented in the medical record. (T-3).

4.9.4. Patients receiving case management will receive recommended clinical preventive services according to age, sex, and other risk factors, irrespective of involvement in case management. (T-1).

4.9.5. All beneficiaries who meet eligibility criteria will be afforded the opportunity to receive case management services. (T-0). Questions regarding patient eligibility for care will be directed to the health benefits office and the Chief of Medical Staff. (T-0).

4.9.6. The Case Manager will obtain consent to provide case management services from the patient or legal guardian prior to acting on the patient's behalf. (T-3).

4.9.7. Documents care provided in the electronic health record using the "ELAN" Medical Expense and Performance Reporting System (MEPRS) code for all face-to-face, telephonic, or secure message interactions using the current version of the Tri-Service workflow electronic health record template (adult or pediatric, as applicable) for case management. (T-3). This requirement does not apply to primary care team nurses performing occasional case management as part of their regular assigned duties. (T-3). Each patient contact will be documented as an electronic health record encounter completed and signed within 3 business days. (T-3). All patients continuing in case management services will have an encounter note completed no less than once per calendar month. (T-3).

4.9.8. The Case Manager will complete review of case management requests/referrals within one business day using the appropriate case management electronic health record template and will document that the case management referral was received and reviewed. (T-3).

    4.9.8.1. Patients not meeting case management criteria will be referred back to the originator of the referral with suggested alternatives. (T-3).

    4.9.8.2. Patients meeting case management criteria will have an initial assessment completed within 5 business days and a comprehensive plan within 30 days of the initial assessment. (T-3).

4.9.9. The Case Manager will conduct a direct person-to-person summary (i.e., verbal communication providing continuity of care and a seamless transfer of information) whenever there is a transfer of care to other levels or places of care (e.g., another medical facility, agency, or a Veterans Affairs facility) for additional treatment and follow-up. (T-3). Documentation in the patient's medical record will include to whom and how the transfer information was conducted. (T-3).

4.9.10. For wounded, ill, or injured service members, the Case Manager:

    4.9.10.1. Will, after receiving informed patient consent, consult with the member's chain of command and medical team to validate the member's base housing needs. (T-0).

    4.9.10.2. Schedule the housing inspection to accommodate the member's needs, appointments, and physical limitations, but will not conduct the inspection. (T-0).

    4.9.10.3. Provide insight and recommendations to the housing inspector related to pertinent medical and special physical requirements so the housing being provided is safe, accessible, and facilitates the care and recovery of the member. (T-0).

4.9.11. Mental Health Case Management

4.9.11.1. Mental health case management for service members is provided by Mental Health staff as outlined in AFI 44-172, *Mental Health*.

4.9.11.2. Patients with both mental health and medical issues may be co-managed by mental health staff and medical case managers. However, non-service member patients who require case management only for mental health issues may be referred to the managed care support contractor.

4.9.11.3. Patients with both medical and mental health issues may be managed in one of the following ways:

4.9.11.3.1. With a single care plan by the medical case manager as caseload allows.

4.9.11.3.2. By the primary care team (for low acuity patients).

4.9.11.3.3. Referred to the managed care support contractor for both medical and mental health case management.

4.10. Utilization Management.

4.10.1. The Utilization Manager:

4.10.1.1. Performs data analysis and reports to the Chief of Medical Staff on a regular basis per the utilization management strategic plan and requirements of the military medical treatment facility and the Population Health Working Group. (T-3). Reports negative trends requiring immediate attention to the Chief of Medical Staff. (T-3).

4.10.1.2. Educates military medical treatment facility staff on the clinical referral process and the tools available to determine appropriate level of care to achieve optimal patient outcomes. (T-3).

4.10.1.3. Reports identified quality of care issues to the Chief of Medical Staff and/or Quality Manager in accordance with military medical treatment facility policy. (T-3).

4.10.1.4. Conducts inpatient length-of-stay reviews and reports unfavorable trends to the Chief of Medical Staff as needed. (T-3).

4.10.1.5. Evaluates clinical practice patterns and trends and provides feedback to the Chief of Medical Staff and clinical areas. (T-3). Provides orientation and periodic training to the clinical staff as required. (T-3).

4.10.1.6. Identifies and refers potential cases to Disease Manager, Case Manager, Discharge Planner, and Deployment Availability Working Group as appropriate. (T-3).

4.10.1.7. Uses Medical Expense Performance Reporting System (MEPRS) code "ELAU" when documenting in the electronic health record. (T-3).

4.10.1.8. In collaboration with TRICARE Operations and Patient Administration (TOPA) flight, notifies primary care manager of known admissions, discharges and emergency room/urgent care clinic visits. (T-3).

4.10.2. The TRICARE Operations and Patient Administration (TOPA) office will notify the Utilization Manager and appropriate primary care manager of all known hospitalizations. (T-3).

Chapter 5

COMPLEX CARE COORDINATION

5.1. Criteria for Complex Care Coordination

5.1.1. Complex care coordination is a service member/veteran-centered, needs-based system designed to support the recovering service member/veteran and their family or caregiver until the criteria for discontinuation have been met. Enrollment into complex care coordination should occur as early as possible. This model is continued as a service member/veteran transitions from an inpatient to outpatient setting, or is applied directly to outpatient service member/veteran meeting potential "need" criteria outlined below.

5.1.2. Service members/veterans needing complex care coordination may include, but are not limited to, those with multiple, complex, severe conditions such as polytrauma injuries, spinal cord disorders, blindness, amputations, significant burns, complex wounds, traumatic brain injuries, psychological trauma, or other cognitive, psychological, or emotional disorders. Complex care coordination needs may result from either combat or non-combat situations. Additionally, the service member may be medically separated/retired from the military or, in the case of a veteran, be unlikely to highly unlikely to return to independent living or employment. Service members or veterans who do not meet above criteria but would benefit from complex care coordination may be included in this model if resources permit.

5.1.3. The responsibility for assessment of complex care coordination need shall be made by the attending physician in conjunction with other members of the interdisciplinary care management team. (T-0).   This includes the command representative and is usually accomplished during the acute/stabilization stage, but may occur at any time during the course of recovery.

5.2. The Lead Coordinator

5.2.1. Will be designated from the care management team for each service member or veteran who requires complex care coordination. (T-0). Lead Coordinator is a role (not a position) designed to simplify the coordination of care.

5.2.2. Will have primary responsibility for maintaining and communicating the interagency comprehensive plan to the service member/veteran. (T-0).

5.2.3. Responsibilities of the Lead Coordinator are detailed in the Memorandum of Understanding between Department of Veterans Affairs and Department of Defense for Interagency Complex Care Coordination Requirements for Service Members and Veterans, July 29, 2014, as referenced in DoDI 6010.24, *Interagency Complex Care Coordination*.

5.3. Provision of Complex Care Coordination

5.3.1. All service members and veterans requiring complex care coordination will receive an Interagency Comprehensive Plan. (T-0). This plan will be prepared and updated by members of the care management team. (T-0)

5.3.2. Patients receiving complex care coordination will continue to receive all recommended clinical preventive services. (T-1).

5.4. Discontinuation of Complex Care Coordination. Complex care coordination and use of the Interagency Comprehensive Plan continues until the case management team reviews and concurs that one of the following end points is reached. (T-0):

5.4.1. Service member/veteran returns to duty or employment with minimal or no limitations.

5.4.2. Service member/veteran has reached a level of stability making continued formal complex care coordination unnecessary.

5.4.3. Service member/veteran requests discontinuation of services.

5.4.4. Death of service member/veteran or presence of other conditions that make complex care coordination unnecessary.

Chapter 6

LIMITED SCOPE MEDICAL TREATMENT FACILITIES

6.1. Military medical treatment facilities designated as Limited Scope Medical Treatment Facilities will make reasonable efforts to adhere to the requirements within this instruction and identify where resource limitations prevent adherence with any requirement. (T-3). These limitations must be provided to inspectors and/or surveyors prior to or at the beginning of inspection and/or survey activities. (T-3)

6.2. The Limited Scope Medical Treatment Facility is not expected to perform all Population Health Working Group functions, but will ensure the performance of functions relevant to the beneficiary population with guidance from the host military medical treatment facility. (T-3)

DOROTHY A. HOGG
Lieutenant General, USAF, NC
Surgeon General

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

AFPD 40-1, *Health Promotion*, 17 December 2009

AFPD 44-1, *Medical Operations*, 9 June 2016

AFPD 46-1, *Nursing Operations*, 20 March 2018

DoDI 6025.20, *Medical Management Programs in the Direct Care System (DCS) and Remote Areas*, 9 April 2013

AFI 33-360, *Publications and Forms Management*, 1 December 2015

AFMAN 33-363, *Management of Records*, 1 March 2008

AFI 41-210, *TRICARE Operations and Patient Administration Functions*, 6 June 2012

AFI 40-701, *Medical Support to Family Member Relocation and Exceptional Family Member Program (EFMP)*, 19 November 2014

DoDI 1010.10, *Health Promotion and Disease Prevention*, 28 April 2014

AFI 44-119, *Medical Quality Operations*, 16 August 2011

AFI 44-172, *Mental Health*, 13 November 2015

Memorandum of Understanding between Department of Veterans Affairs and Department of Defense for Interagency Complex Care Coordination Requirements for Service Members and Veterans, July 29, 2014

DoDI 6010.24, *Interagency Complex Care Coordination*, 14 May 2015

Prescribed Forms

DD Form 2766, *Adult Preventive and Chronic Care Flowsheet*

DD Form 2766C, *Vaccine Administration Record*

Adopted Forms

AF Form 847, *Recommendation for Change of Publication*

Abbreviations and Acronyms

ACG—Adjusted Clinical Group

AFI—Air Force Instruction

AFMAN—Air Force Manual

AFPD—Air Force Policy Directive

ASIMS—Aeromedical Services Information Management System

BDQAS—Biometric Data Quality Assurance Service

DCS—Direct Care System

DMHRSi—Defense Medical Human Resource System – internet

DoD—Department of Defense

DoDI—Department of Defense Instruction

EFMP-M—Exceptional Family Member Program – Medical

HCPCS—Healthcare Common Procedure Coding System

HEDIS®—Healthcare Effectiveness Data and Information Set

ICD—International Classification of Diseases

MEPRS—Medical Expense Performance Reporting System

OPR—Office of Primary Responsibility

RUB—Resource Utilization Band

SGA—Administrator

SGB—Biomedical Sciences Corps Executive

SGH—Chief of the Medical Staff

SGN—Chief Nurse

SGP—Chief of Aerospace Medicine

TOPA—TRICARE Patient Operations and Patient Administration

Terms

Beneficiary—A person eligible for healthcare services.

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

Case Management—A collaborative process under the population health continuum that assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's healthcare needs through communication and available resources to promote quality, cost effective outcomes

Exceptional Family Member Program—Established by the DoD to identify and serve sponsors with family members who have special needs.

Medical Home—A team-based model of primary care service delivery, led by a primary care manager, which provides continuous, accessible, family-centered, comprehensive, compassionate, and culturally-sensitive healthcare in order to achieve the best outcomes. The medical home focuses on providing or arranging for all the patient's healthcare needs for all stages of life to include, acute care, chronic care, preventive services, and end of life care.

Patient—A person requiring or receiving medical or dental care or treatment.

Population Health—Improving the health of a population by assessing the factors contributing to health status, encouraging healthy behaviors and reducing the likelihood of illness through focused prevention and the development of increased resilience in pursuit of optimal health and well-being.

Population Health Management—Specific activities by a healthcare system to improve the health of its patient population beyond the goals of individual care and treatment; also known as Population Medicine.

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

Primary Care Team—Team led by a healthcare provider who oversees and coordinates the general preventive, diagnostic, and therapeutic care for a particular patient.

Service Member—An active member of an armed service. This includes active duty as well as Guard and Reserve members in an active capacity, but does not include non-active (i.e. retired or separated) sponsors.

URAC®—The organization previously known as the Utilization Review Accreditation Commission.