

**15 APRIL 1994**

**Health Services**

**HEALTH CARE PROGRAMS AND  
RESOURCES**



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OPR: HQ USAF/SGH  
(Col Harry F. Laws II)

Certified by: HQ USAF/SG  
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1. The Air Force depends on its Medical Service to help maintain a fit and vital force, save life and limb, prevent undue suffering, and preserve military strength during contingencies. As much as possible, the Air Force Medical Service (AFMS) must also care for authorized beneficiaries who are not on active duty. This directive outlines policies needed to carry out these responsibilities.
2. The AFMS will use resources efficiently while making sure people get appropriate health care--from the right source and for the proper amount of time. The Air Force will also use these resources to promote health and a healthy environment, and to support the goals and objectives of the AFMS.
3. In delivering health care, the AFMS will meet or exceed Federal or state requirements and industry standards.
4. The AFMS will make sure military medical units are ready to respond to contingencies.
5. The organizational structure and environment within the AFMS will promote personal development and career satisfaction for its personnel.
6. Following are established responsibilities and authorities:
  - 6.1. The Office of the Air Force Surgeon General (HQ USAF/SG) provides policies governing health care, delivery of health services, and medical readiness. HQ USAF/SG determines and validates resource requirements, and allocates resources to complete AFMS missions. HQ USAF/SG also ensures AFMS's readiness, evaluates resource use and policy, and offers the Air Force's medical views on policies or legislation to the Department of Defense (DoD).
  - 6.2. Major command (MAJCOM) surgeons allocate resources to military treatment facilities (MTF) to make sure personnel are organized, trained, and equipped for peace and war. MAJCOM surgeons guide and monitor the MTFs to obtain the best health care possible with available resources. They also help collect and report data to higher headquarters.

6.3. MTF commanders are responsible for all MTF resources and collections. They identify needs and manage resources to care for eligible people under priorities prescribed by law. Through the MAJCOM surgeons, they also identify unresourced patient needs and priorities to HQ USAF/SG. They make sure medical personnel are trained and other resources are available for contingencies in peace and war.

6.4. HQ USAF/REM and NGB/SG develop and maintain standards for medical readiness within their respective components.

7. This policy applies to HQ USAF/SG, MAJCOM surgeons' offices, Air Force MTFs, and the Air Reserve's medical components.

8. See [Attachment 1](#) for measures of compliance to this policy.

9. See [Attachment 2](#) for a listing of terminology.

10. See [Attachment 3](#) for a listing of related directives and instructions.

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**Attachment 1 MEASURING COMPLIANCE WITH POLICY**

**A1.1.** HQ USAF/SG will measure success in making efficient use of medical resources by evaluating efficiency as measured by the Cost Per Medical Work Unit (MWU) and the overall rate of expenditure growth through the use of Expenditure Targets. Also, the overall health of personnel will be measured by the noneffectiveness rate.

A1.1.1. The Air Force can collect information on the Cost Per MWU (attachment 1) from the Medical Expense and Performance Reporting System, Retrospective Case Mix Analysis System (RCMAS), and the Operating Budget Ledger (OBL). Specifically, financial obligation information will be derived from Program Element Code (PEC) 87792 (Station Hospitals and Clinics) and PEC 87711 (Medical Centers) of the OBL. The Cost Per MWU using PECs 87792 and 87711 reflect those costs most closely associated with the delivery of health care. The Air Force will measure Cost Per MWU as a ratio of costs to MWUs generated.

A1.1.2. To determine the health status of the forces on active duty, HQ USAF/SG can use the RCS: HAF-SG(M)7118, *Report of Patients*, which shows the number of bed days per 1,000 active duty members. It will display this noneffectiveness rate as monthly lost days per 1,000 active duty members. The goal is a downward trend, which reflects fewer noneffective days lost to hospitalization **Attachment 2**.

A1.1.3. After the Air Force has established Expenditure Targets (ET) or spendline **Attachment 3**, obligation information can be collected from the CHAMPUS Catchment Area Billing Report and the Operating Budget Ledger (OBL). The ET will involve establishment of a predetermined budget (combination Direct Care and CHAMPUS dollars) for the health services provided to a defined population (eligible beneficiaries as derived from the Defense Medical Information System (DMIS) for a given time period (fiscal year). The Air Force will measure a percentage deviation (plus or minus) from the established targets.

Figure A1.1. Sample Metric of Cost per Medical Work Unit (MWU).

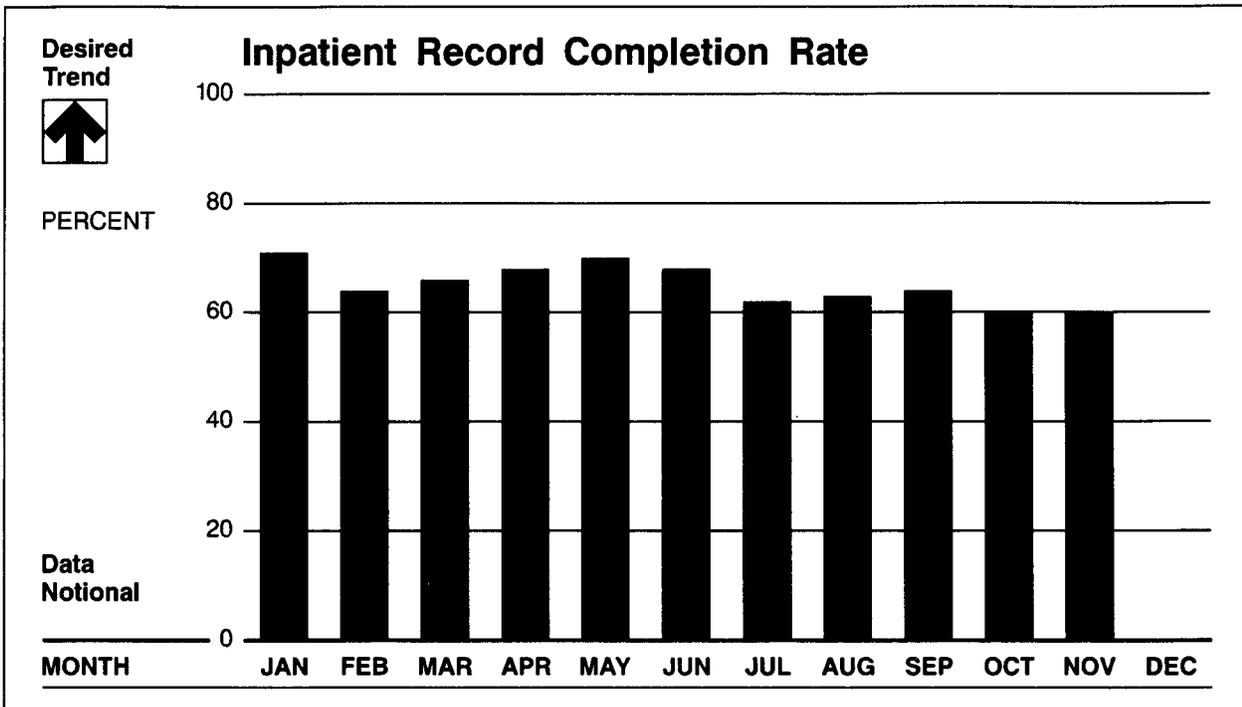


Figure A1.2. Sample Metric of Noneffectiveness Rate.

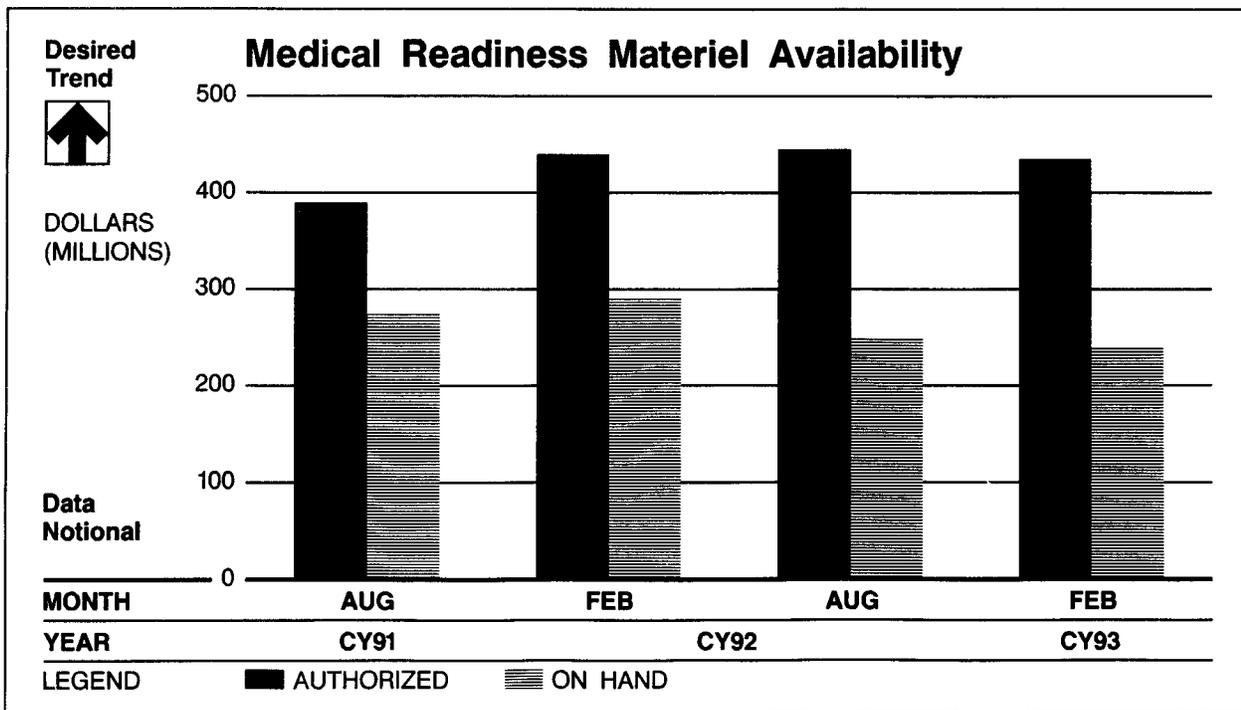
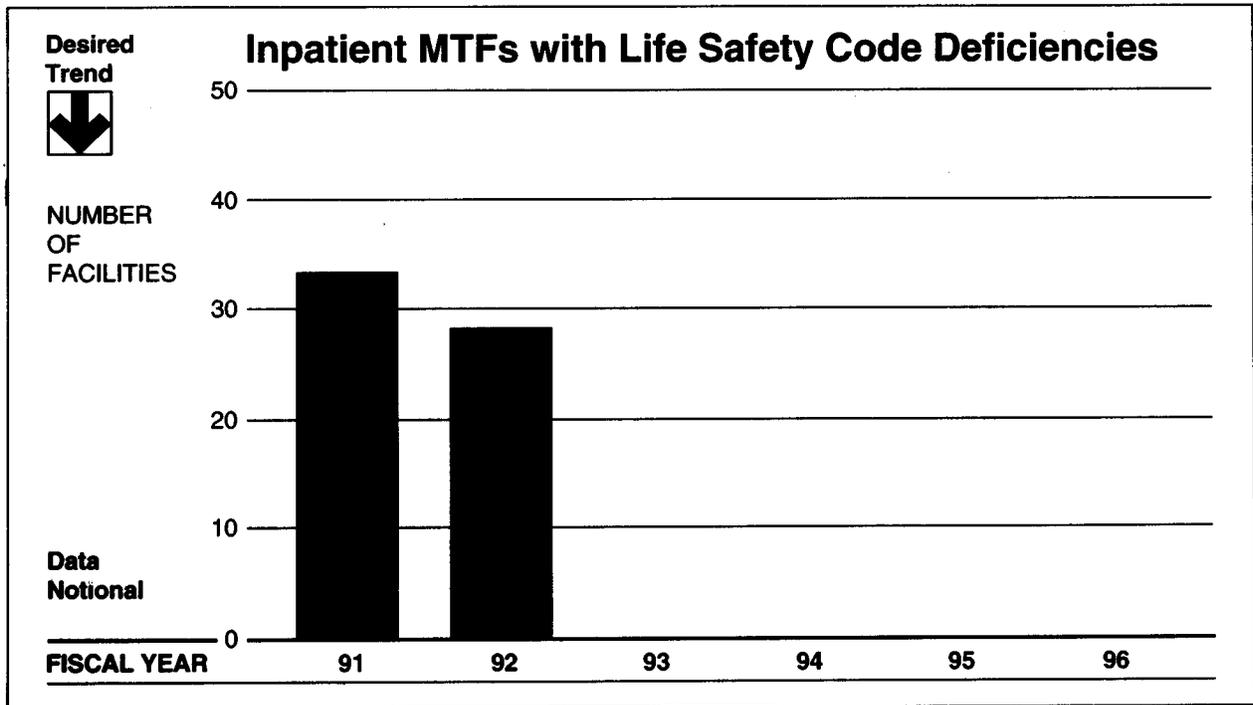


Figure A1.3. Sample Metric of Expenditure Target (Spendline).



**Attachment 2****TERMS EXPLAINED**

**Case Mix Index (CMI).**—The sum of all the case weight (CW) divided by the number of patients. This number is the average CW for all patients and reflects the average relative resource consumption per patient. This is a numeric way to calculate the complexity and level of resource intensity of the care delivered.

**Case Weight (CW).**—An adjustment to the diagnostic related group (DRG) relative weight to account for individual patient differences within the same DRG. Differences could be a prolonged length of stay or a transfer in or out of a facility. For example, an uncomplicated DRG 9, Spinal Disorders and Injuries, has a CW of 3.2092, but a prolonged complicated DRG 9 might have a CW of 15.1824 or higher.

**Diagnostic Related Group (DRG).**—A set of related diseases and disorders of the body. There are over 500 DRGs that encompass all diagnostic categories and diagnoses.

**Diagnostic Relative Weight.**—Based on historical cost data, each diagnostic related group (DRG) is assigned a numeric value that reflects the relative resource consumption for that DRG.

**Dollars/Relative Case Mix Index.**—This ratio provides the cost of the overall patient load adjusted for the average complexity of care needed. Improvements, such as more efficient use of money for the same complexity of cases, or for providing care to more complex cases with the same amount of money, are reflected in a downward trend.

**Relative Case Mix Index (RCMI).**— Changes in current medical practice may dictate change in diagnostic related group (DRG) weights. DRG weights are periodically adjusted to reflect these changes, limiting the ability to compare case mix indexes (CMI) over time. DoD Health Affairs provides an adjustment factor that statistically corrects each adjustment back to a base year, thus allowing comparison over time. The RCMI is the CMI divided by this adjustment factor.

**Attachment 3****RELATED DIRECTIVES AND INSTRUCTIONS*****Implementing Publications***

Title 10 U.S.C. 8013, *Secretary of the Air Force, Designee Program*, April 6, 1991

Public Law 97-174, *Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act Policy Guidelines on the DoD Coordinated Care Program*, May 4, 1992

DoD Instruction 6010.12, *Military-Civilian Health Service Partnership Program*, October 22, 1987

DoD Directive 6010.13, *Medical Expense and Performance Reporting System for Fixed Military Medical and Dental Treatment Facilities*, February 3, 1986

DoD Instruction 6010.15, *Third Party Collection Program*, March 7, 1991

DoD Directive 6010.17, *National Disaster Medical System*, December 28, 1988

DoD Instruction 6010.18, *CHAMPUS Health Care Finder and Participating Provider Program*, November 9, 1989

DoD Directive 6015.5, *Joint Use of Military Health and Medical Facilities and Services*, February 5, 1981

DoD Instruction 6015.20, *Changes in Services Provided at Military Medical Treatment Facilities*, December 3, 1992

DoD Instruction 6025.12, *Use of Joint Healthcare Manpower Standards*, March 1994

DoD Directive 6310.7, *Medical Care of Foreign Personnel Subject to the North Atlantic Treaty Organization Status of Forces Agreement*, December 18, 1962

DoD Directive 6480.5 *Military Blood Program* June 16, 1972

***Interfacing Publications***

DoD Manual 7110.1-M With Change 1, *Department of Defense Budget Guidance Manual*, May 1990

DoD Manual 7220.9-M, *Department of Defense Accounting Manual*, October 1983

JCS Pub 4-02, *Doctrine for Health Service Support in Joint Operations*, No Change

Volume I, Annex F, *War and Mobilization Plan*, July 1988

*Policy and Guidance and Joint Commission on the Accreditation of Healthcare Organization's Accreditation Manual*, No Change

***Interfacing Departmental Publications***

AFI 10-201, *Status of Resources and Training Systems (SORTS)*, (formerly AFR 55-15)

AFI 10-401, *Operation Plan and Concept Plan Development and Implementation*, (formerly AFRs 28-3, 28-4, 28-5)

AFPD 32-40, *Disaster Preparedness*, (formerly AFR 355-1)

AFPD 38-1, *Organization*, (formerly AFR 26-2)

AFI 38-201, *Determining Manpower Requirements*, (formerly AFRs 25-5 and 26-1, Volume 3)

AFM 67-1, Volume V, *Air Force Medical Materiel Management System*, No Change

**NOTE:**

Other related policies are in AFPDs 41-2, Medical Support, and 44-1, Medical Operations.