This instruction implements AFPD 44-1, *Medical Operations* and provides guidance and standards for Air Force Family Health Clinic business practices and support to the Family Health Teams (FHT). This AFI applies to active duty, Civil Service, Air Reserve Component, contract personnel and volunteers working in active duty medical treatment facilities. This AFI does not apply to Air Force Reserve Medical Units, Air National Guard Medical Groups and Aeromedical Evacuation Squadrons. The AFI integrates the principles of population health into daily operations in the health care of the FHT’s enrolled population. It partially implements or supports multiple DOD and Air Force publications including, but not limited to: DODI 6025.20, *Medical Management Programs*, AFI 44-102 *Medical Care Management*, AFI 44-119, *Medical Quality Operations* and AFI 46-101 *Nursing Services and Operations*. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with Air Force Manual (AFMAN) 33-363, *Management of Records* and disposed of in accordance with Air Force Records Information Management System (AFRIMS) Records Disposition Schedule (RDS) located at https://www.my.af.mil/gcss-af61a/afirms/afirms/.

**Application:** Family Health Operations (FHO) becomes effective upon the formal announcement of implementation *Medical Treatment Facility* (*MTF*) by *MTF*, as designated by AFMOA/CC following appropriate training of MTF staff by implementation team. Non-FHO MTFs will not implement the FHO Structure prior to formal designation. Non-FHO MTFs are encouraged, however, to utilize guidance herein to improve processes consistent with current policy guidance which does not involve personnel or structure changes.

This instruction is a new publication and must be reviewed in its entirety.
Submit all supplements to this Air Force Instruction (AFI) to AFMOA to be staffed for approval. Send comments and suggested improvements on **AF Form 847**, Recommendation for Change of Publication, through channels, to AFMOA/SGH, 485 Quentin Roosevelt Rd, Bldg 171, Port San Antonio, San Antonio, TX 78226.

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Chapter 1

OVERVIEW

1.1. Purpose for Family Health Operations (FHO).

1.1.1. Deliver highest quality, evidence-based, patient-centered care to enrolled patients through team-oriented processes, good access, high continuity, communications, prevention, education and coordinated management of disease. Employ this approach to ensure operational readiness and operational health of military members.

1.1.2. Create an innovative, rewarding and productive practice environment that attracts and retains highly qualified, top performing medical professionals.

   1.1.2.1. Utilize to maximum effect the skills of all team members with each team led by a physician.

   1.1.2.2. Emphasize continuous improvement of team processes centered around the principles of the Patient Centered Medical Home (PCMH).

   1.1.2.3. Integrate technological tools into team processes to enhance communications with patients and provide agile tracking of health parameters for individual patients and across the team’s population of patients.

   1.1.2.4. Assure clinical currency and readiness for members of the team.

1.2. Goals of FHO.

1.2.1. Establish the FHT as the Patient-Centered Medical Home for AF beneficiary enrolled family health patients.

1.2.2. Provide optimal patient-centered care for enrolled patients using evidence-based clinical practice grounded in established population health principles.

1.2.3. Establish standard processes, alignment and roles for FHTs as a foundation for continuous improvement focused on the principles of the Patient Centered Medical Home.

1.3. Roles and Responsibilities.

1.3.1. AF Surgeon General (AF/SG).

   1.3.1.1. The office of primary responsibility (OPR) for FHO.

   1.3.1.2. Ensures adequate medical resources are planned, programmed and budgeted to meet FHO requirements.

1.3.2. Assistant Surgeon General for Operations (SG3).

   1.3.2.1. OPR for policy and guidance for FHO.

1.3.3. Air Force Medical Operations Agency (AFMOA).

   1.3.3.1. OPR for overall execution of FHO.

   1.3.3.2. Recommends policy in coordination with military treatment facilities (MTFs) and higher headquarters.
1.3.3.3. Develops FHO requirements and business rules; reviews and updates them at least annually.

1.3.3.4. Provides clinical information management (IM) functional requirements to Healthcare Informatics Branch (SG6H) for population health management and outcomes measurement.

1.3.3.5. Provides an Applied Clinical Epidemiology (ACE) function to develop and deploy decision support techniques and tools utilizing medical informatics platforms in cooperation with AF/SG6. The techniques and tools integrate with clinical workflow and support quality health care as well as continuous improvement of team processes

   1.3.3.5.1. ACE develops and deploys in cooperation with AF/SG6 techniques and tools for communicating information to health care teams and enrolled patients using an array of communication tools such as secure digital messaging. This will support application of evidence-based best clinical practices by medical home teams, enhance the availability of information to patients, and improve the efficiency of communications.

1.3.3.6. Provides clinical analysis support to MTFs for population health outcomes.

1.3.4. MAJCOM Commander (MAJCOM/SG).

1.3.4.1. OPR for execution of FHO at the MAJCOM level.

1.3.4.2. Coordinates with AFMOA and AFMSA on required major policy changes and advise MAJCOM/MTFs on issues related to FHO as appropriate.

1.3.5. Medical Group Commander (MDG/CC).

1.3.5.1. OPR for FHO at the MTF level.

1.3.5.2. Ensures that resources allocated by AF/SG are aligned and utilized IAW this instruction. Ensures that military nurses and technicians assigned to FHTs are assigned for a minimum of 2 years unless prevented by circumstances outside the MDG’s control.

1.3.5.3. Monitors and enforces compliance with this instruction within the MDG.

1.3.6. MDOS Commander (MDOS/CC).

1.3.6.1. Coordinates with SGH, SGN, SGA and MDSS/CC to ensure appropriate facilities and staffing are applied to FHO efforts.

1.3.7. MDSS Commander (MDSS/CC).

1.3.7.1. Coordinates with SGH, SGN, SGA and MDOS/CC to ensure appropriate facilities and staffing are applied to FHO efforts and IAW AFMS Flight Path for the AF Combat Wing Organization.

1.3.8. Medical Group Chief of Medical Staff (SGH)

1.3.8.1. Responsible for clinical leadership of FHO including program development, execution, monitoring and evaluation of MTF FHO.

1.3.8.2. Facilitates continuity of care and staffing. Provides clinical leadership and mentorship to clinical staff; practices in the clinical setting when possible, consistent with
current privileges and scope of practice. Sole waiver authority for changing 90 appointments per week requirement for providers based on local workload issues and maturity of medical home providers with regards to continuity greater than 90% no longer requiring this level of central booking.

1.3.8.3. Specifically responsible for approval of provider schedules and templates. Oversees, in conjunction with the MDOS/CC, Group Practice Manager (GPM), Healthcare Integrator (HCI) and Flight Commander (Flight/CC), FHO procedures pertaining to patient continuity and access, including, but not limited to, appointment availability and booking protocols.

1.3.8.4. Coordinates with Chief Nurse (SGN), Administrator (SGA), MDOS/CC and MDSS/CC to ensure appropriate facilities and staffing are applied to FHO efforts and IAW AFMS Flight Path.

1.3.8.5. Leads MTF Population Health activities and chairs Population Health Function. The SGH ensures enrollment is acuity-based, leveled and matched to individual provider capabilities. Directs clinical aspects of medical management.

1.3.8.6. Responsible for supervision of GPM and Healthcare Integrator (HCI). Oversees Medical Management program to include, but not limited to, Disease Management (DM), Utilization Management (UM) and Case Management (CM).

1.3.8.7. Ensures accomplishment of FHT care coordination meetings; assists HCI in prioritization of care using available databases.

1.3.8.8. Leads clinical aspects of medical management meetings.

1.3.8.9. Responsible for timely development and approval process for CPGs; ensures staff are trained on protocol use (and documentation of training completed) and appropriately utilized/supervised by provider staff.

1.3.8.10. Responsible for review of provider-level metrics with the individual providers IAW this instruction.

1.3.8.11. Responsible for oversight in the development and implementation of disease management programs and supports the organization in delivering clinically appropriate programs.

1.3.8.11.1. In conjunction with disease managers, reviews and approves the disease management plan annually before forwarding to ECOMS for final review/approval.

1.3.9. Chief Nurse (SGN)

1.3.9.1. Collaborates with MDOS/CC, Flight/CC and Senior 4N0 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. Works with squadron commanders, flight/cc, Senior 4N0 Functional Manager and Resource Management Office (RMO) to ensure the Unit Manpower Document (UMD) and Unit Management Personnel Roster (UMPR) accurately reflect current manning and location of nurses and medical technicians in support of FHO structure.

1.3.9.2. Collaborates with SGH, SGA, MDOS/CC and MDSS/CC to ensure appropriate facilities and staffing are applied to FHO efforts.
1.3.9.3. Collaborates with SGH and 4N Functional Manager on development of support staff protocols and algorithms (if used). Ensures appropriate Executive Committee of the Medical Staff (ECOMS) approval is obtained before use of protocols. Ensures protocols meet current nursing standards and scope of care for involved nursing staff and medical technicians, with appropriate training and documentation.

1.3.9.4. Collaborates with SGH to ensure appropriate review and approval of telephone triage decision support tools.

1.3.9.5. Along with the SGH, facilitates selection and implementation of Clinical Practice Guidelines (CPGs).

1.3.10. Medical Group Administrator (SGA).

1.3.10.1. In coordination with MDOS/CC, responsible for facilities and staffing of administrative functions in support of FHO. Leads and tracks contracting efforts for hiring of clinic staff supporting FHO.

1.3.10.2. Responsible for effective facilitation and coordination of MTF patient care activities with Managed Care Support Contractor (MCSC) patient care activities in support of FHO (examples include discharge planning, referral tracking and network urgent care availability in support of continuity).

1.3.10.3. Works with RMO to ensure the UMD and UMPR accurately reflect current authorizations, assigned manning and location of clinic staff in support of FHO structure.

1.3.11. Senior 4N0 Functional Manager.

1.3.11.1. Responsible for establishing and maintaining continuity of technician staff in support of FHT on daily and long term basis.

1.3.11.2. In coordination with SGN and Flight/CC, develops UTC assignments for 4N0s.

1.3.11.3. In coordination with SGN, responsible for development and deployment of technician support staff protocols and algorithms IAW AFI 44-102, 44-119 and 46-101 in support of FHO.

1.3.11.4. Provides clinical leadership and mentorship to enlisted members of FHT; participates in clinical operations when possible in accordance with his/her scope of care.

1.3.11.5. Coordinates FHO activities/functions with Senior 4A0 Functional Manager.

1.3.12. Group Practice Manager (GPM).

1.3.12.1. Responsible for initial development and ongoing modification of provider templates to ensure access and demand management in accordance with this instruction. Works closely with providers to ensure ample provider input based on historic and projected needs of enrolled population.

1.3.12.2. Coordinates all MDSS support functions with MDSS leadership to ensure proper support is provided to execute the operational mission.

1.3.12.3. Acts as advisor to appropriate officer and enlisted Corps consultants to assist in alignment of resources to assure staffing supports the FHO structure.
1.3.12.4. In collaboration with FHT leadership will advise SGA, via the Facility Utilization Board (FUB) process, on space requirements to successfully accomplish FHO IAW FHO structure.

1.3.12.5. Responsible for management of acuity-based enrollment under the oversight of the SGH and in coordination with clinical leadership and Managed Care as appropriate.

1.3.12.6. Appointed Access Manager by MDG/CC. Works in collaboration with providers and clinic leadership to ensure adequate supply of appointments through management of templates, schedules and appointing procedures.

1.3.12.6. Responsible for developing business rules for use of acute care within the MTF and network care to manage excess acute demand as needed (“pop off”). Coordinates plan/changes with Managed Care and MDG executive leadership team.

1.3.12.7. Ensures training of the medical office manager is accomplished. If organized in the same rating chain, GPM will also supervise and rate the medical office manager.

1.3.12.7.1. One 4A0 is earned in the model for all enrolled facilities but an additional 4A0 is earned for more than 10 providers. MTFs can utilize them as front desk receptionists (see duty description in 1.4.6.1.) or as office managers (see duty description in 1.4.6.2.) as they see fit.

1.3.12.8. Supervised and rated by the SGH or Chief GPM.

1.3.12.9. Emphasis will be placed on GPM role. Additional duties will be limited. GPM will remain in the role for two years.

1.3.13. Health Care Integrator (HCI).

1.3.13.1. Responsible for the supervision and training of the disease management, case management and utilization management nurses.

1.3.13.2. HCI, as a MDG asset, will assist with FHO as follows:

1.3.13.2.1. Identifies individual and populations of patients at risk for chronic, complex and co-morbid conditions and provides actionable data from various sources such as the Military Health System Population Health Portal (MHSPHP) data for use by the care coordination team (CM, DM, UM nurses and FHT).

1.3.13.2.2. Directs, in coordination with the FHT leader and SGH as appropriate, DM, CM and UM nurse responsibilities for individual patient care and interaction within the medical management team in support of the FHT to which the patient is empanelled.

1.3.13.3. Supervised and rated by the SGH (except in larger facilities where the HCI is assigned solely to Family Health Clinic; then they will be supervised and be rated by Family Health Flight/CC). If HCI is dual-hatted as SGN, rating will be determined by SGN flight path.

1.3.13.4. Analyzes Military Health System Population Health Portal (MHSPHP) data for trends and provides recommendations to PHF for development of comprehensive population health needs.
1.3.13.5. Along with provider champion, facilitates implementation of new CPGs within the MDG.
1.3.13.6. Works closely with GPM to facilitate optimal functioning of FHO.
1.3.13.7. Acts as an advisor to appropriate officer and enlisted corps consultants to maximize Population Health and Medical Management efforts.
1.3.13.8. Additional duties should be limited as mission allows in order to maintain focus on HCI role.
1.3.13.9. One HCI is earned based on every 12,000 enrollees to the facility.

1.3.14. Disease Management Nurse
   1.3.14.1. Supervised/rated by the HCI.
   1.3.14.2. Develops and executes medical management activities in collaboration with HCI, FHT, SGN and SGH. Provides staff training on DM program and process and on CPG implementation and maintenance. Uses TRICARE Management Activity (TMA) Medical Management Guide as a resource in the performance of these duties.
   1.3.14.3. Identifies, develops and executes appropriate multi-disciplinary disease management activities and interventions as part of the MTF’s disease management plan that is approved by ECOMS.
   1.3.14.4. Identifies, directs and tracks appropriate patients for entry into approved CPGs for management of their specific diseases/conditions.
   1.3.14.5. Educates individuals and groups with chronic conditions IAW CPGs.
   1.3.14.6. Actively participates in team and MTF meetings as required and directed pertaining to disease/medical management.
   1.3.14.7. Provides direct patient care in the execution of outpatient care service as required.
   1.3.14.9. Tracks health care/DM outcomes of individual patients with chronic care conditions.
   1.3.14.10. Certification by the Health Sciences Institute through its Chronic Care Professional certification is highly desirable.

1.3.15. Case Management Nurse.
   1.3.15.1. Supervised/rated by the HCI except in larger facilities that have a Medical Management Director. Medical Management Director is not a separate billet on the UMD. Where identified, it is an additional duty. At those larger facilities the CM nurse will be rated by the Medical Management Director. Identifies individuals with chronic, catastrophic, complex, high utilization, high-risk or high-cost health issues who would benefit from case management services.
   1.3.15.2. Provides case management and/or care coordination to individual patients IAW accepted standards/guidelines. Uses TMA Medical Management Guide as a resource in the performance of these duties.
1.3.15.3. Develops and executes individualized multi-disciplinary care plan in conjunction with patient/family.

1.3.15.4. Coordinates with MTF and civilian medical resources to assure smooth transition, minimizing fragmentation of care.

1.3.15.5. Actively participates in team and MTF meetings as required and directed pertaining to case/medical management to include Care Coordination Team meetings.

1.3.15.6. Educates staff on CM role.

1.4. Family Health Clinic Roles and Responsibilities.

1.4.1. Flight/CC.

1.4.1.1. Responsible for implementation of FHO at the flight level.

1.4.1.2. Coordinates with SGH, SGN, Senior 4N0 Functional Manager and squadron commander(s) to ensure assignment and alignment of clinical staff IAW this instruction.

1.4.1.3. Ensures flight personnel are adequately trained and supervised to maximize clinical currency.

1.4.1.4. Ensures that encounter coding is accomplished in timely manner IAW current standards.

1.4.1.5. Ensures MEPRS (Defense Medical Human Resources System internet [DMHRSi]) coding is completed by all staff and is timely and appropriate IAW current standards.

1.4.1.6. Reviews metrics with clinical staff IAW this instruction.

1.4.1.7. Continues to maintain their own corps-specific clinical competency and currency by performing clinical duties in addition to command responsibilities.

   1.4.1.7.1. For flights equal to or greater than 50 personnel, minimum of 25% of duty time will be spent in corps-specific clinical functions.

   1.4.1.7.2. For flights less than 50 personnel, minimum of 50% of duty time will be spent in corps-specific clinical functions.

1.4.2. NCOIC.

1.4.2.1. Responsible for supervision of enlisted clinical staff and determination of direct supervision and rating chain.

1.4.2.2. Responsible for training and appropriate use of technician protocols within the flight; ensures appropriate documentation of training.

1.4.2.3. Maintains clinical role as medical technician as one of five technicians assigned to an FHT at levels similar to Flt/CC as described in 1.4.1.7.1. and 1.4.1.7.2.

1.4.2.4. Consideration should be given to assigning this individual to a provider with decreased patient enrollment such as Flt/CC to allow time for administrative duties.

1.4.3. Provider
1.4.3.1. The family physician on each FHT will be the clinical team leader. Individual will ensure the daily performance of team huddles, periodic team care coordination meetings to maximize team communication and prioritize care.

1.4.3.2. If there is more than one family physician on the FHT, the senior-ranking physician will be the clinical team leader.

1.4.3.3. Team providers will be responsible for the care of their empanelled patients. They will work directly with GPM to maximize access to allow for care of their empanelled population. Ninety centrally available and unrestricted appointments per week is the minimum number of appointments expected for each provider when available for entire week in the clinic. Appropriate use of walk-in appointments, group appointments, etc. will be utilized to care for empanelled population.

1.4.3.4. Team providers will work directly with the HCI and disease/case management nurses to develop strategies for the care of their patients with more complex disease states. They will be involved in care coordination activities (e.g. Care Coordination Team) as necessary.

1.4.3.5. Team providers will manage their FHT population when their partner is out on leave or TDY. The GPM will work with teams during these times to manage templates to maximize access and distribute acute care IAW this instruction.

1.4.4. Family Health Team Nurse.

1.4.4.1. Will have at least three years nursing experience. Less experience may be waived by AFMOA/SGN on a case-by-case basis. Ambulatory care certification is recommended and preferred. Competency skills for ambulatory practice will be documented in Competency Assessment Folder (CAF).

1.4.4.2. Responsible for nursing care provided to FHT enrolled patients.

1.4.4.3. Will provide care in accordance with accepted clinical practice guidelines, support staff protocols or decision support tools.

1.4.4.3.1. Clinical practice guidelines will be used for disease management of patients with chronic conditions.

1.4.4.3.2. Locally or centrally-developed support staff protocols or algorithms will be used for common, low-acuity diseases/conditions. Protocols that are independent of a provider visit will be coordinated between SGN and SGH then reviewed and approved initially and thereafter annually by the Executive Committee of the Medical Staff (ECOMS). They will contain a training plan, a flow chart of the process (including exclusionary criteria), competency verification (for nurses) or AFTR documentation (for technicians), an AHLTA template and AHLTA questionnaire or SF 600 overprint.

1.4.4.3.3. Decision support tools (DSTs) will be used for management of symptom-based telephone calls. DSTs will be reviewed and approved initially and annually by ECOMS. Training on appropriate use of DSTs will be documented in the nurse’s CAF.

1.4.4.4. Participates in the training of team medical technicians as appropriate.
1.4.4.5. Participates in hands-on patient care and counseling as indicated by the specific patient encounter.

1.4.4.6. Participates in all FHT team huddles and other team building/team training as directed by team lead.

1.4.5. Medical Technician (4N0) or Civilian Equivalent.

1.4.5.1. Participates in patient care encounter in accordance with documented training.

1.4.5.2. Assists provider by obtaining and documenting clinical information during patient encounter. Will utilize AFMOA-approved AHLTA screening/intake workflow algorithms as directed.

1.4.5.3. When trained, may perform and document specific portions of the physical exam as well as procedures in accordance with appropriate support staff protocols or algorithms as described in section 1.4.4.3.2.

1.4.5.4. Required, at times, to perform administrative functions including, but not limited to, staffing of clinical check-in area, record retrieval, management of equipment and supplies, etc., as required.

1.4.5.5. Assists FHT nurse with functions such as contacting patients with normal lab results and other clinical tasks according to support staff protocols. Support staff protocols for this purpose will adhere to use of strict scripting and any encounter that causes deviation from the script will drive care back to the team nurse or provider.

1.4.5.6. Will have access to and working knowledge of the PIMR application to support FHT Force Health Management.

1.4.6. Health Services Management Personnel (4A0) or Civilian Equivalent (see roles and responsibilities in 1.3.12.7.1).

1.4.6.1. Front Desk Receptionist (Recommend GS or Contract).

1.4.6.1.1. Greets the patient.

1.4.6.1.2. Verifies patient identity and eligibility in Defense Eligibility Enrollment Reporting Systems (DEERS).

1.4.6.1.3. Checks in the patient and enters patient information into the Armed Forces Health Longitudinal Technology Application (AHLTA).

1.4.6.1.4. Obtains Third Party Collection Information.

1.4.6.1.5. Identifies patients on Personnel Reliability Program (PRP).

1.4.6.1.6. Verifies patient demographics and directs patient to update in DEERS if required. Will enter any new contact information (minimum phone number) in the COMMENTS section of AHLTA. Note: Demographic information updated elsewhere in AHLTA will be overwritten at next CHCS update with DEERS.

1.4.6.1.7. Determines from patient if visit is injury related; ensure AF Form 1488 is completed if visit is injury related.

1.4.6.1.8. Provides patient with any visit required paperwork and clinic instructions.
1.4.6.1.9. Routes patient to appropriate location for the visit.
1.4.6.1.10. Schedules follow-up visit for patient if required.
1.4.6.1.11. Tracks, or assists with tracking, diagnostic results/route to appropriate PCM/Specialist.
1.4.6.1.12. Assists Office Manager and GPM as needed.
1.4.6.1.13. Trains, as appropriate and assists Medical Technicians (4N0s) in the proper completion and maintenance of paperwork and outpatient medical records.
1.4.6.1.14. Performs other patient administrative functions consistent with the 4A0 skill set as appropriate to the Family Health Clinic setting.

1.4.6.2. Medical Office Manager (recommend military 4A0 (minimum E-5) or GS equivalent (minimum GS-7))
1.4.6.2.1. Assists GPM with identifying and managing patient demand by utilizing historical workload data using tools such as Composite Health Care System (CHCS) or Template Analysis Tool.
1.4.6.2.2. Assists GPM in developing and maintaining provider templates.
1.4.6.2.3. Inputs appointment templates/schedules into CHCS.
1.4.6.2.4. Coordinates patient referrals with Referral Management Center (RMC) if a referral is required. Obtain referral reports from RMC when required and route to appropriate PCM. Note: T-cons to the ordering provider are the usual method by which RMC notifies providers of results. The Office manager may have to obtain paper copies, or route the referral results to the PCM when he or she is not the ordering provider.
1.4.6.2.5. Performs End of Day processing at the end of clinic each day.
1.4.6.2.6. Orders/restocks office supplies as required.
1.4.6.2.7. Coordinates required documentation with appropriate clinical and support functions.
1.4.6.2.8. Aids clinical staff in maintenance of preventive health databases for FHTs.
1.4.6.2.9. Contacts/schedules patients requiring preventive health visits in coordination with HCI.
1.4.6.2.10. Assists RMO in auditing Third Party Collections to ensure maximum MTF reimbursement.
1.4.6.2.11. Supervises, rates and ensures training of the Family Health Clinic front desk personnel.
1.4.6.2.12. Obtaining national Medical Office Specialist Certificate within 12 months of assuming duties is highly encouraged.

1.5. **Family Health Clinic Structure.**
1.5.1. Family Health Team (FHT).
1.5.1.1. Each FHT will consist of 2 providers (military or civilian), 5 medical technicians (4N0 or civilian equivalent) and 1 nurse (46N3 or civilian equivalent). The team lead will be a board certified/board eligible family physician and the second provider will be either a mid-level provider (Physician Assistant or Family Nurse Practitioner), a general medical officer (GMO) or another family physician. If all physician authorizations cannot be filled by board certified/board eligible family physicians, the team lead will be the provider with the greatest level of clinical experience. Care should be taken to balance the military and civilian team to the greatest extent possible.

1.5.1.2. The FHT physician will provide clinical oversight and precepting for the mid-level provider as required. If the physician on the team is a GMO or the team does not have a physician assigned for any reason, assignment for clinical oversight/precepting will be determined locally and divided amongst the available family physicians.

1.5.1.3. At smaller facilities with only two providers, both providers will be physicians. The Air Force Personnel Center (AFPC) and the Family Medicine consultant will make every effort to assign board certified (BC) or residency trained board eligible (BE) family physicians as available manning allows.

1.5.1.4. Patients will be enrolled to providers by name; each provider will act as the Primary Care Manager (PCM) for his/her panel of patients.

1.5.1.5. This team structure is not applicable for family medicine residency clinics and staffing remains as directed by previous models.

1.5.2. Family Health Element (FHE).

1.5.2.1. Each element will consist of 2-4 family health teams.

1.5.2.2. The element leader will be the most qualified individual within the element as determined by the MDOS/CC or designee.

1.5.3. Family Health Flight (FHF).

1.5.3.1. The family health flight will be comprised of all family health elements. At facilities that have a single FHE or possibly single FHT, FH assets may fall under a larger organization within the MDG as directed by the MDG/CC (e.g. Primary Care Flight).

1.5.3.2. The Flight/CC will be the most qualified individual within the flight as determined by the MDOS/CC or designee.

1.5.4. FHT Support Functions.

1.5.4.1. Administrative support, Behavioral Health Optimization Program (BHOP), DM, CM and utilization management (UM) personnel will be considered integral to the FHT in management of Family Health Clinic patients for the purposes of this AFI, regardless of supervision.

1.5.4.2. Administrative support (4A0 or civilian equivalent) authorizations for the Family Health Clinic (FHC) are earned as an initial requirement of 1, with an additional 4A0 (or civilian equivalent) earned for every 10 providers in the FHC.

1.5.4.3. Disease management nursing authorizations are earned based on disease burden for empanelled population to FHC and Internal Medicine Clinic, if present.
1.5.4.4. Case management and utilization management personnel are MDG assets utilized by the FHT in the care of empanelled patients. Authorizations earned are not specific to FHO and not discussed in this instruction.

1.5.5. Space requirements.

1.5.5.1. A minimum of two exam rooms per provider and office space to accommodate two providers, a nurse and five Medical Technicians (4N0s) per FHT.

1.5.5.2. Exam rooms should be configured in standard fashion to enable clinic flexibility and maximal use of space by available providers. Exact location of all team members will be determined locally, as influenced by space constraints, but will ensure that team members are in close proximity.

1.5.6. Special Missions.

1.5.6.1. Preventive Health Assessment (PHA).

1.5.6.1.1. PHA will be managed by Aerospace Medicine IAW AFI 44-170, Preventive Health Assessment.

1.5.6.1.2. The active duty member’s primary assigned provider will continue to be responsible for any face-to-face visit required for PHA. The individual performing this exam may be modified as mission requirements dictate IAW the PHA AFI and PHA business rules.

1.5.6.1.3. Staffing for the PHA cell will be assigned outside of the family health clinic IAW AFI 44-170, Preventive Health Assessment.

1.5.6.2. Personnel Reliability Program (PRP).

1.5.6.2.1. PRP clinics, where they exist, will be aligned under Flight Medicine. The organizational and structure components of this AFI do not apply to these separate PRP clinics.

1.5.6.2.2. If the MTF does not have a separate PRP clinic, PRP patients may be enrolled to Flight Medicine or Family Health as directed by MTF leadership. The PRP program will continue to be managed by the SGP IAW the appropriate AFI.

1.5.6.2.3. If PRP patients are still seen in the family health clinic, enrollment distribution of PRP patients will be determined by MDG/CC. Recommendation would be to minimize number of providers seeing PRP patients on regular basis although all providers will still need to be familiar with PRP and complete MDG training requirements. Recommendation also made that at facilities with larger PRP missions that Competent Medical Authority (CMA) and alternate CMA are on the same FHT when those roles fall to the family health clinic.
Chapter 2
OPERATIONS

2.1. Concept of Operations.

2.1.1. All clinics formerly known as Primary Care, Family Practice or Family Medicine will now be named Family Health Clinic. This clinic will be focused on care for the empanelled population employing evidence-based clinical practice, coordinated team care and prevention. In smaller MTFs where the Family Health Clinic falls under a larger primary care flight, the name of the flight and any subsequent duty titles will remain unchanged.

2.1.1.1. The only exception to this will be clinics associated with Family Medicine Residency programs. To distinguish between the clinics (if separate in the facility), these clinics will be designated the Family Medicine Residency Clinic.

2.1.2. The Family Medicine Physician will be the FHT Lead.

2.1.2.1. Initial requirement (“opening cost”) for all facilities will be two physicians with the goal to assign two board certified/board eligible family physicians as noted in 1.5.1.2.

2.1.3. Patient continuity is an essential feature of the Family Health Clinic as the patient-centered medical home for its empanelled patients.

2.1.3.1. Appointing protocols will be built to maximize continuity with patients appointed to their primary FHT provider and FHT providers appointed with their empanelled population to the maximum extent possible.

2.1.3.2. The process of cross booking patients to other FHC teams should be minimized and done only when there are extended TDYs, deployments or prolonged absences. Action plans need to be developed to anticipate short and long term provider and clinic support staff shortages, (i.e. TDY, leave, illness and deployments). Identify opportunities and implement a process of backfills, (i.e. scheduling of floaters, non-empanelled medical officers/providers, IMAs, etc) to maximize patient continuity.

2.1.4. A minimum of 90 centrally available appointments per week per provider and 360 centrally available appointments per month per provider will be available 30 calendar days out in accordance with ATC Guidelines. For weeks with fewer than 5 duty days (i.e., holiday, family day), the available appointment requirement will be prorated accordingly (i.e., 72 appointments if 4 days, 54 appointments if 3 days, etc.).

2.1.4.1. Centrally available appointments may be booked at all levels to include appointing clerks, TRICARE On-Line (TOL) and clinic personnel with emphasis on minimal booking accomplished by clinic personnel. Number of appointments available on TRICARE-On-Line (TOL) to be in accordance with ATC Guidelines.

2.1.4.2. Providers will not be expected to maintain this level of access during periods of leave/TDY or extended training (e.g. Operational Readiness Exercise [ORE]/Operational Readiness Inspection [ORI], Medical Unit Readiness Training [MURT]) involving an entire day and the MTF level and provider/MTF level appointment metrics will reflect the prorated amount of centrally available appointments based off of available time. These periods of absence will be properly annotated within DMHRSi.
2.1.4.2.1. Providers will be expected to maintain this level of access (schedule additional centrally available appointments on subsequent days) when appointments lost due to events such as staff meetings, training days, etc. less than 1 duty day. Every effort should be made to minimize scheduling of these events during clinic hours. Clinical absences of one duty day or longer (i.e., leave, TDY) will not be “made up” and the required number of available appointments will be prorated accordingly (see 2.1.4).

2.1.4.2.2. Additional appointments needed to maintain above standards may be spread over the week or month as determined by population needs for access.

2.1.4.3. Providers will have the authority, with reasonable lead-time, to adjust their schedule/templates as long as access and available appointment standards are maintained. Routine schedule adjustments will not result in patient cancellations/rescheduling.

2.1.4.4. The appointment availability standards will not apply to Family Medicine Graduate Medical Education (GME) programs. These programs will continue to adhere to standards established by the Accreditation Council for Graduate Medical Education (ACGME).

2.1.4.5. Physicians who provide additional services mandated by AFMS guidance (e.g. Allergy Extender) for the entire MDG population will have the requirement for centrally available appointments prorated accordingly. Consideration should be given to decreasing enrollment for these physicians if panel access is adversely affected.

2.1.4.6. Physicians not involved with residency education but involved with required precepting for formal medical education (i.e. medical students, Phase II PA training program) will have the requirement for centrally available appointments prorated accordingly. Care should be taken to accurately measure the actual time spent precepting in the process of this proration.

2.1.4.7. Providers who have duty limiting conditions that require shortened duty days will have available appointment requirement prorated to account for hours available in clinic.

2.1.5. RVU productivity, using enhanced RVUs, will be maintained at the provider and MTF level in accordance with current fiscal year Business Plan targets.

2.1.5.1. RVU monthly goals will not be prorated as the benchmark average takes leave/TDY into account.

2.1.5.2. RVU productivity standards will not apply to Family Medicine Residency programs. These programs will continue to adhere to standards established by the ACGME.

2.1.5.3. It must be recognized that appointment availability and RVU production are metrics that look at single facets of patient care. Attention must be given to all measures of clinic performance.

2.1.6. Each facility will be responsible for empanelment of 2,500 patients per FHT (two providers), normally resulting in a 1,250:1 ratio for each provider.
2.1.6.1. Flexibility within actual empanelment to individual providers/teams will be allowed as long as the facility maintains an overall average of 2,500 per FHT.

2.1.6.2. Facilities may consider balancing panels within an FHT based on patient acuity/complexity and demand (e.g. family physician 1,150; mid-level provider 1,350), as long as the facility total enrollment achieves a ratio of 2,500:1 per FHT assigned, averaged across the facility.

2.1.6.3. Facilities may also consider balancing panels across FHTs based on additional duties (e.g. element leader 1,000; other clinic providers 1,300) using the same total enrollment requirement.

2.1.6.4. Family Medicine Residency programs will enroll to maximum of 1,050 patients per provider pod (staff physician, PGY-1, PGY-2, PGY-3). Decreased enrollment numbers are based on additional requirements for staff (ward attending, precepting, procedures) and residents (ward duties, clinical rotations outside family medicine) that minimize available clinic time and affect patient access. Balancing of these residency panels and actual enrollment numbers will be based on training guidelines established by the ACGME.

2.1.7. Aggressive template management will be used to enable provider-managed time providing standards for appointment availability are met for the provider.

2.1.7.1. Providers will utilize this time for procedures, high-acuity care, walk-in appointments (as needed), group medical appointments, etc.

2.1.7.2. Providers may also use this time for admin functions (Medical Evaluation Board (MEB)/Review In-Lieu-Of (RILO), Officer Performance Report (OPR)/Enlisted Performance Report (EPR), etc), physical fitness time, personal appointments, etc., as required.

2.1.7.3. At MTFs that offer inpatient care, active duty family physicians will be required to perform inpatient duties (OB care is highly encouraged but not required) within the scope of their credentials. Inpatient rounding may take place during this provider managed time. At locations where a family physician manages the entire inpatient family medicine service (i.e. ward attending or modified hospitalist approach) or there is significant shared inpatient workload, the requirement for centrally available appointments will be prorated accordingly. Care should be taken to accurately measure the actual time spent involved in inpatient care in the process of this proration.

2.1.8. Staff continuity requirements.

2.1.8.1. The goal for technician support of a provider is that the two assigned technicians for that provider will be available and working with that provider on a daily basis. The minimum expectation is that continuity will be maintained between a provider and at least one of his/her assigned technicians for each clinic session.

2.1.8.2. Military unique missions will make this goal difficult to attain 100% of the time. Metrics will measure the availability of technician support and appropriate thresholds will be determined by data from initial test sites.
2.1.8.3. Medical technicians (4N0) will be assigned to the family health clinic for a minimum of 2 years. During that time they should be assigned to the same FHT unless mission performance would be adversely affected by keeping them in place.

2.1.8.4. Nurses will be assigned to the family health clinic for a minimum of 2 years. During that time, they should be assigned to the same role/team unless mission demands dictate otherwise.

2.1.8.5. Each FHT will develop strategies to communicate regularly amongst themselves (e.g. team huddles) to disseminate info, promote team building, etc. In addition to these areas, time will be allotted for process improvement, team training, discussion of team roles, etc. This may be done at the FHT level or flight level (e.g. clinic training at monthly staff meeting).

2.1.9. Maximizing communication is crucial. Coordination and cross-talk between MTF functional areas within and across squadrons on a regular basis is essential and expected. At a minimum, the following cross-talk will occur:

2.1.9.1. MDOS/CC and MDSS/CC will ensure coordination of resources if/when extended hours/weekend clinics are required.

2.1.9.2. MDOS/MDSS cross-talk will occur regularly to streamline processes that affect both squadrons. Issues such as RMC support to FHT in managing administrative referral issues and obtaining network lab and consultation results and TRICARE Operations and Patient Administration (TOPA) support for the FHT are key examples.

2.1.9.3. SGN will oversee workload of the FHT, CM and DM nurses based on empanelled population health needs and ensure backfill to the FHT during team nurse shortages.

2.1.9.4. FHTs will conduct periodic patient panel review to assess the team’s population health efforts. These meetings appropriately include (but not limited to) the FHT, CM nurse, DM nurse, HCI and GPM. Including the SGH at small MTFs would be appropriate. Meetings topics will include access, team population health performance and complex patient management.

2.2. Clinical Operations. This section directs day-to-day operations of the FHT and key interactions with other MTF functions. The following documents should be readily available to all stakeholders as the MTF implements this AFI: “A Guide to Population Health”, “Medical Management Guide”, “The MTF Referral Management Center User’s Guide” and “Air Force Medical Service Policy on Access to Care.” These references will be considered recommended reading for MTF Executive Staff, FHT leaders, GPM, HCI and medical management team members and should be included in their orientation to their FHT role.

2.2.1. FHT Patient Population.

2.2.1.1. The cohort of patients that make the FHT their medical home may not match the enrollment reflected in the MHSPHP for several reasons related to MHSPHP business rules. “Must see” patients such as contractors and Department of Defense Dependent Schools (DODDS) teachers will be included OCONUS. Accurate patient registries are essential to FHO.
2.2.1.2. The HCI, in collaboration with TOPA and the GPM will maintain current patient lists using available databases such as MHSPHP, Integrated Clinical Data Base (ICDB) and CHCS to define the FHT’s patient populations for the purpose of Medical Management and delivery of clinical preventive services (CPS) to medical home patients. This will likely mandate the use of locally developed and maintained databases. The HCI may also use other systems not identified here, that have yet to be developed, if they are approved for use as an AFMS-wide enterprise solution.

2.2.1.3. Medical Home Patients: The MTF Executive Committee, based upon recommendations of the Population Health Function (PHF), must make the determination if there are subsets of enrollees: those who make the MTF their “medical home” (e.g. those who choose to obtain family health care from the MTF) vs. those who are empanelled to the MTF, but obtain their Family Health care elsewhere. The approach to prevention and management of chronic disease differs for these enrollee subsets, particularly in CPS management. “Medical home” patients can be proactively managed through the FHT and become the most accurate population upon which to measure MTF performance. However, the enrollees who do not appear to make the MTF their medical home present a significant challenge to the MTF Executive Committee concerning continued enrollment and proactive vs. reactive management of their care. The MDG Executive Committee Minutes will reflect local policy on this issue at least on an annual basis.

2.2.2. Enrollment (Patients new to the MTF).

2.2.2.1. TRICARE Prime patients initiate the enrollment process in the MTF. Patient transfers can be accomplished in the MTF or online. The actual administrative enrollment is done by the TRICARE Service Center (TSC). Normally, the TSC will also assign the patient to a PCM based on availability of open panels.

2.2.2.2. The FHT, TOPA and TSC will collaborate to make the actual provider assignment.

2.2.2.3. Acuity-Based enrollment: The MTF will actively seek to match prospective enrollee needs with MTF capacity (balanced patient load, specialty mix, individual provider currency). This process must be a collaborative effort between the GPM, TOPA, FHT and any specialty clinics that accept PCM enrollment with oversight provided by the SGH and medical directors for the involved clinics. The mechanism for MTF input to the TSC automatic enrollment-by-name must be coordinated with the Managed Care Support Contractor through an MOU where appropriate.

2.2.2.4. Initial enrollment assessment: The key in this process is a brief Needs Assessment done by the MTF for the purpose of appropriate enrollment only. Initial screening may require record review, however, the minimum record review requirement is a rapid review of the patient’s PIMR or other care summary for level of care required. Further review as described below is based on this initial screen. Further review for needs assessment for the purpose of developing care plans may be delayed until assignment to a PCM is made.
2.2.2.5. The initial medical reviewer will make the determination to schedule an intake evaluation/appointment if indicated by the review or if the prospective enrollee is requesting early access.

2.2.3. Care Plan Development for new enrollees to the FHT.

2.2.3.1. The FHT or medical management team will perform a more comprehensive needs assessment of each new enrollee as soon as possible after assignment to the PCM only if the patient appears to require UM/DM/CM or other complex care.

2.2.3.2. Active Duty Service Member (ADSM) needs assessment is initiated by the PHA cell through review of the latest PHA. The PHA cell will schedule an appointment with the PCM as required.

2.2.3.3. Comprehensive needs assessment for new non-AD enrollees will be accomplished through records review and/or an intake appointment. Early referral to the Medical Management Team as soon as these patients are identified as candidates for DM/UM/CM intervention is appropriate. Care plans range from simply providing Clinical Preventive Services (PHA for ADSMs) to complex care plans requiring significant medical management involving DM/UM/CM-directed care involving multidisciplinary participation. Care plans do not require separate documentation beyond normal AHLTA documentation. Care plan review and updates are required based upon acuity and will be accomplished as part of the medical management process, in AHLTA.

2.2.4. Medical Management (MM) Program.

2.2.4.1. MM is an integrated managed care model that promotes UM, CM and DM. Includes CPG programs as the approach to managing complex patient care by decreasing variation in clinical management. MM ties together clinical and business operations in the FHT to the MTF business plan.

2.2.4.2. The MTF Commander will appoint an officer to establish and oversee coordinated MM activities. This individual will normally be the SGH, but may be another qualified, interested individual from any corps. In all cases, the SGH will provide clinical leadership and consultation.

2.2.4.3. UM is an MTF-wide asset that provides shared support to FHTs.

2.2.4.3.1. UM, in collaboration with FHT, CM and DM nurses, HCI and GPM determine measures to target and manage enrollees and/or processes that relate to high-cost, high-volume or problem-prone diagnoses, procedures, services and beneficiaries who have demonstrated high utilization rates. PHF and AFMOA provide direction and consultation in selecting appropriate measures in relation to the strategic plan and meeting the needs of the MTF. The UM uses TMA Medical Management Guide in performance of these duties.

2.2.4.3.2. UM nurses will collaborate with DMs, CMs and the FHT as active members of medical management and interdisciplinary care meetings, as required, to ensure effective patient utilization of resources.

2.2.4.3.3. UM will make appropriate recommendations to DMs and CMs for high-utilization or high-risk enrollees to be entered into these processes.
2.2.4.3.4. TOPA will provide UM and the appropriate FHT with a daily list of admissions of active duty enrollees, including those in network and other non-federal hospitals. The executive staff will work with the MCSC via specific MOU if necessary, to ensure timely notification of admissions and pending discharges.

2.2.4.3.5. The Referral Management Center (RMC) will function as an integral part of UM processes within the MTF.

2.2.4.3.5.1. The RMC will operate in accordance with the standardized business rules for referrals and authorizations, to include, but not limited to for the purpose of FHO: referral appointing, consult tracking and obtaining results from referred care within 10 business days of the test or consultation.

2.2.4.3.5.2. The RMC will not assume responsibilities the MCSCs are contractually required to provide including but not limited to medical necessity reviews, covered benefit reviews, or network appointing.

2.2.4.3.5.3. The RMC will ensure results of referrals are available to the referring provider within 10 business days of the accomplished provider visit. This will be in writing via fax, secure e-mail, secure web-based applications or AHLTA. MTF executive committee will be actively engaged in solving problems with timely resulting of referrals. This may require close collaboration on a one-on-one basis with the MCSC and individual providers as necessary. Active engagement by MTF professional staff with civilian colleagues such as PCM courtesy privileges at local hospitals in addition to MDG/CC and SGH participation in local medical societies/functions whenever possible provide huge returns in referral management.

2.2.4.3.5.4. The FHT (PCM) will ensure referrals contain adequate information and details for appropriate RMC handling and routing. PCMs will maintain awareness of specialty and ancillary services available within the MTF when accomplishing referrals to the MCSC network, such that only services not available within the MTF are outsourced whenever possible. Awareness of specialty and ancillary services will be assisted by a Capability Report provided by the RMC. PCMs will establish finite episodes of care within their referrals whenever possible. Monitoring these issues is the responsibility of the SGH and are key agenda items for the Executive Committee of the Medical/Professional Staff meeting.

2.2.4.3.5.5. Specialty clinics within the MTF will not routinely screen referrals for acceptance within the MTF. Access will be made adequate to handle in-house referrals under normal circumstances. Chronically inadequate access in a specialty clinic requires MTF leadership involvement at all levels to optimize operations.

2.2.4.4. Disease Management: Disease Managers will be nurses assigned to work under the HCI in support of Medical Management for FHTs.

2.2.4.4.1. The disease manager’s primary responsibility is to develop and execute disease management for the FHT and positively impact their empanelled patients’ disease and chronic condition outcomes in accordance with applicable CPGs when available.
2.2.4.4.2. The disease manager’s secondary responsibility is to support the FHT nurse providing direct outpatient care, as directed. This care includes nursing assessment, planning, implementation and evaluation; tele-health activities; medication administration; nursing procedures; staff and patient education and training.

2.2.4.4.3. The disease manager is required to complete all orientation and training activities required of the disease management role and responsibilities and those required for the clinical nurse role and responsibilities.

2.2.4.4.4. Division of role responsibilities will be ideally coordinated among the disease manager, the FHT and the HCI, but may include SGN and/or SGH input as appropriate.

2.2.4.4.5. The disease manager develops implements and evaluates a disease management program according to the disease management steps as described in the *Medical Management Guide*, DoD TMA, current ed. Disease manager nurses will be trained upon and use current Information Management/Information Technology (IM/IT) tools such as the Complex Patient Management Tool (CPMT), Integrated Clinical Database (ICDB) including the Proactive Patient Management module (PPM) and spreadsheets such as Excel® to manage their cohorts.

2.2.4.4.6. The disease manager documents all patient encounters in accordance with DoD, AF and local policies and guidance to include any established AHLTA AIM forms/templates, MEPRs and coding guidelines.

2.2.4.4.7. The disease manager collaborates with the FHT and the CM and UM on all aspects of Population Health and Disease Management activities. Assists in the development of the MTF Medical Management Plan in support of the Business Plan to ensure there is a process in place for collecting disease management data, monitoring performance, identifying opportunities for improvement and initiating performances improvement programs.

2.2.4.4.8. The disease manager participates in the orientation, education and training of disease management activities for clinical and non-clinical staff. He/she may serve on committees, work groups, task forces at the MTF, or as its representative for other agency taskings.

2.2.4.4.9. The disease manager coordinates and participates in interdisciplinary team meetings, designated MTF meetings and specific medical management, disease management and care coordination meetings. Shares knowledge and experiences gained from own clinical nursing practice and education relevant to nursing and disease management.

2.2.4.4.10. The disease manager is empowered and expected to proactively handle “first call” questions, symptom and problem-based issues for patients with DM protocols, such as requests for medication refills, self care advice, referrals, CPS and acute needs relevant to the DM protocol. These calls can provide an opportunity for patient status validation, patient education and for coordination with CM or UM as necessary.
2.2.5. CPGs are essential tools in DM and as such are integral to the DM support of FHO.

2.2.5.1. The PHF recommends CPGs to the Executive Committee of the Medical Staff (ECOMS), which is the approval body, based on the needs of the MTF and UM data (as outlined in 2.2.4.3.). Implementation will be documented in MTF Executive Committee minutes. AFMOA/SGHC will actively consult in the selection process as requested by the MTF.

2.2.5.2. All AFMS MTFs will select and implement CPGs after a thorough assessment and evaluation of their beneficiary population. The assessment includes, but is not limited to, age, gender, beneficiary category, risk factors and disease burden. Once disease burden is identified, the MTF can select the appropriate CPG.

2.2.5.3. The disease manager will assist with implementation of locally-approved CPGs. DM will work with CPG Champion and CPG Facilitator. CPG Champion will be a credentialed provider who is knowledgeable about the disease process and CPG being implemented. The CPG Facilitator will be knowledgeable about group dynamics so that they can leverage group dynamics to accomplish clinical goals. The CPG Facilitator should also be able to pull data required to measure compliance with timelines during implementation and outcomes following implementation. ECOMS will approve all clinical practice guidelines adapted for MTF use initially and annually.

2.2.5.4. The disease manager (or individual CPG managers) in collaboration with the HCI and FHT will collect and analyze appropriate outcome measures relative to the CPG; the PHF will recommend changes to CPGs where appropriate. AFMOA/SGHC will provide consultation as needed for data analysis, implementation, sustainment and performance measurement of CPGs.

2.2.5.5. Disease managers will document patient care in BGAZ when seeing patients in their DM role. When not working DM role (i.e., backfilling FHT nurse), will document patient care and workload in the appropriate MEPRS code.

2.2.6. CM, like UM, is an MTF-wide activity that provides support to the FHTs based on the latter’s enrollment.

2.2.6.1. CM nurses will collaborate with DMs and FHTs and be active members of interdisciplinary patient care coordination meetings to ensure effective patient case management and care coordination is accomplished.

2.2.6.2. Patients appropriate for Case Management can be identified at any step in the care continuum by any member of the healthcare/care coordination team. These patients may have acute and/or chronic illnesses, complex trauma care needs, combat stress, residuals of traumatic brain injury, community adjustment and social issues, addictions and high utilization of healthcare services. For initial case load determination, the Complex Patient Management Tool (CPMT) can be used to provide rapid assessment of patients with the most apparent need.

2.2.6.3. The case manager will document and code their services in AHLTA using DoD established coding guidelines (reference “Appendix E: Coding Case Management Services”) to track CM services. Use of standardized AHLTA templates is highly recommended.
2.2.6.4. Discharge planning will be managed by the discharge planners or case managers, or the FHT if there is no CM or DP at the MTF. Patients appropriate for case management are often identified at discharge from any inpatient service in the direct care system or in the network.

2.2.6.5. The discharge planner or case manager will begin discharge planning upon admission and update the care plan as discharge approaches. The care plan will include ancillary services and referral management office as necessary. The first follow-up appointment will be given to the hospitalized patient before discharge as an MTF standard.

2.2.6.6. PCMs are highly encouraged to participate in discharge planning by visiting hospitalized patients in their panels. SGH at outpatient facilities will pursue avenues such as “Courtesy Privileges” at local hospitals to facilitate this process.

2.3. Business Operations.

2.3.1. Enrollment.

2.3.1.1. In concert with the FHT, the GPM will work closely with the TOPA flight to ensure the right patient is assigned to the right provider based on acuity of the patient and skill set of the provider (i.e. chronic pain patient requiring long-term narcotics typically best cared for by physician rather than mid-level provider).

2.3.1.2. During in-processing of new patients, complexity and special patient needs will be considered in distribution of patients among providers (acuity balancing, see 2.2.2.2). This determination will typically be performed by MTF personnel at venues such as Medical Right Start, etc.

2.3.1.3. TOPA will inform the GPM and the FHT when trends, such as disproportionate enrollment to specific provider/FHT, are occurring that may affect access within the Family Health Clinic.

2.3.2. Access Management.

2.3.2.1. The GPM and FHTs will develop templates that provide a minimum of 90 centrally available (bookable) appointments per week per provider when the provider is available in clinic the entire week. An entire week is defined as a full five day week, if the provider is out for a full day for any reason; the number of appointments will be prorated accordingly i.e. 72 appointments if 4 days, etc. Type of appointments available will be determined by actual demand of population. Detail codes may be used when needed; however, excess use of detail codes may result in restriction of access. Freezing, blocking or other similar restrictions on the 90 centrally available appointments per week is prohibited but may be used for any appointments over that minimum.

2.3.2.2. The GPM and FHTs should examine population demand on a quarterly basis at a minimum and adjust templates/schedules to match demand.

2.3.2.3. While efforts will be made to avoid cross-booking, during surge operations and extended providers absences i.e. deployments, the remaining providers may need to see patients from other FHTs. GPMs will coordinate with staff and adjust templates to minimize encroachment on provider managed time for these cross-booked patients. Additionally, cross-booking may be required in areas where network acute care is lacking
(e.g., OCONUS) but use should be minimized to exceptional circumstances. When an Independent Duty Medical Technician (IDMT) is seeing patients in the FHC, they will be considered part of the FHT they are working with. Any patients seen by them will not be considered cross-booked.

2.3.2.4. The GPM will provide clinic staff with projected demand by number/types of appointments required to meet demand. Providers will review population demand and work with GPM to construct templates to meet the demand.

2.3.2.5. The MTF will strive for first call resolution when feasible. The key element in this success is having schedules opened 30-45 days out with maximum bookable appointment available.

2.3.3. Schedules.

2.3.3.1. All clinics will establish a minimum staffing threshold for the Family Health Clinic to meet access requirements. Provider schedules should be made well in advance to ensure appointments are loaded in CHCS a minimum of 30 days out. Leaves, TDYs, down days and other time off should be approved and will be coordinated to minimize impact on access. Schedule changes after appointments have been loaded into CHCS should be minimized. The GPM will assist FHT leadership in projecting FHT member absences to ensure adequate access.

2.3.3.2. Time off should be projected as far out as feasible. MTF leadership will establish local policy.

2.3.3.3. Schedule changes will be approved by the Family Health Flight/CC and MDOS/CC as necessary.

2.3.3.4. Patients affected by facility cancelled appointments will be offered a new appointment within access standard based on the date/time of their original request.

2.3.4. Appointing.

2.3.4.1. Telephony system phone tree should reflect design of FHO to ensure patient can expeditiously reach PCM booking clerk for their assigned PCM.

2.3.4.2. Appointment booking guidance will be created to ensure a patient is first booked to their PCM. If PCM is not available the patient should be booked to the other provider on their FHT. Local policies will dictate additional guidance if neither of the FHT providers is available.

2.3.5. Coding.

2.3.5.1. Utilize current coding auditors to ensure coding is accurate. Auditors should communicate positive and negative trends in data and provide training where required to maximize accuracy.

2.3.5.2. Accurate coding is imperative to drive optimal template and appointing management. Accurate coding will ensure proper staffing, clinical mix and supplies/equipment to match the demand of your population. Accurate coding also maximizes third party collections efforts.

2.3.6. MEPRS.
2.3.6.1. Each FHT will be assigned a unique 4-letter MEPRS (BGAx). Given the finite number of available MEPRS codes for use, if the number of teams exceeds the number of available MEPRS codes, two FHT’s will be joined under a single MEPRS code.

2.3.6.2. All personnel assigned to the FHT will use the specific MEPRS code. If work is performed on another team that appropriate code will be used.

2.3.6.3. Cost pooling will only be used for truly “shared” clinic personnel such as 4A personnel assigned.

2.3.6.4. Accuracy of MEPRS data is crucial. Staff needs to record accurate data for hours worked in primary clinical MEPRS. All staff is required to use the proper MEPRS code for activities performed outside their primary clinical MEPRS (e.g. readiness training, fitness time, etc.) and ensure accurate reporting of actual hours for these additional activities.

2.3.6.5. To evaluate the efficiency of time allotted to patient care, all FHT personnel will report FHT-related hours in three DMHRSi subtasks: face-to-face patient care, non face-to-face patient care and non clinical administrative duties performed within the clinic.

2.3.6.6. DMHRSi Subtasks Applicable to all FHT MEPRS codes. The following is an example of the subtask structure for BGAA. The subtasks will be replicated for each MTF MEPRS code.

Task Number: BGAA_DMIS_FF
Task Name: Face-to-Face
Description: Face-to-Face Clinical Care

Task Number: BGAA_DMIS_NF
Task Name: Non Face-to-Face
Description: Non Face-to-Face Clinical Care (Reviewing Labs, Charting, etc.)

Task Number: BGAA_DMIS_NC
Task Name: Non Clinical
Description: Non Clinical Administrative Duties within the Clinic (Flt Meetings, Clinic Mgmt, etc.)

2.3.6.7. Actual hours will be reported for each subtask. Hours reported in the Face-to-Face subtask will accurately represent appointment schedules. Actual hours will also be reported for all other activities that have a unique MEPRS code (refer to your MTF MEPRS Program Manager's facility-unique list of available MEPRS codes).

2.4. Deployment Operations.

2.4.1. Due to the high deployment tempo of family health physicians and mid-level providers, especially physician assistants, it is essential that all Family Health Clinic staff be aligned appropriately in the proper AEF block. Proper AEF block alignment is the responsibility of the MTF and will be worked in close coordination with AF/SG Family Medicine Consultant and other functional consultants as needed. Clinics will work with MTF readiness staff to ensure assets are evenly spread in accordance with the following guidelines.
2.4.1.1. The two providers on the FHT will not be aligned in the same AEF block and to avoid under lap they should be assigned to a non-contiguous block (e.g. Block 1 and 3 or block 2 and 4).

2.4.1.2. Technicians assigned to a specific provider should be assigned to the same AEF block as their provider.

2.4.1.3. Active duty clinic nurses assigned to an FHT should be assigned to the same AEF block as one of the FHT providers.

2.4.2. Consultant Balanced Deployments (CBD) are integral to the current deployment management. To maintain visibility for the AFSC specific consultants, it is the responsibility of the individual and/or MTFs to work though their MAJCOM to inform the consultant of any unique circumstances (i.e. board exams) which would preclude deploying during a specific block in the AEF cycle.

2.4.2.1. The AF/SG Family Medicine Consultant will actively make recommendations regarding the personnel within their control to optimize the placement of the right personnel at the right time in the right location in support of deployed operations, as well as MTF garrison operations.

2.4.2.2. Active management and communication with the MAJCOM and consultant is essential to minimize the impact of deployment on MTF patient care.
Chapter 3

OPERATIONAL MEASUREMENTS

3.1. Operational Metrics.

3.1.1. Continuity of Care.

3.1.1.1. Continuity of care is a cornerstone of quality family medicine. It not only improves patient outcomes but also patient and provider satisfaction with care.

3.1.1.2. The percentage of patients seen by a provider and FHT that are empanelled to them will be measured. Continuity of care will also be measured from the patient’s perspective.

3.1.1.3. This data will be pushed to the MDG/CC and to the individual providers on a monthly basis. This data should be reviewed with clinic staff on a monthly basis with POC to be determined by the MDG/CC. Suggested POC is SGH, GPM or Flight/CC.

3.1.2. Technician Support.

3.1.2.1. Lack of technician support for providers is consistently felt to be the top impediment to delivery of care by family health providers. The FHO model emphasizes the availability of the same two assigned technicians to their provider on a consistent basis.

3.1.2.2. Measurement of technician availability will be via the measure of the ratio of available full time equivalent (FTE) 4N0s to the providers on the team.

3.1.2.3. This data will be pushed to MDG/CC on monthly basis and should be reviewed with clinic staff on a monthly basis. POC is the Flight/CC.

3.1.3. Appointment Availability.

3.1.3.1. Lack of available appointments consistently impedes the ability for patients to achieve first call resolution when trying to make an appointment. Additionally, it also shifts the burden of booking appointments to other clinical staff, most often the nursing staff, which focuses their efforts on clerical tasks rather than currency-based activities.

3.1.3.2. Providers will make available 90 appointments/week in accordance with ATC guidelines when schedules open at the 30-45 day mark. Providers will not be held to this standard for periods of leave/TDY.

3.1.3.3. This data will be pushed to MDG/CC on monthly basis and should be reviewed with clinic staff on monthly basis. POC is the GPM.

3.1.4. Patient Outcome Measures.

3.1.4.1. While all other measures will ultimately contribute to good patient outcomes, the most important current measure of quality patient care is HEDIS derived data.

3.1.4.2. The currently tracked individual HEDIS measures will be combined into a composite score based on national percentile ranks for each of the individual measures and presented as individual and composite scores.
3.1.4.3. These HEDIS scores will be pushed to the MDG/CC on a monthly basis and will be reviewed by the SGH with the providers on a monthly basis. The POC will be determined by MDG/CC but HCI is recommended.

3.1.5. Productivity.

3.1.5.1. RVU production will continue to be measured and pushed to the MDG/CC. This will provide a baseline “snapshot” of productivity but needs to be focused on in context of more important measures such as patient outcomes.

3.1.5.2. Providers will be compared with RVU targets provided by the annual business plan.

3.1.5.3. This data will be pushed to the MDG/CC and should be reviewed on a monthly basis with providers. The POC is to be determined by MDG/CC but SGH, Flight/CC or GPM is recommended.

3.1.6. Patient Satisfaction.

3.1.6.1. Patient satisfaction will continue to be measured via the Service Delivery Assessment (SDA).

3.1.6.2. The MDG/CC will receive SDA reports for all questions and in addition the question that pertains most to the FHT “On a scale of 1 to 5 with 1 being “Completely Dissatisfied” and 5 being “ Completely Satisfied” how would you rate your satisfaction with the provider you saw? (Currently Question #5) will be broken down by provider.

3.1.6.2.1. The results of the SDA for that question will be reviewed with individual provider/team on a monthly basis. The POC will be determined by the MDG/CC, although the SGH or Flight/CC is recommended.

3.1.7. Case Mix Index.

3.1.7.1. Maximizing scope of practice and currency is an important focus of FHO. This index will measure a combination of complexity of patients seen (ICD-9 codes), procedures accomplished (CPT codes) and the amount of care rendered at each encounter (E&M codes).

3.1.7.2. Many variables that affect this index are outside of the control of the individual provider. As such, this measure is seen as a way to look at a provider’s individual practice before and after implementation of FHO. No comparison between MTFs or even between providers at the same MTF is intended with this measure.

3.1.7.3. This data will be pushed to the SGH via provider push reports on a monthly basis. This data will be reviewed by the SGH with individual providers on a monthly basis. Recommended POC is the SGH.

3.1.8. Network Care.

3.1.8.1. While the goal of PCMH is to deliver care for all of our empanelled patients’ needs, there will be times when use of network emergency room or acute/convenience care is needed and in fact may be appropriate.
3.1.8.2. Use of emergency room/acute care/convenience care by empanelled population will be measured at the BGA level and will also include measure of urgent care and emergency department utilization within the MTF, if applicable.

3.1.8.3. This data will be pushed to the MDG/CC on a monthly basis and should be reviewed with clinic staff on a monthly basis. POC is the GPM.

3.2. Inspections.

3.2.1. The Air Force Inspection Agency (AFIA) may perform a Health Services Inspection (HSI) of essential components of FHO 90 days after formal implementation of FHO.

3.2.2. MTFs are not to be inspected on FHO until designated as FHO sites by AFMOA/CC. Until such designation, MTFs will continue compliance with current “PCO” HSI checklists.

3.2.3. AFMOA FHO implementation team will coordinate HSI FHO inspection checklists with AFIA prior to formal implementation.

3.2.4. FHI test MTFs will continue to be inspected according to current HSI checklists; discrepancies during interim inspections that appear to be caused by FHI testing will be coordinated with AFMOA prior to assessment.

CHARLES B. GREEN,
Lieutenant General, USAF, MC, CFS
Surgeon General
Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References
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AFI 44-102, Medical Care Management, 1 May 2006
AFI 44-119, Medical Quality Operations, 24 September 2007
AFI 44-170, Preventive Health Assessment, 10 December 2009
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Abbreviations and Acronyms
ACGME—American College of Graduate Medical Education
AEF—Air Expeditionary Force
AFIA—Air Force Inspection Agency
AHLTA—Armed Forces Health Longitudinal Technology Application
AFMOA—Air Force Medical Operations Agency
ATC—Access to Care
BC—Board Certified
BE—Board Eligible
BGA—MEPRS code indicating Family Health Clinic place of care
BHOP—Behavioral Health Optimization Program
CAF—Competency Assessment Folder
CDM—Constant Deployer Model
CHCS—Composite Health Care System
CM—Case Manager; Case Management
CMA—Certified Medical Assistant
CPG—Clinical Practice Guidelines
CPMT—Complex Patient Management Tool
CPS—Clinical Preventive Services
DEERS—Defense Eligibility Enrollment Reporting System
DM—Disease Manager; Disease Management (Not Diabetes Mellitus in this AFI)
DMHRSi—Defense Medical Human Resources System internet
DODDS—Department of Defense Dependent Schools
DST—Decision Support Tool
ECOMS—Executive Committee of the Medical Staff
EPR—Enlisted Performance Report
FHC—Family Health Clinic
FHE—Family Health Element; two to four FHTs
FHF—Family Health Flight
FHI—Family Health Initiative; the development and testing process for FHO concept
FHO—Family Health Operations
FHT—Family Health Team; the basic clinical operating unit in FHO
FUB—Facility Utilization Board
GME—Graduate Medical Education
GMO—General Medical Officer
GPM—Group Practice Manager
HCI—Health Care Integrator
HEDIS—Healthcare Effectiveness Data and Information Set
HSI—Health Services Inspection
ICDB—Integrated Clinical Data Base
IDMT—Independent Duty Medical Technician
MCSC—Managed Care Support Contractor
MDG—Medical Group
MEPRS—Medical Expense and Performance Reporting System
MDOS—Medical Operations Squadron
MDSS—Medical Support Squadron
MEB—Medical Evaluation Board
MHS—Military Health System
MHSPHP—Military Health System Population Health Portal
MM—Medical Management
MOU—Memorandum of Understanding
MTF—Medical Treatment Facility
MURT—Medical Unit Readiness Training
OCONUS—Outside Continental United States
OPR—Office of Primary Responsibility or Officer Performance Report
ORE—Operational Readiness Exercise
ORI—Operational Readiness Inspection
PCM—Primary Care Manager
PCMH—Patient Centered Medical Home
PCO—Primary Care Optimization
PHA—Periodic Health Assessment
PHF—Population Health Function
PIMR—Preventive Health Assessment and Individual Medical Readiness
POC—Point of contact
PPM—Proactive Patient Management
PRP—Personnel Reliability Program
RILO—Review In Lieu Of (MEB)
RMC—Referral Management Center
RMO—Resource Management Office
RVU—Relative Value Unit
SGA—Medical Group Administrator
SGH—Chief of the Medical Staff
SGN—Chief Nurse
SGP—Chief of Aerospace Medicine
TDY—Temporary Duty
TOL—TRICARE on LINE
TOPA—TRICARE Operations Patient Administration
TSC—TRICARE Service Center
UM—Utilization Management
UMD—Unit Manpower Document
UMPR—Unit Management Personnel Roster

Terms

Administrator (SGA)—Medical Service Corps who defines resources and facility requirements; secures and manages medical resources and information; limits institutional risk; establishes and maintains external organizational relationships essential for health care operations.

Air Force Medical Operations Agency (AFMOA)—oversees execution of the Air Force Surgeon General policies supporting Air Force expeditionary capabilities, healthcare operations
and national security strategy. It provides expert consultative leadership support to 75 military treatment facilities and eight major commands to ensure cost-effective, modern and prevention-based healthcare.

**Chief Nurse (SGN)**—The senior nurse at the MTF appointed by the MTF/CC to oversee all nursing care at the installation.

**Chief of the Medical Staff (SGH)**—The medical provider at the MTF appointed by the MTF/CC to oversee all clinical care at the installation.

**Case Management**—A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes.

**Case Mix Index**—Measurement of the complexity of patients seen.

**Disease Management**—A system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant. It is the process of reducing healthcare costs and/or improving quality of life for individuals by preventing or minimizing the effects of a disease, usually a chronic condition, through integrative care.

**Decision Support Tools**—Tools that are used by Registered Nurses to facilitate comprehensive telephonic assessment of patients and placement in appropriate level of care; tools that facilitate telephone triage of patients.

**Family Health Operations**—A model for PCMH in the Family Health Clinics in the AFMS.

**Family Health Team**—A group of staff that is responsible for healthcare of a panel of patients. Normal team composition consists of two providers, one nurse and five medical technicians caring for empanelment of 2500 patients.

**Family Health Element**—Two to four family health teams.

**Family Health Flight**—All family health elements.

**Group Practice Manger (GPM)**—Measures/analyzes clinical processes with emphasis on improving product line performance. Functions as the clinic business manager and MTF access manager.

**Healthcare Informatics Branch**—supports Air force General’s requirements for information technology and management.

**Health Care Integrator (HCI)**—Leads assigned teams in population health initiatives that integrate all aspects of care along the health continuum.

**Healthcare Effectiveness Data and Information Set (HEDIS)**—A tool used by more than 90 percent of America's health plans, including TRICARE, to measure performance on important dimensions of care and service.

**Medical Group (MDG)**—The base-level organization responsible for the coordination and delivery of health care services to eligible beneficiaries.

**Medical Management**—An integrated managed care model, consisting of case management, disease management and utilization management.
Military Treatment Facility (MTF)—A DoD health care provision location, whether clinic or hospital.

Operational Metrics—Tools to monitor the status/performance of day-to-day operations of the Family Health Clinic.

Patient Centered Medical Home (PCMH)—A health care setting that facilitates partnerships between individual patients, their personal physicians and when appropriate, the patient’s family. 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 in a culturally and linguistically appropriate manner.

Referral Management Center—Area of the clinic that functions to specifically appoint, track and obtain results for care referred outside of the Family Health Clinic.

Utilization Management—The evaluation of the appropriateness, medical need and efficiency of health care services procedures and facilities according to established criteria.

Unit Manpower Document (UMD)—A planning and programming document depicting the MTF allocations by job code, grade and location of the “space”.
## CITATIONS USED IN PUBLICATION

Table A2.1. Citations Used In Publication.

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