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Medical

***PATIENT CENTERED MEDICAL HOME
OPERATIONS***

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This publication implements Air Force Policy Directive (AFPD) 44-1, *Medical Operations*. It provides guidance and procedures on Patient Centered Medical Home Operations for Air Force Family Health, Pediatric, Internal Medicine, and Flight and Operational Medicine Clinics, and to primary care Graduate Medical Education (GME) Programs (Family Health, Pediatric, and Internal Medicine). It applies to individuals at all levels who provide primary care services to beneficiaries in active duty medical treatment facilities. This AFI does not apply to Air Force Reserve Medical Units, Air National Guard Medical Groups, or Aeromedical Evacuation Squadrons. 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 AF Form 847, *Recommendation for Change of Publication*; route AF Forms 847 from the field through the appropriate chain of command. 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 the Air Force Records Disposition Schedule (RDS) located in the Air Force Records Information Management System (AFRIMS), or any updated statement provided by the AF Records Management office (SAF CIO/A6X). 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 compliance items publications. The use of the name or mark of any specific manufacturer, commercial product, commodity, or service in this publication does not imply endorsement by the Air Force.

SUMMARY OF CHANGES

This document has been substantially revised and must be completely reviewed. The content has been significantly reduced and tiered to identify waiver authority for unit level compliance items. Content that outlines outdated roles and responsibilities has been removed.

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Chapter 1

PROGRAM OVERVIEW

1.1. Purpose for Patient Centered Medical Home (PCMH) Operations.

1.1.1. To deliver the highest quality, evidence-based, patient-centered care to enrolled patients through team-oriented processes, enhanced access, improved provider continuity, superior communications and coordinated prevention, education, and management of patients. This approach will provide operational health and readiness for all military members and promote optimal clinical currency for the members of the team.

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

1.1.2.1. To utilize to maximum effect the skills of all team members.

1.1.2.2. To emphasize continuous improvement of team workflow processes and patient flow. PCMH operations integrate technological tools to enhance communications with patients and provide agile tracking of health parameters for individual patients and across the population of patients.

1.2. Goals of PCMH.

1.2.1. Establish the Medical Treatment Facility (MTF) as the Medical Home for enrolled beneficiaries.

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, clinic alignment, roles for health care team members, and continuous improvement to execute the principles of PCMH.

1.3. Core Principles of PCMH.

1.3.1. There are seven core principles of PCMH: patients will have a personal provider, the provider will direct the medical practice, the team will care for patients in a whole person orientation, patient care will be coordinated/integrated, quality of care and patient safety are paramount, the team will provide enhanced access, and payment will be reformed. In addition, medical homes will consistently measure and seek to improve performance within the core principles through innovation and continuous quality improvement initiatives.

Chapter 2

ROLES AND RESPONSIBILITIES

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

- 2.1.1. Serve as the office of primary responsibility for PCMH Operations.
- 2.1.2. Ensure adequate medical resources are planned, programmed, and budgeted to meet requirements.

2.2. Director, Medical Operations and Research (AF/SG3/5) ensures: policy and guidance are in place for PCMH Operations.

2.3. Air Force Medical Operations Agency/Patient Centered Medical Home Branch (AFMOA/SGHC) shall:

- 2.3.1. Serve as the OPR for execution of PCMH Operations.
- 2.3.2. Recommend policy in coordination with MTFs and higher headquarters.
- 2.3.3. Develop PCMH requirements and business rules; reviews and updates them at least annually. Update may be based upon input from MTFs, MAJCOM/SGs, Air Force Inspection System data analysis, and other sources.
- 2.3.4. Provide clinical information management (IM) functional requirements to Defense Health Agency (DHA) Healthcare Informatics Branch for population health management and outcomes measurement for PCMH operations.
- 2.3.5. Provide PCMH clinical analysis support to MTFs.
- 2.3.6. Provide Clinical Decision Support (CDS) functions to develop and deploy techniques and tools utilizing medical informatics platforms in cooperation with DHA Healthcare Informatics Branch. These techniques and tools will integrate with clinical workflow processes and will support quality health care and continuous improvement by applying evidence-based clinical practices, enhancing the availability of information to staff and patients, and improving the efficiency of communications.

2.4. MAJCOM Surgeon (MAJCOM/SG) shall:

- 2.4.1. Serve as the OPR for MAJCOM level execution of PCMH.
- 2.4.2. Coordinate with AFMOA/SGHC and Air Force Medical Support Agency (AFMSA) on required major policy changes.
- 2.4.3. Advise MAJCOM/MTFs on issues related to PCMH as appropriate.

2.5. Medical Group Commander (MDG/CC) or equivalent:

- 2.5.1. Shall serve as the OPR for execution of PCMH at the MTF level, (T-2).
- 2.5.2. Will ensure that resources allocated by AF/SG for PCMH operations are utilized in accordance with (IAW) this instruction, (T-3).

2.5.3. Will ensure that PCMH personnel are assigned to PCMH positions where they are earned and remain in place for no less than two years, **(T-3)**. If local mission dictates otherwise, the MDG/CC will make the final decision.

2.5.3.1. Time spent on deployment, or wing mandatory duties such as “Honor Guard” do not count toward fulfilling this two year requirement.

2.5.3.2. The MDG/CC must approve any “matrixing” of staff assigned against a PCMH authorization into other duties, (e.g. moving PCMH staff to Wing Exec duty, UDM, etc.) and ensure that these decisions are documented in the MTF Executive Committee Minutes, **(T-3)**.

2.5.4. Will monitor and enforce compliance with this instruction within the MTF. **(T-2)**.

2.5.5. Will ensure clinic staffs work at their maximum ability of their skill set and training to maintain clinical currency, **(T-3)**.

2.5.6. Will ensure Medical Operations Squadron Commander (MDOS/CC), Chief of Medical Staff (SGH), Chief Nurse Executive (SGN), Medical Group Administrator (SGA), Aerospace Medicine Squadron Commander (AMDS/CC) and Medical Support Squadron Commander (MDSS/CC) coordinate with each other to provide appropriate facilities, resources, and staffing to PCMH efforts and are IAW Air Force Medical Service (AFMS) Flight Path for the AF Combat Wing Organization and this AFI, **(T-3)**.

2.5.7. In collaboration with the SGH, SGA, SGN, and squadron commanders, locates the GPM, HCI and Medical Management personnel within or in close proximity to the PCMH Clinics to maximize their support.

2.6. Medical Group SGH:

2.6.1. Shall provide clinical leadership and guidance of the MTF PCMH clinical operations including program development, execution, monitoring, and evaluating, **(T-3)**.

2.6.2. Guides and advises the SGP, squadron commanders and appropriate functionals on continuity of care and PCMH clinic staffing.

2.6.3. Practices in the clinical setting consistent with current privileges and scope of practice.

2.6.4. Oversees, in conjunction with the Squadron Commanders, Chief of Aerospace Medicine (SGP), Group Practice Manager (GPM), Healthcare Integrator (HCI) and Flight Commanders, PCMH procedures pertaining to patient continuity and access, including, but not limited to, appointment availability and booking protocols.

2.6.4.1. Maintains general oversight of provider templates and schedules, in conjunction with Squadron/CCs, SGP, GPMs, HCI, and Flight Commanders/Flight Chief to provide appointment availability.

2.6.4.2. In coordination with Squadron/CC, Flight Commanders, the GPM, and the Access to Care Function, provides local waiver authority for increasing or decreasing 90 appointments per full week per Family Health or Pediatric provider requirement based on local workload issues, experience/clinical capability of providers, inpatient/currency requirements, mission essential functions (i.e. overseas clearance, deployment health), and/or provider contract limitations, **(T-3)**. Ensures appointment availability to meet patient demand for all other primary care clinics, **(T-3)**.

2.6.4.3. Will document any decision to increase or decrease appointment availability in MTF Executive Committee or Executive Committee of Medical Staff (ECOMS) minutes. **(T-3)**. MTFs should identify situations that require appointment increases or decreases on a frequent basis and develop a policy letter, **(T-3)**.

2.6.5. Will ensure provider team panels are acuity-based, leveled, and matched to individual provider capabilities, **(T-3)**.

2.6.6. Ensures appropriate medical management personnel attend PCMH care coordination meetings at the team level on a regular basis, **(T-3)**.

2.6.7. Assists HCI and Medical Management (MM) nurses in patient care prioritization.

2.6.8. Will ensure timely adoption, training, and utilization of evidence-based Clinical Practice Guidelines (CPGs) within the MTF IAW AFI 44-175, *Clinical Medical Management Programs*, **(T-3)**.

2.6.9. Shall provide support and advice in the timely adoption, training, and utilization of secure messaging as the preferred method of communication with patients in all primary care clinics except Flight and Operational Medicine, **(T-3)**.

2.6.10. Will review provider-level PCMH metrics (e.g. Continuity, Patient Satisfaction, etc.) with individual providers on a monthly basis IAW this instruction. **(T-3)**. SGH may utilize CarePoint Application Portal Medical Home Performance Indicator metrics to accomplish this.

2.6.11. Shall ensure that the identified PCMH metrics are tracked and presented to MTF leadership on a monthly basis, **(T-3)**.

2.7. Medical Group SGP:

2.7.1. Will provide operational leadership and oversight of PCMH mission support operations including program development, execution, monitoring, and evaluating, **(T-3)**.

2.7.2. Facilitates Flight Medicine continuity of care and PCMH clinic staffing in collaboration with squadron commanders, Chief of Medical Staff (SGH), and appropriate functional.

2.7.3. Practices in the clinical setting consistent with current privileges and scope of practice.

2.7.4. Shall advise the SGH about building clinic panels based on operational/occupational risk, **(T-3)**.

2.7.5. Oversees, in conjunction with squadron commanders, SGH, GPM, HCI, clinic flight commanders, development of mission-essential tasks/activities for line support (METALS) for clinical teams caring for Airmen.

2.7.6. Will ensure accomplishment of Flight Medicine PCMH care coordination meetings (1041 meeting) at team level on a regular basis to include appropriate medical management personnel as needed, **(T-3)**.

2.8. Medical Group SGN:

2.8.1. Collaborates with Squadron/CCs, Flight Commanders and Senior 4N0 Functional Manager for the orientation, training and allocation of nursing and medical technician resources IAW this instruction and AFI 46-101, *Nursing Services and Operations*.

2.8.2. Collaborates with SGH, SGA, MDOS/CC, AMDS/CC and MDSS/CC to provide appropriate facilities, resources, and staffing to PCMH efforts.

2.8.3. Works with Squadron/CCs, Flight Commanders/Flight Chiefs, Senior 4N0 Functional Manager, and Resource Management Office (RMO) to routinely update the Unit Manpower Document (UMD) and Unit Management Personnel Roster (UMPR) to accurately reflect current manning and duty location of nurses and medical technicians in support of PCMH structure, **(T-3)**.

2.8.4. Will ensure that all PCMH nursing staff are working to the full extent of their scope of practice and training, **(T-3)**.

2.8.5. Will ensure all PMCH staff understand their role in and utilize the following:

2.8.5.1. Team application of enhanced access tools such as AFMOA-approved Support Staff Protocols (SSP), Nurse Advice Line (NAL), etc. **(T-3)**.

2.8.5.2. Timely training, adoption, and utilization of centralized NAL within the MTF (Applies to CONUS only), **(T-3)**.

2.8.5.3. Secure messaging, **(T-3)**.

2.8.5.4. Clinical Practice Guidelines (CPGs), **(T-3)**.

2.8.5.5. CarePoint Application Portal tools, **(T-3)**.

2.8.5.6. Tri-Service Workflow (TSWF) forms and tools, **(T-3)**.

2.9. SGA:

2.9.1. Shall be responsible, in coordination with MDOS/CC, AMDS/CC, and MDSS/CC for facilities, resources, and staffing of administrative functions in support of PCMH, **(T-3)**.

2.9.2. Shall lead and track contracting efforts in conjunction with appropriate Squadron/CCs for hiring of clinic staff supporting PCMH and will coordinate with the SGH, SGN and Senior 4N0 Functional Manager to ensure any contract clinic personnel have appropriate skills to perform duties in PCMH, **(T-3)**.

2.9.3. Facilitates effective communication and coordination of MTF patient care activities with TRICARE Regional Contractor (TRC) in support of PCMH team processes (examples include discharge planning, referral tracking, and network urgent care availability).

2.9.4. Will work with RMO to accurately reflect current authorizations, assigned manning, and location of clinic staff in support of PCMH structure on the UMD and UMPR, **(T-3)**.

2.10. Senior 4N0 Functional Manager:

2.10.1. Will establish and maintain continuity of 4N0, Licensed Vocational Nurse (LVN), and Licensed Practical Nurse (LPN) staff in support of PCMH teams on both daily and long term basis, **(T-3)**.

2.10.2. In coordination with SGN, Flight Chief/NCOIC, will assign 4N0s to Unit Type Codes (UTC), **(T-3)**.

2.10.3. Coordinates appropriate skill level balance for in-garrison operations and deployment requirements.

2.10.4. Provides clinical leadership and mentorship to 4N0 or civilian equivalent members of PCMH teams.

2.10.5. Shall practice in clinical operations IAW his/her scope of care as a primary duty, or if squadron superintendent a minimum of 10% of duty time, **(T-3)**.

2.10.6. Coordinates PCMH activities/functions with Senior 4A0 Functional Manager.

2.10.7. Will collaborate with SGH/SGN and flight leadership to develop training plan for all staff on 4N0 Career Field Education and Training Plan (CFETP), **(T-2)**.

2.11. Senior 4A0 Functional Manager:

2.11.1. Will establish and maintain continuity of 4A0 or civilian equivalent staff in support of PCMH teams on both daily and long term basis, **(T-3)**.

2.11.2. Shall coordinate with Squadron/CCs and Flight Chief/NCOIC, who assigns 4A0s to Unit Type Codes (UTC), **(T-3)**.

2.11.3. Coordinates appropriate skill level balance for in-garrison operations and deployment requirements.

2.11.4. Provides clinical leadership and mentorship to 4A0 or civilian equivalent members of PCMH teams.

2.11.5. Will practice in clinical operations regularly IAW his/her scope of care as a primary duty, **(T-3)**.

2.11.6. Coordinates PCMH activities/functions with Senior 4N0 Functional Manager.

2.11.7. Will collaborate with SGA and flight leadership to develop training plan for all staff on 4A0 Career Field Education and Training Plan (CFETP), **(T-2)**.

2.12. MDOS/CC and AMDS/CC:

2.12.1. Will ensure PCMH teams accomplish daily huddles to improve communication amongst team members, cover manning issues, review of scheduled patient lists, and identification of proactive and preventive tasks to be accomplished for the day, **(T-3)**.

2.12.2. Will ensure PCMH teams accomplish weekly huddles to plan and discuss proactive, patient-centered care to include a review of patients scheduled for the following week, identification of proactive patient care needs (such as mammograms, lab test completion/result review, etc.), review of manning, and review of tasks that need to be accomplished for the week, **(T-3)**. The MM team should be included in this meeting to perform indicated care coordination activities.

2.12.3. Shall ensure templates and schedules are configured to achieve the patient-PCM continuity of 70% and patient-team continuity of 90% to the maximal extent, **(T-3)**.

2.12.3.1. Shall ensure judicious utilization of cross-booking when necessary for acute access only within the remaining 10% of available (non-team continuity) appointments to maintain patient-MTF continuity, **(T-3)**.

2.12.3.2. Will ensure a minimum of 90 bookable appointments per provider per full week for Family Health and Pediatrics; other clinic appointment minimums will be determined after consultation with their respective AFMOA Consultant and the AFMOA PCMH Branch Chief, **(T-3)**.

2.12.3.3. Will collaborate with SGH and Flight Commander to adjust, either upward or downward, the 90 appointments per provider per full week and document in MTF Executive Committee or ECOMS minutes with reasoning identified, **(T-3)**.

2.12.4. MDOS/CC and AMDS/CC will ensure that Flight Commander/Flight NCOIC actively work on PCMH teams in their AFSC role as a primary duty and track this as an element of the business plan and performance feedback as follows:

2.12.4.1. In flights with less than 25 personnel, a minimum of 75% of duty time will be spent in PCMH team operations and documented on applicable time sheets, **(T-3)**.

2.12.4.2. In flights with 25 to 50 personnel, a minimum 50% of duty time will be spent in PCMH team operations and documented on applicable time sheets, **(T-3)**.

2.12.4.3. In flights with greater than 50 personnel, a minimum 25% of duty time will be spent in PCMH team operations, and documented on applicable time sheets, **(T-3)**.

2.12.4.4. During times of high demand or decreased staffing, MDOS/CC and AMDS/CC may direct Flight Commander/Flight Chief and 4A and 4N functionals to defer non-mission essential administrative supervisory duties.

2.12.5. Minimizes meetings involving PCMH supervisory personnel, to include providers, during patient care hours. When necessary ad hoc meetings during patient care hours are identified after the appointment schedule is published, the meeting should be scheduled during planned administrative time and approval by the MDG/CC must be obtained.

2.13. GPM:

2.13.1. Will work in conjunction with providers and clinic leadership (e.g. Flight Commander/Flight Chief, etc.) on initial development and ongoing modification of provider templates, **(T-3)**.

2.13.2. Will provide data on historic and projected needs as part of demand analysis, **(T-3)**.

2.13.3. Advises appropriate officer and enlisted leaders in alignment of resources to assure staffing supports the PCMH structure.

2.13.4. Collaborates with PCMH team leadership and advise SGA, via the appropriate space utilization committee, on space requirements to successfully accomplish PCMH Operations.

2.13.5. Collaborates with providers and clinic leadership to provide an adequate supply of appointments through management of templates, schedules, appointing procedures and utilization of access enhancing tools (such as Secure Messaging and TRICARE Online).

2.13.6. Utilizes AFMS tools such as the AFMS PCMH Access checklist to evaluate all opportunities to address MTF access needs.

2.13.7. Will develop business rules for use of appointments within the MTF and referrals to the civilian network to manage patient demand, **(T-3)**.

2.13.8. Shall coordinate business rules/changes with TRICARE Regional Contractor (TRC) and MTF executive leadership team, **(T-3)**.

2.13.9. Will ensure booking protocols are kept current and provided to appointing staff, **(T-3)**.

2.13.10. Coordinates training and supervision of the PCMH medical office manager (if applicable).

2.14. HCI:

2.14.1. Will support appropriate acuity based enrollment in coordination with clinical leadership, PCMH teams, GPM, SGH, and TRICARE Regional Contractor (TRC), **(T-3)**.

2.14.2. Will assist PCMH teams by identifying individuals and populations of patients at risk for chronic, complex, and co-morbid conditions and provide actionable data from various sources for use by the team, **(T-3)**.

2.14.3. Will direct, in coordination with the PCMH team leader(s), Flight Commander, and SGH/SGN as appropriate, Disease Manager (DM), Case Manager (CM), and Utilization Manager (UM) nurse responsibilities for individual patient care and interaction in support of the PCMH team to which the patient is empanelled, **(T-3)**.

2.14.4. Shall analyze population data for trends and provide recommendations for development of comprehensive population health programs in support of PCMH, **(T-3)**.

2.14.5. Assists PCMH team members to initiate CarePoint Application Portal accounts.

2.14.6. Will provide training to PCMH team members so they understand how to utilize CarePoint tools to evaluate care provided to their patients, **(T-3)**.

2.14.7. Along with provider champion, will facilitate training on and implementation of new CPGs within the MTF, **(T-3)**.

2.14.8. Will facilitate annual review and update of currently used CPGs, **(T-3)**.

2.15. Disease Management (DM) Nurse:

2.15.1. Develops and executes disease management activities in collaboration with HCI, PCMH teams, SGN, and SGH, IAW AFI 44-102, *Medical Care Management*.

2.15.2. Will identify patients that may benefit from DM Programs and notify PCMH team, **(T-3)**.

2.15.3. Will provide DM services to these patients and develop/execute individualized DM intervention plans in conjunction with patient/family IAW accepted standards/guidelines, **(T-3)**.

2.15.4. Shall document DM interventions/education in patient's electronic health record (AHLTA) **(T-3)**.

2.15.5. Will provide PCMH staff training on DM Programs and CPG implementation and maintenance, **(T-3)**.

2.15.6. Collaborates with the PCMH teams on DM activities. The DM will maintain a current registry of patients to whom he/she is providing DM services, **(T-3)**. Patients moving into DM care (into the registries), and graduating from primary DM care back to the team (off the registries) will be coordinated with the PCMH team, and be documented in an AHLTA note, **(T-3)**.

2.15.7. Shall provide routine updates and outcome metrics on PCMH patients enrolled in DM programs to PCMH teams, **(T-3)**.

2.15.8. Educates PCMH staff on DM Nurse role.

2.16. Case Management (CM) Nurse:

2.16.1. Identifies individuals with chronic, catastrophic, complex, high utilization, high-risk, or high-cost health issues who would benefit from CM services and notify PCMH teams, IAW AFI 44-102.

2.16.2. Will provide CM and/or care coordination to these patients and develop and execute individualized multi-disciplinary care plan in conjunction with patient/family IAW accepted standards/guidelines, **(T-3)**.

2.16.3. Will document CM interventions, care coordination, and outcomes in patient's electronic health record (AHLTA), **(T-3)**.

2.16.4. Shall provide PCMH staff training on CM programs, **(T-3)**.

2.16.5. Will collaborate with PCMH teams on CM activities. The CM will maintain a current registry of patients to whom he/she is providing CM services, **(T-2)**. Patients moving into CM care (into the registries) and graduating from primary CM care back to the team (off the registries) will be coordinated with the PCMH team, and be documented in an AHLTA note, **(T-3)**.

2.16.6. Shall provide routine updates and outcome metrics on PCMH patients enrolled in CM programs to PCMH teams, **(T-3)**.

2.16.7. Shall provide care coordination guidance on any patients the PCMH team is providing care coordination for, **(T-3)**.

2.16.8. Educates PCMH staff on CM role.

2.17. Utilization Management (UM) Nurse:

2.17.1. In collaboration with the PCMH teams, HCI, GPM, and CM/DM nurses, determines which measures and processes should be targeted for in-depth review, and IAW AFI 44-102. Processes that relate to high-cost, high-volume or problem-prone diagnoses, procedures, services and beneficiaries who have demonstrated high utilization rates are all typically reviewed by UM nurses.

2.17.2. In conjunction with the TRICARE Operations and Patient Administration staff, provides PCMH team staff with a daily list of patients admitted to civilian hospitals.

2.17.3. Educate PCMH staff on UM role.

2.18. TRICARE Operations and Patient Administration (TOPA):

2.18.1. Shall provide PCMH team staff with a daily list of RegAF (active component) enrollees admitted to hospitals including those in network and other non-federal hospitals, **(T-3)**.

2.18.2. The Executive Staff works with the TRC via a specific MOU if necessary to ensure timely notification of admissions and pending discharges.

2.19. Flight Commander responsible for a PCMH clinic:

2.19.1. Shall implement PCMH at the flight level, **(T-2)**.

2.19.2. Will coordinate with SGH, SGN, Senior 4N0 Functional Manager and Squadron/CCs to ensure assignment and alignment of clinical staff IAW this instruction, **(T-3)**.

2.19.3. Will ensure that appropriate administrative and clinical documentation is completed, to include: training, supervision, coding, AHLTA close out of encounters, DMHRSi coding, and the use of SSPs. Ensure flight personnel are adequately trained and supervised, **(T-2)**.

2.19.4. Will ensure all flight staff are trained on PCMH specific information utilizing the PCMH Orientation Toolkit and/or Patient Centered Medical Home Optimization Course (PCMHO Course) prior to start of independent practice within the flight, **(T-3)**.

2.19.5. Collaborates with SGH and Squadron/CC to adjust, either upward or downward, the 90 appointments per provider per full week.

2.19.6. Shall review specified clinic and team metrics with all assigned clinic staff IAW this instruction, **(T-3)**.

2.19.7. Will maintain their own corps-specific clinical competency and currency by performing clinical duties in addition to supervisory responsibilities, **(T-3)**.

2.19.8. Flight Commander is not a separate authorization in PCMH clinics, and is assigned in a clinical role functioning in their primary AFSC; therefore, assignment of Flight Commander duties need to be carefully considered based on the needs of the clinic's mission and IAW this AFI.

2.19.8.1. In flights with less than 25 personnel, Flight Commander will spend a minimum of 75% of their duty time actively working on PCMH teams in their AFSC role and will document this time on appropriate time sheets, **(T-3)**.

2.19.8.2. In flights with 25 to 50 personnel, the Flight Commander will spend a minimum of 50% of their duty time actively working on PCMH teams in their AFSC role and will document this time on appropriate time sheets, **(T-3)**.

2.19.8.3. In flights with greater than 50 personnel, the Flight Commander will spend a minimum of 25% of their duty time actively working on PCMH teams in their AFSC role and will document this time on appropriate time sheets, **(T-3)**.

2.19.8.4. If the Flight Commander is a provider, may consider a smaller empanelment; if nurse, may consider assigning to a smaller team.

2.19.9. Will ensure PCMH teams accomplish daily huddles to improve communication amongst team members and shall cover manning issues, review of scheduled patient lists, and tasks to be accomplished for the day, **(T-3)**.

2.19.10. Will ensure PCMH teams accomplish weekly huddles to plan and discuss proactive, patient-centered care to include a review of patients scheduled for the following week, identification of proactive patient care needs (such as mammograms, lab test completion/result review, etc.), review of manning, and review of tasks that need to be accomplished for the week, **(T-3)**. The MM team should be included in this meeting to perform indicated care coordination activities.

2.19.11. Will ensure all PCMH staff are assigned to and consistently works with only one PCMH team to maintain continuity with their assigned provider team, **(T-3)**.

2.20. Flight Chief/NCOIC:

2.20.1. Shall be responsible for supervision of Medical and Administrative Technicians and determination of direct supervision and rating chain, **(T-3)**.

2.20.2. Will train staff on, and ensure appropriate use of, enhanced access tools such as secure messaging, SSPs, and CPG use within the flight; ensures appropriate documentation of training, **(T-3)**.

2.20.3. Will ensure all enlisted flight staff are trained on PCMH specific information utilizing the PCMH Orientation Toolkit and/or Patient Centered Medical Home Optimization Course (PCMHO Course) prior to start of independent practice within the flight, **(T-3)**.

2.20.4. Will maintain their own corps-specific clinical competency and currency by performing clinical duties in addition to supervisory responsibilities, **(T-3)**.

2.20.5. Will work in their primary AFSC on a PCMH team according to the staffing and duty time guidance specified in paragraphs 2.19.8.1-2.19.8.3. of this instruction, **(T-3)**.

2.20.6. Does not routinely assign non-clinical duties to enlisted staff during patient care hours.

2.21. PCMH Provider Team Lead:

2.21.1. Should be the senior ranking or most experienced provider assigned to that team. The SGH may choose to designate an experienced mid-level provider as the PCMH team lead if the mid-level is the most appropriately experienced provider.

2.21.2. Will ensure the performance of daily and weekly team huddles and periodic team care coordination meetings to maximize team communication and prioritize patient care, **(T-3)**.

2.21.3. Ensures all providers on the team are responsible for the care of their empanelled patients, **(T-3)**. When a provider on the PMCH team has a short term absence, the other providers will provide coverage for those empanelled patients. Longer term absences, such as deployments, will necessitate administrative re-enrollment of patients.

2.21.4. Will collaborate with GPM to make appointments available to care for their team's empanelled population, IAW AFI 44-176, *Access to the Care Continuum* **(T-3)**.

2.21.5. Will facilitate appropriate use of enhanced access tools to meet demand of patients empanelled to the PCMH team (secure messaging, walk-in or group appointments, nurse/technician run clinics, etc.), **(T-3)**.

2.21.6. Encourages PCMH team members to collaborate with the HCI, DM and CM to develop strategies for the care of their patients with more complex disease states.

2.21.7. Encourage PCMH team members to be involved in care coordination activities and meetings as necessary.

2.21.8. Will participate in the training of team nurses, medical technicians, and administrative technicians as appropriate, **(T-3)**.

2.21.9. Encourages appropriate and full utilization of PCMH team and support team members to include Internal Behavioral Health Consultant (IBHC) and Behavioral Health Care Facilitator (BHCF) assets.

2.21.10. Will lead and ensure all PCMH team members participate in PCMH team huddles and other team building/team training, **(T-3)**.

2.22. PCMH Provider:

2.22.1. Shall be responsible for providing care and continuity of care to their empanelled patients, **(T-2)**.

2.22.2. Proactively notifies the PCMH Team Lead and Flight Commander of any significant planned absences.

2.22.2.1. Will conduct a provider-to-provider hand off for all complex patients, **(T-3)**.

2.22.2.2. Makes every effort to accomplish recurring follow up care for empanelled patients before his or her departure.

2.22.3. Will ensures his or her team provides care to empanelled patients in a proactive, patient-centered, and evidence-based manner to meet demand including the use of: secure messaging, scheduled appointments, walk-ins, RN/4N run clinics, use of Support Staff Protocols (SSP), Pharm-D and Physical Therapy clinics, phone consults, etc., **(T-3)**.

2.22.4. Is familiar with the Career Field Education and Training Plan (CFETP) and the capabilities of the 4Ns (and civilian equivalents) assigned to their team, utilize them IAW the CFETP, and participate in their training with appropriate documentation completed.

2.22.5. Will work directly with the HCI, CMs, DMs, Internal Behavioral Health Consultant (IBHCs), Behavioral Health Care Facilitators (BHCFs), and Special Needs Coordinators (SNCs) to develop strategies to care for their empanelled patients with more complex disease states, **(T-3)**.

2.22.6. Will review referral results, hospital and emergency department admissions and discharges, and coordinate care as needed; including contacting patients NLT 72 hours of a discharge from an inpatient unit or emergency department to ascertain needs and follow up care, **(T-3)**.

2.22.7. Will participate in training of team staff as needed, **(T-3)**.

2.22.8. Participates in daily and weekly team huddles and team building/training events.

2.23. PCMH Team Nurse:

2.23.1. Optimally, possesses at least three years nursing experience. Less experience may be waived by AFMOA Provision of Nursing Care Division on a case-by-case basis.

2.23.2. Will demonstrate competency verification of skills for ambulatory practice as directed by the SGN, **(T-3)**. This competency verification should be documented in Competency Assessment Folder (CAF) or electronic equivalent, **(T-3)**.

2.23.3. Will be responsible for nursing care, counseling, and care coordination provided to PCMH enrolled patients as indicated by the specific patient encounter, **(T-3)**.

2.23.4. Shall plan and coordinate the disposition of proactive and preventive care to patients, **(T-3)**.

2.23.4.1. Will notify patients of preventive services that are needed (such as mammograms, PHAs, well baby visits, immunizations) on a routine and as needed basis (i.e. Monthly), **(T-3)**.

2.23.4.2. Will notify enrolled patients who have chronic diseases and are not followed in DM of required laboratory and/or diagnostic testing on a routine and as-needed basis (i.e. Monthly), **(T-3)**.

2.23.5. Provides care IAW accepted nursing AFIs, Medical Group Policy, and CPGs as directed by the Flight Commander and SGN, **(T-3)**.

2.23.6. Shall obtain, maintain, and routinely utilize access to CarePoint Application Portal tools for proactive patient management, **(T-3)**.

2.23.7. Utilizes locally or centrally-developed Decision Support Tools (DSTs) for management of symptom-based telephone calls.

2.23.7.1. DSTs will be reviewed and approved initially and annually by ECOMS and noted in the minutes.

2.23.7.2. Training on appropriate use of DSTs will be documented in the nurse's CAF or electronic equivalent, **(T-3)**.

2.23.8. Participates in the training of team medical and administrative technicians as appropriate.

2.23.8.1. Has access to and/or working knowledge of the Air Force Training Record (AFTR) for enlisted training documentation accomplishment.

2.23.8.2. Shall have training on and working knowledge of the CFETP for the 4N0 and 4A0 career fields, **(T-3)**.

2.23.9. Will participate in all PCMH team huddles and other team building/team training as directed by team lead, **(T-3)**.

2.23.10. Coordinates with appropriate staff to receive training on the IM/IT platforms.

2.23.11. Will ensure their team provides care to empanelled patients in a proactive, patient-centered, and evidence-based manner to meet demand including the use of: secure messaging, scheduled appointments, walk-ins, RN/4N run clinics, use of Support Staff Protocols (SSP), Pharm-D and Physical Therapy clinics, phone consults, etc., **(T-3)**.

2.24. 4N0 or Civilian Equivalent:

- 2.24.1. Shall participate in hands-on patient care and counseling as indicated by the specific patient encounter and IAW their CFETP and training, **(T-3)**.
- 2.24.2. Civilian equivalent LVN/LPNs are considered equal in scope of practice to 5/7 level or higher 4N0.
- 2.24.3. Inquires if patient is signed up for secure messaging during patient encounter. If patient is not already signed up, encourages patient to do so.
- 2.24.4. Will assist provider by obtaining and documenting clinical information prior to and during patient encounter, **(T-3)**.
- 2.24.5. Shall utilize AFMOA-approved TSWF screening/intake algorithms as directed, **(T-3)**.
- 2.24.6. After training completed/competency validated, will perform and document specific portions of the physical exam as well as procedures IAW the CFETP, their respective state's scope of practice, and appropriate SSPs or algorithms as approved by ECOMS, **(T-3)**. Training is to be documented as appropriate (AFTR).
- 2.24.7. Will perform or assist in accomplishing administrative tasks and functions including, but not limited to, staffing of clinical check-in area, record retrieval, management of equipment and supplies, etc. on an as needed basis, **(T-3)**.
- 2.24.8. Shall assist PCMH team nurse with functions such as contacting (using Secure messaging as first choice) patients with normal lab results and other clinical tasks according to the CFETP and SSPs. SSPs 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, **(T-3)**.
- 2.24.9. Will identify and notify patients of preventive services that are needed (such as mammograms, PHAs, well baby visits, immunizations) on a routine basis, **(T-3)**.
- 2.24.10. Will identify and notify patients who have chronic diseases and are not followed in DM of required laboratory and/or diagnostic testing on a routine basis, **(T-3)**.
- 2.24.11. Have access to and working knowledge of the Preventive Health Assessment and Individual Medical Readiness (PIMR) application, to include Aeromedical Services Information Management System (ASIMS), to support PCMH Force Health Management.
- 2.24.12. Obtains, maintains, and routinely utilizes access to CarePoint Application Portal tools for proactive patient management.
- 2.24.13. Participates in all PCMH team huddles and other team building/team training as directed by team lead.

2.25. PCMH team 4A0 (or Civilian Equivalent):

- 2.25.1. Shall assist GPM with identifying and managing patient demand by utilizing historical workload data using tools such as CHCS or Template Analysis Tool (TAT), **(T-3)**.
- 2.25.2. Shall assist GPM in developing, inputting, and maintaining provider templates/schedules in CHCS, **(T-3)**.

2.25.3. Coordinates patient referrals with RMC and PCMH team as needed including:

2.25.3.1. Will assist the patient given a referral by providing briefing on expectations or directing patient to RMC, **(T-3)**.

2.25.3.2. Will obtain referral reports from RMC when needed and route to appropriate provider, **(T-3)**.

2.25.3.3. Will place T-cons to the ordering provider (as the usual method to notify a provider of results) for any results received, **(T-3)**.

2.25.3.4. Will obtain paper copies or route the referral results to the PCM when he or she is not the ordering provider, **(T-3)**.

2.25.4. Will perform End of Day processing at the end of clinic each day in line with SGH or Flight Commander guidelines, **(T-3)**.

2.25.5. Shall order/restock office supplies as required, **(T-3)**.

2.25.6. Will coordinate required documentation with appropriate clinical and support functions on behalf of the PCMH team, **(T-3)**.

2.25.7. Will aid clinical staff in maintenance of preventive health databases for PCMH teams, **(T-3)**.

2.25.8. Shall contact/schedule patients requiring preventive health visits in coordination with HCI and PCMH Team members, **(T-3)**.

2.25.9. Shall schedule patients for return appointments at the direction of the PCMH provider, **(T-3)**.

2.25.10. Will assist RMO in auditing Third Party Collections (TPC) forms to provide for maximum MTF reimbursement, **(T-3)**.

2.25.11. Will supervise, rate, and train the PCMH Clinic front desk personnel, **(T-3)**.

2.26. Front Desk Receptionist:

2.26.1. In the absence of an authorized Front Desk Receptionist position or 4A, PCMH enlisted team members will provide coverage for Front Desk Reception duties and should be equitably distributed among all enlisted AFSCs. All staff who work the front desk will provide a professional and customer-friendly atmosphere in reception area when welcoming patients.

2.26.2. Shall verify patient identity and eligibility in Defense Eligibility Enrollment Reporting Systems (DEERS) using appropriate AF-approved methods, **(T-3)**.

2.26.3. Will check the patient in and enter patient information into AHLTA, **(T-3)**.

2.26.4. Will obtain Third Party Collection Information and forward to RMO at close of business daily, **(T-3)**.

2.26.5. Shall identify patients on Personnel Reliability Program (PRP) and flag record, and initiate start of MTF process for care of PRP patients IAW AFI 41-210, *Tricare Operations and Patient Administration Functions* **(T-2)**.

2.26.6. Will verify patient demographics and direct patient to update DEERS information if required, **(T-3)**. Will enter any new contact information (i.e. address and phone number) in Composite Health Care System (CHCS) utilizing the Demographics Module, **(T-3)**.

2.26.7. Identifies whether patient is enrolled in Secure messaging; if not, encourage patient to do so and aid with the flow of secure messages.

2.26.8. Will determine from patient if visit is injury related; if so, starts AF Form 1488, and notifies team 4N, **(T-3)**.

2.26.9. Will assist patient to complete required visit paperwork and provides clinic instructions to patient, **(T-3)**.

2.26.10. Shall route patient to appropriate location for the visit, **(T-3)**.

2.26.11. Will schedule follow-up visit for patient if required at the end of the appointment, **(T-3)**.

2.26.12. Will track, or assists with tracking, diagnostic testing results. Provides hard copy results, or enters t-con to appropriate staff members, **(T-3)**.

2.26.13. Assists Office Manager and GPM as needed.

2.26.14. Will train, as appropriate, and assist 4N0s in the proper completion and maintenance of outpatient medical records, **(T-3)**.

2.26.15. Performs other patient administrative functions consistent with the 4A0 skill set as appropriate to the PCMH Clinic setting.

Chapter 3

PCMH OPERATIONS

3.1. PCMH Clinic Structure.

3.1.1. PCMH Team Composition.

3.1.1.1. PCMH teams will be set up as follows: Family Health will have one registered nurse, five 4Ns and two providers, one being a board certified or board eligible Family Medicine Physician the other being a General Medical Officer (GMO), Physician Assistant (PA), Family Nurse Practitioner (FNP), or another Family Medicine Physician. Beginning in FY 2016 the PCMH staffing model for Family Health will be revised to the extended team model. The key features to this change include but are not limited to: 3 to 5 provider teams and the addition of 4As to the teams. MTFs are authorized to transition to this model prior to FY2016 but must coordinate their transition through the PCMH Branch AFMOA/SGHC. **(T-3)**. Pediatric teams will have two nurses, four 4Ns, one 4A and two providers, one will be a board eligible Pediatrician, the other may be a Pediatric Nurse Practitioner. PCMH teams will adhere to the guidelines, unless a variation is authorized by PCMH Branch, AFMOA/SGHC, **(T-3)**. Team builds for IM, Flight Medicine, and GME programs will be developed through AFMOA, SG consultants, and the corporate process. Once established and programmed MTFs will adhere to the new staffing models, **(T-3)**.

3.1.1.2. All PCMH staff will be assigned to and consistently work with only one PCMH team to maintain continuity with their assigned provider team, **(T-3)**.

3.1.2. PCMH Team Enrollment.

3.1.2.1. Family Health and Pediatrics PCMH teams will be enrolled to an average of 1250 patients per provider; see section 4.3 of this instruction for provider enrollment guidance, **(T-3)**. Flight Medicine, Internal Medicine, and Graduate Medical Education Clinics enrollment will be determined once those clinics are stood up. Once established, team enrollment levels will only be changed via coordination with the PCMH Branch, AFMOA/SGHC, **(T-2)**.

3.1.3. PCMH Team Support Functions.

3.1.3.1. Other personnel in the MTF are considered integral to the optimization of PCMH operations and include, but are not be limited to:

3.1.3.1.1. Internal Behavioral Health Consultant (IBHC) works as a consultant to the PCMs on behavioral health issues and provide brief evidenced-based interventions to patients across a wide variety of medical and mental health conditions.

3.1.3.1.2. Behavioral Health Care Facilitator (BHCF) are specially trained registered nurse assigned to primary care clinics who track, monitor, and assist with adherence to pharmacological treatment. They primarily work with patients presenting with depression, post-traumatic stress disorder (PTSD), and generalized anxiety, and provide updates to the PCM on treatment adherence and progression. The BHCF will collaborate closely with the IBHC provider and PCM team to coordinate behavioral

health care and provide motivational interviewing to assist patients with basic problem-solving to promote behavioral change where indicated, (T-3).

3.1.3.1.3. Special Needs Coordinator (SNC) oversees and manages the installation EFMP-M program IAW AFI 40-701, *Medical Support to Family Member Relocation and Exceptional Family Member Program*. The SNC is an integral member of the overseas clearance process and identifies sponsors and their family members with special needs to determine the ongoing necessary medical and educational services required for family members based on specific conditions, to support access to specialized services at the current and projected duty assignment, and to protect federal rights and entitlements for mobile family members. The SNC, with the SGH, will provide initial and annual training to MTF clinical personnel on the use of DoD criteria for identifying family members with special medical and educational needs, and EFMP-M referral procedures, (T-3).

3.1.3.1.4. Referral Management Center (RMC) Staff are responsible for following referral business rules IAW AFI 44-176, (T-3). Clinical teams should direct patients to go to the RMC after receiving a referral and prior to leaving the MTF. The RMC staff is responsible for briefing patients on the process of obtaining care via a referral and ensuring MTF staff is aware of current referral management processes.

3.1.3.1.5. Pharmacist-provided services include, but are not limited to, services related to medication therapy management, ambulatory care, prescription renewal, over the counter medications, and medication reconciliation.

3.1.4. Space requirements.

3.1.4.1. PCMH Operations have found that a minimum of two exam rooms per provider and office space to accommodate the team create a more successful environment.

3.1.4.2. Exam rooms should be configured in a standard fashion within each clinic to enable clinic flexibility and maximal use of space by available providers (T-3).

3.2. PCMH Neighborhood.

3.2.1. The PCMH team is the central hub of patient information, primary care provision, and care coordination. All care that happens outside of the PCMH is considered part of the PCMH Neighborhood.

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

3.2.3. PCMH teams and neighborhoods will need to effectively communicate, provide safe and timely coordination of care/hand-offs, and integrate care practices (such as co-management determinations, effective flow of information, etc.) in a bi-directional manner to provide the highest quality care to the patient, (T-3).

3.3. PCMH Special Programs.

3.3.1. Preventive Health Assessment (PHA).

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

3.3.1.2. The active component member's primary assigned provider will continue to be responsible for any face-to-face visit required for PHA, but may direct another qualified provider to complete the exam as mission requirements dictate IAW AFI 44-170, **(T-3)**.

3.3.1.3. Staffing for the PHA cell will be assigned outside of the Family Health Clinic IAW AFI 44-170.

3.3.2. Personnel Reliability Program (PRP).

3.3.2.1. Where existing, PRP clinics/programs will be aligned under Flight/Operational Medicine, **(T-3)**.

3.3.2.2. If the MTF does not have a separate PRP clinic, PRP patients may be enrolled to Flight Medicine or FHC as directed by MTF leadership.

3.3.2.3. If PRP patients are enrolled in the FHC, distribution will be determined by MDG/CC. The MDG/CC and SGP should determine the best approach to meet access needs while maintaining requirements of the PRP program, **(T-3)**.

3.3.3. Enhanced Access.

3.3.3.1. Enhanced Access describes a suite of strategies essential to PCMH. Access in this context should no longer be considered only an appointment with a provider, but rather the entire spectrum of options a MTF PCMH can deliver to provide care to the patient.

3.3.3.2. Enhanced Access options include, but are not limited to, secure messaging, nurse/tech run clinics, Support Staff Protocols, Group Appointments, Nurse Advice/Telephone Consults, Pharm-D Clinics, and Physical Therapy Clinic within the PCMH Clinic.

3.3.3.3. PCMH clinics will utilize Enhanced Access options and utilize the Enhanced Access Toolkit provided by AFMOA SGHC, **(T-2)**.

Chapter 4

GUIDANCE AND PROCEDURES

4.1. Continuity of Care.

4.1.1. Continuity is the foundation of PCMH and is defined as maintaining an ongoing personal relationship between the patient and their provider. To build this relationship requires continuity.

4.1.1.1. MTFs will develop appointing protocols that will maximize continuity whereby enrollees are appointed to their assigned primary care manager or team to the maximum extent possible, **(T-3)**.

4.1.1.2. Under standard operations the strategies to maintain continuity within Family Health and Pediatric clinics should be executed with the goal of achieving the following:

4.1.1.2.1. Patient - PCM (provider) continuity should be maintained at or greater than 70%, **(T-2)**.

4.1.1.2.2. Patient - PCMH Team continuity should be maintained at or greater than 90%, **(T-2)**.

4.1.1.3. Provider continuity, Team continuity, and cross booking standards for Internal Medicine, Flight/Operational Medicine, and GME clinics have not yet been standardized. All PCMH clinics will meet all access standards IAW AFI 44-176, **(T-2)**.

4.1.1.4. For all PCMH clinics the process of cross booking patients to other PCMH teams should be minimized; appointing protocols should be constructed with this goal in mind, **(T-2)**.

4.1.1.4.1.1. However, judicious use of cross booking within Family Health and Pediatric clinics may be used when necessary for acute access within 10% of available appointments to maintain patient-MTF continuity, **(T-3)**.

4.1.1.4.2. Under specific conditions of extended provider absences (deployment, hiring gaps, etc.), patients may be administratively re-empanelled equitably among the remaining PCMH providers for continuity purposes, with the expected impact on apparent cross booking and continuity rates.

4.1.1.5. Every effort should be made to see AD patients within the empanelled clinic; AD should only be deferred to urgent care/ER locations during the duty day under appropriate clinical situations (i.e. true or suspected medical emergency) or during times of extreme provider shortage, **(T-3)**.

4.1.1.6. Residency clinics may require more cross-booking than non-residency clinics due to educational requirements that decrease provider availability in clinic. Residency leadership, in conjunction with GPMs, will manage schedules to minimize this to greatest extent possible.

4.1.1.7. MTFs will utilize other strategies in order to maintain continuity, to include:

4.1.1.7.1. The Access Checklist to assist in developing action plans to minimize effects of short and long term provider and clinic support staff shortages.

4.1.1.7.2. Ensuring processes are in place to provide backfill to any member of the PCMH team practicing in the clinic setting to provide for maximal patient continuity.

4.1.1.7.3. Implementation of enhanced access (utilizing tools described in paragraph 3.3.3. of this instruction) to the fullest extent possible within all PCMH clinics not only to improve continuity but to optimize care and improve access.

4.2. Appointment Availability.

4.2.1. A minimum of 90 centrally available appointments per week per Family Health and Pediatric provider will be open and available to be centrally scheduled IAW AFI 44-176, (T-2).

4.2.2. For weeks with fewer than five duty days (i.e., holiday, family day), the available appointment requirement will be prorated accordingly, typically at 18 appointments per day (i.e., 72 appointments if four days, 54 appointments if three days, etc.), (T-2).

4.2.3. Centrally available appointments are those that may be booked at all levels to include appointing clerks, TRICARE On-Line (TOL), Nurse Advice Line and clinic personnel.

4.2.3.1. Detail codes may be used when needed; however, excess use of detail codes may result in restriction of access and is discouraged.

4.2.3.2. Freezing, blocking or other similar restrictions on the 90 centrally available appointments per week is prohibited, (T-3).

4.2.4. During periods of leave/TDY, significant support staff shortages, or extended training (e.g. Operational Readiness Exercise [ORE], etc.) involving an entire day, schedules will reflect the prorated amount of centrally available appointments based on provider available time. These periods of absence are to be properly annotated within DMHRSi, (T-3).

4.2.5. Clinical absences of one duty day or longer (i.e., leave, TDY) are not to be made-up and the required number of available appointments are to be prorated accordingly.

4.2.6. For less than a full day absence, appointments are to be “made up”. These appointments should be as proximal to the time of absence as possible to maintain necessary access.

4.2.7. The SGH, in coordination with the Squadron/CCs and Flight Commander, may waive the requirement to make up appointments lost to absences less than a full day if those absences are related to required medical group functions (required meetings, readiness-related functions, etc.) and the reduction in available appointments does not significantly impact patient access. A complete analysis of patient access and demand should be completed prior to this determination.

4.2.8. The SGH, in conjunction with Squadron/CC, Flight Commander, Credentials Function, and when appropriate the SGP, may also waive number of available appointments based on issues that may affect provider ability to deliver safe/quality care, (T-3). These situations include, but are not limited to the following: experience level of providers (recently out of training), significant call responsibilities that affect reasonable provider “crew rest”, provider inpatient responsibilities, provider illness or other medical conditions. The SGH will document any waived requirements in Executive Staff Committee or ECOMS minutes, (T-3).

4.2.9. Providers are to have the authority, with reasonable lead-time, to adjust their schedule/templates as long as access and available appointment standards are maintained, **(T-3)**. Routine schedule adjustments are not to result in patient cancellations/rescheduling, **(T-3)**.

4.2.10. The appointment availability standards will not apply to Internal Medicine, Flight Medicine or GME programs. These programs will continue to adhere to standards established between the MTF and AFMOA/SGHC PCMH Branch and must comply with AFI 44-176. In addition, each program needs to assess its true demand requirement for the empanelled population and meet that requirement.

4.2.11. Physicians who provide additional services mandated by AFMS guidance (i.e. Allergy Extender) for the entire MTF population or perform mission essential functions (e.g. overseas clearance, deployment line processing, etc.) for the entire MTF population will have the requirement for centrally available appointments prorated accordingly, **(T-3)**.

4.2.12. Providers who have conditions that require shortened duty days will have available appointment requirement prorated to account for hours available in clinic, **(T-3)**.

4.2.13. At MTFs that offer inpatient care, active component physicians assigned to PCMH clinics will be required to perform inpatient duties within the scope of their credentials, **(T-3)**. Inpatient rounding may take place during provider managed time. At locations where a PCMH clinic physician manages the entire inpatient medical service or there is significant shared inpatient workload, the requirement for centrally available appointments will be prorated accordingly, **(T-3)**. Care should be taken to accurately measure the actual time spent involved in inpatient care in the process of this proration.

4.3. PCMH Enrollment.

4.3.1. Enrollment targets will be based on the number of PCMs authorized at each MTF according to the applicable enrollment targets as set forth in the annual Performance Plan (PP), **(T-2)**. Balancing of residency panels and actual enrollment numbers will be based on training guidelines established by the ACGME.

4.3.2. Flexibility within actual enrollment to individual providers/teams is allowed as long as the facility maintains the overall patient/provider ratio required for the respective clinic type. Facilities may also consider balancing panels across teams based on additional duties (i.e. element leader 1,000; other clinic providers 1,300) using the same total enrollment requirements for the respective clinic.

4.3.3. Facilities may consider balancing panels within a clinic/team based on patient acuity/complexity and demand (i.e. family physician 1,150; mid-level provider 1,350), as long as the facility/clinic total enrollment achieves the required ratios.

4.3.3.1. Patients will be empanelled to providers based on the patient's specific needs and the skill set of the provider, **(T-3)**.

4.3.3.2. PCM patient panels will be equalized across the MTF to ensure an acceptable distribution of patient acuity levels between PCMs, **(T-3)**.

4.3.4. Aggressive template management is used to enable provider-managed time providing standards for appointment availability are met by the provider. This can will be utilized for procedure visits, high-acuity care, MEBs, OPRs, etc.

4.3.5. Providers may be required at times to see “must see” patients such as contractors and Department of Defense Dependent School (DODDS) patients. These patients are not enrolled patients.

4.3.6. PCM enrollments will be equalized across the clinic to distribute patient acuity levels that are appropriate to clinical training and experience between PCMs IAW paragraph 2.12.1. of this instruction, **(T-3)**.

4.4. Staff Continuity.

4.4.1. Every effort will be made to have two assigned technicians available and working with each provider on a daily basis **(T-3)**. 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, **(T-3)**.

4.4.2. All PCMH staff will be assigned to the PCMH clinic for a minimum of two years, **(T-2)**. During that time they should be assigned to the same PCMH team unless mission performance would be adversely affected by keeping them in place, **(T-2)**.

4.4.3. During significant support staff shortages, the SGH may authorize clinics to have decreased appointments.

4.5. Huddles.

4.5.1. Maximizing communication within the PCMH team is crucial.

4.5.2. PCMH teams will conduct huddles IAW paragraphs 2.11.1-2.11.2 of this instruction.

4.6. Team Training/Continuous Improvement Activities.

4.6.1. Additional time may be allotted for process improvement, team training, discussion of team roles, etc. and may be done at the team level or flight level (i.e. clinic training at monthly staff meeting).

4.7. Medical Home Patients.

4.7.1. The MTF Executive Committee, based upon recommendations of the Population Health Function (PHF), must identify subsets of enrollees who make the MTF their “medical home” vs. those who are empanelled but obtain their health care elsewhere, **(T-3)**.

4.7.2. Local policies for specific approaches to preventive management of these subsets will need to be developed, **(T-3)**.

4.8. Staff Availability.

4.8.1. All clinics will establish a minimum staffing threshold to meet patient care needs, **(T-2)**.

4.8.2. All PCMH Clinic staff leaves, TDYs, and other planned time off should be projected/approved at a minimum of 6 months out, except in extenuating circumstances, and will be coordinated to minimize impact on access, **(T-3)**. MTF leadership will establish local policy on this issue, **(T-3)**.

4.8.2.1. Schedule changes after appointments have been loaded into CHCS should be minimized and require SGH approval, **(T-3)**.

4.8.2.2. The GPM assists PCMH team leadership and Flight Commander/Flight Chief in projecting team member absences to provide adequate access. The Flight Commander/Flight Chief maintains approval authority for all absences within the flight.

Chapter 5

BUSINESS OPERATIONS

5.1. MEPRS.

5.1.1. Each PCMH team will be assigned a unique 4-letter MEPRS (BGAx, BDAX etc.) and appropriate clinic builds, **(T-3)**.

5.1.2. Accuracy of MEPRS data is crucial. Staff will record accurate data for hours worked in their primary MEPRS, **(T-3)**.

5.1.3. All staff are required to use the proper MEPRS code for activities performed outside their primary clinical MEPRS (e.g. readiness training, fitness time, etc.) and accurately report actual hours for these additional activities, **(T-3)**.

5.1.4. To evaluate the efficiency of time allotted to patient care, all PCMH team personnel will report PCMH team-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, **(T-3)**. Examples are as follows:

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.)

5.1.5. Actual hours will be reported for each subtask.

5.2. Deployment Operations.

5.2.1. Proper AEF block alignment is the responsibility of the MTF and will be worked in close coordination with AF/SG Family Medicine, Pediatric, Internal Medicine, or Flight Medicine Consultants as needed.

5.2.2. The providers on a PCMH team will not be aligned in the same AEF block, **(T-3)**.

5.2.3. Technicians assigned to a specific provider may be assigned to the same AEF block as their provider as manning permits. NOTE: The senior 4N Functional Manager will provide skill level balancing for both in-garrison and garrison operations when assigning technicians to the same AEF block.

5.2.4. Active component clinic nurses assigned to a PCMH team may be assigned to the same AEF block as one of the team providers.

5.2.5. 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 through their MAJCOM to inform the AF/SG Consultant of any unique circumstances (i.e. board exams, surgery, pregnancy) which would preclude deploying during a specific block in the AEF cycle.

5.2.5.1. The AF/SG Consultants 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, **(T-3)**.

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

Chapter 6

OPERATIONAL MEASUREMENTS/METRICS

6.1. Continuity of Care.

6.1.1. Continuity of Care will be measured as:

6.1.1.1. PCM Continuity: the percentage of patients seen by the provider to whom they are enrolled.

6.1.1.2. Team Continuity: the percentage of patients seen within the PCMH team provider pool.

6.2. HEDIS Measures.

6.2.1. The most important currently available measure for patient preventive care is HEDIS derived data.

6.2.2. PCMH Clinics will track patient HEDIS metrics that are appropriate to the patients enrolled in that clinic, **(T-3)**.

6.2.3. Currently tracked individual HEDIS measures are combined into a composite score based on national percentile ranks for each of the individual measures and presented as individual and composite scores.

6.2.4. These HEDIS measures should be reviewed by the SGH with the providers on a monthly basis, **(T-3)**.

6.3. Patient Satisfaction.

6.3.1. Patient satisfaction will continue to be measured via the Service Delivery Assessment (SDA) until further notice.

6.3.2. The results of the SDA will be reviewed with PCMH teams on a monthly basis, **(T-3)**.

6.4. ED/UCC Utilization.

6.4.1. 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 rooms or urgent care clinic may be appropriate.

6.4.2. Use of emergency room or urgent care clinic by empanelled population will be measured at the MTF level.

6.4.3. These data sets are available on the CarePoint Application Portal and will 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 Commander.

6.5. PCMH Metric Goals.

6.5.1. All PCMH clinics, to include Family Health, Pediatrics, Flight Medicine, Internal Medicine, and Graduate Medical Education (GME) Clinics will strive to achieve or exceed the following PCMH goals:

6.5.1.1. ED/UCC Utilization rate of less than 3.0 per 100 enrolled beneficiaries.

6.5.1.2. Patient Satisfaction of 95% or greater as measured by the satisfied and very satisfied combined score for responses to the compiled standardized AFMS SDA questions.

6.5.1.3. HEDIS score of 90th percentile or greater for each of the HEDIS measures identified by the MHS Clinical Quality Forum and Clinical Measures Steering Panel.

6.5.1.4. Continuity is the foundation of PCMH and defined as a personal relationship between the patient and their provider. To build this relationship requires Continuity.

6.5.1.4.1. MTFs will develop appointing protocols that will maximize continuity whereby enrollees are appointed to their assigned primary care manager or team to the maximum extent possible, **(T-3)**.

6.5.1.4.2. Efforts to meet continuity goals will be conducted in concert with and not at the expense of meeting access standards IAW AFI 44-176.

6.5.1.4.3. Under standard operations the strategies to maintain continuity within Family Health and Pediatric clinics should be executed with the goal of achieving the following:

6.5.1.4.3.1. Patient - PCM (provider) continuity should be maintained at or greater than 70%, **(T-3)**.

6.5.1.4.3.2. Patient - PCMH Team continuity should be maintained at or greater than 90%, **(T-3)**.

6.5.1.4.3.3. Continuity standards for Internal Medicine, Flight/Operational Medicine, and GME clinics have not yet been standardized.

6.5.1.4.3.4. For all PCMH clinics, the AFMS cross booking goal is 0%.

6.5.1.4.3.4.1. Judicious use of cross booking may be used when necessary for acute access in order to maintain patient-MTF continuity.

6.5.1.4.3.4.1.1. Within Family Health and Pediatric clinics, if necessary, up to 10% of available appointments may be cross booked to maintain patient-MTF continuity.

6.5.2. SGHs will ensure that the identified PCMH metrics are tracked and presented to MTF leadership on a monthly basis, **(T-3)**.

6.5.3. MTFs not meeting the targeted goals for the above PCMH metrics will develop and implement strategies to reach these goals, **(T-3)**.

6.6. Staff Satisfaction.

6.6.1. AFMOA PCMH Branch will conduct twice yearly AFMS clinic staff (AD and GS employees) satisfaction surveys. PCMH staff are expected to participate in this survey to the maximum extent possible.

6.6.2. Results of this survey are briefed to the AF/SG during the Strategic Objectives updates and disseminated to all MTFs in the Performance Management Forums.

6.7. Secure Messaging Utilization.

6.7.1. Patient Initiated Messages as well as Provider and Team Initiated Messages are to be tracked on a monthly basis by AFMOA SGHC staff and briefed at the Performance Management Forums.

6.8. Performance Management Forums.

6.8.1. Air Force PCMH Operations are evaluated on a routine basis on their performance in the following: Readiness measures, Continuity, ED/UCC utilization, HEDIS, Patient Satisfaction, Secure messaging Utilization, Patient Safety and Quality measures, Business Plan execution, and Open encounters.

6.8.2. MTFs will attend Performance Management Forums every 4 months in the group they are assigned, (T-3). MDG/CCs and/or other MTF staff as requested by the MDG/CC are given the opportunity to discuss their MTFs successes and challenges.

6.9. Inspections.

6.9.1. The Air Force Inspection System (AFIS) Unit Effectiveness Inspections (UEIs) includes a continual evaluation of PCMH operations (via the Program Managers, Self-Assessment Program Manager, Commanders, Wing Inspection Teams, MAJCOM/Inspector General (IG) and Surgeon General (SG)), and AFMOA. The Air Force Inspection Agency (AFIA) SG supports MAJCOM/IGs in conducting the medical component of the UEI Capstone Event IAW AFI 90-201, *Air Force Inspection System*.

6.9.2. MTFs are inspected according to The Joint Commission/AAAHC PCMH accreditation standards as determined by the central AFMS accreditation contract.

6.9.3. All AFMS MTFs will seek an evaluation of their PCMHs as directed by the AF/SG.

THOMAS W. TRAVIS, Lieutenant General,
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Surgeon General

Attachment 1**GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION*****References***

AFI 40-701, *Medical Support to Family Member Relocation and Exceptional Family Member Program*, 15 February 2012.

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

AFI 44-102, *Medical Care Management*, 20 January 2012.

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

AFI 44-170, *Preventive Health Assessment*, 30 January 2014.

AFI 44-175, *Clinical Medical Management Programs*, 10 November 2011.

AFI 44-176, *Access to the Care Continuum*, 12 September 2011

AFI 46-101, *Nursing Services and Operations*, 28 October 2011

AFI 90-201, *Air Force Inspection System*, 2 August 2013.

AFMAN 10-3902, *Nuclear Weapons Personnel Reliability Program (PRP)*, 13 November 2006

AFPD 44-1, *Medical Operations*, 1 September 1999

AFPD 46-1, *Nursing Services*, 1 September 2011.

DoD 5210.42-R, *Nuclear Weapons Personnel Reliability Program (PRP) Regulation*, 30 June 2006

DoD TRICARE Management Activity *Medical Management Guide*, 2009,
<http://www.tricare.mil/tma/ocmo/publications.aspx>

Prescribed Forms

None

Adopted Forms

AF Form 847, *Recommendation for Change of Publication*

Abbreviations and Acronyms

AEF—Air Expeditionary Force

AFIA—Air Force Inspection Agency

AFIS—Air Force Inspection System

AFPD—Air Force Policy Directive

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
BHCF—Behavioral Health Care Facilitator
CAF—Competency Assessment Folder
CAP—CarePoint Application Portal
CBD—Consultant Balanced Deployments
CFETP—Career Field Education and Training Plan
CHCS—Composite Health Care System
CM—Case Manager; Case Management
CPG—Clinical Practice Guidelines
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
DST—Decision Support Tool
ECOMS—Executive Committee of the Medical Staff
FHC—Family Health Clinic
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
IM—Internal Medicine
MEPRS—Medical Expense and Performance Reporting System
MDOS—Medical Operations Squadron
MDSS—Medical Support Squadron
MEB—Medical Evaluation Board
MM—Medical Management
MOU—Memorandum of Understanding
MTF—Medical Treatment Facility
OPR—Office of Primary Responsibility or Officer Performance Report

PCM—Primary Care Manager

PCMH—Patient Centered Medical Home

PHA—Preventive 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

SGA—Medical Group Administrator

SGH—Chief of the Medical Staff

SGN—Chief Nurse

SGP—Chief of Aerospace Medicine

TDY—Temporary Duty

TOL—TRICARE Online

TOPA—TRICARE Operations and Patient Administration

TRC—TRICARE Regional Contractor

TSWF—Tri-Service Workflow

UEI—Unit Effectiveness Inspection

UM—Utilization Management

UMD—Unit Manpower Document

UMPR—Unit Management Personnel Roster

WIT—Wing Inspection Team

Terms

Administrator (SGA)—Medical Service Corps who defines resources and facility requirements; secures and manages medical resources and information; limits institutional risk; and 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 produce cost-effective, modern and prevention-based healthcare.

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

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

Chief of Aerospace Medicine (SPG)— Provides operational leadership and oversight of PCMH mission support operations including program development, execution, monitoring, and evaluating

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.

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.

Group Practice Manager (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 Surgeon 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 Treatment Facility (MTF)— A military facility established for the purpose of furnishing medical and/or dental care to eligible individuals.

Medical Management—An integrated managed care model, consisting of case management, disease management and utilization management.

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 provider 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.

PCMH Team—A group of staff that is responsible for healthcare of a panel of patients.

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”.