Department of Defense

TRICARE

2009

MEDICAL MANAGEMENT GUIDE

Version 3.0

DoD TRICARE Management Activity

- MEDICAL MANAGEMENT ESSENTIALS
- UTILIZATION MANAGEMENT
- CASE MANAGEMENT
- DISEASE MANAGEMENT
- MEDICAL MANAGEMENT TOOLS

Instructions:

When accessing this Guide from the CD-ROM:

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Executive Summary

INTRODUCTION

The Department of Defense (DoD) TRICARE Management Activity (TMA) values all staff involved in the delivery of high-quality health care to DoD beneficiaries — Service members and their families. TMA is constantly working to provide the most current information to its partners in this effort.

The *Medical Management Guide* is issued by the Office of the Assistant Secretary of Defense for Health Affairs (ASD [HA]) and TMA, Office of the Chief Medical Officer (OCMO), Population Health and Medical Management Division (PHMMD). The Guide covers the components of a Medical Management (MM) program, including applicable principles, implementation concepts, processes, and tools/databases for Utilization Management (UM), Case Management (CM), and Disease Management (DM). It complements the 2001 *DoD Population Health Improvement Plan and Guide* published by TMA and the Government Printing Office (http://www.tricare.mil/ocmo/download/mhs_phi_guide.pdf, and ▶ **CD-ROM Resource ES-1**).

The ASD (HA) annually signs a five-year performance plan for the Defense Health Program (DHP) with the Secretary of Defense, along with Army, Navy, and Air Force Assistant Secretaries for Manpower and Reserve Affairs. MM-related measures (i.e., metrics) highlighted in the FY 2009 DHP Plan (▶ **CD-ROM Resource ES-2**) include:

- Beneficiary satisfaction with the health plan.
- Inpatient production target (relative weighted products [RWP]).
- Outpatient production target (relative value units [RVUs]).
- Primary care productivity (RVUs per primary care provider per day).
- Medical cost per member per year.

LEGISLATIVE GUIDANCE

Under legislative mandates, the ASD (HA) submits an annual report to Congress regarding healthcare delivery for 9.4 million Military Health System (MHS) beneficiaries. The 2009 report documents the MHS goal of providing high-quality care, improving performance through clinical and process outcomes, and increasing patients' confidence in the care they receive.

Version 3.0 of the Guide draws more specifically from the *Report to Congress on the Comprehensive Policy Improvements to the Care, Management and*

Transition of Recovering Service Members, released by the DoD and the Department of Veterans Affairs (VA) on Sept. 16, 2008 (▶ **CD-ROM Resource ES-3**). That policy, developed in response to Title XVI, Sections 1611 and 1615 of the National Defense Authorization Act (NDAA) of 2008 (▶ **CD-ROM Resource ES-4**), focuses on improving healthcare delivery within Medical Treatment Facilities (MTFs) by addressing MM-related issues (Sec. 1611) and facilitating the transition of Service members from Active Duty status to civilian life (Sec. 1615).

The DoD/VA policy was based on the following findings and recommendations:

- *An Achievable Vision: Report of the Department of Defense Task Force on Mental Health* (2007) (▶ **CD-ROM Resource ES-5**)
- *Rebuilding the Trust: The Independent Review Group on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center* (2007) (▶ **CD-ROM Resource ES-6**)
- *The Secretary of Veterans Affairs Task Force on Returning Global War on Terror Heroes* (2007) (▶ **CD-ROM Resource ES-7**)
- *Serve, Support, Simplify: The President's Commission on Care for America's Returning Wounded Warriors* (2007) (▶ **CD-ROM Resource ES-8**)
- *Honoring the Call to Duty: Veterans' Disability Benefits in the 21st Century* (Veteran's Disability Benefits Commission, 2007) (▶ **CD-ROM Resource ES-9**)
- *The President's Task Force to Improve Health Care Delivery for Our Nation's Veterans* (2003) (▶ **CD-ROM Resource ES-10**)
- *The Report of the Congressional Commission on Service Members and Veterans Transition Assistance* (1999) (▶ **CD-ROM Resource ES-11**)
- *The President's Commission on Veterans' Pensions* (1956) (▶ **CD-ROM Resource ES-12**)

More specifically, the DoD/VA policy reflects the overarching theme of the report *Rebuilding the Trust: The Independent Review Group (IRG) on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center*, which recommends permanent changes in MM administration as the most effective way to promote treatment for wounded, ill, and injured Service members returning from the Afghanistan and Iraq theaters — Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), respectively. (See also **Appendix C, Definitions**, Global War on Terrorism [GWOT] and Overseas Contingency Operations [OCO].)

DESCRIPTION OF GUIDE CONTENTS

The Guide is organized as follows:

Section I, Medical Management Essentials, describes crucial components of MM within the MHS, including the link between MM and Population Health and the dynamics between UM, CM, and DM in helping reduce unnecessary or inappropriate services and/or duplication of services. This section also looks at universally applicable MM considerations, such as the utilization of information technology and how to protect the privacy of personal health information (PHI).

Section II, Utilization Management, discusses the application of UM within the Direct Care System (DCS). It provides information on the structure and processes needed to develop and implement an effective UM program, including a seven-step process for quality improvement (QI). It also contains subsections on Utilization Review (UR), decision support tools, and Referral Management (RM). Further, it provides guidance on implementing the MTF review and appeals process and includes a variety of useful tools, such as sample job descriptions and a completed MTF UM plan. As in the CM and DM sections, it includes a subsection describing how patient outcomes are measured, with examples of potential measures.

Section III, **Case Management**, discusses the MTF approach to CM. In the military setting, CM targets Active Duty Service members (ADSMs) and beneficiaries with complex, multi-system healthcare needs and family members with special needs who require care coordination or CM services. This section focuses on the most current legislative priorities for CM in the MHS, including a more integrated approach to physical and psychological rehabilitation, and recovery coordination and transition activities. Further, it provides information on the structure and processes needed to develop and implement an effective CM program, including key process steps, discharge planning and care coordination, and guidance on establishing local CM programs. As in the UM and DM sections, it includes a subsection describing how patient outcomes are measured, with examples of potential measures.

Section IV, **Disease Management**, discusses DM within the DCS. DM employs evidence-based medicine to guide health care for patient populations with common chronic diseases or conditions (e.g., diabetes, asthma). When implemented effectively, DM can improve patient satisfaction and quality of life, and reduce medical costs. This section includes information on clinical practice guidelines (CPGs) as an important DM tool and provides guidance on establishing a DM program. As in the UM and CM sections, it includes a subsection describing how patient outcomes are measured, with examples of appropriate measures.

Section V, **Medical Management Tools**, describes current information systems, data marts, tools, and applications used within the MHS that can help MM staff evaluate the effectiveness of their programs.

Appendices

- Appendix A lists specific and general references by section, as applicable.
- Appendix B provides a list of common acronyms related to MM in the MHS.
- Appendix C provides a list of common definitions related to MM in the MHS.
- Appendix D lists MM-related resources (e.g., organizational websites, journals).

The Guide is available in hard copy, on CD-ROM, or as a download from the PHMM Division Support Center website: http://www.tricare.mil/ocmo/OCMO_PHMM.cfm.

CONTACT INFORMATION

Assistant Secretary of Defense, Health Affairs/
TRICARE Management Activity
Office of the Chief Medical Officer
Population Health and Medical Management
Division
5111 Leesburg Pike
Suite 810
Falls Church, VA 22041
COMM: (703) 681-0064
DSN 761-0064
FAX: (703) 681-1242

CD-ROM RESOURCES

ES-1 DoD TMA *Population Health Improvement Plan and Guide* (2001)

ES-2 *DoD Defense Health Plan (DHP) 2009 Highlights*

ES-3 *Report to Congress on the Comprehensive Policy Improvements to the Care, Management and Transition of Recovering Service Members* (Sept. 16, 2008)

ES-4 National Defense Authorization Act (NDAA) of 2008, Title XVI, Sections 1611 and 1615

ES-5 *An Achievable Vision: Report of the Department of Defense Task Force on Mental Health* (2007)

ES-6 *Rebuilding the Trust: The Independent Review Group (IRG) on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center* (2007)

ES-7 *The Secretary of Veterans Affairs Task Force on Returning Global War on Terror Heroes* (2007)

ES-8 *Serve, Support, Simplify: The President's Commission on Care for America's Returning Wounded Warriors* (2007)

ES-9 Veteran's Disability Benefits Commission, *Honoring the Call to Duty: Veterans' Disability Benefits in the 21st Century* (2007)

ES-10 *The President's Task Force to Improve Health Care Delivery for Our Nation's Veterans* (2003)

ES-11 *The Report of the Congressional Commission on Service Members and Veterans Transition Assistance* (1999)

ES-12 *The President's Commission on Veterans' Pensions* (1956)

Acknowledgements

Version 3.0 of the *Medical Management Guide* was prepared by the Population Health and Medical Management Division (PHMMD) in collaboration with the Tri-Service Medical Management Working Group. Service subject matter experts (SMEs) in Utilization Management (UM), Case Management (CM), and Disease Management (DM), as well as healthcare administrators, contributed valuable input toward ensuring a complete and current product.

A special thanks to the many healthcare professionals across the Military Health System (MHS) who provided critical feedback on the final draft. Technology, Automation and Management (TeAM), Inc. provided professional technical, editorial, training, and graphics expertise in revising the Guide, developing accompanying Web-based learning modules, and designing appropriate graphical elements.

TRICARE Management Activity Population Health and Medical Management Division

Patricia Dorn, CAPT, NC, USN
Teresa M. Long, DHSc, MPA, BSN, CCM

Army

Catherine A. Mozden, COL, AN
Carla M. Dickinson, MAJ, AN
Pamela S. Birgenheier, MN, RN, CCP
Marjory K. Waterman, MN, RN
Betty I. Thomas, MS, RN
Patricia W. McGregor, RN, CPHQ
Judy C. Terry, MN, RN

Navy

Annette M. Von Thun, CDR, MC
Mary B. Greenberg, CDR, NC
Laurie S. MacGillivray, CDR, NC
Moise Willis, CDR, NC
Vanessa D. Richards, LCDR, NC
Anne M. Cobb, RNC, MSN, CMAC
Susan R. Blankenship, MS, BSN, RN, CCM
Lisa J. Cockran, RN, CCP, NHC
Joan I. McLeod, RN, MGA
Leanne M. Repko, MPP

Air Force

Carol Andrews, Lt Col, NC
Deona J. Eickhoff, Lt Col, NC
Sabrina M. Preston-Leacock, Lt Col, NC
Melanie A. Prince, Lt Col, NC
Brij B. Sandill, Lt Col, NC
Tammy R. Tenace, Lt Col, NC
Iwona E. Blackledge, Maj, NC
Shawn Dunne, Maj, NC
Karyn L. Revelle, Maj, NC
Paula M. Winters, Maj, NC
Sherry A. Herrera, MSN, NE-BC, CPUM, CMAC
Beverly K. Luce, MHSA, BSN, RN, CCM

U. S. Department of Veterans Affairs

Karen M. Ott, RN, MSN

Industry

Terry Kelley, BSN, RN, CCM — Case Management Society of America

Contractor Support

Technology, Automation and Management (TeAM), Inc.

- Charles G. Davis, CEO, Program Manager
- Anne F. Cook, Technical Writer/Editor
- Keira R. Thrasher, Senior Curriculum Developer
- Syreeta M. Collier, Logistics Coordinator
- Valerie Thompson, Graphic Designer

Military Patient Centered Medical Home Model

This model was used with permission from and was created by the National Naval Medical Center Patient Centered Medical Home and by CDR Kevin Dorrance, USN, MC.

Cover Photo

Source: http://www.defenseimagery.mil/
Photographer: MSgt Steve Cline

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MEDICAL MANAGEMENT ESSENTIALS

MEDICAL MANAGEMENT ESSENTIALS

TRICARE

Department of Defense

Medical Management Essentials

SECTION I

INTRODUCTION

Definition of Medical Management

In the healthcare industry, organizations have established programs or systems to improve clinical outcomes and manage rising healthcare costs. This is broadly referred to as the field of "Medical Management" (MM).

The 2006 Department of Defense Instruction (DoDI) 6025.20, *Medical Management (MM) Programs in the Direct Care System (DCS) and Remote Areas* (▶ **CD-ROM Resource MME-1**, and http://www.dtic.mil/whs/directives/corres/pdf/602520p.pdf) defines MM as an "integrated managed care model that promotes Utilization Management (UM), Case Management (CM), and Disease Management (DM) programs as a hybrid approach to managing patient care." MM includes a shift to evidence-based, outcome-oriented programs that place "a greater emphasis on integrating clinical practice guidelines into the MM process, thereby holding the system accountable for patient outcomes" (DoDI 6025.20). This guide provides specific, how-to guidance on establishing MM programs within Military Treatment Facilities (MTFs) in accordance with the DoD instruction.

The three components of MM are commonly defined as follows:

- Utilization Management: An organization-wide, interdisciplinary approach to balancing cost, quality, and risk concerns in the provision of patient care. UM is an expansion of traditional Utilization Review (UR) activities to encompass the management of all available healthcare resources, including Referral Management (RM).
- Case Management: A collaborative process under the Population Health continuum that assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes.
- Disease Management: An organized effort to achieve desired health outcomes in populations with prevalent, often chronic diseases for which care practices may be subject to considerable variation. DM programs use evidence-based interventions to direct patient care. DM programs also equip the patient with information and a self-care plan to manage his/her own health and prevent complications that may result from poor control of the disease process. The term "condition management" includes non-disease states (e.g., pregnancy).

See also **Appendix C, Definitions**.

Both patients and MTF leadership have been driving forces for more efficient, effective, and integrated MM programs in the following ways:

- In today's healthcare arena, patients are more informed and empowered consumers. As a result, they demand more choice in their healthcare benefits than ever before.
- MTF leadership strives to control rising healthcare costs, demonstrate return on investment (ROI), and ensure that patients are provided with safe, quality care. MTF leadership is key to providing the organizational structure, appropriate resources, and necessary expertise to ensure the success of any MM program.

Primary Care Management Team Approach

Primary care in the MHS revolves around the role of the Primary Care Manager (PCM) — this PCM model is built on the documented value of patients, with consistent access to comprehensive primary care, achieving better health outcomes, improved patient experience, and more efficient use of resources. In this model, each patient has an ongoing relationship with a personal primary care provider trained to provide continuous and comprehensive care.

While the MHS primary care system is ultimately supervised and led by a PCM, the concept of a team of healthcare professionals, under the leadership of the credentialed provider team leader, is widely accepted and highly valued as a key component of the MHS culture. The PCM model in the MHS has been expanded to include the concept of a Patient-Centered Medical Home (PCMH), as illustrated in Fig. 1. In the PCMH, patients have a continuous relationship with a medical home that offers stability and continuity of care as well as serving as the point of first contact when problems or questions arise.

MM is an integral part of the PCM model and PCMH team approach to patient care. Case managers assist the PCM team in coordinating, communicating, and integrating care. Disease managers assist the team in consistently implementing evidenced-based, clinical-based guidelines. Utilization managers assist the team in the optimal allocation of scarce medical resources within the medical home.

The successful application of MM activities within MTFs is geared toward achieving the primary target goals of improving access and quality, managing cost, and optimizing readiness.

In addition to applying to the civilian-based Purchased Care System (PCS), MM traverses the Direct Care System (DCS), which encompasses Army, Air Force, and Navy facilities in the North, South, and West regions of the United States; and overseas in the designated region Outside of the Continental United States (OCONUS). MTF staff work closely with their Contracting Officer's Representative/ Contracting Officer's Technical Representative (COR/ COTR) to help ensure that MTF activities are closely coordinated to meet patient needs. Fig. 2 depicts the MHS MM model.

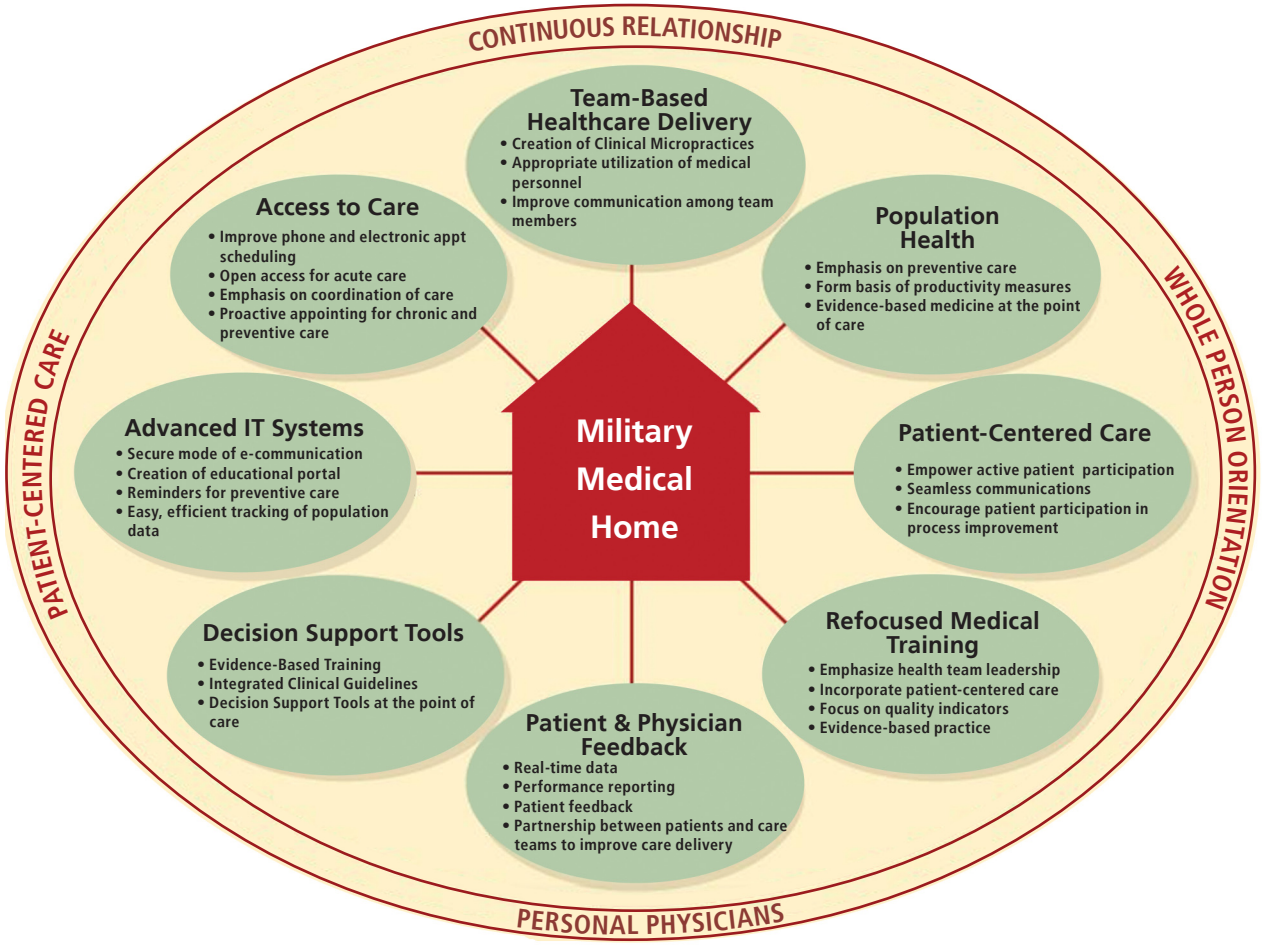


Fig. 1 – Military Patient Centered Medical Home Model

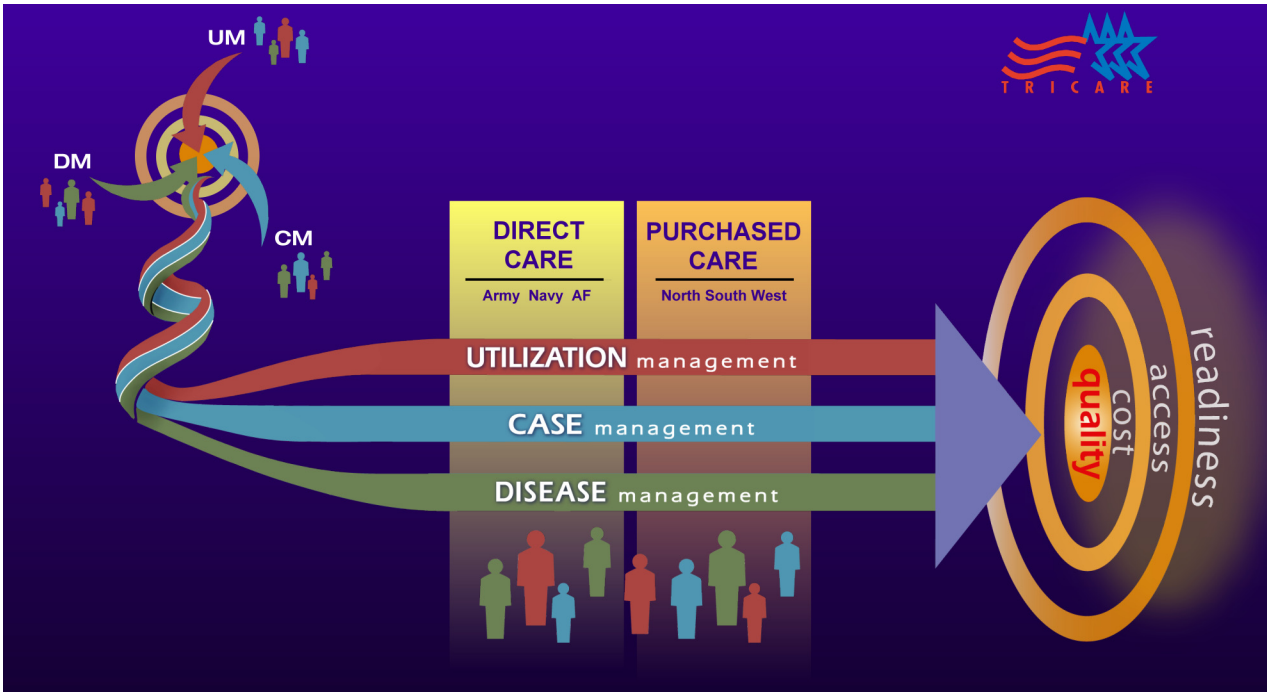


Fig. 2 – MHS Medical Management Model

Policy Requirements for Medical Management within the Direct Care System

DoDI 6025.20 defines terms for MM, implements policies, assigns responsibilities, and specifies content for component activities within the MTF. It also codifies support for an interdependent MM system between the DCS and Purchased Care System (PCS). The instruction outlines the following minimal requirements:

Medical Management *(General)*

- Designate one individual to be responsible for the facility's MM program.
- Establish an integrated MM plan and program using the quality improvement approach.

Utilization Management

- Use systematic, data-driven processes to a) proactively define referral patterns for focused interventions and b) identify and improve clinical and business outcomes.
- Incorporate UR activities using the same generally accepted standards and criteria for medical necessity, appropriateness, and reasonableness when reviewing the quality, completeness, and adequacy of health care provided within the MTF.
- Adhere to the established MTF review and appeal process.
- Establish a referral and authorization management process for internal and external referrals in accordance with MHS policies.
- Establish a solid relationship with the Managed Care Support Contractor (MCSC) — see **TRICARE and Other Benefit Programs, Working with Managed Care Support Contractors**, later in this section.
- Establish processes to monitor, manage, and optimize access to care within the MTF (e.g., to meet demand and access standards by maximizing use of template management tools).
- Encourage collaboration and communication among all MM staff, including clinical and business personnel, to promote efficient, effective, and high-quality care and services.

Case Management

- Use CM to manage the health care of patients with multiple, complex, chronic, and/or catastrophic illnesses or known conditions that meet CM criteria.
- Provide the appropriate level of care (e.g., care coordination, discharge planning) for individuals requiring special assistance (e.g., wounded warriors).
- Coordinate the transfer of information with MCSC CMs when patients require CM outside the DCS.
- Encourage case managers to communicate with all members of the healthcare team, especially with other MM personnel.
- Use CM to promote a seamless transition from one duty station to the next for families enrolled in the Exceptional Family Member Program (EFMP) and Special Needs Identification and Assignment Coordination (SNIAC) programs, and who are also enrolled in a CM program.

Disease Management

- Assess the population to determine the need for specific DM programs by evaluating MTF Population Health data through various information systems.

- Use evidence-based tools such as clinical practice guidelines (CPGs) as part of the DM program, after designated local MTF authorities have reviewed and approved them.
  - o CPGs are systematically developed, nationally recognized statements that help practitioners and beneficiaries make appropriate decisions about healthcare services, depending on clinical circumstances.
  - o It is important to note that while CPGs are most frequently discussed as a tool for DM, they are also an integral resource for all MM programs.
- Monitor CPG outcomes and compliance to identify practice pattern variances and trends.
- Collaborate with other MTF and MCSC MM staff to promote consistent program goals and continuity of care.

Medical Management Goals and Approach

MM emphasizes the integration of evidence-based practices, including CPGs, and focuses on holding healthcare systems accountable for optimizing patient outcomes. Specifically, the universal goals of MM include the following:

- Improve patient outcomes through coordinated/integrated practices.
- Incorporate the goals of UM, CM, and DM.
- Provide more efficient approaches to healthcare delivery.
- Shift the focus from cost containment to continuous quality improvement.
- Recognize the dynamic of MM components within the Population Health continuum (see Fig. 4, Integrated Medical Management Model [IM3]).

In the MHS, the MM "umbrella" comprises UM, CM, and DM as a three-pronged strategy to accomplish these goals. Based on data analysis, MTFs may implement programs for specific care situations or chronic conditions. For example, when applied appropriately:

- UM may reduce overutilization of either the Emergency Department (ED) or inpatient setting by identifying patients with chronic diseases (e.g., asthma) that have a significant impact on healthcare outcomes and costs.
- CM can be used to assist patients with multiple co-morbid diseases or special healthcare needs (e.g., exceptional family members, complex patients, wounded warriors) and develop interdisciplinary plans to meet those needs.
- DM may minimize complications in those with a particular chronic disease and help mitigate the long-term consumption of healthcare resources for a specific population. Along with case managers, disease managers can provide important health education and advocacy by helping patients adhere to their treatment plans and gain control over and responsibility for their own health care.

The MM approach in the health industry has evolved rapidly in recent years. This evolution can be attributed to several factors, including:

- The desire to increase the effectiveness of patient-provider relationships and improve clinical outcomes.
- Greater demand to contain costs and improve return on investment (ROI) (i.e., to demonstrate value).
- The need to improve technology and communication to facilitate data collection, analysis, and information sharing (Utilization Review Accreditation Commission [URAC], 2005).
- The need to fulfill regulatory and legislative mandates per the Code of Federal Regulations (CFR).

MM policy and programs built from high-quality data collection, proper analysis, interpretation, dissemination, and outcome measurement ensure better clinical outcomes and improved quality of care for MHS beneficiaries. Cohen and Cesta (2001) cite three major types of outcome that are measured in healthcare systems:

- High-quality care – Measured by complications, readmission rates, morbidity and mortality, and patient satisfaction. These quality measures (i.e., metrics) reflect greater accountability on the part of healthcare providers to patients and other stakeholders.
- Decreased or appropriate costs – Include measures such as length of hospital admission, avoidable admission days, decrease in ED visits, and decrease in excessive utilization of outpatient appointments. In military CM, appropriate costs are also measured by retaining care in the DCS (i.e., MTFs) if the capability and capacity exist. This outcome relates directly to a MTF's business plan.
- Improved health status — Often measured through surveys that examine how a patient perceives the impact of health on quality of life. Other measures may include functional health status, reduction or elimination of symptoms, resumption of employment, or improved coping mechanisms.

It should be noted that many of the same resources used to calculate corporate outcome measures are available to MM teams at the MTF level. Further, healthcare teams should be apprised of and aligned with other quality and outcome measure sets that fall under the rubric of Quality Management (QM). One particular example is quality measures for perinatal care. MTF performance for obstetrical surgery, complications, post-partum readmissions, and neonatal mortality rates is tracked using the National Perinatal Information Center (NPIC) dataset for comparison across both the MHS and civilian facilities. Other sources for quality measures include the National Surgical Quality Improvement Program (NSQIP) and the Anesthesia Report and Monitoring Panel (ARMP). Local QM representatives should be able to provide greater detail on which measures and data sources are tracked at a specific MTF. (**Section II, Utilization Management; Section III, Case Management; and Section IV, Disease Management** each offer detailed discussions of outcome measurement.)

THE LINK BETWEEN MEDICAL MANAGEMENT AND POPULATION HEALTH

The link between MM and Population Health is an important one, with the trend in recent years for organizations to incorporate total Population Health techniques as part of their MM programs. Four Population Health concepts specific to military medical care are:

- Maintain a fit and healthy Active Duty population (which affects readiness).
- Improve the health status of the enrolled population.
- Improve the efficiency and effectiveness of the MTF healthcare delivery system.
- Improve the military community population health status.

In order to incorporate Population Health techniques, MM and Population Health staff need to evaluate the current health practices of MTF enrollees and identify opportunities to improve the health of that beneficiary population. The key Population Health process elements listed below relate directly to MM:

1. Population Identification and Assessment
2. Demand Forecasting
3. Demand Management
4. Capacity Management
5. Evidence-based Care and Prevention
6. Program Evaluation and Feedback

Fig. 3 illustrates the relationship between Population Health elements and environmental influences within the military community.

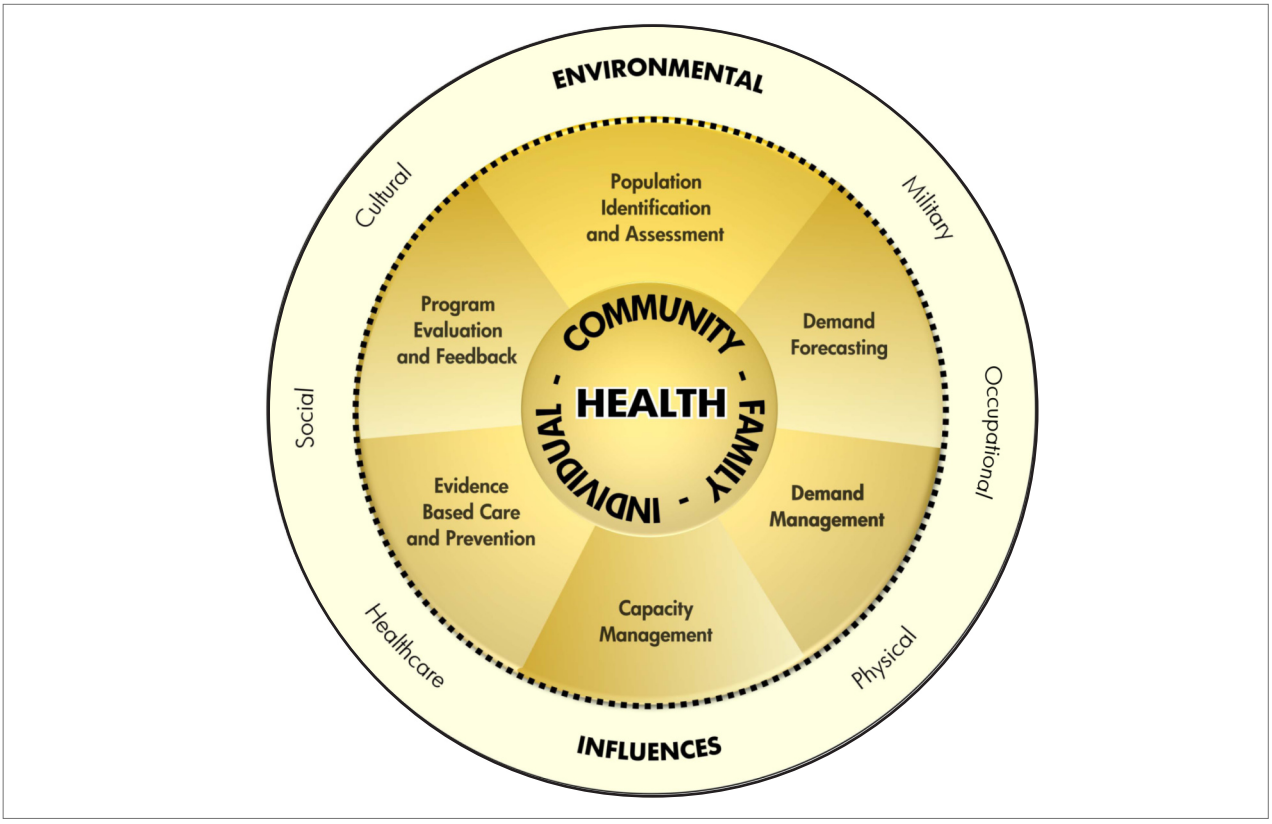


Fig. 3 – MHS Population Health Model (2001)

Because many of the process steps are similar, Population Health and MM staff often collaborate on developing, reviewing, and meeting program goals.

For example:

- UM activities focus on the four Population Health principles of defining the population, applying epidemiological methods to describe the population and its risks, identifying and employing evidence-based interventions, and managing information — all in the interest of supporting ongoing assessment, planning, and performance monitoring/improvement.
- Population-based CM coordinates care and services for groups with similar characteristics. Case managers are responsible for "managing health, illness, prevention, and coordination of care and services, including during acute episodes or hospitalization." The case manager's role is to "develop and manage a comprehensive plan of care throughout the continuum in a way that takes advantage of all the resources an integrated system has to offer" (Qudah, Brannon, 1998).
- Population Health looks at the broader population in a larger context, while DM focuses on a particular segment of the population with a specific set of co-morbidities. DM activities are directly linked to population identification, evidence-based care and prevention, and program evaluation and feedback.

Population Health Elements in Action

Population identification and assessment involves studying and understanding the population, which may consist entirely of beneficiaries within the MTF or represent a subset of that group. Regardless of the actual size of the population, you should be able to identify sub-populations that may benefit from specific programs. Knowing your population allows you to extract information on age, gender, and disease burden in the interest of planning healthcare services that best meet beneficiary needs.

Demand forecasting involves making an estimate of the volume of care required by a population or population subset. This requires not only accurate demographic and disease information, but also population-specific knowledge of healthcare needs, established clinical practice standards (chronic and preventive), and system- or Service-specific demands (e.g., pre-deployment exams). Population identification and assessment activities allow MM staff to anticipate, or "forecast," the healthcare needs of the relevant population or sub-population.

Demand is typically measured by aspects such as workload units by provider type, number of specific treatments, and pharmacy demand. By understanding the demand forecast for an MTF, the healthcare team can determine staffing and budgetary requirements and prioritize programs to support health promotion, prevention, and chronic care services.

Demand management involves proactive intervention to reduce the rate of unnecessary healthcare resource utilization while encouraging

patients to use healthcare resources appropriately. Related activities include:

- Evaluating primary care manager (PCM) assignments to address the right patient mix for the provider role and to generate even patient distribution among providers.
- Optimizing the activities of all healthcare team members during patient visits.
- Utilizing functions such as nurse triage, group appointments, etc.
- Promoting the enrollment of beneficiaries to providers at the MTF when sufficient MTF resources are available.
- Educating beneficiaries about primary care triage systems and self-care programs (e.g., advice lines, Web-based materials).

Capacity management involves matching the needs of the population served (as identified during demand forecasting) with the quantity and quality of services available at the MTF. Related activities include:

- Implementing proactive strategies to meet forecasted demand.
- Managing clinical processes.
- Clarifying staff roles and responsibilities.
- Controlling leakage to the network.

To accomplish these endeavors, it is important to optimize the supply of healthcare resources to align with beneficiary needs or demand. This may include:

- Identifying actions that will reduce excess healthcare demand.
- Improving processes to increase system "throughput" (amount of work completed within a given period of time).
- Using evidence-based practices to perform the right actions at the right time.

In terms of patient demand, the Capacity Management element is affected by both actual healthcare needs and military readiness requirements. From the healthcare team perspective, it is affected by factors such as provider, support staff, and ancillary staff availability; physical space; equipment needs; and appointment processes.

Evidence-based care and prevention involves using a systematically developed, research-based approach to health care. This approach increases the quality of care delivered, reduces variation, and decreases cost. When evidence-based care is practiced, patients will typically experience an enhanced quality of life as a result of higher functional status, greater ability to self-manage, and less frequent hospitalizations. Evidence-based care is informed by research rather than provider consensus. It relies on an interdisciplinary team to manage care and provide referral to health promotion and education resources.

Program evaluation and feedback rests on the assumption that Population Health programs and their respective outcomes (as with any other aspect of health care) should be evaluated to determine performance and progress. This element incorporates a range of tools and programs to a) identify and address barriers to achieving desired outcomes, and b) make changes, as needed, to improve healthcare delivery processes.

TRICARE AND OTHER BENEFIT PROGRAMS

MTF Commanders are responsible for all health care provided or purchased within their catchment/market area. As such, they have direct control over appointment and referral services as well as over MM programs for their TRICARE Prime enrollees.

The TRICARE healthcare program (http://tricare.mil) serves Active Duty Service members (ADSMs), National Guard and Reserve members, retirees, their families, survivors, and certain former spouses worldwide. TRICARE contracts augment MTF services. Each MTF, Multi-Service Market Office (MSMO), and TRICARE Regional Office (TRO) must work with its regional contractor (see **Working with Managed Care Support Contractors**, later in this section) to develop individual memoranda of understanding (MOUs) that establish programs and activities specific to that particular facility. Contract implementation may vary based on how each facility interprets an MOU. For additional information on TRICARE, contact your local TRICARE Service Center (TSC) and/or Benefits Counseling and Assistance Coordinator (BCAC).

TRICARE offers special programs, including the Extended Care Health Option (ECHO), Continued Health Care Benefits Program (CHCBP), and Computer/Electronic Accommodation Program (CAP). For more information, go to http://tricare.mil/mybenefit/home/overview/SpecialPrograms.

Most beneficiaries will have TRICARE as their primary provider or payor. But MM staff, specifically UM and CM personnel, also need to have a basic understanding of other programs beneficiaries may be enrolled in, such as:

- Medicare, Medicaid: http://www.cms.hhs.gov/
- Supplemental Security Income (SSI): http://www.ssa.gov/ssi/
- Social Security Disability Insurance (SSDI): http://www.ssa.gov/disability/
- U.S. Family Health Plan: http://www.usfhp.com/
- U.S. Department of Veterans Affairs (VA): http://www.va.gov/

See **Appendix C, Definitions**; and **Appendix D, Resources** for more information.

Working with Managed Care Support Contractors

The United States are divided into three TRICARE regions. Each of the regions has a regional contractor that helps administer the TRICARE benefit plan. This role is defined as the Managed Care Support Contractor (MCSC). MCSCs provide a variety of functions, including:

- Establishing TRICARE provider networks.
- Operating TRICARE service centers.
- Operating customer service call centers.
- Providing administrative support, such as enrollment, care authorization, and claims processing.
- Communicating and distributing educational information to beneficiaries and providers.

MCSCs work with their TRO to manage the benefit at the local level, and receive overall guidance from TMA headquarters (TRICARE Fact Sheets, TRICARE Regional Contractors for the United States, 2006). (See also **Appendix C, Definitions**.)

The MHS necessitates close collaboration between MM staff located in the DCS, embodied by the MTF — an Active Duty setting; and the PCS, embodied by the MCSC — in a civilian setting. Patients benefit when their healthcare services are smoothly coordinated between the DCS and PCS. This "hand-off," or patient transition, is the act of transferring MM functions from one responsible entity to another. Patients may frequently transition between the MTF and the network, or between individual MTFs.

By contract, the MCSC runs programs that manage the health care of individuals with high-cost conditions or with specific diseases addressed by proven clinical management programs; this responsibility extends to providing MM services for beneficiaries enrolled in ECHO. The MCSC also assumes responsibility for enrolled beneficiaries with catastrophic, high-risk, high-cost situations whose care occurs (or is projected to occur), in whole or in part, in the civilian sector. Program specifications vary by region and are governed by specific MTF MOUs with the MCSC.

THE LINK BETWEEN CLINICAL AND BUSINESS OPERATIONS

The fundamental concepts in determining appropriate MM measures within the MTF are a) integration with the Command's measures and b) alignment with the local MTF's strategic vision and business plan.

Business planning "encompasses all strategic goals and activities needed to ensure an organization's survival and growth," with the outcome of the business planning cycle being "a consolidated MHS business plan that serves as a primary input to the Prospective Payment System (PPS)." In this regard, Tri-Service business plans provide "a common framework across the MHS for improving and measuring performance" in the DCS (FY 2010-2012 Navy Bureau of Medicine and Surgery [BUMED] Business Planning Supplemental Guidance, ▶ **CD-ROM Resource MME-2**).

According to the DoD's Defense Health Program (DHP) FY 2009 budget estimates, the DoD's total health costs more than doubled between 2001 and 2006, from $19 billion to $38 billion — an increase representing 8 percent of the DoD budget. This increase was attributed to a combination of benefit enhancements, increased beneficiary use, stable cost shares, and high healthcare inflation. Those costs were projected through trend analysis to reach $64 billion, or 11.3 percent of the DoD budget, by FY 2015 (refer to ▶ **CD-ROM Resource ES-2**, *DoD Defense Health Plan (DHP) 2009 Highlights*).

The business plan is the MTF's roadmap for financial success, but clinical operations, in collaboration with Resource Management staff, are crucial in determining that road map. It is therefore essential for clinical staff to actively engage in the business planning process. Their knowledge gives them the ability to validate baseline historical data such as enrollment, outpatient/inpatient workload, and out-patient/inpatient utilization.

The staff primarily involved in producing workload, documentation, and coding should be consulted when the MTF is determining a particular department's productivity targets or goals (e.g.,

number of relative value units [RVUs]). Clinical professionals will also be involved in implementing some of the critical initiatives identified within the business plan, such as RM and evidence-based health care (i.e., DM). (See also **Integrating Utilization, Case, and Disease Management Functions; Staffing for Combined Functions**, later in this section.)

Eight critical initiatives frame business planning in the MTF:

1. Improve Access to Care
2. Improve Provider Productivity
3. Manage Referrals
4. Labor Reporting (performed through the Medical Expense & Performance Reporting System, or MEPRS: http://www.meprs.info/ — see also **Section V, Medical Management Tools**)
5. Improve Documented Value of Care (Coding)
6. Evidence-based Health Care
7. Manage Pharmacy Expenses
8. Expeditionary Planning (Readiness)

To help MTF Commanders execute their local business plans, the MHS has established MM as part of both its clinical and business operations. Business planning offers the opportunity for annual strategic management by creating a defined relationship between current performance and the critical requirements needed to reach market goals. As a new resource allocation methodology, business planning forecasts healthcare needs within the DCS and PCS with budgets focused on outputs rather than inputs. MM measures are calculated at various levels within the MHS, with a number of sources that centrally calculate and display measures from Service-level aggregate to provider-level detail. (See **Section V, Medical Management Tools**, for information and resources related to Tri-Service business planning.)

INTEGRATING UTILIZATION, CASE, AND DISEASE MANAGEMENT FUNCTIONS

Integrating MM components not only improves clinical outcomes; it improves organizational efficiency and effectiveness. For example, while more CM and DM personnel are used to implement comprehensive and integrated MM programs, staffing needs shift as fewer direct UM-related authorizations are needed.

Integrating UM, CM, and DM functions in the MTF facilitates transitions of care and stewardship of resources. The National Transitions of Care Coalition (http://www.ntocc.org/) advocates for and has developed tools to support transitioning patients.

Historically, MTFs placed UM within their Business Operations or Resource Management department, while CM and DM were placed within the Nursing department. This produced significant fragmentation of services, higher staffing requirements, and increased costs. It also generated the view, particularly among providers, that the priority of UM staff was to save money for the institution rather than to provide safe and quality health care to patients.

Current trends focus on co-locating UM and CM resources to maximize and balance both clinical and business outcomes. Fully integrating UM and CM staff has helped improve the overall quality of

care through a highly synergistic effect, with the following results:

- Significant decrease in the duplication of effort and redundancy.
- Decrease in negative outcomes from improper or poor handoffs.
- Improvement of overall workload management.
- Improvement in the appropriate patient use of benefits.

UM, CM, and DM have many similarities in terms of goals, concepts, and tasks. The key to success is establishing links of communication between programs or departments. In this regard, it is helpful to consider these three MM components within the context of a healthcare **continuum** as described in the *2001 DoD Population Health Improvement Plan and Guide* (next iteration due to be published in 2011). The Guide is available at http://www.tricare.mil/ocmo/download/mhs_phi_guide.pdf (see also **Executive Summary, ▶ CD-ROM Resource ES-1**).

Continuum is defined as an uninterrupted period, referring to the various stages of health and applications of the CM process. It may be seen as running parallel to a "preventive model" that measures cause and effect in MM interventions. This model comprises three phases, as described in part by Wilson, Carneal, and Newman (2008) (see **▶ CD-ROM Resource MME-12** for full article):

- Primary prevention is about preventing the onset, or incidence, of disease (e.g., through vaccinations).
- Secondary prevention is about detection of disease.
- Tertiary prevention is about the prevention of further suffering among end-stage prevalent cases (e.g., through ameliorating pain and providing psychosocial comfort).

Based on this model, success (achievement of outcomes) can be understood in one of two ways:

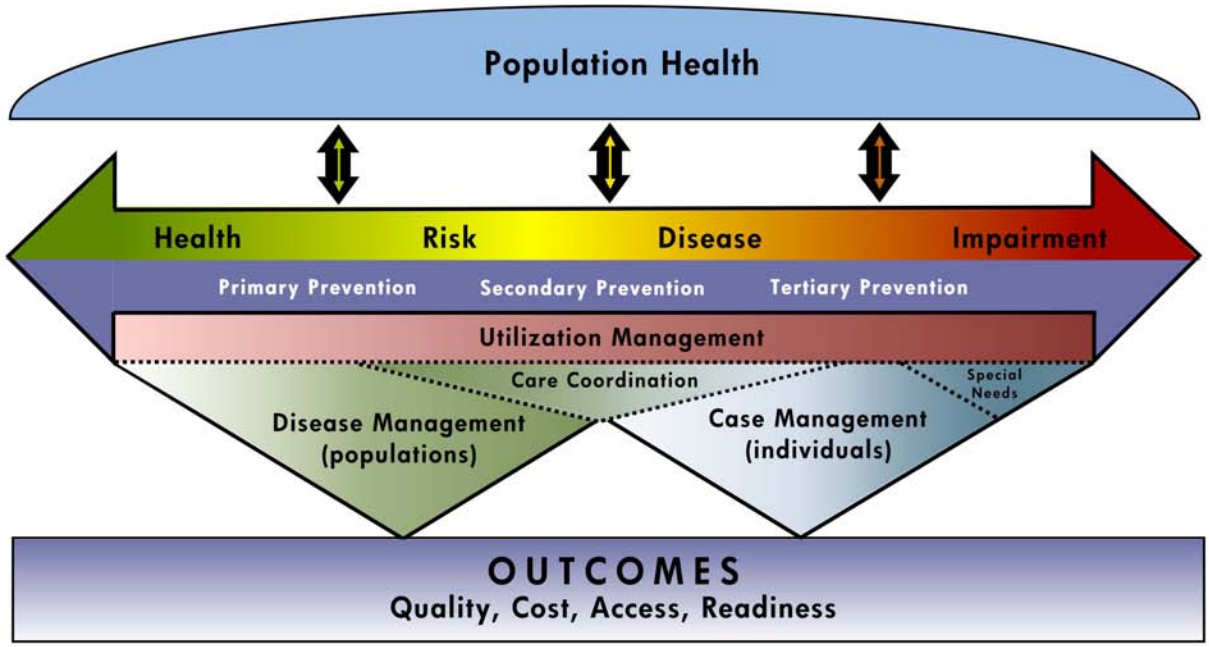
- Slowing, halting, or reversing advancement within the same phase.
- Slowing, halting, or reversing transition to the next phase.

Fig. 4 illustrates how UM, CM, and DM functions interact within the MHS in the context of the Population Health continuum and in keeping with the three levels of prevention.

While the end goal is to integrate the components of MM, MTFs may first need to develop their individual UM, CM, and DM programs. Fig. 5 compares and contrasts each component.

Some challenges may prevent successful integration. For example, each Service — from the headquarters to the local MTF level — organizes its medical services and departments differently, using a variety of titles, terms, and personnel resources. Additionally, there continues to be a lack of process standardization within the Services themselves. Identification of poor clinical outcomes or other red flags (e.g., an inability to meet access standards, longer lengths of stay, or outliers of any performance measure) may indicate system or organizational issues rather than a clinical problem.

Integrated Medical Management Model (IM3)



The Integrated Medical Management (MM) Model (IM3) is a pictorial representation of the clinical approach to patient management (i.e., MM) along the healthcare continuum. The components of the model are as follows:

- The curved arc depicts how MM falls within the spectrum of Population Health. The clinical activities of Utilization Management (UM), Case Management (CM), and Disease Management (DM) are geared toward achieving healthy populations.
- The vertical arrows indicate the integration of Population Health and MM functions.
- The large horizontal arrow depicts the healthcare continuum, illustrating the correlation between health, risk, disease, and impairment states and their alignment with primary, secondary, and tertiary prevention efforts. A patient may move anywhere along the healthcare continuum.
- The red bar represents UM activities and functions along the entire healthcare continuum. UM functions include collecting and analyzing data that assist CM and DM in identifying populations or individuals who may benefit from services.
- The green triangle highlights DM activities and functions. DM typically intervenes on the left side of the healthcare continuum with populations who benefit from DM, using primary and secondary prevention activities.
- The blue triangle highlights CM activities and functions. CM typically intervenes on the right side of the healthcare continuum with individuals who benefit from CM, using secondary and tertiary prevention activities.
- The middle triangle is the area where clinical interventions may fall in both DM and CM. These are patients who need assistance with care coordination but do not require either extensive DM or long-term CM services.
- The purple bar indicates the MM requirement to link UM, CM, and DM activities to outcomes of readiness, quality, cost, and access. Outcomes are the foundation of MM activities in the Military Healthcare System (MHS).

Source: 2001 DoD Population Health Improvement Plan and Guide (see Executive Summary, CD-ROM Resource ES-1)
Fig. 4 – Integrated Medical Management Model (IM3)

Distinctions between UM, CM, and DM		
Utilization Management	**Case Management**	**Disease Management**
Characteristics of Target Population		
• Cost-based approach • Most expensive patients, providers, and procedures • Patients who may not be at the appropriate level of care • Patients not medically authorized for hospital admission and specific procedures • Patients who underutilize or overutilize services	• Individual approach • At high-risk for costly, adverse medical events and poor health outcomes • Medically, socially, and/or financially vulnerable	• Population-based approach • Diagnosed with specific disease or condition
Methods for Identifying Patients		
Analysis of Encounter or Claims Data		
• Tracks over/underutilization of services and costs	• Searches for patients with patterns of repeated hospitalizations or ED visits	• Searches for patients with selected ICD-9 diagnosis codes
Analysis of Pharmacy Data		
• Reviews provider prescription patterns for high-cost brand versus low-cost generic medications • Evaluates compliance with CPG requirements or Drug Utilization Evaluations (DUEs) within the MTF	• Reviews medication profiles for various individuals or populations (medication misuse, elder non-adherence)	• Searches for prescriptions commonly used for specific diseases (i.e., Albuterol for asthmatics)
Referrals		
• Aggregate data in terms of practice patterns for referrals • Prospective review of referrals • Referrals meet Severity of Illness and Intensity of Service criteria (InterQual®)	• Providers who identify patients as "high risk" or "vulnerable" • Self/family referrals • Specific beneficiary screening criteria	• Providers who identify patients with a particular diagnosis or condition
Preadmission/Concurrent Review		
• Identifies patients in need of more intensive interventions whose length of stay might be long and resource utilization high • Provides opportunity to coordinate with case management • Tracks appropriateness of care	• Identifies expensive, complex cases (red flags) prior to/during admission • Identifies organizational processes that need to be streamlined to better address patient needs and increase efficiency	• Identifies patients with specific diseases/conditions who could benefit from an outpatient disease management program for monitoring and reinforcement of patient/family education
Patient Education		
• Generally no formal education; however, patients should be informed of the different levels of care and the appeal process • Providers are educated on recurring initiatives and roles in process improvement	• Generally no classes developed by the program itself, although may refer to external classes • Generally no standardized curriculum • Generally no standardized educational materials; individual-specific	• Program may have developed its own classes • Standard curriculum • Standardized educational materials • Tailored to individual situation
Relative Reliance on National, Evidence-based, Disease-specific Guidelines		
• Not applicable (uses InterQual® and Milliman Ambulatory Care Guidelines™ criteria, which are based on best practices during utilization reviews)	• Moderate	• Extremely high
Relative Reliance on Protocols and Standardization		
• Moving toward better use of information in clinical practices, identification of needs and referrals to targeted support services; and greater use and more consistent delivery of evidence-based practices	• Moving toward better use of information in clinical practices (i.e., critical pathways), identification of needs and referrals to targeted support services; and greater use and more consistent delivery of evidence-based practices	• High

Source: Chen, A., et al., (2001, March). Best Practices in Coordinated Care. Mathematica Policy Research Institute, Inc.

Fig. 5 – Distinctions between UM, CM, and DM

MTF-specific circumstances will dictate whether distinct, standalone programs or integrated MM processes are required. Large MTFs may choose to have individualized UM, CM, and DM programs. In such cases, effective communication can be accomplished through regular face-to-face meetings (e.g., patient care conferences, individual meetings, e-mail, MM team meetings, Population Health Working Group, teleconferencing). In smaller MTFs, there may be staffing limitations that mean one or two staff members are responsible for several MM components.

When developing an integrated MM program, network with your peers at other similar-sized facilities to partner and share information. This consultation process should be expanded to include sister Services and civilian organizations (e.g., URAC, CMSA, hospitals).

Staffing for Combined Functions

Although the composition, organization, mission, etc. of each MTF varies greatly, general staffing guidelines should be followed. According to a 2003 Air Force study, *Access to Care* (First Consulting Group), healthcare organizations should establish the right staffing mix based on specific criteria to address the quantity and complexity of beneficiaries' needs. The study made the following recommendations:

- A written staffing plan should be developed with clearly defined roles and responsibilities.
- Leadership should analyze actual staffing patterns, program requirements, and findings from quality improvement and benchmarking activities and apply that analysis to staffing decisions.
- Performance indicators must be set in consideration of the complexity of patient care needs.
- Performance monitoring should be an ongoing process between clinical and administrative personnel.
- The staffing plan should be updated periodically based on changing patient care needs.

An organization's position descriptions, mission and vision, and business plan can help in the development of objectives for utilization managers, case managers, and disease managers. Those objectives provide a basis for constructing core competency and performance assessments for each position. Objectives and competencies should evolve as roles evolve. New employees should complete a competency self-assessment at the beginning of their orientation programs. The director can then individualize orientation and training to their specific needs.

When integrating a UM, CM, or DM role into an MM program, MTF leadership should review the overall program and assess the effectiveness of each aspect of the program. Occasionally, trouble areas may arise that hinder the ability of staff to focus on their primary responsibilities. Such areas include job overload, roles with a limited sphere of influence, responsibility for multiple roles or extra duties, and unclear priorities. Ensure that staff have role clarification in addition to the skills, equipment, mentoring, and support to be successful in their positions.

MTFs located OCONUS face additional challenges in staffing MM. Typically, overseas regions offer far fewer candidates with the requisite expertise to be

successful in MM activities than are available in the United States. This may force MTFs to make the critical decision of leaving positions empty; or of hiring inexperienced staff and training them, with the knowledge that these staff are likely to remain in the position for two to three years at most. (See **Section III, Case Management**, for more information on OCONUS considerations.)

MTFs need to promote close collaboration among all MM staff and encourage them to communicate with other MTF departments or personnel, such as:

- The local TRICARE Service Center Coding and coding auditing departments.
- Information Management (IM)/Information Technology (IT).
- Patient Administration.
- Population Health Resource Management.
- Quality/Risk Management — MM program measures may align with those obtained as part of an MTF's quality program — for example, benchmarking against Healthcare Effectiveness Data and Information Set (HEDIS®) measures. HEDIS® is a tool used by more than

Questions to Consider When Creating an Integrated MM Program

- What are our objectives?
- What are our short- and long-term goals?
- What are the health needs of our population?
- What are our current UM, CM, and DM resources? Who are our experts in those areas?
- How should we integrate MM roles?
- How do we facilitate inter-organizational integration? What are the advantages to our MTF? Which stakeholders should be involved in this effort?
- Which roles are responsible for making which specific decisions to move a patient efficiently and cost-effectively through the system?
- How do we promote standardization of UM, CM, and DM processes among team members?
- How do we maintain or restructure individual titles and scopes of work?
- How do we currently handle referrals?
- How do our nurse reviewers alert CM staff that a patient needs evaluation for CM?
- What are the DRG procedures for our patient population?
- Which ICD-9, DRG, and current procedural terminology (CPT) codes do we use most frequently for inpatient and outpatient visits?
- Which processes can we automate to expedite tasks and reduce administrative costs?
- Which continuum of care, patient safety, discharge planning, or other regulations apply? Which roles are responsible for ensuring that specific regulations are followed?
- Which types of information from external systems would be useful for our MM functions? Who has access to that information?
- Which mode of information sharing will increase our effectiveness? How can we facilitate it?
- Which tools do we currently have in place to standardize processes, measure outcomes, maintain reports, and document variances?
- Where do we report MM data?
- Which staff members have the authority to make changes regarding reported MM data?

Fig. 6 – Questions to Consider when Creating an Integrated MM Program

90 percent of America's health plans to measure performance on important dimensions of care and service. To view the current HEDIS® measures, go to http://www.ncqa.org/. (See also **Section IV, Disease Management**.)

- Relevant MSMO.
- Relevant TRO.
- MCSCs — Contractually, MCSCs are responsible for different aspects of MM within their region. Depending on the local memorandum of understanding (MOU) between an MCSC and MTF, the MCSC may have additional processes or activities in place to support patient care activities.
- Medical staff (e.g., Medical Director).
- Nursing staff (inpatient and ambulatory).
- Decision support (e.g., data analysis) staff.

Successfully integrating UM, CM, and DM functions requires careful strategic planning and effective resource allocation. Even if integration plans are included during development of the overall MM plan, MM staff need to consider some key questions, as shown in Fig. 6.

ESSENTIAL CONSIDERATIONS FOR MEDICAL MANAGEMENT STAFF

Benefitting from Information Technology

Information technology (IT) is the approach of processing and disseminating data through the use of computers or other electronic devices and "virtual" communication tools (e.g., the Internet). Some healthcare facilities still rely largely on a paper-based system to collect, store, retrieve, and disseminate data. However, IT is the preferred method in today's healthcare arena, where quick access to usable, reliable information is critical for effective decision-making.

The MHS Population Health Portal (MHS Portal, or MHSPHP) is an excellent resource for tools and templates related to MM activities within the MTF. The Portal demonstrates the benefit of applying advanced technology across the enterprise, allowing for information-sharing by multiple users within Army, Air Force, and Navy MTFs. For more information, see **Section V, Medical Management Tools**.

"With healthcare costs once again rising significantly faster than inflation, though for different reasons than existed two decades ago, pressure is being placed once again on the entire healthcare industry, including health plans, to identify ways to be more proactive in managing the health of individuals. Medical management and predictive modeling are key components of this effort" (Kongstvedt, 2007).

Predictive modeling is "a set of tools used to stratify a population according to its risk of nearly any outcome … ideally, patients are risk-stratified to identify opportunities for intervention before the occurrence of adverse outcomes that results in increased medical costs" (Cousins, et. al., 2002). For a broader perspective on predictive modeling, refer to ▶ **CD-ROM Resources MME-2** and **MME-3**.

Effective utilization of IT resources and systems enhances the ability of MM staff to meet the goals of the patient, the MM department, and the MTF. "The information system is a purposefully designed system that brings people, data, information, and

procedures together for the purpose of managing information to support operations, management, and decision functions important to an individual, team, or organization" (Powell and Tahan, 2008). IT can be used in innumerable ways within the MM arena, as demonstrated in the examples below.

UM staff can use IT systems to:

- Identify variations in provider practice patterns.
- Identify clinics within the DCS with access-to-care issues.
- Review and track referrals for network care.
- Analyze patient patterns of use within the MTF.

CM and DM staff can use IT systems to:

- Identify patients who may benefit from their services.
- Manage voluminous information about their patients.
- Document care and services.
- Analyze, track, and provide outcome reports.

As Powell and Tahan discuss in their book, the Case Management Society of America's *Core Curriculum for Case Management*, a well-designed IT system should:

a. Enable data to be viewed in several places by several people at the same time in a format that is understandable.
b. Ensure appropriate information security is maintained at all times.
c. Communicate with other systems in real time or near-real time.
d. Provide users with the ability to filter out unnecessary information.
e. Act as a central repository for patient and population levels of data.
f. Generate user-specific reports enabling users to evaluate outcomes.
g. Standardize terminology, documentation practices, and reporting functions.

Despite significant benefits associated with IT implementation, MM staff should be aware of its limitations, including:

- Lack of interconnectivity across several different systems, which can result in fragmentation of care and services.
- Information security practices that can hinder timely and consistent access to information.
- Non-standard IT terminology, which can frustrate communications between healthcare team members managing patient information.
- The absence of an intuitive ability to make patient care decisions when something "just doesn't feel right."

Privacy and Confidentiality of Patient Information

Records, documents, and data generated in the course of MM may contain information subject to the Privacy Act, Medical Quality Assurance protection, and/or regulations under the Health Insurance Portability and Accountability Act (HIPAA), Title 45, CFR Parts 160 and 164 (see **Appendix C, Definitions**). HIPAA addresses the use, disclosure, and security of protected health information (PHI). MM staff should complete HIPAA training, become familiar with HIPAA rules, and contact their local Privacy Officer for further guidance. (See also **Section V, Medical Management Tools; Tools for Utilization, Case, and Disease Management Collaboration; Protected Health Information Management Tool**.)

PROGRAM SUSTAINMENT

Program sustainment is a frequently overlooked step that should begin upon initiation of new programs. It is important for the MM plan to match the needs of the organization and its primary stakeholders. In the MTF, providers transfer and deploy. This means new providers are always entering the system, along with new beneficiaries. It is therefore crucial to continuously promote your services to healthcare team members, patients, and families; and to educate them on how to refer.

Leadership and organizational culture are key factors in effective program sustainment. With this in mind, the MM plan should:

- Develop a leadership strategy to gain and maintain support at all levels of the organization.
- Clearly describe the benefits of the program and regularly report on its progress to stakeholders.
- Include feedback from patients, providers, and other healthcare team members.
- Build a seamless organizational culture by integrating MM with other MTF programs.
- Make sure MM program data are communicated as feedback to clinical and executive staff.
    - Providers must be actively engaged as key members of the MM team.
    - Practice patterns must change to meet the goal of clinical and financial outcomes improvement.

An important sustainment strategy is to promote the MM program through marketing. Marketing involves planning and executing the conception, promotion, and distribution of services that satisfy individual and organizational objectives.

To develop a successful marketing strategy, you must first define the services your department has to offer. Ask questions such as the following: Do we currently have MM services? If working in an inpatient facility, does that facility require discharge planning?

The next step is to determine the target audience. Do you market only to your healthcare providers or do you allow patients and their families to self-refer?

Understanding your organization's mission will help you develop your plan. Where does the organization need you to focus your services? On patients with high utilization? On wounded, ill, and injured Service members? On patients with complex needs? On ADSMs, family members, or retirees? Who is using most of the organization's resources?

After developing the plan, it is time to promote your services. Suggestion: Develop brochures for providers and for patients, for the different services you offer, or for *all* services (▶ **CD-ROM Resource MME-4** provides a sample MM marketing brochure; see also **Section III, Case Management, ▶ CD-ROM Resource CM-23**). It may be useful to develop a simple reference pocket card for providers featuring trigger diagnoses for referral, screening criteria, how to refer, and a phone number to call with questions.

Other methods for promoting your services include:

- Speaking at professional staff meetings.
- Communicating with your organization's leadership.
- Advertising in the clinic or hospital newsletter.

Explain the benefits of using your services to the provider, patient, and family. The initial challenge is to gain exposure.

SUMMARY

To successfully implement MM in the MTF, MM staff should incorporate Population Health principles and integrate evidence-based, business, and Resource Management practices. More specifically, MM program design should reflect the integration of UM, CM, and DM functions to optimize patient outcomes. Leadership support, active provider engagement, appropriate resource allocation, and inter/intradepartmental communication all play a role in sustaining an effective MM program.

CD-ROM RESOURCES

MME-1 Department of Defense Instruction (DoDI) 6025.20, *Medical Management Programs in the Direct Care System (DCS) and Remote Areas* (2006)

MME-2 Article: Meek, Julie A., DNS.: Predictive Modeling and Proactive Care Management, Part I – *Lippincott's Case Management* (July/August 2003)

MME-3 Article: Meek, Julie A., DNS.: Increasing Return on Investment Potential in Care Management, Predictive Modeling and Proactive Care Management, Part II – *Lippincott's Case Management* (September/October 2003)

MME-4 Sample Medical Management Marketing Brochure – Air Force

MME-5* HA Policy Memo on Implementation for Prospective Payment Systems (2004)

MME-6* HA Policy on Right of First Refusal (2005)

MME-7* HA Policy for Active Duty Service Member Enrollment to TRICARE Prime (2005)

MME-8* HA Policy on Short-term Solutions for the Enterprise-wide Referral and Authorization System (2005)

MME-9* HA Interim Policy for Medical Management

MME-10* Article: Despite Barriers, MCOs Integrate Case, Disease, Utilization Management Functions – *Managed Care Week* (March 14, 2005)

MME-11* Article: Mullahy, C. M. The Effective Integration of Utilization and Case Management –*The Case Manager (TCM)* (March/April 2000)

MME-12 Article: Wilson, Carneal, and Newman, Documenting Case Management Outcomes: Advancing The Science While Preserving The Art –*Case In Point (CIP) (February/March, 2008*)

**Not referenced in text*

UTILIZATION MANAGEMENT

UTILIZATION MANAGEMENT

Department of Defense

TRICARE

Utilization Management

SECTION II

INTRODUCTION

Effective Utilization Management (UM) is a key process within Medical Management (MM) for improving the quality of health care and ensuring the cost effectiveness of healthcare services. UM relates to all components of a healthcare delivery system, including care within the primary, specialty, and inpatient settings.

This section discusses the concept of UM and how to develop an effective UM program within the Direct Care System (DCS). It describes a seven-step process for quality improvement and includes information on Utilization Review (UR), decision support tools, Referral Management (RM), and the grievance and appeal process. This section also covers the role and necessary qualifications of today's UM professional.

Fig. 7 illustrates the focus of UM activities throughout the various stages of the healthcare continuum. Specifically, as the focus of healthcare delivery moves along the Population Health continuum from primary through tertiary prevention, UM helps guide the quality and cost effectiveness of healthcare services.

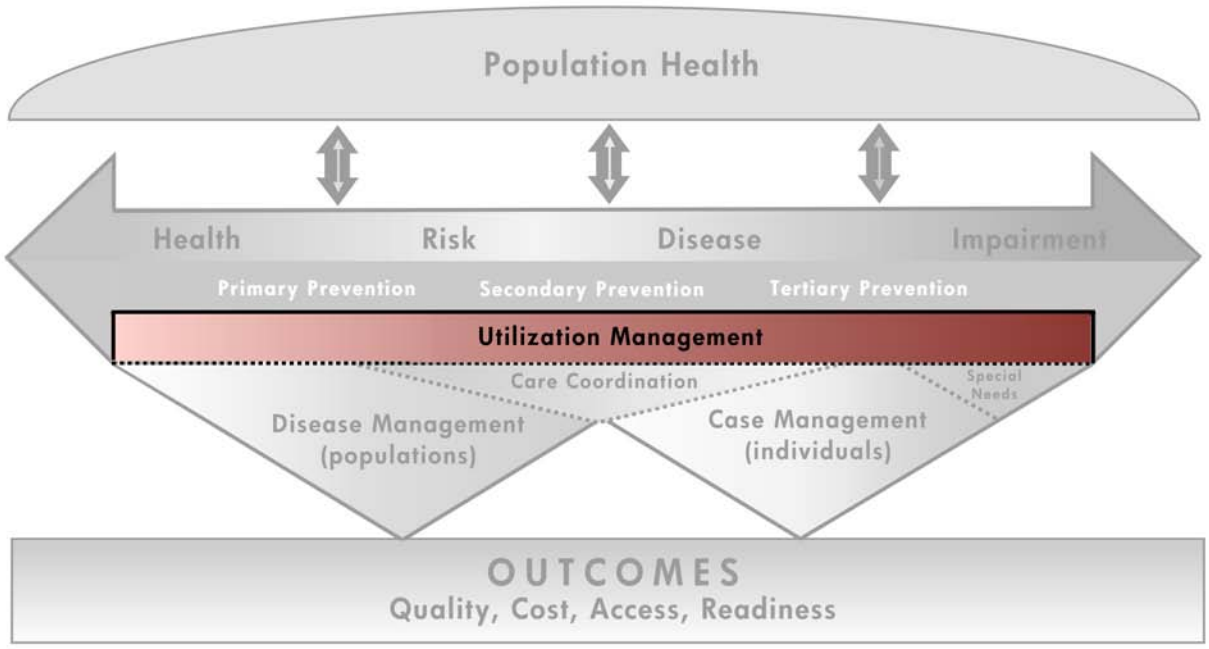


Fig. 7 – Utilization Management within the MHS Integrated MM Model (IM3)

*See also Section I, Medical Management Essentials: Fig. 4, Integrated Medical Management Model (IM3) with Key info, page 14.

As discussed in **Section I, Medical Management Essentials**, the recent trend in MM has been to replace traditional approaches with more care coordination activities based on an integrated MM model.

Definition, Goals, and Purpose

UM is a methodology that addresses the issue of managing the use of resources in the delivery of health care, while also measuring the quality associated with the delivery of that care (McKesson, 2009).

UM is an organization-wide, interdisciplinary approach to balancing quality, risk, and cost concerns in the provision of patient care. It is the process of evaluating the medical necessity, appropriateness, and efficiency of healthcare services. "Utilization review takes a retrospective view of cases, while UM describes proactive procedures and processes" (Freedman, 2006). UR is the process of determining whether all aspects of a patient's care, at every level, are medically necessary and appropriately delivered (McKesson, 2009).

In addition, UR in the private sector includes many of the following activities: pre-certification review, admission review, continued stay review, retrospective review, discharge planning, bill review, and individual medical Case Management (CM).

The ultimate goal of UM is to maintain the quality and efficiency of healthcare delivery by:

- Providing patients with the appropriate level of care.
- Coordinating healthcare benefits.
- Promoting the least costly, most effective treatment benefit.
- Determining the presence of medical necessity (see **Appendix C, Definitions**).

The purpose of UM within the Military Treatment Facility (MTF) is to identify, monitor, evaluate, and resolve issues that may result in inefficient healthcare delivery or that may have an impact on resources and services.

UTILIZATION MANAGEMENT COMPONENTS

As with CM and Disease Management (DM), the role of UM in the MTF is part of a progressively integrated approach that emphasizes the importance of facilitating environments, treatments, and procedures that generate opportunities for improved clinical outcomes and/or cost avoidance.

In the practice of UM, such facilitation is accomplished through the regular application of UM monitoring — a form of data analysis. The UM monitoring process provides MTFs with a "warning system" that can help identify at-risk patients at the earliest opportunity for intervention, such as during the preadmission and concurrent review processes. For example, patients with specific diseases/conditions scheduled for admission to the hospital can be identified and referred as potential candidates for CM or DM services. These patients may require proactive discharge planning to help address their post-hospitalization needs.

Appropriate data analysis and reporting provides UM personnel with a foundation for improving

performance and developing a sound program through an action plan. Effective data analysis can reveal obstacles to implementing the action plan. This helps decision-makers refine that plan and establish new priorities for the next cycle of performance improvement.

The Seven-Step Quality Improvement Process

A key element of any UM program is to follow a quality improvement (QI) process. A seven-step process is used here (see Fig. 8), based on QI activities recommended by the 2008 *Accreditation Association for Ambulatory Health Care Handbook* (for more information, go to http://www.aaahc.org/).

As shown in Fig. 8, in the "ideal" process (numbers 1 through 7) the seven steps progress in a linear manner. However, in practice the process allows for flexibility and may not always begin at Step 1. For example — as shown in letters a, b, and c in the figure — after attempting to fix a problem, you may need to adjust what you are measuring then re-determine the gaps before continuing forward.

This seven-step QI process is just one of many different models that can be used to develop a UM program. MTFs can choose any model (such as FOCUS PDCA or Lean Six Sigma), as long as the approach offers a systematic, step-by-step technique. Using a template based on a seven-step QI process, a UM plan would consist of three columns or sections for UM, CM, and DM. (▶ **CD-ROM Resource UM-1** provides a UM plan template based on a seven-step QI process, which can be customized for MTF use. ▶ **CD-ROM Resource UM-2** provides a completed example.)

The seven steps for establishing a UM action plan are listed below in sequential order based on standard expectations as data becomes available.

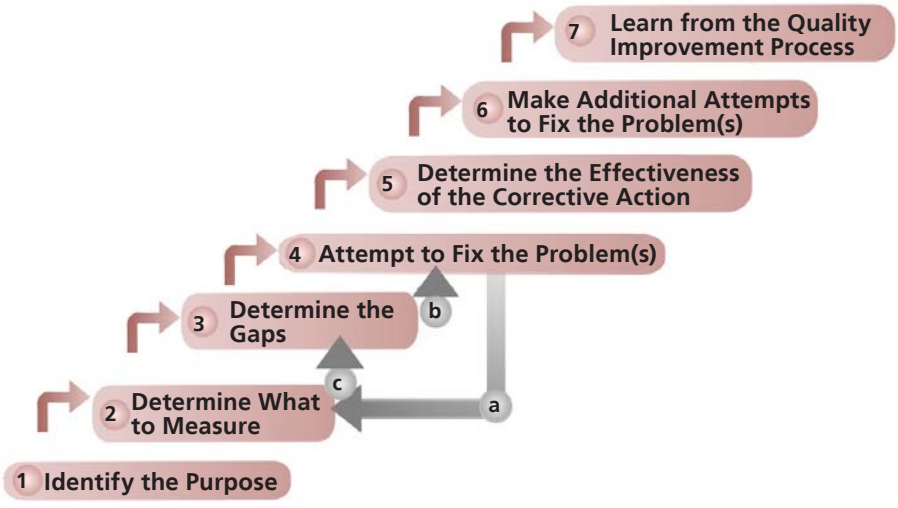


Fig. 8 – Seven-Step Quality Improvement Process

1. Identify the Purpose

Step 1 is to identify priorities for focus and examination. Priorities evolve from utilization data, suspected problem areas, MTF strategic goals, Command initiatives, and directives from an MTF's Service Branch and/or other higher authority. When defining priorities, UM staff should solicit input from all departments/services within their MTF.

2. Determine What to Measure

Step 2 is to select measures (i.e., metrics) and collect data relevant to the MTF — this despite the fact that there is no higher-level mandate to obtain a specific set of measures.

Utilization managers should select measures and collect data based on priorities. Typically, these measures relate to:

- High-cost, high-volume, or "problem-prone" diagnoses, procedures, and services.
- Patients who have demonstrated high utilization rates.

The definition of what constitutes a problem-prone situation varies by setting. For example:

- **Inpatient services** — Refers to diagnoses including those related to high mortality, high morbidity, prolonged length of stay (LOS), high readmission rates, and preventable admissions.
- **Ambulatory services** — Includes multiple visits for the same condition across various settings (e.g., primary care clinic, Emergency Department [ED], specialty care) or with multiple providers. Also includes polypharmacy (e.g., when the patient has been prescribed seven or eight concurrent medications), unexpected admissions, or death following ambulatory surgery.

Utilization measures facilitate the MTF's ability to:

- Identify Service Branch-specific areas for focused UR.
- Develop reports that display the applicable data elements for study.
- "Drill down" for patterns of care.

A data query can either focus on a particular, identified problem or issue (e.g., number of ED visits in the MTF and network during the past year for all Active Duty Service members [ADSMs]); or be expanded to include a broad range of data elements (e.g., all inpatient and outpatient visits for the past year for all patient categories) that might help identify potential trends or patterns of care that give cause for concern. (See also **Section V, Medical Management Tools**.)

If the data include a general range of elements, it is best to sort those data into categories to distinguish where problems may lie. For example, one table or report may list high-cost, high-volume, or problem-prone diagnoses and procedures for patients with demonstrated high-cost, high-volume, or highly complex utilization patterns (i.e., "high utilizers"). Your data must make sense to the people who are receiving the information and be considered valid (*Hospital Peer Review*, 2008).

Categories are used to present data clearly. They do not imply that ambulatory care facilities should study only outpatient data; an ambulatory care

facility might evaluate inpatient admissions to the Purchased Care System (PCS) to identify opportunities for cost savings or coordination of care.

UM staff should remember that they are not always expected to perform the role of data miner. Rather, they need to identify who has access to data (e.g., M2 users, data analysts, decision support staff) and partner with them by asking what is really going to affect patient care, who needs to be involved, and how to make the process a priority for decision-makers (Hospital Peer Review, 2008).

3. Determine the Gaps

Step 3 is to determine the gaps, if any, between actual and desired conditions. Identify:

- Any red flags or undesirable trends and variations from internal/external benchmarks and comparative data.
- Other potential areas for process improvement.

When comparing MTF performance to national benchmarks, you must take into account differences between the MHS and the civilian health system (notably the unique MHS benefit, funding structure, military mission, diverse healthcare environments, and population distribution). You must also consider risk adjustment and severity of illness (i.e., through a case mix index) when comparing an MTF to a civilian facility or comparing one MTF to another.

By drilling down further, MTF staff can identify high-volume diagnoses, procedures, and services; and individual patients with high utilization rates. They can then define significant trends and determine where to focus primary, secondary, and tertiary preventive interventions (see **Section I, Medical Management Essentials** and **Appendix C, Definitions**). This can help UM staff identify and refer patients who might benefit from specific management strategies, such as CM or DM. When evaluating data related to a particular occurrence, priorities will vary from facility to facility. Staff in a smaller MTF may elect to focus on their five most frequently performed procedures, while staff in a larger MTF might study their 10 or even 15 most frequently performed procedures. Alternatively, MTF staff might focus on the most problematic or prevalent diagnoses rather than the most frequent.

4. Attempt to Fix the Problem(s)

Step 4 is to attempt to fix the problem(s) by prioritizing opportunities for improvement based on the MTF's strategic goals, population needs, quality initiatives, and patient safety considerations. Here it is important to focus on areas with the greatest cost-to-benefit ratio and the highest probability for success. When evaluating which processes to improve, be sure to consider whether or not the applicable measures are reliable and valid. When reviewing those measures, consider where you can realize improvements within the data systems or data collection and reporting processes to ensure data accuracy and reliability, which, in turn, affects decision-making.

Formulate an action plan and attempt to fix the problem, which involves selecting appropriate strategies to address each priority stated in the UM program. This plan should include milestones and delineate individuals or departments responsible for meeting those milestones.

UM strategies may include a wide range of interventions to:

- Target gaps in healthcare delivery.
- Enhance performance and quality of care.
- Assist in managing resources and improving the health of patients.
- Refer patients who might benefit from other programs, such as CM and DM.

How you determine the most appropriate type of intervention will depend on the needs of the population; the MTF's capabilities, resources, and goals; and available metric data. Consider incorporating various UM strategies as well as other MTF programs (e.g., Population Health, Information Management, or Resource Management) into the action plan.

Implement the action plan by performing the interventions identified. Staff members responsible for implementing parts of the plan must:

- Document their actions and any issues, obstacles, lessons learned, etc. This documentation will serve as formal feedback for future reference and help establish continuity in process improvement.
- Report that information to the appropriate supervisor.

5. Determine the Effectiveness of the Corrective Action

Step 5 is the crucial step of determining how effective you have been in implementing a corrective action. This step includes refreshing data elements at consistent and regular intervals. It is essential to evaluate the impact of the actions taken so you can determine whether the UM program was successful. Compare the action(s) taken to the outcome goals and measures. Were there other unknown or new factors that allowed for successful implementation? If the desired result or outcome was *not* achieved, then refine, adjust, or re-implement the strategies and re-measure after an appropriate interval. Repeat this step until the desired outcome is achieved without undesirable or unintended consequences.

6. Make Additional Attempts to Fix the Problem(s)

Step 6 is to continue to address any outstanding issues by periodically monitoring the measures. This will help you sustain any change or process improvement through successive generations of staff and/or organizational structure, once you have achieved desired outcomes.

7. Learn from the Quality Improvement Process

Step 7 is to ensure you have learned from the QI activity by evaluating outcomes. This step helps you determine whether you have achieved your goals and makes it easier to update the UM program, if needed. If goals have *not* been achieved, identify impediments (e.g., limited resources, poor training, ineffective communication). Discuss and validate findings, formulate with the process owners a plan to address those findings, and communicate the results of that evaluation to the involved departments and MTF leadership through the appropriate channels.

When updating the UM plan, make sure it continues to reflect current goals and mission needs. If

applicable, redefine UM priorities and begin a new performance improvement cycle. Consider incorporating the strategy that resulted in successful outcomes into a written MTF policy that formally incorporates prolonged sustainment of those improvements as "routine business."

This QI process format is not mandatory. MTF staff may use whichever format best meets their needs, but they should include all of the steps described in the QI process when conducting UM. The range of goals and priorities will vary by MTF.

As noted in Step 2, while MM staff are not always required to act as data miners themselves, they are responsible for assisting data analysts by identifying issues, asking appropriate questions, and selecting the relevant data elements when querying various data marts.

Utilization Review

Utilization Review (UR) as a component of UM is integral to the success of both the MTF's MM and business plans. UR is the process of determining whether all aspects of a patient's care, at every level, are medically necessary and appropriately delivered (McKesson, 2009). It is *systematic* because there is a prescribed sequence in applying the criteria and in further reviewing the case if criteria are not met. It is *criteria-based* because factors based on sound clinical principles and processes are applied objectively in the first step of the evaluation process.

Review criteria may be employed as a screening tool during the first level of UR when:

a) The purpose is to manage resource utilization.
b) There is a potential to deny payment for services that are not medically necessary or that do not represent the most appropriate level of care.

Care is never denied for failure to meet criteria. Failure to meet criteria is only an alert that the case requires further examination by a physician or other qualified second-level reviewer.

UM staff perform UR to ensure patients receive the right care, at the right time, in the right place, with the right provider, and at the right cost. Without proper UR, the cost of health care, particularly specialty care referred inappropriately to the PCS, will spiral out of control. There is an absolute correlation between specialty care referrals (e.g., RM) and business planning processes. (See also **Section I, Medical Management Essentials**, and **Section V, Medical Management Tools**, for more information on business planning and business plans.)

All healthcare services for which payment is sought should undergo review for appropriateness of utilization. UM staff should work with business or patient administrative personnel to set up a process in which third-party (insurance) payors are given priority consideration. For example, third-party payors may require completed prospective reviews from the MTF for surgery (e.g., hysterectomy, gastric bypass) before they will provide authorization and reimbursement for a surgical procedure performed within the MTF.

UM staff can also apply review criteria to assist the MTF in identifying areas for improvement within the system. For example:

- If a group of admissions are reviewed retrospectively using McKesson® InterQual® evidence-based decision support criteria and a large number do not meet admission criteria, further investigation is warranted to determine and resolve the underlying cause.
- If a group of cases referred for specialty care does not meet Milliman Care Guidelines®, a training issue may exist indicating the need for additional clinical education.

In both instances cited above, the criteria or guidelines have been used to reveal potential areas for improvement, but the admissions and referrals were not denied. (For more information, see **Outcome Measurement and Management**, later in this section.)

The MTF's plan for UR may include more focused reviews in which it identifies a list of healthcare services for which preauthorization and concurrent review may be required. It is neither necessary nor cost effective to perform a 100 percent review of all referrals for medical necessity. Criteria for UR may include, but are not limited to, services defined by any of the following characteristics:

- Costly
- Known to pose potential medical risks for members
- Known to produce variable outcomes
- New or investigational
- Often performed for cosmetic reasons
- Overutilized
- Utilized differently by various providers

Types of Review

The procedures for UR may be:

- Prospective (before care is provided —preadmission)
- Concurrent (while care is in process — hospitalization)
- Retrospective (after care has been provided — discharge)

Prospective review is designed to evaluate proposed treatment, determine medical necessity, and assess the appropriate level of care prior to the delivery of services. When performing reviews, referrals to CM or DM target early intervention to improve outcomes. Formal prospective review determinations require timely attention. Prospective reviews are only valid for 30 days. If treatment was authorized but not initiated within the window, the review should be repeated.

Concurrent review is designed to evaluate care while it is occurring to validate medical necessity, appropriateness, and quality of care. The reviewer also looks for delays in service or complications, assesses if tests are appropriate, or evaluates the status of discharge planning.

Inpatient concurrent review consists of two components:

- *Admission review* is conducted within 24 hours of admission or on the next business day to verify the appropriateness and medical necessity of the hospitalization. Documentation in the medical record should justify the admission and plan of care. Discharge planning must begin at the time of admission to resolve potential issues that may delay timely discharge or prevent the best patient outcome.

- *Continued stay review* is conducted at regular intervals throughout hospitalization to assess the need for continued inpatient treatment. Review is usually conducted at prescribed time frames throughout hospitalization or with a change in the level of care or the addition of procedures. If the patient is staying longer than originally anticipated, CM should be notified. Patient-specific discharge plans should identify the need for follow-up (see also **Section III, Case Management, Discharge Planning**).

Retrospective review is conducted after treatment and/or services are completed. It may identify targets for future prospective or concurrent review. Third-party payors may require retrospective review to verify that the care being billed was actually provided.

- This process utilizes specific data elements to measure outcomes, identify areas of concern that may require implementation of a quality improvement project, and evaluate the effectiveness of health care.

Focused retrospective review concentrates on one aspect of care, such as appropriateness of service. *General retrospective review* examines the entire spectrum of care including quality, utilization, coding, appropriateness, necessity, and so forth.

Outcome Measurement and Management

Measuring UM outcomes involves data collection and analysis, and appropriate reporting. This process is essential for a successful program, but it can be challenging to understand and apply the available information systems and resources used by the DoD. (Refer to **Section V, Medical Management Tools**, for data information systems and analysis that are vital to successful MM measurement and integration for both clinical and business practices.)

UM outcome measures are commonly divided into daily, monthly, and quarterly summaries and tracked over specific time frames according to the process improvement or business planning needs of the facility. Fig. 9 provides examples of UM measures for outpatient, ancillary, and inpatient services.

The TRICARE Management Activity (TMA) Population Health and Medical Management Division (PHMMD) maintains a centralized, external contract to license and distribute specific criteria and guidelines to MTFs and TRICARE Regional Offices (TROs). The selected products are believed to be the best choices for the MHS, although they are not the only products available in the industry. These products include McKesson InterQual evidence-based clinical decision support criteria, which cover a broad spectrum of medical/surgical and behavioral health care; and Milliman Care Guidelines, which address the ambulatory care arena.

McKesson® InterQual® — http://www.mckesson.com

McKesson InterQual evidence-based clinical decision support criteria are sets of measurable, objective, clinical indicators reflecting the need for hospitalization and for diagnostic and therapeutic services in both the medical/surgical and behavioral health arenas.

Sample UM Data Elements or Measures

Outpatient Measures

Ambulatory procedures (CPT) per 1000 MTF enrolled per month/per year

- Identify procedures with the highest frequency.
  - Is the highest frequency of a given procedure within the MTF or the Purchased Care System (PCS)?
  - If higher in the PCS, is that procedure available within the MTF? If yes, identify causes for referral and consider strategies for recapturing care.
- Conduct a focused retrospective review to determine if the highest frequencies meet medical necessity criteria. If high numbers do not meet the criteria, consider a short-term prospective review for high frequency/high cost.

ED encounters per 1000 MTF enrolled per month/per year

- Identify high ED utilizers.
- Consider CM, education, DM, and marketing of an advice line.
  - Is there inappropriate use or over-utilization of the ED? Is there an access issue?
  - Are there implications for community outreach (e.g., is there a high volume of fractures)?
  - Is there a pattern to the cause?
  - Which safety factors might be missing to prevent fractures?

High volume ICD-9-CM principal diagnoses for ED visits for MTF enrolled per month/per year

- Identify the highest occurring principal diagnoses within the ED.
- Identify patterns by enrollee and by type of visit. Consider CM, DM, etc.
  - Are there implications for community outreach (e.g., is there a high volume of fractures)? Is there a pattern for the cause?
  - Which safety factors might be missing?

Ancillary Measures

Radiology procedures per MTF enrolled per month/per year

- Identify the highest volume procedures.
  - Are criteria available that must be met prior to ordering a high-cost radiological procedure? Are they being used?
- Identify the referral rate to the PCS if the procedure is available in house.
- If unacceptable and inappropriate procedures are being ordered, determine whether criteria exist to address the problem.
  - If there are existing criteria, ensure all providers are educated in their use.
  - If not, consider forming a team to develop criteria.

Inpatient Measures

MTF average length of stay (ALOS) per diagnosis-related group (DRG) per month/per year

- Identify the overall MTF ALOS.
- Identify the highest frequency DRGs and compare them to the overall MTF ALOS.
  - Are one or more DRGs skewing the overall ALOS?
- Compare MTF ALOS to external averages.
  - Is the MTF ALOS higher or lower?
- Stratify by department/service (medical, surgical, maternity, newborn, behavioral health) and identify problem areas for further study.
- Conduct a DRG-specific retrospective focused review to determine if discharge planning, CM, clinical pathways, or other strategies are indicated for aberrant DRGs.

Is concurrent review indicated for a brief period to pinpoint barriers to timely discharge?

Admission rate per 1000 MTF enrolled per month/per year

- Stratify by MTF and PCS and compare admission rates.
- Identify the reasons for PCS admissions if your MTF has the same inpatient resources.
  - Why are MTF beds unavailable?
  - Can steps be taken to decrease MTF LOS and increase capacity?
  - What are the preventable admission rates?
  - Are there indications for CM, DM, etc.?
- Stratify data by department/service. Select priority and use the UM process to form an action plan.
- Stratify by DRG and/or diagnoses to identify the target population for intervention.

Top diagnoses for same-day surgeries with unplanned admissions for MTF enrolled per month/per year

- Consider reasons for the admissions.
- Were any of these preventable?
- Are there clusters or patterns to the preventable admissions?
- Is a quality review indicated?

Fig. 9 – Sample UM Data Elements or Measures

Sample UM Data Elements or Measures (cont.)

Outpatient Measures

ICD-9-CM principal diagnoses seen within the outpatient setting for MTF enrolled per month/per year

- Identify the highest occurring diagnoses.
- Stratify by medical, surgical, and behavioral health; and by adult/pediatrics.
- Would group visits for select diagnoses be appropriate?
- Are CPGs in use? Are they being used correctly? Is provider education indicated?

Procedures (CPT): Top high volume for MTF enrolled per month/per year

- Identify the highest occurring procedures within the outpatient setting.
- Stratify by adult and pediatric categories.
- Conduct a focused review to confirm the medical necessity and appropriateness of high-volume procedures.

Specialty referrals per MTF enrolled per month/per year

- Stratify by referrals within the MTF and referrals to the PCS.
- If there is a high volume of referrals sent to the PCS, determine contributing factors.
- Reference Milliman Ambulatory Care Guidelines™ or InterQual® criteria.
- Are these guidelines being used to assist PCMs?
- Could the care be managed by the PCMs? Is PCM education indicated?

Ancillary Measures

Inpatient Measures

Total discharges within 24 hours of an admission for MTF enrolled per month/per year

- Distinguish inappropriate admissions (i.e., those that did not meet medical necessity or level-of-care criteria).
- Conduct a focused review to identify underlying causes.
- Select appropriate strategies.
  - Was the observation level of care more appropriate?
  - Is that level of care available within the MTF?
  - Can you potentially designate certain beds as observation-level?

Top DRGs by RWP for all MTF enrolled per month/per year (Note: DRG Weight Table lists RWP for each DRG)

- Identify the highest frequency DRGs for the date range.
- Identify the ALOS for individual DRGs.
- Utilize the DRG weight table to identify relative weights and LOS.
- Stratify by department/service.
  - Are there patterns that warrant further investigation?
  - Are preventable admissions included in the top DRGs?
  - Are CM, DM, discharge planning, or other strategies indicated?

Total MTF admissions for enrolled population by principal diagnosis per month/per year

- Stratify by department/service and key demographics.
- Identify patterns and potential problem areas.
- Compare admission diagnosis to principal diagnosis to identify potential patterns (e.g., admission diagnosis is rule-out myocardial infarction while the principal discharge diagnosis is gastroenteritis).
- Conduct a focused review to confirm the appropriateness of targeted admissions.

MTF readmission rate for same or related diagnosis within 30 days of discharge for MTF enrollees per month/per year

- Identify potential quality-of-care concerns.
- Compare the first and second or subsequent discharges for a specific enrollee.
  - Were the first discharge or subsequent discharges potential premature discharges?
  - Was the readmission related to insufficient discharge planning, patient education, or follow-up care?

Fig. 9 (cont.) – Sample UM Data Elements or Measures

These criteria are not based on diagnosis but rather on the severity of the patient's illness and the intensity of the services required. Thus, they serve as criteria for all hospital care, regardless of location or facility size. McKesson InterQual products are packaged in criteria sets that are continuously evolving. The DoD licensing agreement provides Web-based access, with online modules available for distance learning through the TMA PHMMD Support Center at http://www.tricare.mil/ocmo.

Milliman Care Guidelines® — http://www.careguidelines.com

The Milliman Care Guidelines target conditions ordinarily seen by primary care managers (PCMs) in the ambulatory care arena.

These guidelines:

- Provide clinical detail about diagnostic and therapeutic approaches, and about referrals and procedures.
- Introduce and integrate pharmaceutical and management considerations.
- Define the assessment and treatment modalities that should occur at the primary care level prior to referral for specialty care.
- Help PCMs provide the fullest spectrum of care at the most appropriate level, while helping the MTF conserve specialist resources.

The guidelines are not intended to be used without the judgment of a qualified healthcare provider with the ability to consider each patient's individual circumstances. They are updated every one to two years, or as necessary, to reflect industry changes.

The guidelines are published by Milliman in a Web-based format and are accessed through its CareWeb portal (http://www.careguidelines.com/login-careweb.htm). Access via CareWeb requires a DoD account, which provides a username and password. Access is granted only to users employed directly by the MTF. For more information and log-on instructions, contact your local MTF or designated TMA point of contact (POC).

A Milliman Care Guidelines distance learning training module is available through the Population Health and Medical Management Division (PHMMD) Support Center at http://www.tricare.mil/ocmo. (► **CD-ROM Resource UM-3** shows screenshots and provides descriptions of various Milliman resources.)

Provider Profiling

Provider profiling can be defined as the identification, collection, collation, and analysis of data to develop a provider-specific characterization of performance. The process represents an important application of analytics to improve quality and reduce costs. The data analysis that results from provider profiling gives providers a more complete picture of the quality of care they provide.

Provider profiling can be tailored to meet specific needs based on the healthcare delivery model. According to Kongstvedt (2007), profiles should share the following characteristics:

- Accurately identify the provider in the profile.
- Accurately identify the specialty of the provider.
- Help improve the process and outcome of care in both dollar and quality outcomes.

- Have a firm basis in scientific literature and professional consensus.
- Meet certain statistical thresholds of validity and reliability.
- Compare the provider to the norm.
- Cost the minimum amount possible to produce.
- Respect patient confidentiality.

When profiling a provider, consider the level of analysis involved. Profiling at the individual provider level is often not possible because the number of episodes for each physician is too small. The resulting statistical instability introduces too much error to generate robust comparative conclusions. Instead, profiling should be performed at the clinic/group level. This also has the advantage of taking into account the fact that care is delivered by teams of providers, particularly for complex and chronic diseases.

Referral Management

Referral Management (RM), considered a subcomponent of a UM program, is the process of managing and tracking internal/external patient referrals within the MTF, to another MTF (i.e., within the DCS), or to network specialists (i.e., to the PCS). RM provides a mechanism for determining patient access to specialty clinics, durable medical equipment (DME), and network inpatient admissions that use evidence-based criteria and predetermined clinical/business outcomes.

RM is an important business and clinical process within the MHS. It provides a clear capability to minimize costs for care referred to the network. RM goals are to promote continuity of care, timely intervention, access to care, recapture care appropriately, and make informed decisions about the most effective utilization of resources.

MTFs hold primary responsibility for coordinating the tracking and closure of specialty referrals for their enrolled population. A referral is the process of directing an MHS patient from one healthcare provider to another within the DCS, or to a network (preferably) or non-network (as necessary) civilian provider. A referral request is expected in most cases; in some circumstances, a preauthorization may be required. A consult report, known as a Clearly Legible Report (CLR), is the primary method used to close out a referral.

The RM process involves two types of component: clinical and administrative.

The clinical component includes performing UR for medical necessity of specialty referrals and determining appropriateness of care. RM staff should apply the use of approved clinical practice guidelines (CPGs) and proactively identify and refer patients for CM or DM.

The use of clinical practice guidelines (CPGs) can facilitate the RM process, since recommended referrals for specialty care are included within the practice guidelines (see **Section IV, Disease Management**, and **Appendix C, Definitions**, for more information on CPGs). The ability to verify the appropriateness of a referral for a particular disease or procedure is available as a function in Milliman Ambulatory Care Guidelines (http://www.careguidelines.com/brochures/ac/ACebrochure.pdf) and McKesson InterQual evidence-based decision

support criteria. Clearly identifying recommended referral points can decrease inappropriate referrals and improve the timeliness of appropriate referrals.

The administrative component of RM relates primarily to managing the electronic transmission of specialty referral requests from the MTF to the MCSC, to include ensuring referrals meet access and continuity of care standards.

Administrative staff need to closely monitor and track the return of referral results. Tracking of referrals encompasses monitoring, timeliness of result return, and legibility. The utilization manager initiates services by sending a referral to the Managed Care Support Contractor (MCSC) (see also **Section I, Medical Management Essentials, TRICARE and Other Benefit Programs, Working with Managed Care Support Contractors**). Contact the MCSC in your region on how to appropriately send a referral.

With contract modifications, the MCSC performs benefit and medical necessity reviews for all patients except ADSMs. RMC staff must perform benefit and medical necessity reviews for ADSMs since the MCSC will not deny their care. However, the MTF may establish its own internal review process to select referrals for appropriateness and medical necessity.

Additionally, red flag situations such as the following may require further review:

- Travel
- Out-of-area care
- Non-network provider requests
- Continuity of care
- Care following PCS enrollment

The MTF should have an established process to appropriately respond and coordinate high-expense requests. However, these items are available to the beneficiary but should be closely reviewed for cost containment and appropriately addressed by MTF staff prior to "defer to network."

The following are some tips for implementing a successful RM program:

- Perform retrospective reviews to validate referral patterns.
- Evaluate the appropriateness of referrals for ADSMs and the strategy for further review.
- Evaluate multiple referrals for quality and continuity of care (e.g., referrals for new versus established patients).
- Maintain current capabilities list to facilitate Right of First Refusal (ROFR) opportunities.
- Monitor access for specialty appointments within the MTFs through sound template management.
- Identify opportunities to refer patients for CM or DM.
- Collaborate and coordinate processes and problem resolution with the MCSC.
- Educate patients and staff about the referral process.
- Establish a tracking process to account for 100 percent referrals.

Referral Management Center (RMC)

The ASD (HA)/TMA have mandated the establishment of a Referral Management Center (RMC) within each MTF or multi-service market. The RMC functions as the primary source for processing specialty referrals. With the exception of multi-service markets, the RMC should be

the "one-stop shop" for both MTF and MCSC personnel and, most importantly, for the patient.

The RMC is the place where the MTF can maximize its MM plan through the recapture of specialty care and containment of its TRICARE Prime enrollees (access and demand management). The RMC operates in accordance with the standardized business rules for referrals and authorizations. Duties include referral administration, appointments, and tracking. Each Service Branch has developed its own particular RM processes. RMC staff should have a working knowledge of the TRICARE benefit program as it applies to referrals (*TRICARE Operations Manual 6010.51-M*). ► **CD-ROM Resources UM-4** and **UM-5** contain RM policy memoranda for the Army and Navy. ► **CD-ROM Resource UM-6** is a comprehensive document that provides guidelines for establishing an RMC. The Army and Navy medical departments defer to the *Air Force RMC Guide*.

Active Duty Service Member Referrals

Referrals for ADSMs require special attention. The MCSC does not perform medical necessity or benefit review on ADSM referrals. Once the ADSM referral is reviewed and approved by the MTF, the MCSC will not deny care to the patient.

The MTF Commander or designee is the approval authority for network specialty care for ADSMs. UM staff members need to complete a medical necessity and benefit review on the referral and make a recommendation to the MTF approval authority for approval/disapproval of the specialty care requested. Within the recommendation, consideration for approval hinges on medical necessity and on the need to meet mission requirements. For example, in one scenario an ADSM is suffering from a severe case of pseudofolliculitis that requires dermatology visits every six weeks. In this case, due to the severity of the disease process, the dermatologist refers the patient for laser hair removal. However, laser hair removal is not currently a covered benefit. Yet in this case, laser hair removal is a long-term solution that should ultimately decrease the need for multiple visits to the dermatologist, which in turn will decrease time away from the ADSM's duty section/mission. As a result, UM staff would recommend that the procedure be approved.

Elective care without prior approval is prohibited. Written approval must be obtained from the ADSM's Squadron or Unit Commander and MTF Commander. The ADSM must notify his/her PCM prior to the elective care and, finally, the MTF within three days of treatment. Elective care requires the member to provide the report of care describing treatment, medications ordered, etc., to be filed in his/her medical record.

For elective care in the private sector, the ADSM is responsible for all expenses related to his/her own care, travel, and standard leave for all time away from duty. Convalescent leave is not authorized. ADSMs are also ineligible under such circumstances for any compensation related to elective care. In a DCS that offers elective services, members are eligible for permissive Temporary Duty (TDY) and convalescent leave, with the ADSM responsible for all expenses.

It is important to note that approval for a non-covered benefit only applies to ADSMs. There also may be Service Branch-specific directives or policies

that preclude receipt of certain care/procedures. UM staff must be aware of Line of Duty (LOD) policies of their respective Service Branch in order to appropriately process LOD-related referrals.

MTFs should have a protocol in place for the MTF Commander designee during initial review of referrals, to identify those that could go forward to the MCSC and those that need further review/approval.

Authorization

RM staff should be aware of authorization policies *(TRICARE Operations Manual 6010.51-M*, Chapter 8, Section 5, Referrals/Preauthorizations/ Authorizations) as they review referrals for appropriateness. An authorization (or preauthorization) is defined as a "prior authorization for payment of medical/surgical or psychological services based on certain criteria that are generally accepted by qualified professionals to be reasonable for diagnosis and treatment of an illness, injury, or mental disorder" (Code of Federal Regulations [CFR], Title 32, National Defense — Chapter 1, Section 199.2, *Definitions*). It is essentially a determination that a referral for civilian health care represents a request for services that are:

- Covered as a TRICARE benefit.
- Medically necessary and delivered in an appropriate setting.

A consult report is not required because it will be provided during the referral process.
Not all referrals require prior authorization. Referrals that require close scrutiny are usually high-cost or problem-prone procedures or services. After analyzing data for the MTF's existing practice patterns, MTF staff should decide which service line, if any, would require preauthorization review.

MCSCs maintain a preauthorization list based on best business practices for their region on the TRICARE website (http://www.tricare.osd.mil) or at the local TRICARE Service Center (TSC).

Episode of Care

A business principle utilized by MCSCs as part of the referral process is the concept of "episode of care" (EOC). An EOC is a range of predefined procedure codes that can be performed by a single provider to render reasonable medical services related to a specific condition. It may include an initial assessment, follow-up interventions, and reassessments in accordance with best business practices.

Applying an EOC as a business rule in RM can be advantageous because an EOC:

- Is based on claims data.
- Conforms to norms of civilian clinical practice/community standards of care vs. overutilization.
- Enhances accurate and timely claims processing.
- Incorporates MCSC best practices.
- Minimizes the frequency of communications between the MTF and the MCSC, network provider, and patient.
- Provides clarity on package or bundle of services being ordered or requested.
- Provides positive return on investment (ROI).

When the MCSC approves the MTF's referral for treatment, a referral letter is sent to the civilian provider. The referral letter authorizes the services or EOC, using current procedural terminology (CPT) codes that can be rendered to either "evaluate only" (provide second opinion) or "evaluate and treat" the patient's condition.

MTFs should be reassured that the application of EOCs is a best business practice that should not increase healthcare costs, due to safeguards built into the process. That is, the approval of an EOC only applies to care for the original diagnosis or specialty referral ordered by the MTF PCM.

The network provider should not refer the patient back to his/her PCM for more specialized care. When a patient requires admission to the hospital or referral to a similar or more specialized provider, the original network provider must submit a request for another referral to the MCSC (e.g., non-invasive cardiologist to a cardiac surgeon, orthopedist to a physical therapist or an orthospine surgeon). Cardiology cannot refer a patient to an unrelated specialty such as urology or endocrinology; such requests must come from the PCM.

At this point, the MTF has the opportunity to recapture the patient based on the MTF's capabilities and capacity to render the new care (e.g., Right of First Refusal [ROFR]). The patient must return to the PCM for a new referral if any of the following occur:

- There is a break in medical care.
- The period of time between treatments is greater than one year.
- The authorization has expired.

The Electronic Referral Process

The RMC will access an electronic copy of the referral via CHCS/AHLTA (see **Section V, Medical Management Tools**) or, in very limited cases, a paper copy and review it for appropriateness and completeness. If the MTF/DCS does not have the capability or capacity to process the document, the referral will be forwarded manually or via an autofax solution to the MCSC for specialty care approval/authorization. Referrals to the MCSC will include the minimum data elements found in the *TRICARE Operations Manual* (see Fig. 10).

Once the MCSC receives the referral via fax, he/she enters it into the referral tracking system, assigns level-of-service CPT codes, and verifies that all needed information is present. If information is missing, the referral will be returned to the PCM via the RMC. The MCSC will perform a medical necessity review (MNR), as needed, and a covered benefit review (CBR).

If the referral *passes* the MNR and CBR, the MCSC will notify the patient, the MTF, and the selected network provider that network specialty care has been authorized.

If the referral *does not pass* the MNR and CBR, the patient and MTF will be notified of the denial. The denial notice will be faxed to the MTF's RMC and mailed to the patient. The patient has the right to initiate an appeal with the MCSC.

TRICARE OPERATIONS MANUAL	
Referrals/Preauthorizations/Authorizations	
Required Data Element	**Description/Purpose/Use**
Request Date/Time	DDMMYY/hhmm
Request Priority	STAT/24-hour/ASAP/Today/72-hour/Routine
Requester • Referring Provider NAME • Referring Provider NPI • Referring TF • Referring MT NPI	Name of PCM/MTF individual provider making request HIPAA National Provider Identifier (NPI) — Type 1 (individual) Name of Military Treatment Facility (MTF) HIPAA National Provider Identifier (NPI) — Type 2 (organizational)
Patient Information	
Sponsor SSN	
Patient ID	EDI_PN (from DEERS), if available
Patient Name	Full name of patient (if no EDI_PN available)
Patient DOB	Date of birth (required if patient not on DEERS)
Patient Gender	
Patient Address	Full address of beneficiary (including zip code)
Patient Telephone Number	Telephone number (including area code), if available
Clinical Information	
Patient Primary Provisional Diagnosis	Description
Reason for Request	Sufficient clinical info to perform MNR
Service	
Service1 — Provider	Specialty of service provider
Service 1 — Provider Sub-specialty	Additional sub-specialist Info, if needed (free text clarifying info entered, with reason for request — e.g., Pediatric Nephrologist)
Service 1 — By Name Provider Request if Applicable — First and Last Name	Optional info regarding preferred specialist provider (free text)
Service 1 — Service Type	Inpatient, specialty referral, DM purchase/rental, other health service, etc. DME provider to do CMN
Service 1 — Service Quantity (optional)	Number of visits, units, etc.
CHCS Generated Order Number (DMIS-YYMMDD-XXXXX)	Unique Identifier Number (UIN) — The DMIS of the referring facility identified in the "Referring MTF" field on this request (Date in format indicated — consult order number from CHCS)

Source: TRICARE Operations Manual 6010.51-M, Chapter 8, Section 5, (Aug. 1, 2002)

Fig. 10 – TRICARE Referrals/Preauthorizations/Authorizations

Communication between MTFs and MCSCs

- There will be a single RM POC at the MTF with one phone and fax number.
- MTF staff will fax referrals to the MCSC (some MTFs may be using e-fax to perform this function).
- MTF staff will not be responsible for coding the diagnosis or procedure(s).
- MTF staff must implement the use of English-language text.

Patient Clinical Information

- Referring providers will include pertinent clinical information in the referral.
- The referring provider and/or the RMC personnel have primary responsibility in coordinating the transfer of information to the civilian provider(s).

Medical Necessity and Covered Benefit Determinations

- The MCSC will review all referrals to the network for medical necessity and covered benefit determinations, including the associated appeals processes within the PCS. However, the MTF is responsible for all referrals for ADSMs and for the MTF appeal process.
- No preauthorization is needed for the first eight visits of non-ADSM patients who seek mental health care with network providers. There is no requirement for MTFs to manage the care of patients who self-refer. Mental health care for ADSMs needs to be preauthorized.

Utilizing Military Treatment Facility Capability and Right of First Refusal Reports

MTF staff must:

1. Provide the MCSC with accurate, current listings of the MTF's capabilities so ROFR reports can be forwarded for MTF care, as appropriate.
    - o MTF staff will regularly update MCSC capability listings.
2. Review all incoming referrals before the close of the following business day for routine ROFR requests.
    - o Urgent ROFRs will include personal telephone contact initiated by MCSCs and near-immediate (not to exceed 30 minutes) acceptance or declination by MTF representatives.

MTFs must notify the MCSC of receipt of a routine referral within one business day when the referral has been accepted. However, if the MTF does not respond to an ROFR, either negatively or positively, the MCSC will assume an implied declination and the patient will be appointed to the network (TMA Memorandum, Policy Guidance for Referral Management, 2004). It is the MTF's responsibility to provide clinical feedback to the referring civilian provider within 10 business days.

Additional Information

The MCSC does not provide referral services for TRICARE Standard, TRICARE Plus (T-Plus) TRICARE for Life (TFL), or North Atlantic Treaty Organization (NATO) patients, or for those covered by other health insurance (OHI). The RMC is responsible for assisting with these referral requirements.

Referrals may be required for urgent care deferred to the network. Routine primary care in the local area without a referral could generate point-of-service charges for the beneficiary.

MTFs are required to track and account for all initial specialty care referral requests going out of/into the MTF on their way to resolution for TRICARE Prime and ADSM referrals, including those not tracked by the MCSC (e.g., T-PLUS, OHI). For network care arranged through the MCSC, network specialty care providers will provide CLRs to the MCSC within 10 business days of the patient encounter for "Evaluation Only" referrals and within 30 days of the patient encounter for "Evaluate and Treat" referrals, except where exempted by MCSC contract modification. The MCSC is contractually required to forward CLRs to the RMC, which will annotate referral receipt and forward the CLR to the referring provider.

The referring provider/PCM team is responsible for acknowledging the results by review/signature and for forwarding the results for filing in the patient's medical record. The RMC is responsible for reconciling outstanding referral results with the MCSC. Prior to the MCSC reconciliation, the RMC should first review MCSC Web-based tools and filed claims, and conduct in-house retrieval (e.g., from clinics or the mail room).

RMCs should also provide to the PCM on a regular, recurring basis a list of referrals without results, which indicate that no patient appointment was made and/or that no report was received.

The Grievance and Appeal Process

Overview

According to DoDI 6000.14, *Patient Bill of Rights and Responsibilities in the Military Health System* (2007), MHS patients have the right to an efficient process for resolving differences with their healthcare providers, MTFs, or MCSCs; this includes being able to rely on a system of internal and external review. The directive states that the patient be given an opportunity to appeal the MTF's decision regarding medical necessity determinations. It also requires the MTF appeal process be consistent with the reconsideration procedures under CFR Title 32, National Defense, Chapter 1, Section 199.15 — Quality and Utilization Review Peer Review Organization (PRO) Program; and Section 199.10 — Appeal and hearing procedures.

The PRO Program is required by Title 10 of the U.S. Code (U.S.C.) 1079(o). Medical benefits authorized by TRICARE in civilian facilities are required by this regulation to be the same as those benefits authorized in facilities of the Uniformed Services for patients under Title 10 1077(a), except as may be specifically limited by other statutory provisions under Chapter 55 of Title 10.

The DCS uses CFR Title 32, National Defense, Chapter 1, Part 199 — Civilian Health and Medical Program of the Uniformed Services to determine the scope of the medical benefit in MTFs. The scope of the benefit is relevant in determining whether a requested healthcare service is medically necessary (an appeal issue) or a covered benefit (a grievance issue).

The grievance and appeal processes are applicable to all TRICARE beneficiaries, subject to the limitations described in the section for uniformed patients (see **Special Considerations for Active Duty Service Members**, later in this section). The provision of or denial of healthcare services for ADSMs based on medical readiness requirements or fitness-for-duty determinations is not subject to the grievance or appeal process. Complaints may be made through the appropriate Chain of Command or to the Inspector General (IG). Fitness-for-duty determinations are addressed through the Medical Evaluation Board (MEB) and Physical Evaluation Board (PEB) processes (see **Section III, Case Management, Disability Evaluation System**).

The **grievance** process applies for complaints about specific treatment or coverage (benefit) decisions other than medical necessity. It is therefore essential for MTFs to determine whether the patient's dispute involves a grievance or an appeal.

The **appeal** process applies when healthcare services are denied by an MTF based on the determination that the services are not medically necessary. In such cases, the MTF will neither provide nor authorize TRICARE payment for services.

Grievances

TRICARE defines a grievance as a written complaint or concern about a non-appealable issue regarding the perceived failure by any member of the healthcare delivery team, including TRICARE-authorized providers, military providers, regional contractors, or subcontractor personnel, to provide appropriate and timely healthcare services, access, or quality; or to deliver the proper level of care or service. The grievance process allows the opportunity to report in writing any concern or complaint regarding healthcare quality or service to which the patient believes he/she is entitled (*TRICARE Operations Manual, 6010.51-M*, Chapter 12, Section 9).

Examples of grievances include:

- Coverage determinations.
- Factors related to quality assurance.
- Length of the waiting period to obtain an appointment.
- MTF determinations of space-available care (including availability of services, pharmaceuticals, equipment, or other items).
- Undue delays at an office when an appointment has been made.
- Refusal of a PCM to provide access to services or to refer a patient to a specialist.

Filing a Grievance

To initiate the grievance process, the patient or patient's representative submits his/her grievance in writing through the Customer Service department, the patient advocate, or a similar mechanism developed by the particular MTF for review by the MTF Commander. The Commander (or designee) appoints an "investigator" (most likely the acting Chief of Medical Staff) to review the grievance.

Within 60 days of the date of the written grievance request, the MTF Commander (or designee) forwards a written reply to the patient that includes findings regarding the grievance.

The MTF Commander's (or designee's) decision is final. The reply includes the name of a contact person who can address questions regarding the review findings.

Appeals

An appeal is an administrative review of program determinations regarding the medical necessity of healthcare services (including behavioral services) made under the legal and regulatory provisions (*TRICARE Operations Manual 6010.51-M*, Chapter 13, Appeals and Hearings). MTF staff are responsible for protecting the rights of appealing parties at all levels of the appeal process. That responsibility begins with the initial denial determination and ends when a final resolution is achieved. Further levels of appeal should progress only if the patient wants to continue the process (i.e., if the patient disagrees or is dissatisfied with the decision) or if the reviewing authority upholds the initial denial.

The MTF appeal process involves three levels of *review* followed by three levels of *appeal*. The rationale for multiple levels is twofold:

1. The process allows for a check and balance within the system.
2. The process provides for objective decision-making, progressing from the lowest to the highest level in the appeal Chain of Command.

The process also provides for *internal* and *external* chains of responsibility.

- The internal chain begins with the first level of *review*, at the MTF; and ends with the first level of *appeal*, to the MTF Commander.
- The external chain includes the third and fourth levels of *appeal* to the National Quality Monitoring Contractor (NQMC) and TMA, respectively.

Fig. 11 summarizes the MTF review and appeal process, including reviewer qualifications and guidelines.

Filing an Appeal

Appealing Party

The appealing party is the patient affected by the initial denial determination. Participation in an appeal is limited to any party associated with the initial denial determination, as well as the authorized representative(s) of the appealing party. The patient may appoint a representative (in writing) to act on his/her behalf during the appeal process.

The MTF provider is not generally an appropriate appealing party for a dependent patient. A dependent denied services may appoint his/her sponsor or any other person as his/her representative subject to the limitation in CFR Title 32, National Defense, Chapter 1, Section 199.10 — Appeal and hearing procedures. Following the representative's appointment, he/she may file an appeal on behalf of the patient.

In cases where the patient is a child under the age of 18 (i.e., a minor), the presumption is the sponsor is the appointed representative who can appeal on behalf of the child without a specific designation or appointment, as long as the sponsor is the custodial parent.

MTF Review and Appeal: Internal Review

Level of Review/Appeal	Reviewer Qualifications	Review Process (Reviewer Actions)	Outcome	Timelines	Appealing Party
First-level Review	• Non-physician reviewer • Usually registered nurse or licensed practical nurses trained in utilization review	• Utilizes criteria as a tool to review for medical necessity. • May approve requested services based on criteria. • May not deny services.	• **Approves** requested services; OR • **Cannot approve**; forwards to the second-level reviewer for medical standard of care decision.	• **Admission**: By noon of day following admission • **Concurrent**: Within three (3) business days of initial review request • **Prospective**: Within 30 days of initial review request • **Retrospective**: Not applicable	Not applicable
Second-level Review (Initial Denial Determination)	• Non-physician reviewer • Licensed practitioner with a current, valid, unrestricted license in the same or similar specialty as the attending physician or provider. Examples: o Referral Management o Physician Reviewer o Senior Physician o Chief of the Medical Staff	• Contacts PCM or attending physician and/or provider for additional documentation or pertinent medical information. • Approves or denies the requested services based on medical standard of care and available information.	• **Approves** requested services; OR • **Denies** requested services. Notifies patient, his/her representative, and/or attending physician/PCM, in writing, of: o Upheld denial determination o Reason for denial o Patient's rights o Steps to appeal denial if patient chooses to do so	***Notification*** • **Admission**: By noon of day following requested admission • **Concurrent**: Within three (3) business days of initial review request • **Prospective**: Within three (3) business days of initial review request • **Retrospective**: Within 30 days of initial review request	Not applicable
Third-level Review (MTF Reconsideration)	• Medical/Surgical/Specialty • Clinical Peer: o Licensed doctor of medicine, osteopathy, or oral surgery with a current, valid, unrestricted license to practice in the U.S. o Holds active staff privileges and patient care responsibilities in an MTF o Certified by a board recognized by the American Board of Medical Specialties or osteopathic equivalent and practice in the same specialty of the physician provider whose services are under review.	• Contacts attending physician or healthcare provider for additional information. • Makes decision based on medical standards of care and documentation and/or additional information obtained from the attending physician or provider.	• Recommends reconsideration determination approving or denying benefits. • Forwards determination to MTF Commander for review and issuance.	• Refer to timeliness requirements for MTF Commander notification (under First Level of Appeal)	Not applicable

Fig. 11 – MTF Review and Appeal Process: Internal Review

MTF Review and Appeal: Internal Review/Appeal

Level of Review/Appeal	Reviewer Qualifications	Review Process (Reviewer Actions)	Outcome	Timelines	Appealing Party
Third-level Review (MTF Reconsideration)	• Behavioral Health Clinical Peer o Physicians must meet the above criteria with board certification by the American Board of Psychiatry and Neurology. o Cannot be the same individual as in the previous review. Examples: o Internal Reviewer (if available) o External Reviewer (clinician in the same market or region)				Not applicable
First-level Appeal (MTF Reconsideration)	Not applicable			**Request for appeal**: Must be filed within 30 days following the date of the initial denial determination.	Not applicable
	MTF Commander	• Consults with other medical staff (e.g., Chief of the Medical Staff) for guidance, as needed. • Contacts attending physician or healthcare provider for additional information. • Makes decision based on medical standards of care and documentation and/or additional information obtained from the provider and previous levels of review.	• **Approves** requested services and reverses denial determination; OR • **Upholds** initial denial. Notifies patient, his/her representative, and/or attending physician/ PCM, in writing, of: o Upheld denial determination o Reason for denial o Patient's rights o Steps to appeal denial if patient chooses to do so	• **Reversal**; OR • **Upheld Denial Notification** • **Admission**: By noon of day following admission • **Concurrent**: Within three (3) business days of reconsideration review request • **Prospective**: Within three (3) business days of reconsideration review request • **Retrospective**: Within 30 days reconsideration review request	
Prior to an appeal leaving the internal MTF Appeals Process, it is recommended that the case be forwarded to an external entity within the Service's chain of Command. This intermediate level of review between the internal and external Appeals Process will vary depending on each Service's specific processes.					

Fig. 11 (cont.) – MTF Review and Appeal Process: Internal Review/Appeal

MTF Review and Appeal: External Appeal

Level of Review/Appeal	Reviewer Qualifications	Review Process (Reviewer Actions)	Outcome	Timelines	Appealing Party
Second-level Appeal (NQMC: Appeal Requested)	**Request for Appeal to the National Quality Monitoring Contractor (NQMC)** **(Note: It is the beneficiary's responsibility to initiate the appeal request directly to the NQMC)**			Requests for reconsideration shall be postmarked or received by the deadline.	• Beneficiary • Beneficiary's representative
Third-level Appeal (NQMC Reconsideration)	• NQMC • Includes reviewers who are clinical peers of the healthcare provider under review.	• Contacts attending physician or healthcare provider for additional information. • Decisions are based on medical standards of care IAW 32 C.F.R., 199 and documentation and/or additional information obtained from the provider and previous levels of review.	• Approves requested services and reverses denial determination; OR • Upholds initial denial. Notifies patient, his/her representative, and/or attending physician/PCM, in writing, of: o Upheld denial determination o Reason for denial o Patient's rights o Steps to appeal denial and request formal hearing if patient chooses to do so	• **Reversal**; OR • **Upheld Denial**. ***Notification*** Refer to TOM, Chapter 13, Section 4, Paragraph 2.3.2 and 2.4.	Not applicable
	TMA: Hearing Requested			• Request shall be mailed within 60 days after date of NQMC reconsideration determination. • A Hearing Officer is appointed within 60 days following request for hearing.	• Beneficiary • Beneficiary's representative
Fourth-level Appeal (TMA Hearing)	Not applicable	• Hearing Officer is assigned to the case. • Facts relevant to the case are presented in relation to applicable law, regulation, policies, and guidelines. • Decision is based on medical standards of care and documentation and/or additional information obtained from the provider and previous levels of review and testimony presented at the hearing.	• **Approves** requested services and reverses denial determination; OR • **Upholds** initial denial. Notifies patient, his/her representative, and/or attending physician/PCM, in writing, of: o Upheld denial determination o Reason for denial o Patient's rights o Steps to appeal denial if patient chooses to do so	• **Reversal**; OR • **Upheld Denial**. ***Notification*** • Hearing Officer will hold hearing and issue recommended decision to TMA Director within 60 days of written notice of assignment. • Refer to 32 C.F.R. 199.10 for more detailed information regarding timeliness of a hearing.	Not applicable
There are no further appeal rights. The TRICARE Director's decision is final.					

Sources: DoDD 6000.14, Patient Bill of Rights and Responsibilities in the Military Health System. TRICARE Operations Manual 6010.51-M, Chapter 13, Appeals and Hearings. 32 C.F.R. 199, Civilian Health and Medical Programs for the Uniformed Services (CHAMPUS).

Fig. 11 (cont.) – MTF Review and Appeal Process: External Appeal

In such situations, the custodial parent/sponsor or legal guardian may file an appeal and will be seen as possessing the same authority as the appealing party, which also allows him/her to receive notification letters.

Appealable and Non-Appealable Issues

Only issues that relate directly to medical necessity are appealable. Examples of appealable issues include the following:

- Concurrent reviews of inpatient care denials.
- Denial based on inappropriate level of care.
- Denial of a PCM's request for referral to a specialist.
- Denial of inpatient admission.
- Denial of preauthorization for services.
- Denial of request for professional services.
- Denial of supplies and pharmaceuticals.
- Denial of surgical procedures, including invasive and non-invasive tests.
- Termination of previously authorized treatments or services.

An issue may not be appealed unless it relates to medical necessity. Non-appealable issues include the following:

- Care/service that is not a covered benefit.
- Denial of a treatment plan.
- Denial of unproven care.
- Eligibility as a patient.
- Refusal of a PCM to provide access to services requested by the patient. (This is distinguishable from an MTF refusing to allow a patient to seek care from a PCM or denial of a PCM's request for a specialty referral, both of which are medically necessary care in the opinion of the PCM and are therefore appealable. PCMs may not deny access to emergency services.)
- Whether a provider is TRICARE-authorized.

While these issues are not appealable, they may be subject to the grievance process.

Special Considerations for Active Duty Service Members

DoDI 6000.14, *Patient Bill of Rights and Responsibilities in the Military Health System,* identifies ADSMs as a key beneficiary population in the MHS. Yet the DoDI does not expand the scope of benefits or create any entitlement inconsistent with the medical or dental care authorized under Title 10 U.S.C. Chapter 55, Medical and Dental Care or Chapter 47, Uniform Code of Military Justice; or CFR Title 32, National Defense, Chapter 1, Section 199.17 — TRICARE program. ADSMs have an obligation to comply with Service Branch requirements for medical readiness and the special rules and procedures under the Title 10 1074(c) and CFR Title 32, Section 199.16 — Supplemental Health Care Program for active duty members.

An ADSM may *not* file an appeal for reasons any of the following examples:

- A military readiness requirement to obtain a vaccine.
- A decision to delay or deny medical treatment (whether medically necessary or elective) when provision of the treatment would affect a Service's military readiness requirement. For example:
  - An ADSM desires elective surgery, which would adversely impact his/her fitness for duty and medical readiness status.
  - An ADSM requires medically necessary care, which is not available in theater.

The situations described in the examples above would affect the ability of the ADSM or of his/her unit to deploy in a timely manner. Because providing treatment would affect the Service's military readiness requirement, it would not be appealable.

Documentation

If the patient is dissatisfied with a denial decision and wishes to pursue the next level of appeal, he/she may request an appeal of that decision. Every level of the review and appeal process is documented in writing, with all communications submitted by the appealing party and created by the MTF kept on file.

The appealing party has the burden of proof to affirmatively establish by substantial evidence that the healthcare issue in question is a TRICARE benefit or entitlement that is necessary according to medical standards of care. All parties have the opportunity to present, obtain, and examine additional documentation or information for consideration during the appeal process.

MTFs must maintain documentation related to appeals for a minimum of one year after the case is closed, at which time the case should be transferred to the Federal Records Center, according to the *TRICARE Operations Manual*. All documentation related to levels of review and appeal is subject to the same prohibitions against disclosure of information and the same protections as other documentation, according to HIPAA. Initial determinations, reconsiderations, and notifications will follow CFR Title 32, National Defense, Chapter 1, Part 199 — Civilian Health and Medical Program of the Uniformed Services.

Risk Management

MTFs should keep in mind that issuing denials of care to patients bears a fundamental Risk Management liability. Risk Management issues include process standardization, standards of care, treatment delays, obstacles to communication (within the MTF and between the MTF and patients), record-keeping, and confidentiality.

Any additional medical information the attending physician provides, insofar as it is pertinent to the review and/or submitted during any one of the appeal levels, must be subsequently documented as an addendum to the medical record.

The physician/provider reviewer(s) must possess the appropriate credentials and be precise when determining an appeal decision. The MTF should conduct inter-rater reliability testing of reviewers and the facility should be in compliance with applicable regulations. The identity of review coordinators, physician reviewers, or consultants who assisted in the review of the case will not be disclosed, in accordance with Title 10 U.S.C. 1102, *Confidentiality of medical quality assurance records: qualified immunity for participants*.

UTILIZATION MANAGEMENT PROGRAM ACCREDITATION

As part of the TRICARE contract requirement, network facilities are required to obtain and maintain URAC accreditation for their UM programs. For more information, go to: http://www.urac.org.

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THE UTILIZATION MANAGEMENT PROFESSIONAL

Qualifications

The job description of the employee working in the UM department of an MTF will vary depending on the size of the organization and its internal resources. Titles include Utilization Manager, Nurse Consultant, and Clinical Nurse Specialist. The UM professional should possess sufficient clinical knowledge and breadth of experience in patient care to identify the clinical rationale for procedures or tests. He/she should be able to gather necessary information and determine the medical necessity of services and appropriateness of certain levels of care.

Good communication skills are imperative. In their goal of providing UM information to clinicians and hospital leadership, UM professionals may interact closely with the following roles and/or personnel:

1. Population Health Nurse Consultant
2. Health Care Integrator (HCI)
3. Group Practice Manager (GPM)
4. Coders
5. Patient Administration staff
6. Medical Records staff
7. MCSC staff
8. Provider teams
9. MTF MM and Managed Care divisions
10. Resource Management staff

The following are specific education and training requirements for the UM position:

- Licensed Registered Nurse (RN) – i.e., graduate of an accredited nursing program, Bachelor of Science in Nursing (BSN) preferred; or possessing a bachelor's (or higher) degree in a healthcare-related field from an accredited educational institution (position typically occupied by an RN with a BSN).
- A minimum of three years of progressively increasing managed care responsibilities, with a focus in UM and/or a minimum of three years of broad-based clinical nursing experience (UM/UR focus preferred).
- Current Basic Life Support (BLS) certification.
- Knowledge and experience (or comprehension during training) of software and databases currently employed at the MTF (e.g., Composite Health Care System [CHCS], Armed Forces Health Longitudinal Technological Application [AHLTA] — see **Section V, Medical Management Tools**).
- Familiarity with customer-focused and process improvement principles.
- Full-time employment for the past twelve months in a healthcare-related field.
- Valid unrestricted clinical license to practice from the state where the MTF is located or licensed through the Nurse Licensure Compact (NLC) if the UM professional is not Active Duty. For more information and a list of states, visit the joint website of the Nurse Licensure Compact

Administrators (NLCA) and the National Council of State Boards of Nursing (NCSBN): http://www.ncsbn.org.

Desirable qualifications are as follows:

- Certification by a UM-specific program (most desirable) or a professional organization recognized by an accrediting body for UM, such as:
  - American Nurses Association (ANA): http://www.ana.org/ancc
  - American Nurses Credentialing Center (ANCC): http://www.nursingworld.org/ancc/
  - National Association of Healthcare Quality (NAHQ) Certified Professional in Healthcare Quality (CPHQ): http://www.nahq.org
  - McKesson: http://www.mckesson.com/
    - McKesson Certified Professional in Utilization Review (CPUR)™
    - McKesson Certified Professional in Utilization Management (CPUM)™
    - McKesson Certified Professional in Healthcare Management (CPHM)™
- Experience with Microsoft Office software.
- Master's degree.
- Six years of broad-based clinical experience.

Staffing to Support Utilization Management

Personnel functioning separately under the RMC need to establish a direct working relationship with their UM department. While RMC staff might perform many of the tasks related to routine, day-to-day referral processing, there should be a UM professional (e.g., a UM nurse) providing oversight and a link to higher-level data analysis and UR functions. Communication and collaboration between UM and the RMC — as well as with the other components of CM and DM — needs to be seamless.

SUMMARY

As healthcare organizations have implemented MM, a shift has occurred in the UM role from its historical focus on cost containment to a more proactive approach of continuous quality improvement and evidence-based practice. Organizations that use UM solely to determine services and cost (i.e., that implement benefit management) tend to diminish their primary focus on the patient, which can cause interference or delays in coordinating patient care. Nonetheless, UR and preauthorization remain an important part of UM, wherein LOS and appropriateness of care are reviewed, so that problems can be identified early enough for intervention.

A successful, cost-efficient, and effective UM program depends on skilled, well-trained staff informed about current approaches and trends. As the field of UM continues to evolve, every UM staff member should view him/herself as a stakeholder in developing better healthcare delivery models throughout the MHS.

CD-ROM RESOURCES

UM-1 UM Plan Based on Seven-Step QI Process — Template

UM-2 UM Plan Based on Seven-Step QI Process — Completed Example

UM-3 Screenshots of Milliman Care Guidelines Resources

UM-4 Memorandum: *Interim Guidance on Referral Management* – Army

UM-5 Memorandum: *Interim Guidance on Referral Management* – Navy

UM-6 MTF Referral Management Center (RMC) User's Guide (V 6.0, 2008) – Air Force

CASE MANAGEMENT

CASE MANAGEMENT

Department of Defense

TRICARE

Case Management

SECTION III

INTRODUCTION

The Military Health System (MHS) incorporates Case Management (CM) as a component of a comprehensive Medical Management (MM) strategy to:

- Support patients through transitions of care.
- Decrease fragmentation of healthcare services.
- Support patient safety, education, and self-determination by establishing an active partnership with patients, their families, and the entire healthcare team to achieve optimal healthcare outcomes.

Fig. 12 highlights the role of CM over the various stages of health care (see also **Section I, Medical Management Essentials**). Specifically, as the focus of healthcare delivery moves along the Population Health continuum from secondary toward tertiary prevention, a more individualized approach is required to manage the unique circumstances of patients with a particular disease/illness/injury.

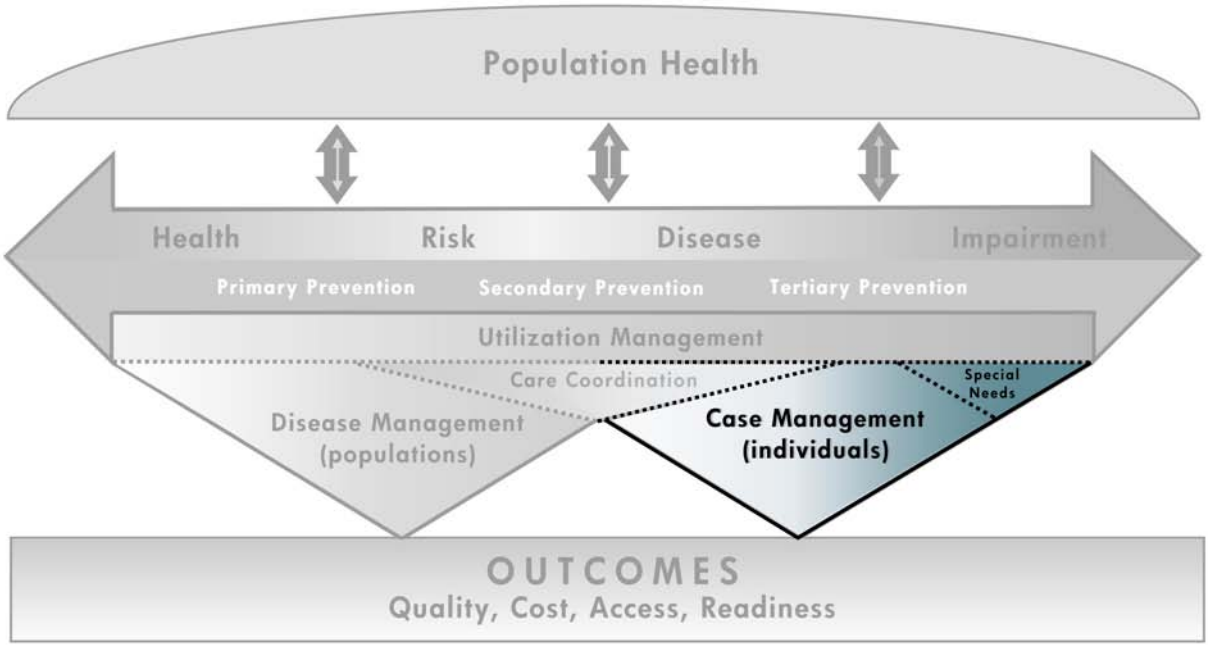

Fig. 12 — Case Management within the Integrated MM Model (IM3)

*See also Section I, Medical Management Essentials: Fig. 4, Integrated Medical Management Model (IM3) with Key info, page 14.

The MHS has established wounded, ill, and injured (sometimes referred to as WII) Service member requirements, which provide a unique level of intensive CM services for Active Duty Service members (ADSMs) with complex medical needs serving in the Army, Navy, Air Force, Coast Guard, and Reserve components.

Definition, Goals, and Purpose

The TRICARE Management Activity (TMA) utilizes the definition of CM employed by the Case Management Society of America (CMSA, 2002), as follows: 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. (See also **Appendix C, Definitions**.)

Military case managers have adopted the CMSA's definition of CM but broadened its application by placing CM under the Population Health continuum (see Fig. 12, above). CM services, which are focused on the individual patient, may overlap with Disease Management (DM), which is based on populations (see **Section IV, Disease Management**). One significant aspect of CM is care for patients with special needs, which may be physical, behavioral, emotional, or educational in nature and may require intense coordination and collaboration among healthcare team members.

Case Management is 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.

"Complex CM" may be delivered to patients with chronic illness resulting from disease or complex injuries. The National Committee for Quality Assurance (NCQA) defines complex CM as follows: The coordination of care and services provided to members who have experienced a critical event or diagnosis requiring the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.

The goal of complex CM is to help members regain optimum health or improved functional capability, in the right settings, and in a cost-effective manner. It involves a comprehensive assessment of the patient's condition; determination of available benefits and resources; and development and implementation of a CM plan with performance goals, monitoring, and follow-up.

Originally, CM almost exclusively targeted inpatients with catastrophic illnesses or injuries. However, a number of developments have served to change that strategy; notably:

- The emergence of the National Committee for Quality Assurance (NCQA): http://www.ncqa.org/.
- The development of accreditation standards by the Utilization Review Accreditation Commission (URAC): http://www.urac.org.

- The enrollment of Medicare and Medicaid populations in managed care plans.
- New legislation mandating CM services (see Sections 1611 and 1615 of the National Defense Authorization Act [NDAA] of 2008 and the DoD/VA response to those recommendations, **Executive Summary ▶ CD-ROM Resources ES-3** and **ES-4**).

While CM continues to focus on catastrophic illness or injury, CM practices are also intensely directed at addressing chronic conditions that are more prevalent in the general patient population. Case managers can affect patient outcomes through proactive interventions across multiple healthcare settings. Additionally, case managers are expected to engage community resources and facilitate ongoing and consistent patient education.

The MHS has three primary goals for CM:

- Improve the care, management, and transition of recovering Service members.
- Broaden the application of CM to include beneficiaries with complex needs and at-risk beneficiaries *before* they require complex care.
- Evaluate the impact of CM on the quality and efficiency of military health care.

Additional goals applicable to caring for wounded warriors are to:

- Assist the recovering Service member in receiving quality medical and behavioral health (BH), which may include lengthy inpatient stays and transistions between facilities or between outpatient medical and BH services.
- Assist the recovering Service member and his/her family in understanding the recommended treatment (including BH services) and in receiving timely access to that treatment.

The goal for patients coping with chronic disease is self-management and patient empowerment. While disease managers provide the medical care needed for the patient's specific disease, the hand-off to case managers supports much-needed, ongoing holistic coping and management strategies as patients strive to achieve optimal functioning and quality of life. Fig. 13 is a useful representation of activities involved in Chronic Care Management.

The purpose of CM is to:

- Promote quality, safe, and cost-effective care.
- Promote utilization of available resources to achieve clinical and financial outcomes.
- Facilitate appropriate access to care.

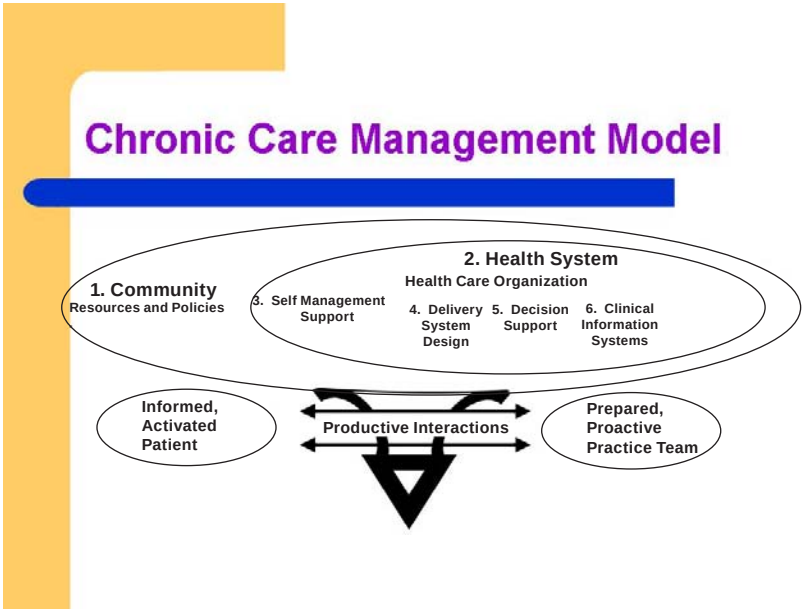

Fig. 13 – Chronic Care Management Model

- Collaborate with the patient/family, physician, healthcare providers, and others to develop and implement a plan that meets the needs and goals of the patient.
- Develop individualized patient plans of care.
- Offer objectivity, healthcare choices, and self-management solutions.

Philosophy

The philosophical key component of CM addresses care that is holistic and patient-centered, with mutual goals that allow for stewardship of resources for both the beneficiary and the healthcare system. By working collaboratively with the healthcare team, case managers help patients identify care options that are acceptable to those patients and their families. This approach promotes adherence to the treatment plan, increasing the rate of successful outcomes and reducing fragmentation of care. Effective CM in the MHS directly and positively affects the social, ethical, and financial well-being of DoD populations as well as the greater communities served by the MHS.

The Military Case Manager

The military case manager's primary role is as advocate for the patient and his/her family within the MHS. This is a vital support function for young ADSMs coping with complex medical conditions, particularly during deployment. Case managers must know how to recognize and ease symptoms of stress and anxiety from illness and injury in ADSMs as well as the associated effects on family members. One of the most important roles a case manager can play in the military environment is to educate the ADSM and his/her family about how to become their own best advocates.

The case manager's experience in patient education, support, and advocacy makes him/her an ideal integrated health manager — a role that maintains communication *with* all providers and facilitates communication *between* all providers. Further, the case manager is involved in all aspects of care by continually assessing the patient, providing information and education, supporting treatment adherence, and evaluating the patient's response.

Relationship building is a key factor in reducing stress when a patient is faced with life-altering events, as well as in helping him/her successfully attain treatment goals. A common strategy for case managers in managing ADSM care is to keep patients informed and help them resolve care-related issues. This inspires confidence in the patient and his/her family that the case manager is the go-to person for guidance and assistance. For example, ADSM families may be required to move frequently as duty stations change; case managers can be proactive in helping them secure access to medical services by coordinating the CM assessment and the patient's treatment plan with the receiving case manager prior to the move date.

The military case manager must remain in close communication with the Managed Care Support Contractor (MCSC) to facilitate a smooth transition while avoiding duplication and fragmentation of services (see also **Section I, Medical Management Essentials, TRICARE and Other Benefit Programs, Working with Managed Care Support Contractors**). MTF CMs work closely with MCSC CMs to exchange feedback and clinical data on the patient's status and to promote uniform documentation of that data.

Given the environment in which the ADSM is employed and the various regulations that govern a Service member's employment, military case managers need to be knowledgeable about:

- Characteristics of the beneficiary population compared with the general U.S. population.
- Military regulations and policies — operational requirements may affect internal CM processes, locations for care, or care delivery timelines.
- The transient nature of the military population worldwide and within different Services.
- The presence of multiple MCSCs.
- Special populations that require CM intervention (i.e., wounded warriors).

Further, military-specific designations, programs, and offices may influence CM processes (examples are listed in Fig. 14).

Military case managers also must understand the TRICARE benefit and how other health benefit programs interface with TRICARE (see **Section I, Medical Management Essentials, TRICARE and Other Benefit Programs**). Case managers can help patients secure the greatest possible benefit by demonstrating knowledge of eligibility requirements associated with these programs; patient/family preferences, financial situation, and degree of access to services; and expected level of family/caregiver support.

▶ **CD-ROM Resources CM-1** and **CM-2** present articles related to military CM. See also **Recovery Coordination Initiatives**, later in this section.

Military-Specific Programs*

- Active Duty Medical Extension (ADME) – Army, Reserves
- Active Duty member casualty/Wounded Warrior Program – All service branches
- Assignment to Medical Hold
- Command-directed programs
- Convalescent leave
- Special Needs Assignment Identification Coordination (SNAIC) – Air Force
- Extended Care Health Option (ECHO)
- Fitness for Duty
- Geographically Separated Units (GSUs)
- Limited Duty - Navy
- Line of Duty (LOD) investigations – All service branches
- Mandatory TRICARE enrollment requirements
- Medical Evaluation Board (MEB)
- Physical Evaluation Board (PEB)
- Medical Retention Processing/Reserve Component –Army
- Military Medical Support Office (MMSO)
- Non-traditional beneficiaries entitled to military medical care (i.e., secretarial designees, refuges, NATO members)
- Patient tracking relative to absent sick status – Army
- Post-Deployment Health Assessment (PDHA)
- Post-Deployment Health Re-assessment (PDHRA)
- Temporary disability retired list (TDRL)
- Warrior Transition Unit (WTU) – Army
- Warrior Transition Battalion / WTB

*See also **Appendix C - Definitions**

Fig. 14 – Military-Specific Designations, Programs, and Offices

CASE MANAGEMENT COMPONENTS

Case Management begins with the identification of individuals with chronic, catastrophic, or complex, high risk, and/or high-cost health issues who meet applicable CM criteria and would likely benefit from CM services. This identification process involves the following three steps:

- Beneficiary Identification/Case Finding
- Case Screening
- Case Selection

1. Beneficiary Identification/Case Finding

Beneficiaries may be identified and referred for CM services at any point in the healthcare continuum. When trying to identify potential candidates for CM, military case managers should consider the following:

- Cases complicated by psychosocial or environmental factors that can affect the patient's ability to achieve optimal health or maintain functioning.
- Cases affected by family and/or military circumstances.
- Catastrophic, extraordinary conditions (e.g., transplants and head injuries) that incur high costs or require substantial resources.
- Chronic conditions complicated by traumatic events.
- High-risk, multiple, or complex conditions or diagnoses.
- Whether there is a need for closer coordination and interaction between the patient and healthcare team.
- Requirements for extensive monitoring.

The case manager may also identify post-hospitalization care requirements candidates for CM by participating in preadmission programs or discharge planning meetings, or by interfacing with ward or clinic staff.

Sources for case finding include, but are not limited to, the items listed in Fig. 15.

Potential Sources for Case Finding

- Admission and Disposition (A&D) lists
- Daily inpatient census review
- Composite Health Care System (CHCS) ad hoc reports
- Daily inpatient ward rounds
- Emergency Department (ED)/Urgent Care rosters
- Exceptional Family Member Program (EFMP)/Special Needs Identification and Assignment Coordination (SNIAC) Program
- Primary Care Manager (PCM) or specialty care reports/referrals
- Self/family members
- Utilization Management (UM)/Disease Management (DM)
- Referral/Consult Management (RM)
- Managed Care Support Contractor (MCSC)
- Unit Manning Document (UMD)
- Other sources, as necessary, per MTF

Fig. 15 – Potential Sources for Case Finding

The case manager evaluates referrals using criteria identified in the CM plan to ascertain whether the beneficiary has either CM or care coordination needs. One way for providers to refer patients is through completion of Standard Form (SF) 513, which may be sent electronically through the Armed Forces Health Longitudinal Technology Application (AHLTA) or other approved electronic systems (see **Section V, Medical Management Tools**). ▶ **CD-ROM Resources CM-3** and **CM-4** provide blank and completed versions of SF 513.

An approach known as "predictive modeling" (Meek, 2003) may be used to identify a narrowly defined group of patients for CM (see **Section I, Medical Management Essentials**, and ▶ **CD-ROM Resources MME-2** and **MME-3**).

The John Hopkins Adjusted Clinical Groups (ACG) Case-Mix System measures morbidity by, among other things, forecasting healthcare utilization. The ACG system evaluates patient populations based on disease patterns, age, and gender**.**

More specifically, the Johns Hopkins ACG methodology is used to:

- Predict high-risk users for inclusion in CM.
- Determine government- or employer-budgeted payment to health plans.
- Allocate resources fairly within programs.
- Set capitation payments for provider groups.
- Evaluate access to care.
- Assess the efficiency of provider practices.
- Improve quality.
- Monitor outcomes.

For more information, go to: http://www.acg.jhsph.edu/html/AboutACGs.htm.

Triggers for Potential Referral

The MHS supports a population-based approach to CM, which coordinates care and services for groups with similar characteristics. Coordinating care for groups of people before they are at risk is a key preventive measure in Population Health improvement. (See **Executive Summary,** ▶ **CD-ROM Resource ES-1**, 2001 *DoD Population Health Improvement Plan and Guide*, or go to: http://www.tricare.mil/ocmo/download/mhs_phi_guide.pdf. Publication of the next iteration of the Guide is expected in summer 2010. See also **Section I, Medical Management Essentials, The Link between Medical Management and Population Health**.)

The following are appropriate triggers for referral to CM (see also **Section II, Utilization Management, Referral Management**). Sometimes referral is based on a diagnosis, condition, or family situation, but other factors include:

- Spinal cord injury.
- Head injury – traumatic and non-traumatic.
- Serious trauma.
- Psychological disorder (including suicide risk).
- Multiple chronic illnesses.
- Cancer diagnosis.
- Neonatal Intensive Care Unit (NICU) admission.
- Transplant* or burn.
- Dual diagnosis.
- Blindness.
- Amputation.
- Poly-substance abuse (can be a result of polypharmacy — when the patient has been prescribed seven or eight concurrent medications).

**May not be based on regional contract. Most transplant contracts occur in the civilian system. In the MTF, the case manager may coordinate with the MCSC on this type of referral.*

Additional factors that may trigger a referral to CM are:

- Non-adherence to the medical treatment plan.
- A need for care coordination between multiple providers/facilities.
- Complicated family dynamics that interfere with recovery and maintenance of wellness.

Case managers working in an Air Force MTF should contact their Health Care Integrator (HCI) and disease manager to coordinate efforts. Army or Navy case managers should contact their Population Health department.

2. Case Screening

A beneficiary may qualify for CM if that patient requires close collaboration and/or communication between healthcare team members, due to the complexities of his/her condition/disease and/or social situation. If the beneficiary does not meet screening criteria for CM enrollment, the case manager contacts the original referral source to communicate the reasons and offer alternative assistance, if available. Nonetheless, the case manager may provide disposition planning and assistance to the patient and act as a reference source for immediate, pressing issues.

(Refer to ▶ **CD-ROM Resource CM-5** for CM screening criteria.)

MTFs should target specific patient populations for CM based on the local CM or MM plan and policies governing MCSC contracts. Case managers should give priority to ADSMs. As noted in the *TRICARE Policy Manual* (available at http://manuals.tricare.osd.mil/), some of the more common conditions/diagnoses that require CM in the MHS include traumatic brain injury (TBI), burn patients, and infants admitted to the NICU. When performing data analysis of utilization rates, frequent or prolonged hospitalizations and treatments (e.g., chemotherapy, pain management, use of monitoring equipment for uterine conditions or apnea) may be a "red flag" indicating patients who could benefit from CM services. The utilization manager can obtain and analyze relevant data and make referrals to CM (see **Section II, Utilization Management**).

3. Case Selection

If the beneficiary meets the screening criteria, the case manager will meet with the beneficiary and offer him/her enrollment into CM. If the beneficiary accepts the offer for CM services, the case manager will provide his/her contact information to the beneficiary. As part of the process of developing a treatment plan, the case manager should also perform an assessment/risk appraisal of the level of severity of the beneficiary's condition and/or the complexity of care required (see ▶ **CD-ROM Resource CM-6**).

Case managers should also provide the beneficiary and his/her family with an introductory letter, enrollment form, and/or marketing brochure explaining CM (see **Promoting Your Program**, later in this section, and ▶ **CD-ROM Resource**

CM-23). The introductory letter should explain the circumstances in which information is released to other entities, and how and when the beneficiary will receive written notification of the plan of care (refer to ▶ **CD-ROM Resource CM-7** for a sample introductory letter).

When a beneficiary agrees to be case managed, the case manager must obtain written consent from either the beneficiary or his/her legal guardian prior to acting on the beneficiary's behalf. Written consent is a legal requirement that allows the case manager to discuss and arrange the beneficiary's treatment plan with other parties. (Refer to ▶ **CD-ROM Resource CM-8** for a sample authorization form for disclosure of medical information and ▶ **CD-ROM Resource CM-9** for an original informed consent form.)

If the beneficiary or his/her legal guardian declines CM services, or if the beneficiary is not accepted into CM, the case manager should document the declination or reason for non-acceptance in the beneficiary's outpatient medical record. The primary care manager (PCM) and the individual who made the initial referral should also be notified of the decision. The beneficiary can be re-referred if his/her status or environment changes. (Refer to ▶ **CD-ROM Resource CM-10** for a non-acceptance letter and ▶ **CD-ROM Resource CM-11** for an inability to contact form.)

As part of the enrollment process, the case manager adds the beneficiary to the CM caseload database, which allows for efficient beneficiary tracking, continuity of care, outcome measurement, and reporting.

The Six-Step Case Management Process

After completing the preparatory steps of beneficiary identification/case finding, case screening, and case selection, the case manager performs the six basic steps of CM:

1. Assessment
2. Planning
3. Implementation
4. Coordination
5. Monitoring
6. Evaluation

Fig. 16 illustrates the six-step CM process.

These essential steps constitute key activities that are systematic, yet dynamic. Your individual Service Branch will have established timelines for *how long* you have to contact a patient and to complete a patient plan of care, and for *how often* you must follow up with your patient and document the plan. For more information on the specific policies of your Service Branch, contact your supervisor or department head.

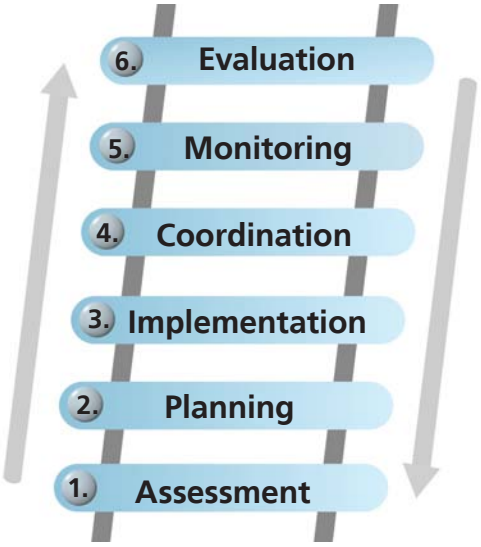

Fig. 16 — The Six-Step CM Process

The six steps of CM are described in more detail below.

1. Assessment

Assessment is a systematic, ongoing activity that involves collecting comprehensive information about a patient's situation, including all relevant sources (military and civilian) to identify individual needs. This includes speaking with the patient, caregivers (if appropriate), and healthcare providers — especially the PCM. Fig. 17 describes categories of assessment.

According to the NCQA (July 2007), case managers need to address the following areas pertaining to their patients:

- Current health status, including condition-specific issues and co-morbidities
- Clinical history, including medications
- Activities of daily living (ADLs)
- Caregiver resources
- Available benefits
- Mental health status
- Advanced directives
- Cultural and linguistic needs, preferences, or limitations
- Financial considerations

Because the assessment process may require the case manager to make multiple contacts, it can take several days to complete an assessment. Once the assessment is complete and problems have been identified, determination is made whether CM criteria have been met and whether to open a CM case. If the decision is *not* to open the patient to CM, the patient is provided with appropriate resources and the referring party is notified of the decision. If a CM case *is* opened for the patient, the next step is to develop a plan of care.

2. Planning

Planning involves determining specific objectives, goals, and actions designed to meet the patient's needs as identified during assessment. Once the patient is accepted into CM, a plan of care is developed. The purpose of the plan is to:

- Address problems.
- Set short- and long-term goals.
- Identify barriers to reaching the stated goals.
- Identify actions that can be taken (i.e., interventions) to resolve any barriers to achieving those goals.

Problems may include:

- Lack of patient access to appropriate specialists or community resources.
- An inadequate patient support system.
- Inappropriate pain management.

Goals may include:

- Short-term goals — e.g., patient access to appropriate specialists or community resources.
- Long-term goals — e.g., the patient's ability to effectively self-manage pain.

A time frame is assigned for meeting each goal.

It is important to keep the following considerations in mind:

- CMSA standards of practice state that measurable goals must be established. Goals that promote cost-effective, quality outcomes must be included in the plan of care and created in collaboration with the patient and family.

Categories of Assessment	
Assessment Subject	**Description**
Demographic Information	• Name, social security number (SSN) • Service branch • Cultural considerations • Financial class (e.g., TRICARE, other health insurance, other benefits) • List of treating physicians, specialties, addresses, telephone numbers • Spiritual needs
Medical History	• Advanced directives/living will/power of attorney • Ancillary services • Pharmacology/use of pharmacy services
Vocational Information	• Education • Impact of health on work status • Occupation
Health Status/ Systems Review	• Age-specific considerations • Health status perception • Learning abilities/comprehension
Current/Projected Resource Utilization	• Community/workplace reintegration • Custodial care needs (activities of daily living) • Durable medical equipment (DME) requirements • Home environment/living arrangements • Medical/functional/disability/rehabilitation status • Beneficiary's diagnosis/prognosis, short/long-term goals • Rehabilitation potential • Skilled and less-than-skilled nursing needs (hrs/day, days/week, daily visits, intermittent visits)
Psychological Status	• Beneficiary's/family's emotional status • Beneficiary's mental status • Compliance issues • Substance abuse issues • Understanding/acceptance of current problem
Community/Social Support	• Age-specific considerations • Assessment of interrelationships between family members • Beneficiary/family propensity for support • Caregiver support system • Cultural considerations, including language barriers • Family members' perception of their care/support role(s) • Marital status • Need for community resources • Spiritual support • Support system (beneficiary, caregiver, community, faith-based)
Health Risk Assessment	• Clinical practice guideline (CPG) screening questions • Clinical preventive services
Home/Environment Assessment	• Fall risk • Beneficiary's living arrangements • Presence of primary caregiver

Fig. 17 — Categories of Assessment

Goals/outcomes must also reflect input from the entire healthcare team.

- Goals for the individual patient are defined after a thorough patient assessment is completed. At that point, the case manager addresses the problems that have been identified. Goals/outcomes are defined based on the resolution of those problems.
  - For example: Patient A needs specialty care that is not readily available in the area where he/she lives. The goal is to provide access to the needed specialist. The case manager's interventions are targeted toward linking the patient with the specialist in a manner that is accessible, affordable, and reliable. When the link between specialist and patient is validated, the problem is resolved and the goal is met. The outcome is appropriate and timely specialty care, when needed.
- Individual goals must be re-evaluated when psychosocial, medical, or financial changes occur. Treatment and plans of care must be adjusted accordingly.

Barriers may include:

- Transportation not being available for patient visits to a specialist.
- Multiple prescribed medications from various providers (i.e., polypharmacy), with the patient unable to manage his/her pain.
- The patient being unaware of available community resources.

There are usually several barriers associated with each problem, which in turn serve to further define that problem.

Multiple *actions/interventions* may be assigned in response to each barrier; these may include:

- Providing research on appropriate and available specialists within the MTF/network who can meet the patient's medical needs.
- Obtaining a list of all medications the patient is taking, including name of prescriber(s) and pharmacy(ies) dispensing the medications.
- Requesting referral to a pain clinic.

The plan of care must be agreed to by the patient and the PCM, and all parties must sign it. The plan should include contacts for medical/behavioral health providers; resources to be explored; verification of medications to be taken; and an assessment of housing needs, transportation, and level of caregiver support.

The plan of care is meant to optimize Direct Care System (DCS) and Purchased Care System (PCS) resources, special health-related programs, and other federal/national/state/local agencies and resources.

3. Implementation

Implementation involves executing actions/interventions identified in the plan of care that will lead to accomplishing stated goals. This process step necessitates communication between healthcare team members, including the patient and his/her family or caregiver(s). At the outset of implementation, the case manager should discuss the goals of the plan of care with the patient and his/her caregiver(s). This includes advising them they will continue to be a resource for the case manager until such time that problems have been resolved

and goals met — at which point, the patient/caregiver(s) can self-manage.

The case manager activates the actions/interventions described in the plan of care, and documents the following types of information:

- Date(s) of contact.
- Who was contacted.
- The purpose of the contact(s).
- What was discussed.
- The outcome of the discussion(s).
- The specific plan for next action/intervention, including the scheduled date.

During implementation, all elements of CM standards of practice must be adhered to along with other applicable guidelines, including clinical practice guidelines (CPGs). The following resources may be useful in this effort:

- VA and DoD CPGs: https://www.qmo.amedd.army.mil/pguide.htm.
- The Agency for Healthcare Research and Quality (AHRQ): http://www.ahrq.gov/. The AHRQ has published and disseminated national CPGs for more than 19 clinical subjects. These are accessible through the National Library of Medicine's Medline service: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi.

Refer to **Section IV, Disease Management**, for more information on CPGs.

4. Coordination

Coordination involves organizing, securing, integrating, and modifying the necessary resources to accomplish the goals set forth in the plan of care. This step directs the patient to appropriate services to achieve seamless and timely continuity of care. Coordination is achieved by identifying patient needs and applying appropriate actions/interventions (see also Step 2, *Planning*).

Coordination of activities helps case managers:

- Avoid duplication of services.
- Ensure timely and appropriate provision of services.
- Identify barriers to care delivery and explore delivery alternatives.
- Match patient needs with available resources.
- Optimize healthcare resources in the MTF and local community.
- Organize and manage the activities outlined in the plan of care.
- Ensure all care providers receive necessary information in a timely manner.

Depending on the availability of services or agencies in the local area, the MTF case manager may need to coordinate with the MCSC. Access to community resources from all levels — local, state, and national — will facilitate coordination of services.

5. Monitoring

Monitoring involves gathering information from relevant sources on an ongoing basis with regard to healthcare activities and services, and to patient adherence to the treatment plan. Case managers conduct monitoring to determine whether planned patient goals have been achieved and how effective the process is for achieving them.

During monitoring, the case manager:

- Ensures timely and appropriate care is provided based on the patient's changing health status and/or environment.
- Ensures timely patient/family and healthcare provider contact and follow-up.
- Establishes and documents progress towards meeting plan-of-care goals.
- Identifies variance(s) from the plan of care and revises the plan accordingly.
- Monitors the result of actions/interventions and care delivery.
- Monitors utilization of healthcare resources.

The case manager will continually assess and monitor the patient's response and adherence to treatments, and decide whether services should continue or new services should be implemented. In this respect, monitoring dovetails with assessment. Monitoring also includes collecting and tracking data.

6. Evaluation

Evaluation is a continuous step in which the case manager measures the patient's response to the healthcare services being delivered. The case manager uses critical thinking skills to analyze the data obtained during monitoring and revises the plan of care to respond to the patient's ongoing needs.

As part of this step, the case manager must make a comprehensive routine assessment of the patient's status and progress toward meeting the goals stated in the plan of care. If no progress is noted, the case manager should determine the reason and revise the plan of care to include interventions that will promote the identified goals.

Other measures of care may include patient/caregiver and healthcare team satisfaction, as well as cost savings.

Case Closure

Planning for case closure begins at the time the patient is accepted into CM. The consistent goal and measure of success of a plan of care is that the patient/caregiver(s) be able to self-manage — that is, to advocate for themselves. Early in a case, it is appropriate for a case manager to make referrals, contact providers, and research resources. As the case progresses, that responsibility needs to be transferred to the patient/caregiver(s), as appropriate.

As the case manager works with the patient/caregiver(s), he/she acknowledges successes in the patient's progress toward greater self-sufficiency. As the case manager assesses a patient's progress toward meeting the goals established in the plan of care, the case progresses toward closure.

Sometimes not all goals are achieved. A case may appropriately be closed based on circumstances such as failed adherence to treatment regimes, change in eligibility, or even death. In some circumstances, it may be useful to conference with another case manager in making the decision about whether to close.

When the decision to close a case is made, the case manager undertakes the following steps:

- Communicates the patient's status with the patient/caregiver(s), provider, and other members of the healthcare team; and informs them of the reason for the closure decision.
- Documents a summary CM note in the patient's outpatient record and documents the closure on the CM tracking log. (Refer to ▶ **CD-ROM Resource CM-12** for a sample case closure summary form.)
- Documents the closure on the CM tracking log or an electronic form such as the ones available through the Air Force's Access Improvement Model (AIM). (Refer to ▶ **CD-ROM Resources CM-13** and **CM-14** for sample AIM forms.)

Documentation

As with all other parts of the medical record, documentation is critical in providing a legal record of patient care. The case manager should document all activities of the plan of care and CM process, including interventions with healthcare team members, health status updates and progress, new problems, and changes in goals. Most importantly, all encounters with the patient and family should be documented, whether those communications are face-to-face, by phone, by e-mail, or through another virtual method.

Documentation guidelines vary depending on local or Service-specific policies. Complete and correct documentation must meet standards established by The Joint Commission (TJC) and other professional organizations (see **Appendix D, Resources**). It is recommended that the documentation occurs in the Armed Forces Health Longitudinal Technology Application (AHLTA) and is coded appropriately. (See **Section V, Medical Management Tools,** ▶ **CD-ROM Resource MMT-1** for more information on AHLTA, sample screenshots of AHLTA templates, and guidance on how to appropriately code patient encounters.)

It is recommended that a satisfaction survey be sent to the patient/caregiver(s) and to provider(s) as an outcome measure for feedback on CM services. Other outcome measures would be performed at this time, including on how the CM services affect the population health of the MTF (▶ **CD-ROM Resources CM-15** and **CM-16** provide sample surveys). See also **Outcome Measurement and Management**, below.

Outcome Measurement and Management

MM outcomes are measured based on quality, cost, access, and readiness (see **Section I, Medical Management Essentials**, including Fig. 2, MHS Medical Management Model). In CM, patient and program outcome evaluation should be performed.

Patient outcome evaluation is an integral part of the CM process and measures patient outcomes using clinical, functional, and/or satisfaction indicators.

Program outcome evaluation focuses on how CM affects healthcare delivery.

Patient-level evaluation usually involves *outcome*-based measurements, while program-level evaluation usually involves *process*-based measurements. Fig. 18 describes sample patient and program evaluation outcomes.

Sample Patient and Program Evaluation Outcomes (Local Level)	
Patient Outcomes	**Program Outcomes**
• **Clinical** ■ Medication compliance (refills, blood pressure, lab values) ■ Reduced LOS ■ Reduce readmissions ■ Use of more appropriate levels of care ■ Cost avoidance	• **Difference between the number of acute care admissions before and after CM is initiated**
• **Psychosocial**	• **Difference between the number of clinic appointments before and after CM is initiated**
• **Functional**	• **Difference between the number of ED visits before and after CM is initiated**
• **Quality** ■ Pain and comfort ■ Condition state — functional, cognitive, quality of life, physiologic indicators	• **Efficiency**
• **Fiscal** ■ Cost per visit ■ Specific cost reductions • Lab tests • Medical supplies • Pharmaceuticals	• **Fiscal impact**
• **Service** ■ Nurse staff satisfaction ■ Interdisciplinary staff satisfaction ■ Patient satisfaction • Follow-up call • Increased access • Increased trust and confidence in the MHS • Reduced patient complaints • Reduced wait times	• **High utilizers**
	• **Quality**
	• **Workload** ■ Number of patients initiated into CM per month ■ Number of CM cases closed per month ■ Number of referrals to DM per month ■ Number of referrals (accepted/denied) to MCSC per month
	• **Prevention Initiatives** ■ Number of women/men who have received prevention screening (e.g., Paps, prostate screenings) ■ Number of children with current immunizations

Fig. 18 – Sample Patient and Program Evaluation Outcomes

Patient Outcome Evaluation

Successful patient outcomes are based on what is expected to happen as a result of the course of the disease and the effect of CM interventions. When the case manager focuses on patient needs and uses a carefully constructed collaborative plan of care, individual goals will be met and the outcome will be cost-effective, high-quality care.

As discussed in **Section I, Medical Management Essentials**, there is a preventive model to measure cause and effect in MM interventions that includes three phases: primary prevention, secondary prevention, and tertiary prevention. Based on this model, success (achievement of outcomes) can be understood as slowing, halting, or reversing either a) advancement *within the same phase* or b) transition *to the next phase*.

Regardless of which CM model is implemented, it is essential to have a measurement system in place. In addition to measuring outcomes, this system must also identify the process of data collection, aggregation, analysis, and reporting (Cesta, Tahan, Fink, 2002). Because of their responsibilities, case managers should make sure to track outcome data for the patients in their caseload to determine the effectiveness, efficiency, and efficacy of CM services.

The success of a CM system depends to a great degree on how well case managers employ outcome data to manage, plan, facilitate, expedite, advocate, coordinate, and evaluate the delivery of patient care. To enable case managers to execute this role, it is important for the MTF to establish an outcome classification system. This system aims at evaluating the CM model used. That model must be standardized across the MTF and used by all case managers (Cesta, et. al.).

There is no best system for measuring outcome indicators. Organizations should identify the one that works best for their providers and customers. Indicators must be measurable — i.e., based on cost per case type or episode of care/illness. Organizations also must delineate the frequency of data collection, the sample, the formulas to be applied in the analysis, and the reporting format. Some organizations may classify the patient's functional ability as independent from clinical indicators, while others may combine the two aspects in conducting their analysis. It is important to define whether the indicator is a patient/family or healthcare organization-related indicator.

Fig. 19 presents examples of patient-related outcome classification.

Program Outcome Evaluation

CM program outcomes should be measured based on CM program goals and the MTF's strategic plan. Once specific outcomes have been determined, the data must be reported through the Chain of Command in order to gain value. (Refer to ▶ **CD-Resource CM-17** for sample CM measurement reporting tools, including preventable admissions, two quantitative cost avoidance/savings reports, and qualitative savings — see different tabs in file.) Fig. 20 presents examples of healthcare organization-related outcome classification.

Classification	Patient/Family-Related Outcomes
Clinical	• Improved patient care outcomes, such as reduced/controlled pain, morbidity, and mortality rates. • Reduction in signs and symptoms of disease and degree of progression of the disease. • Prevention of adverse effects of treatments and complications of illness. • Reduction in practice variation.
Financial	• Optimal and appropriate use of resources and services. • Provision of care in appropriate setting(s) level of care. • Maximal coordination of care among providers. • Streamlining of diagnostic and therapeutic tests and procedures.
Quality of Life	• Improved/maximized physical abilities and level of independence. • Improved psychological, physiological, and social functioning. • Improved state of well being. • Improved perception of health status. • Enhanced self-care abilities/skills. • Enhanced knowledge of healthcare needs.
Satisfaction	• Increased patient/family satisfaction with care. • Improved continuity of care. • Improved patient-nurse and family-nurse relationships.
Source: T Cesta, H Tahan (2003): Case Manager's Survival Guide Winning Strategies for Clinical Practice, 2nd Edition, p. 100-103 (Seminar Nurse Manager), Mosby.	

Fig. 19 – Example of Outcomes Classification: Patient-Related

Other program measures may include preventable admissions rates, a measure that can be stratified by diagnosis. For example, a potential enterprise measurement for DM is the preventable admission rate for CM patients with a primary diagnosis of asthma, diabetes, or congestive heart failure (CHF) compared to the preventable admission rate for non-CM patients with the same diagnoses.

CM outcome measures should be patient-centered and within the context of the organization's overall business plan. If care decisions are challenged by constraints within the facility's business plan, the case manager should collaborate with UM to resolve the dilemma in the most cost-effective manner without compromising quality. These circumstances may warrant a CM team meeting or case conference with other MM professionals and members of the healthcare team. In such cases, it is important to document any variances in the patient's plan of care that will have a direct impact on the outcome measure.

Classification	Healthcare Organization-Related Outcomes
Clinical	• Standardization of care processes (establishing standards of care/case management plans). • Streamlined care processes and delineation of responsibilities. • Improved turnaround time of tests, treatments, and procedures. • Increased compliance with standards of regulatory and accreditation agencies.
Financial	• Appropriate changes in staff mix/skill mix. • Reduced cost (e.g., reduction in length of stay, reduction in or elimination of fragmentation and duplicate services). • Improved reimbursement and revenue. • Reduction in denials of claims. • Improved communication among providers and healthcare staff.
Quality of Life	• Prevention of inappropriate hospitalizations. • Reduction in inappropriate utilization of Emergency Department services. • Provision of a safe environment of care. • Provision of programs that meet patient and family needs. • Improved accessibility to care/services.
Satisfaction	• Improved staff satisfaction. • Reduced rates of burnout, turnover, attrition, and absenteeism. • Enhanced states of communication, collaboration, and teamwork among providers and disciplines (interpersonal, interdisciplinary, and interdepartmental).
Source: T Cesta, H Tahan (2003): Case Manager's Survival Guide Winning Strategies for Clinical Practice, 2nd Edition, p. 100-103 (Seminar Nurse Manager), Mosby.	

Fig. 20 – Example of Outcomes Classification: Healthcare Organization-Related

Fig. 21 lists examples of CM outcome measures.

Measuring program outcomes allows CM to support and objectively track improvements in healthcare processes or any decline in patient progress. Outcome measurement enhances compliance with regulatory and accreditation requirements and standards of practice; and reduces risk by demonstrating compliance with healthcare quality guidelines.

Cost-Benefit Analysis

CM activities can have a significant impact on an organization's business plan. When case managers develop effective outcome measures, they demonstrate value to their MM department and the organization as a whole.

Examples of CM Measures

- **Timeliness of service**
- **Cost avoidance to the Direct Care System (DCS)**
- **Relative Weighted Product (RWP)/Relative Value Unit (RVU) impact of a CM intervention**
- **Recaptured care as a result of CM coordination**
- **Access to specialty care services as a result of CM coordination**
- **Beneficiary satisfaction**
- **Reduced hospital admissions**
- **Patient knowledge of the healthcare treatment plan and benefits**
- **Improved provider/patient interaction**
- **Measures of clinical improvement**
- **Appropriate utilization after CM intervention**
- **Hospital readmissions rate before and after CM intervention**

Fig. 21 – Examples of CM Measures

Outcome measures validate:

- What is effective.
- What is not effective.
- The cost of an intervention.
- Return on investment (ROI).

A cost-benefit analysis is performed to help determine a) whether to make a change or b) how well a planned action (e.g., implementation of a program) may turn out.

A cost-benefit analysis relies on adding up positive factors and subtracting negative ones to determine a net result. The technique is to simply add up the benefits of an action/intervention and subtract the costs associated with that action/intervention. The cost-benefit analysis is closely linked to the "evaluation" aspect of the CM process. As the case manager coordinates services and makes recommendations for care options, he/she should conduct an ongoing cost-benefit analysis regarding those choices.

Another method of demonstrating value is to track and calculate costs that were avoided. Using a log to collect data of your caseload is a straightforward method for expressing quantity and cost effectiveness. (Refer to ▶ **CD-ROM Resources CM-18, CM-19**, and **CM-20** for examples of CM caseload logs.)

According to Kongstvedt (2001), a cost-benefit analysis report for CM should include the following elements:

- Overview of CM intervention (a brief narrative).
- Summary of intervention.
- Actual charges.
- CM fees.
- Savings (e.g., avoided or potential charges; discounted and negotiated reductions; reductions in services, products, and/or equipment).
- Gross savings (potential charges minus actual charges).
- Net savings (gross savings minus CM fees).
- Status of the case (opened or closed).

CM Hard and Soft Savings	
Hard Savings or Avoided Costs*	**Soft Savings or Potential Savings****
• Change in the level of care facilitated by CM • Change in the patient's length of stay (LOS) • Change to a contracted PPO provider • Finding unauthorized charges that are not warranted • Negotiation of duration of services • Negotiation of frequency of services • Negotiation of price of services, supplies, equipment, or per diem rates • Prevention of unnecessary bed days, supplies, equipment, services, or charges *Measurably saved or avoided costs when facilitated by the case manager.	• Avoidance of potential acute care days • Avoidance of potential costs, equipment, and supplies • Avoidance of potential ED visits • Avoidance of potential home health visits • Avoidance of potential hospital admissions • Avoidance of potential legal exposure • Avoidance of potential medical complications • Improved patient/family satisfaction with CM • Improved patient compliance • Improved quality of care or quality of life **Less tangibly measurable than hard savings. If no case manager was assigned to the patient, the potential costs incurred could have been much more than with CM; they represent costs that were avoided most likely because of CM intervention.
Source: Powell and Ignatavicius, 2001	

Fig. 22 – CM Hard and Soft Savings

Cost-benefit analysis takes into account both hard and soft costs incurred as a result of a selected option for care or a choice in service delivery.

Hard costs (or hard savings), also known as "avoided costs," are measured in actual dollars when costs are measurably saved or avoided (Powell and Ignatavicius, 2001). Examples of hard costs may include such items as hospital bills, physician fees, and medical supplies in which the case manager facilitated a change in the level of care, the patient's length of stay (LOS), or negotiated the frequency or duration of services. Hard costs can show clear savings as a result of eliminating duplication of services, reducing Emergency Department (ED) visits, transferring to lower levels of care, reducing hours of care, preventing unnecessary bed days, or reducing the unnecessary use of supplies and equipment.

Soft costs (or soft savings), also referred to as "potential savings," are factors that may not have an exact dollar measurement but that incur a social or personal cost to the patient. Examples of soft costs are lost duty time, avoided ED visits, reduced productivity, and improved quality of life.

Fig. 22 describes CM hard and soft savings.

ESTABLISHING A CASE MANAGEMENT PROGRAM

Organizational Framework

There are multiple types of organizational structure for CM program assignment in inpatient or ambulatory care facilities. Integrating all case managers within one designated department or cost center before assigning them to individual duty throughout the inpatient and outpatient areas is just one model that may add value to the CM program. Hospital or facility size, available services, resources, and staff qualifications often determine the program's structure.

The organizational structure of a CM program should above all serve to support the practice of quality care. This includes ensuring there are a sufficient number of:

- Qualified case managers to service the population (see **The Case Management Professional**, later in this section).
- Data management systems to meet documentation and data mining requirements.
- Support staff to assist the case managers in their clinical management of patients.

The program should also support national CM standards of practice and encourage CM certification. Access to physician consultation, benefits advisors, decision support criteria (e.g., McKesson® InterQual® evidence-based clinical support criteria, Milliman Care Guidelines® — see **Section II, Utilization Management**), decision support staff, and educational resources are essential.

Goals

MHS CM program goals include:

- Establishing processes to proactively identify wounded, ill, or injured Service members who meet the criteria for assignment to clinical CM as determined by Directive-Type Memorandum (DTM) 08-033, Interim Guidance for Clinical Case Management for the Wounded, Ill, and Injured Service Members in the Military Health System (Draft) —http://www.dtic.mil/whs/directives/corres/dir3.html. (See also ▶ **CD-ROM Resource CM-21**.)
- Creating and implementing comprehensive performance measures to facilitate appropriate and successful execution of clinical CM, as outlined in DTM 08-033.
- Establishing processes that will be used to improve care as patients and their families transition along the continuum of care, ensuring seamless hand-off during transitions of care (TOCs) — see **Transition/Coordination of Care, Transition of Care**, later in this section.
- Establishing processes to proactively identify other patients who meet the criteria for CM.
- Ensuring services are rendered in a timely and cost-effective manner without compromising quality of care.
- Assisting patients in maintaining the maximum amount of autonomy and human dignity while helping minimize the impact of long-term changes in living and occupational status, as well as disability level.

To successfully administer CM services, the MTF must establish processes critical to the program. A CM program must target the right population for

CM services. The "80/20 rule," that 20 percent of the population is responsible for 80 percent of healthcare costs, should be a key concept in directing CM interventions. MTFs should systematically identify and analyze their population to find high-*risk* and high-*volume* patients before they become high-*cost* patients.

Implementation

When preparing a plan for CM program implementation, you should address the following questions:

- What is the process for case finding, screening criteria, and selection; and for deciding to enroll eligible beneficiaries into CM?
- Which tools (i.e., clinical pathways, guidelines) will be used to track patient progress?
- Which forms, computer software, or paperwork will be required for documentation or charting?

As discussed throughout this section, it is particularly important to consider:

- Care coordination procedures.
- Case manager qualifications, roles, responsibilities, and job descriptions.
- Discharge planning procedures.
- Intra/interregional transfer policies.
- Outcomes reporting.
- Plans for process improvement.
- Processes for local and regional networking.
- Staff and beneficiary educational programs.
- Standardized beneficiary screening criteria.
- Problem resolution methods.
- Unique ADSM requirements.

It is also important to be aware of challenges related to:

- Patient safety during transition.
- The degree to which collateral programs that directly affect CM are integrated within the MTF.
- The ability to secure reliable connectivity through technology.
- The degree to which practices are standardized among case managers.

The MTF's program will be dynamic and evolving as it matures from its initial stages. To assist in launching a new program, the Web-based MHS Learn CM modules course library provides a variety of useful forms and tools for the case manager. For more information, go to: https://mhslearn.csd.disa.mil.

Quality

Each CM department and program supports the quality program of the MTF Command. CM quality programs are geared toward process improvement, with CM departments offering Command-specific training and professional development programs for case managers. Certification is one mechanism for enhancing quality by standardizing the individual/professional knowledge base for CM practice (see **The Case Management Professional**, later in this section).

Quality-based outcomes may include performance indicators such as improved functional or health status, enhanced quality of life, patient/family/provider satisfaction, adherence to the treatment plan, improved patient safety, appropriate use of

healthcare services, cost savings/avoidance, and patient/caregiver self-management.
Quality measures can be applied internally or externally. For example, an internal quality measure might involve supervisor review of case documentation to encourage standardization. External quality control measures can be established by Service-specific governing bodies. For example, Navy CM at the Bureau of Medicine and Surgery provides documentation reviews for quality and compliance, which helps standardize documentation practices among Navy MTFs and medical clinics.

Performing a quality review supports the concept of "best practice." The OCMO Healthcare Innovations Program is an excellent source for benchmark and process improvements: www.tricare.mil/ocmo/innovations.cfm.

Caseload

The various responsibilities involved in MM-related activities can affect the case manager's ability to provide comprehensive services. A major factor is the number of case managers required in an organization, which depends on the composition (case mix/acuity) of the membership. A case manager's caseload is dependent on many concurrent factors, including:

- Characteristics of the patients served.
- Complexity of the plan of care.
- Geographical area covered.
- Amount of administrative support.
- Availability of community-based services.
- Experience and competency of the case manager.
- Control over funds used in the delivery of care.

Caseload assignment may also be influenced by:

- The clinical needs of the patient.
- The psychosocial needs of the patient/family.
- Cognitive challenges to the patient.
- Treatment adherence issues.
- The demographics of the population served.
- Geographic factors.

The 2008 *Case Management Caseload Concept Paper*, a joint publication of the CMSA and the National Association of Social Workers (NASW), asserts that the clinical practice setting affects the patient-to-case-manager ratio (refer to ▶ **CD-ROM Resource CM-22**). For example, an experienced case manager providing telephonic CM in an outpatient setting can manage a higher caseload than an onsite case manager in an acute inpatient setting. Page 22 of the CMSA's concept paper features a caseload matrix.

Specifics in determining caseload assignments include:

- Intensity of involvement by the case manager.
- Frequency of interventions by the case manager.
- Case acuity.
- Skill training, roles, competencies, and experience of case managers.
- Breadth of the case manager's responsibility.
- The 2007 Dignified Treatment of Wounded Warriors Act (H.R. 1538), which determines caseload assignments for the Medical Care Case Manager (MCCM).
    - o No more than 17 wounded warriors in an outpatient setting are assigned to the MCCM.

Assigning caseloads is a labor-intensive process that includes creating and implementing the plan of care, as well as maintaining documentation of progress toward target goals. Managing the balance of tasks is a critical factor in helping case managers experience job satisfaction in their day-to-day responsibilities. More specifically, assigning a generic ratio of patients to a case manager (a "one ratio fits all" approach) does not support case managers' ability to consistently reach optimal outcomes for their patients. When determining what constitutes a manageable caseload, applying the CMSA's research and lessons learned from implementing a CM program can generate an environment that supports the most desirable patient outcomes.

Discharge Planning

Discharge planning helps sustain or enhance the gains achieved from hospitalization for the continued health and welfare of patients and their families following discharge. Mullahy (1998) describes discharge planning as "assessing the patient's need for treatment after hospitalization in order to help arrange for the necessary services and resources to affect an appropriate and timely discharge." Discharge planning can be provided in multiple settings, whether transitioning the patient from an inpatient hospitalization to another inpatient facility or residential treatment facility; or from an inpatient to skilled nursing facility, home health care, or high-intensity outpatient services.

Discharge planning is critical, as shorter hospital LOS are typical. Ideally, discharge planning begins at preadmission. In planning the appropriate discharge, the case manager must spend time speaking with patients/caregiver(s) to determine what they need and are willing to do at the next level of care, and which resources are available at home. Support can range from video teleconferencing with a Department of Veterans Affairs (VA) polytrauma center to holding conference calls with the family or facilitating site visits.

The staff nurse may perform discharge planning activities when caring for the patient on the inpatient unit. However, the case manager is responsible for overseeing discharge planning activities and for executing the plan as designed.

The discharge planning process includes the following steps.

1. *Assessment.* The discharge planner is responsible for assessing every patient on admission for discharge planning needs — at a minimum every 72 hours until discharge, per McKesson InterQual guidelines (see **Section II, Utilization Management**). The discharge plan must align with the TRICARE benefit and policies. Therefore, it is also important for the discharge planner to obtain information regarding the patient's enrollment status, as this affects the authorization of plan of care upon discharge.
2. *Referral.* Consideration must be made if referrals need to be sent to a social work case manager to address patient/family social issues or to make arrangements such as nursing home placement. Referral can also mean obtaining TRICARE referrals and authorizations to execute the discharge treatment plan. For example, a patient may require assistance with home IV infusion therapy. In this case, referrals and authorizations

would need to be obtained for infusion therapy services. Communication among home health companies, the coordinating case manager, and the ordering provider further serves to reconcile the treatment plan with the service order.

3. *Formulation.* Discharge planning can be very simple or highly complex. It is best accomplished using an interdisciplinary approach to determine the best plan for each patient. In Active Duty cases, the patient's Command may have input on the discharge plan.
4. *Implementation.* The case manager will review each patient's discharge plan with the patient/caregiver prior to discharge and enter the appropriate documentation in the patient's medical record.
5. *Monitoring.* Monitoring the quality and effectiveness of the discharge planning process is a cumulative effort. The importance of timely feedback from providers, patients/caregivers, case managers, and discharge planners cannot be overstated.

Prior to discharge, the case manager may recommend a home assessment to anticipate all environmental needs in conducting a safe discharge. This is an important intervention, especially when the patient is coping with a severe disability that may involve complex mechanical assistance. If the discharge is likely to be complicated, the case manager may convene a pre-discharge planning meeting to verify that both family members and home care providers understand their roles, and that everyone shares similar expectations and goals.

The discharge plan should be family-centered and should take into consideration:

- Patient/family preferences.
- Consideration of existing DoD/VA memoranda of understanding (MOUs).
- TRICARE benefit parameters.
- Qualifications for entitlement programs (e.g., ECHO).
- Previous experience with existing providers and facilities.
- Most appropriate provider/facility for the patient.
- Location of facility and providers, and their ability to meet patient/family needs.
- Understanding of patient-specific goals.
- The parent Command and Patient Administration departments (if the patient is an ADSM).
- Impact on medical readiness and the Disability Evaluation System (DES) process.

Barriers to effective and timely discharge planning include delays in completing discharge details, duplication of services, lack of patient focus, and involvement of available patient transport resources. Some root *problems* in discharge planning include lack of patient involvement/understanding of the discharge plan, poor coordination/communication with the patient/family and/or caregiver(s), and poor communication within medical providers. The patient must agree with the discharge plan to support maximum adherence.

Care Coordination

Care coordination is a function of CM that involves assisting individuals with complex circumstances (i.e., circumstances that place them at risk for diminished independence) in gaining access to needed medical, social, educational, financial, and other services across various organizations and providers. The process coordinates the continuum of care for beneficiaries whose needs exceed routine discharge planning but do not meet the requirements for long-term CM.

Examples of patients who might benefit from care coordination include those who:

- Are at risk for a failed inpatient discharge plan.
- Have special needs (e.g., children, the elderly, newly diagnosed diabetics, individuals with catastrophic injuries).
- Require extensive short-term coordination and management.
- Have greater-than-average needs identified during pre-discharge planning that do not meet the criteria for formal CM.
- Have needs that require medium-intensity interaction with the case manager.
- Have acute, immediate needs that are not expected to require continuous treatment in the long term (e.g., patients receiving a hip replacement).

Accreditation

While MCSC CM programs may be accredited by URAC, the contract is not contingent on accreditation. For more information on URAC's most current CM program accreditation guidelines, go to http://www.urac.org/.

The CMSA provides program accreditation information at http://www.cmsa.org/.

Promoting Your Program

Whether a CM program is being established or is already in place, the key to sustaining the program is to optimize the department through marketing. Once your marketing strategy is established, you will want to build a caseload (see **Caseload**, earlier in this section). Here, the key decision is to expand the services offered to other areas or sustain existing services. ▶ **CD-ROM Resource CM-23** provides a sample CM marketing brochure. You may also want to take advantage of promotional opportunities in *Nurses Week*, *Social Workers Week*, and *Case Managers Week* to market your CM services. See **Section I, Medical Management Essentials**, **Program Sustainment**, for more details on promoting MM programs.

LEGISLATIVE GUIDANCE SPECIFIC TO INTEGRATING PHYSICAL AND PSYCHOLOGICAL REHABILITATION

Title XVI of the National Defense Authorization Act (NDAA) of 2008, Wounded Warrior Matters, Section 1611, addresses the challenges associated with caring for wounded, ill, and injured ADSMs and their families (see **Executive Summary,** ▶ **CD-ROM Resource ES-4**). In this section of the law, the NDAA outlines specific screening, referral, and management requirements for identifying the signs of post-traumatic stress disorder (PTSD), TBI, and BH conditions such as substance abuse and suicide risk. The law places particular emphasis on identifying and reacting to these conditions in response to the increase of

the increase of incidences of severe physical and psychological trauma among Service members serving in Global War on Terror (GWOT) missions, specifically, Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) (see also **Appendix C, Definitions**).

The ongoing deployments related to the GWOT have taken a disproportionate toll on ADSMs and their families. The incidence of PTSD has increased, especially in ADSMs experiencing multiple deployments. TBI has been described as the "signature injury" of OEF and OIF. Often invisible, particularly in those with mild to moderate injury, many of these cases were missed in the early days of the conflict. Today, identification and treatment of this condition is much improved. Now all returning ADSMs are screened for blast exposure and TBI. It is not uncommon for an ADSM to be diagnosed with both PTSD and TBI, each of which requires treatment and intervention. These ADSMs need and benefit from CM during their recovery, but early recognition and intervention are key to successful rehabilitation.

The intent of the NDAA is to ensure that all wounded, ill, and injured ADSMs have the benefit of both clinical and non-clinical CM, and that case managers working with wounded, ill, and injured ADSMs receive appropriate training, including training on PTSD and screening for TBI. Because patients' psychological health often affects their physical recovery, case managers must be trained to recognize behaviors that may indicate substance abuse, depression, or other psychological crisis. In this respect, case managers should become familiar with normal coping mechanisms and the stages of loss and grief.

In many managed care models, physical and behavioral services and care are segregated. This also means that physical illnesses are assessed and managed independently of psychosocial conditions. Yet for those suffering from chronic or complex conditions, a common profile for wounded, ill, and injured Service members, segregated care results in poor outcomes, higher utilization of healthcare services, and increased impairment and disability.

A patient with chronic disease is more likely to have behavioral or psychosocial co-morbidities. Further, medical and behavioral complexities affect overall health outcome, use of healthcare services, quality of life, and treatment adherence (Steifel, 2006).

PTSD and TBI can place great stress on the ADSM's family as well. The case manager plays a critical role in identifying additional resources and programs that enhance the ability of family members to cope with and manage the challenges associated with a PTSD or TBI diagnosis.

Additionally, the case manager's body of knowledge should include an understanding of the following factors that can affect ADSM patients:

- Cultural issues, including those faced by patients living in foreign countries.
- Family dynamics and the impact of the military lifestyle on families.
- Health expectations and behaviors, including demands placed on fit warrior expectations.
- Psychological and neuropsychological assessments, especially post-deployment and depression screening.
- The psychological impact of chronic illness and disability.

- Substance use/abuse/addiction, including the use of dietary supplements.

Disability Evaluation System

When an ADSM suffers from an injury or a chronic illness, the MTF's primary responsibility is to provide medical treatment, with the ultimate goal of returning the ADSM quickly to duty. However, some of these patients may be unable to perform their duties and will be required to enter the Disability Evaluation System (DES). The DES has two distinct stages: the Medical Evaluation Board (MEB) and the Physical Evaluation Board (PEB).

Medical Evaluation Board

The MEB is typically made up of two or three physicians who evaluate the ADSM's injury or illness and plan of care to make a determination on whether the ADSM can adequately perform the assigned duties of his/her position. The ADSM is typically referred to the MEB by the primary care provider or the unit Commander; or the referral may be based on a higher-Command recommendation.

If the ADSM is found fit for duty, the MEB will clear the ADSM and return him/her to duty. If the MEB finds that the ADSM may return to Active Duty and perform his/her duties within a reasonable period of time (typically between eight and 16 months with treatment), the Board may recommend Temporary Duty (TDY) for the ADSM. If the MEB determines that the ADSM is unfit for continued duty, the Board refers the patient to the PEB.

Physical Evaluation Board

There are two types of PEB: informal and formal.

The *informal* PEB (IPEB) is the first step in the PEB process and is defined by the following aspects:

- It includes three voting members — one must be a physician and one must be a nonmedical officer.
- The ADSM may not be physically present.
- The ADSM may agree with the recommendation of the IPEB or request reconsideration at a formal PEB.

The *formal* PEB is defined by the following aspects:

- It includes three voting members — one must be a physician and one must be a nonmedical officer.
- It allows the ADSM to appear before the board, present evidence and testimony, call witnesses, review all documents used by the board, and provide any additional documents he/she deems important to his/her case.
- The ADSM is generally represented by an attorney.

A final determination from the formal PEB will be one of the following:

- Separation without Benefits
- Separation with Severance Pay
- Permanent Disability Retirement (PDR)
- Temporary Disability Retirement List (TDRL)
- Return to Duty

The ADSM has a right to appeal the formal PEB determination through his/her Service's appellate review agency. Certain ADSMs who are determined to be unfit for duty may be able to remain on Active

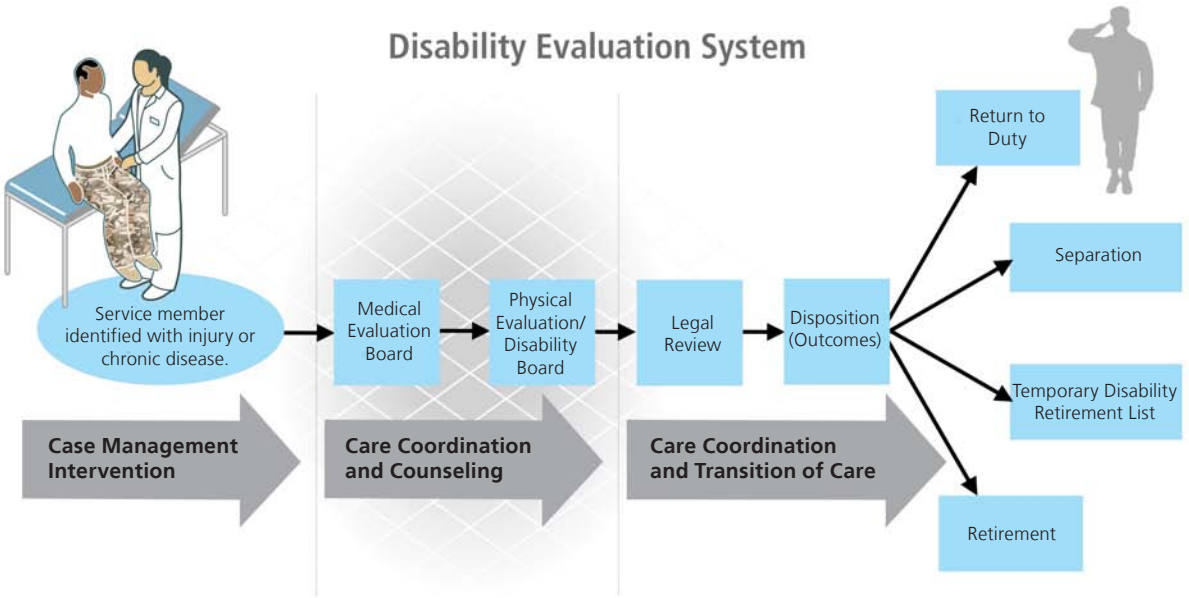

Fig. 23– Disability Evaluation System (DES)

Duty through the Continuation of Active Duty (COAD) program. The ADSM must complete the COAD application process with his/her PEB Liaison Officer (PEBLO).

Fig. 23 illustrates the DES.

For more information on the MEB/PEB process and specifics for each Service Branch, refer to *Methods and Actions for Improving Performance of the Department of Defense Disability Evaluation System* (Marcum, Emmerichs, Sloan, Thie, 2002). See also **Appendix C, Definitions**.

Other Types of Evaluation

The case manager should be aware of the processes regarding military physical examinations for Service members on Release from Active Duty (REFRAD) status or who are leaving the Service due to retirement or separation. Members released from Active Duty, National Guard, or Reserve service have the option of requesting a REFRAD physical when changing from Active to Reserve status. The military unit coordinates the REFRAD physical exam, which should be performed at the MTF.

As the basis for DoD/VA rating their disability compensation, Active Duty, Guard, or Reserve Service members who are separating or retiring from service should undergo one physical exam. Combining the DoD's separation physical exam with the VA's Compensation and Pension (C&P) exam helps streamline the process and minimize costs.

RECOVERY COORDINATION INITIATIVES

In September 2008, the DoD and VA responded to the NDAA requirements on wounded warrior matters in their *Report to Congress on the Comprehensive Policy Improvements to the Care, Management, and Transition of Recovering Service Members* (*NDAA Section 1611 and 1615*) (see **Executive Summary,** ▶ **CD-ROM Resource ES-3**). The DoD/VA report outlines provisions implemented by the two departments that affect MTF case managers.

Federal Recovery Coordination Program

NDAA 2008 requires the Services (Army, Navy, Air Force, Marines) to establish a recovery coordination program for wounded, ill, and injured Service members who have significant illness or injury such that they may be medically retired or separated from the military.

In January 2009, the Under Secretary of Defense issued Directive-Type Memorandum (DTM) 08-049, *Recovery Coordination Program: Improvements to the Care, Management, and Transition of Recovering Service Members* (RSMs): http://www.dtic.mil/whs/directives/corres/pdf/DTM-08-049.pdf. See also ▶ **CD-ROM Resource CM-24**.

DTM 08-049 states the purpose of the DoD Recovery Coordination Program (RCP), as follows:

- Provide for improvements to the care, management, and transition of RSMs and their families.
- Develop and implement standardized policies, processes, personnel programs, and tools to accomplish comprehensive care coordination.
- Adjust policies and operational procedures, as necessary, based on data collected during the first six months after the signature date of the DTM.

The Services have since established the Federal Recovery Coordination Program (FRCP), which is operated by the VA. Service members participating in this program are expected to have lifelong care needs. (▶ **CD-ROM Resources CM-25** through **CM-32** provide more detailed information on the FRCP, including program descriptions, forms, and a national resource directory.)

Recovery Care Coordinators

Referral for the FRCP is through a screening process performed by the Services that considers acuity in both medical and nonmedical (e.g., financial, housing, family support) areas. The VA program provides senior-level clinical nurses and social workers, designated as federal Recovery Care Coordinators (RCCs), to provide oversight of the recovery plan for catastrophically injured ADSMs.

If the ADSM meets the criteria, he/she is referred to an RCC who:

- Develops a Federal Individual Recovery Plan (FIRP) with the ADSM along with his/her family and recovery team.
- Provides oversight of the FIRP to help meet the ADSM's and his/her family's needs.

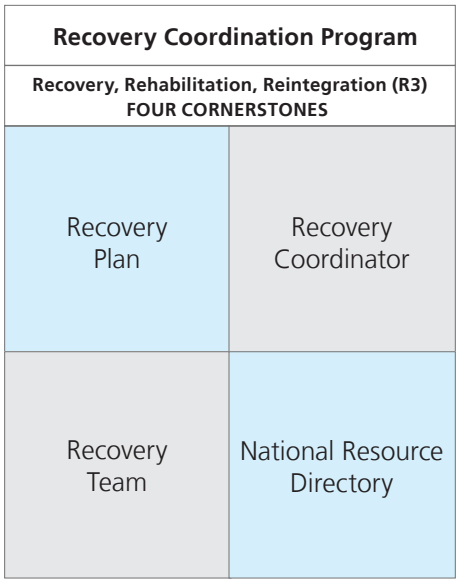

Fig. 24 – Recovery Coordination Program

New Roles for CM in the NDAA

Recovery Care Coordinators
- Responsible for assistance to Service member (i.e., access)
- Employed by Military Branch

Medical Care Case Managers (MCCMs)
- Licensed, healthcare professional
- Understand Rx and receive appropriate care

Non-Medical Care Managers (NMCMs)
- Finance, personnel, admin, transitional, family support

Federal Recovery Coordinators
- Primary responsibility/oversight for R3
- Employed by Veterans Administration: LCSW or RNs

Source: National Defense Authorization Act

Fig. 25 – New Roles for CM in the NDAA

The FIRP plan should track with the plan of care developed by the recovery team as a whole.

The RCC continues to work with the ADSM and his/her family throughout the recovery, rehabilitation, and transition process to meet their needs. For best outcomes, the RCC is treated as a member of the overall outpatient recovery team that includes clinical and non-clinical staff. The RCC participates in team discussions and plan-of-care development.

Additional resources specific to wounded warrior care are found in the June 2008 provision of the NDAA (H.R. 5658 — see **Appendix D, Resources**). Figs. 24 and 25 describe aspects of wounded warrior care coordination under the NDAA.

TRANSITION/COORDINATION OF CARE

Transition of Care

In the military, unique transitions of care (TOCs) occur when patients move:

- From the DCS to the PCS.
- From MHS care to VA care.
- Among multiple Service-level settings — for example: An injured Marine receives emergency care in an Air Force ED, is transferred to a Navy medical center for limb-saving surgery, is rehabilitated in an Army setting, and is moved jointly between his/her home base primary care and the VA for PEB purposes.
- From one TRICARE regional case manager to another.

- Between Commands.
- Between facilities (e.g., rehabilitation hospitals, psychiatric hospitals, skilled nursing facilities).
- From one hospital unit to another.
- From one level of care to another (e.g., acute care to outpatient care or to home health care).
- From overseas to stateside.

Case managers need to maintain awareness that care transitions and care coordinations require continuous monitoring, and to develop or refine processes that support patient TOCs. An organization's CM program should empower staff to create tools and tracking mechanisms that allow for enhanced communication, monitoring, and follow-up. Performance measures of success are not only essential to documenting outcomes; they provide secondary value in "forcing" patient CM follow-up.

Effective and safe transitions depend on effective communication between the transferring facility (where the transition originates) and the receiving facility (where the patient is sent). In addition to the healthcare team, the patient/caregivers need to actively participate in the TOC process. (▶ **CD-ROM Resource CM-33** provides a TOC implementation plan.)

For more information on TOCs, visit the National Transitions of Care Coalition (NTOCC) website: http://www.ntocc.org.

Service-Specific Care Transition Programs

CM services for Warriors in Transition (WTs) are centered on holistic healing of the body, mind, heart, and spirit and on transition back to duty status or civilian life. Each Service has its own integrated care transition program, as follows:

1. Warrior in Transition Program (WT) and Army Wounded Warrior Program (AW2): https://www.aw2.army.mil/index.html, http://mhs.osd.mil/WoundedWarrior.aspx
2. Navy Safe Harbor: http://www.npc.navy.mil/CommandSupport/SafeHarbor/
3. Air Force Wounded Warrior Program (AFW2): http://www.woundedwarrior.af.mil/
4. Wounded Warrior Regiment (WWR): http://www.woundedwarriorregiment.org/WWR.aspx

Appendix D, Resources, provides more detail on Service-level wounded warrior recovery coordination programs and related CM roles, such as the Warrior Transition Unit (WTU) Nurse Case Manager.

Inter/Intra-Regional Transfer

When a beneficiary enrolled in CM within the MTF relocates to another region, the MTF case manager in the originating MTF ("transferring" case manager) is responsible for ensuring continuity of care and a smooth transition for the patient and family to the case manager at the relocation site ("receiving" case manager).

The process for transfers includes the following:

- Once it is determined that a beneficiary in CM is moving to a new location, the transferring case manager requests/documents written permission to communicate with the receiving case manager in the new location, from either the beneficiary or his/her legal representative.

- The transferring case manager contacts the receiving case manager as soon as possible to initiate and coordinate the transfer.
- The transferring and receiving case managers collaborate on a transition plan to verify that services are available and in place at the new location.
- If the beneficiary's relocation is imminent and a receiving case manager cannot be identified, the transferring case manager contacts the CM point of contact (POC) at the TRICARE Regional Office (TRO) before the Service member departs.
- The case manager uses the Inter/intra Regional Transfer Form to document information. The form will include identification of any special needs or programs that address special needs, such as EFMP or ECHO. (▶ **CD-ROM Resources CM-34** and **CM-35** provide inter/intra-regional transfer documents for ADSM and MHS-eligible, non-ADSM beneficiaries.)
- When a transfer involves an organ transplant, en route aeromedical evacuation (AE) services (see **Aeromedical Evacuation**, below), complex transportation arrangements, or a high visibility case, the transferring case manager coordinates with the TRO case manager.
- The transferring case manager provides instructions for expediting the medical record transfer and identifying caregiver(s), special needs issues, transportation, or other assistance, as required. A cost/benefit analysis is recommended, particularly if the transfer is from the DCS to the PCS.
- Prior to the transfer, the transferring case manager documents the beneficiary's health status, case manager contact information, and actions (including the rationale).
- The receiving case manager also documents the communication (including transfer instructions or requests) in the appropriate hard copy or electronic medical record.
- The transferring case manager continues to provide CM services until the beneficiary has transferred enrollment to the receiving case manager at the new location.

Additional responsibilities for the transferring case manager may involve:

- Arranging medically appropriate patient transport.
- Coordinating care with the provider at the transferring/receiving sites and with the patient's family.
- Ensuring availability of supplies/equipment during transport and at the receiving location.
- Confirming an initial appointment with the receiving MTF for EFMP families.
- Identifying and ensuring availability of resources to accomplish the transfer.

Aeromedical Evacuation

Aeromedical evacuation (AE) is the transportation of patients under medical supervision to and between medical treatment facilities by air transportation. This includes timely evacuation of patients from a combat zone.

The Health Service Support (HSS) patient movement mission in joint operations is designed to minimize the effects of wounds, injuries, and disease by rapidly evacuating affected personnel from the location of wounding, injury, or illness in a combat theater to a hospital in the continental United States (CONUS). The patient movement system operates

worldwide to regulate all Service component patient movements and is supported by the following:

- Global Patient Movement Requirements Center
- U.S. Transportation Command (USTRANSCOM)
- Aeromedical Evacuation Coordination Center
- Defense Medical Regulating Information System
- Theater patient movement requirements centers
- Joint patient movement teams
- In-transit visibility
- Service component evacuation assets

The transferring MTF is responsible for transporting patients between the MTF and the aerial port of embarkation. The movement of patients from one level of treatment to another for more definitive treatment, or between and within levels of treatment, requires in-depth planning, adequate resourcing, and skillful execution (Joint Publication 4-02.2 — *Joint Tactics, Techniques, and Procedures for Patient Movement in Joint Operations*).

Fig. 26 illustrates how AE services are coordinated.

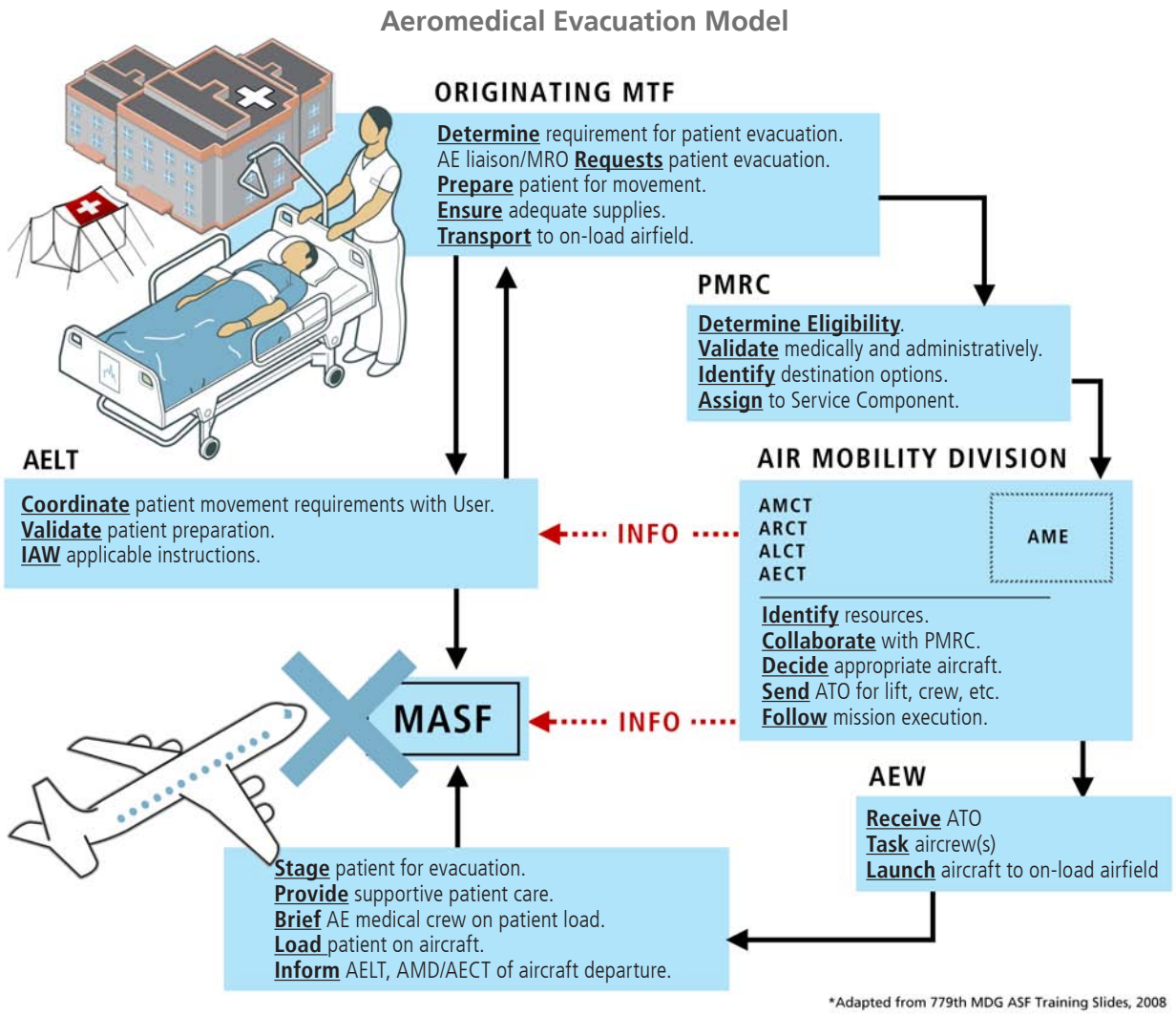

Fig. 26 – Aeromedical Evacuation (AE)

Patient movement has advanced to support critical care capabilities via the AE system. Patients returning to CONUS MTFs with complex and catastrophic injuries and/or complicated medical sequelae (abnormal condition resulting from a previous disease) will likely require CM services and may benefit from enrollment into one of the Services' warrior care programs. Case managers need a basic understanding of patient movement through the AE system, as it offers perspective on patients' medical and psychosocial health needs from onset of injury or illness to definitive treatment in stateside MTFs. For more information, contact your MTF Patient Administration office.

Coordination of Care

Coordination from the MHS to the Department of Veterans Affairs

Depending on eligibility (i.e., Service-connected condition or disability), Active Duty, retired, or separated Service members may receive health care from the VA's Veterans Health Administration (VHA). In 1996, Congress established Public Law 104-262, the Veterans Health Care Eligibility Reform Act, in which enrolled veterans are entitled to a medical benefits package that emphasizes preventive and primary care. For more information on eligibility and enrollment, refer to the VA website: http://www.va.gov/healtheligibility/coveredservices/StandardBenefits.asp.

The DoD and VA (VHA and Veterans Benefits Administration [VBA]) continue to partner to improve the dialogue and collaboration between the two departments at all levels, focusing on the ability to identify and serve all ADSMs who have sustained injuries or illnesses in combat operations.
When the transition of healthcare services is required between an MTF and a VA medical center (VAMC), the MTF case manager (or patient administrative staff, as appropriate) is responsible for coordinating the transfer with the VHA Liaison located at the MTF and/or the OEF/OIF Care Management Team located at the VAMC. To locate the appropriate VHA Liaison for referral, refer to the contact list table on ▶ **CD-ROM Resource CM-36** (this list is continuously updated).

When the MTF case manager identifies the requirement to transfer care to the VA, he/she completes a referral packet to include the DoD/VA Liaison Referral Form (▶ **CD-ROM Resource CM-37**) with a discharge plan and medical record documentation.

Once the VHA Liaison receives the referral form and medical record documentation, he/she initiates the referral with the accepting VAMC. Depending on the urgency and request for healthcare services, the transition time may occur as quickly as a few days.

Coordination for Active Duty Service Members in the TRICARE Prime Remote Program

The Military Medical Support Office (MMSO) is a Tri-Service agency providing CM services for the following populations:

- ADSMs enrolled in the TRICARE Prime Remote (TPR) program.
- Reserve and National Guard members injured in the line of duty (LOD).
- New accessions awaiting the start of training.

- Any ADSM en route to a first school, training, or permanent duty station who is not yet enrolled in the TPR or in an MTF.

While the organization and scope of responsibility for the MMSO may change over time, its main mission will continue to directly support the healthcare needs of ADSMs in TPR. For more information, visit the MMSO website at http://www.tricare.mil/tma/MMSO/.

Through clinical review, oversight, preauthorization, and coordination for all specialty care referrals, the MMSO verifies that remote and non-enrolled ADSMs are receiving needed medical care within TRICARE standards. MMSO staff identify fitness-for-duty issues and make recommendations to Commands for referral to MTFs or the MEB. Staffed by a team of registered nurses (RNs), the CM division identifies cases and plans of care that include non-covered benefits or experimental procedures, and consults with specialty advisers to obtain clinical opinions and recommendations. Based on the recommendations of those advisers and the patient's condition, the nurses will either continue the care in the remote area or make a referral to the nearest, same-Service MTF.

The MMSO's primary CM responsibilities relate to:

- Chronic and complicated cases.
- Long-term care for remotely located Service members and those who have sustained a TBI or spinal cord injury (SCI), or have been blinded.

When an ADSM sustains a TBI, SCI, or has been blinded, and it has been decided to refer the patient to the VA program under the national MOU, the MTF case manager should contact the MMSO case manager as soon as possible to facilite authorization for admission to a VAMC. The MMSO case manager can also answer questions regarding processes for care once the patient is released from the VA.

As a conduit between the beneficiary and TRO, the MMSO can act as an information resource to assist MTF case managers with problems or complicated issues. Although case information can be faxed to the MMSO, it is recommended that the CM division be contacted directly by telephone for assistance.

Coordination for Exceptional Family Member Program and Special Needs Families

Enrollment in the Exceptional Family Member Program (EFMP), also referred to as Special Needs Identification and Assignment Coordination (SNIAC), is used during the assignment process to identify ADSMs whose family members have special needs. Special needs range from medical, dental, and mental health concerns to educational or developmental requirements.

The purpose of early identification is to verify that necessary services are available upon change of duty stations. The EFMP proactively considers a family member's special requirements while assisting families in finding and using appropriate services and programs with the dual goal of increasing family self-sufficiency and improving self-advocacy skills. (Note: Not all EFMP families require CM; however, all CM families with qualifying special needs should be enrolled in the EFMP.)

Each Service administers the program differently (e.g., point of contact [POC] titles may vary; program responsibilities may be located in different departments). The sponsor of the family member with special needs must also enroll in the program. Families usually self-identify, but medical personnel may also identify eligible members during routine healthcare visits.

EFMP eligibility should be re-evaluated on a regular basis, since a family member's status may change. Case managers or special needs coordinators should assist the EFMP member; especially during the coordination of overseas screening, processing, and enrollment. Since there is minimal medical oversight in the EFMP, case managers may provide the necessary structure to promote standardization, uniformity, connectivity, and transferability of benefits from one TRICARE region to another.

When an ADSM is notified of potential duty relocation or must complete a move expeditiously *and* a dependent family member has special needs, the following steps should occur:

- The transferring case manager obtains authorization from the sponsor or legal guardian for release of information from the adult beneficiary with the special need(s) prior to discussing healthcare arrangements with the ADSM.
- The transferring case manager consults the receiving case manager to determine available medical care and special needs resources in the location of possible assignment.
- The transferring case manager provides the necessary clinical data so the receiving region can make a determination on the availability of resources. This may include, but is not limited to:
    - Additional programs the family is currently engaged or enrolled (e.g., ECHO).
    - Case history and current treatment plan, including stability of condition and rehabilitation, if indicated.
    - Discovery date and summary of medical condition.
    - Support system at home.

If the family member's needs cannot be met in the receiving region/location and the ADSM proceeds with assignment to that region/location, the case manager must discuss with the ADSM the potential or actual impact on the family member's care and the need for coordination with regions/locations on the availability of medical care. In such cases, the following process applies:

- The transferring case manager will document the following in the CM transition plan:
    - Current needs, services, and medical condition(s) of the affected family member(s).
    - Communication with the TRO informing the receiving case manager of the potential/actual shortfalls in healthcare resources required by the beneficiary.
    - Discussion with the receiving case manager regarding the identification of potential gaps or shortfalls in local healthcare resources.
    - The Service member's decisions on the plan of care and follow-up plan.
- The receiving case manager will:
    - Assist family members in coordinating the care needed upon arrival to the new duty station.
    - Coordinate with schools to transfer Individual Education Plans (IEPs).
    - Document interventions and decisions made.

Transition/Coordination Challenges

The World Health Organization (WHO) in collaboration with TJC and TJC International agreed in April 2007 on a list of nine National Patient Safety Goals (NPSGs). Based on the list of current NPSGs, the most important challenges to seamless TOC identified by the Commission include:

- *Communication.* It is critical to share current, comprehensive information within and among care providers and delivery systems. The acronym SBAR, for Situation-Background-Assessment-Recommendation, is an easy-to-remember mechanism for communicating on issues that require a clinician's immediate attention and action. SBAR is recommended as a tool in one of the NPSGs used in hospital settings when patients are transferred from one unit to another (http://www.ccforpatientsafety.org/common/pdfs/fpdf/presskit/PS-Solution3.pdf).
- *Medication accuracy/reconciliation.* Transitions are the most common situation in which medication errors occur. Medication accuracy/reconciliation is a process designed to prevent medication errors at patient transition points (http://www.ccforpatientsafety.org/common/pdfs/fpdf/presskit/PS-Solution6.pdf).
- *Accountability and responsibility.* Healthcare professionals involved in a patient's care, both clinically and administratively, are responsible for breaking down barriers that impede TOCs. Case managers may face legal accountability when patients are not transitioned appropriately or in a timely manner.
- *Role clarification.* It can be difficult to assign accountability if there is confusion about the roles of various healthcare team members in the transition of care for a patient in CM. Ongoing communication via all available systems (e.g., telephone, secure e-mail, paper documents) and care conferences can minimize confusion when specific roles are identified.
- *Follow-up.* This is one of the most effective actions a case manager can take in promoting safe and complete TOC. Case managers should use caution when relying on the patient or family/caregiver(s) to be entirely responsible for follow-up. The patient's condition may be a limiting factor, impeding his/her ability to secure care as part of the medical plan. Conversely, the family/caregiver(s) may be subject to stressors unrelated to healthcare issues that are impeding effective follow-up or maintenance of the care plan.

For more information, go to http://www.who.int/.

Other Types of Transition/Coordination

Title XVI of the National Defense Authorization Act (NDAA) of 2008, Wounded Warrior Matters, Section 1615 (refer to ▶ **CD-ROM Resource ES-4**), focuses on facilitating the transition of Service members from Active Duty status to civilian life. In the MTF, the case manager arranges for housing modifications, assistive devices, or adaptive equipment. As previously discussed, this may involve collaboration with the VA to identify the best options for an ADSM's physical and behavioral rehabilitative care.

Case managers strive to help patients return to activities that are productive, meaningful, and rewarding to them, which is extremely important for their recovery and quality of life.

Aspects of this process include:

- Disability compensation (e.g., worker's compensation and auto insurance).
- Ergonomics.
- Job analysis, job modification, job accommodation, and job hardening.
- Job development and placement.
- Life care planning.
- Military boards and medical retirement procedures.
- Other military programs.

Outside the Continental United States (OCONUS) and TRICARE Global Remote Overseas (TRGO) Program

CM plays an important role in supporting Service members Outside the Continental United States (OCONUS). Specifically, case managers working at specialty treatment centers or MTFs may be called on to assist in the acceptance and transfer of complex patients from other MTFs for specialized treatment.

ADSMs serving overseas must be enrolled in the TRICARE Global Remote Overseas (TRGO) program, where available. For more information, go to: http://www.military.com/benefits/tricare/tricare-overseas/tricare-global-remote-overseas.

North Atlantic Treaty Organization (NATO)

Members of the North Atlantic Treaty Organization (NATO) Armed Forces occasionally call upon MTFs or their host Service Branch medical clinics to provide care to their overseas Service members and/or families. In such cases, the case manager needs to be familiar with individual countries' arrangements with the United States before arranging care.

Depending on the scope of any signed agreements, ADSMs or their family members may only be eligible, for example, for outpatient direct care medical treatment. To understand enrollment and eligibility requirements in individual countries, the case manager should access the following websites:

- http://www.tricare.osd.mil/recip
- http://www.nato.int/structur/countries.htm

CM also comprises an important UM role when it comes to understanding and working within the boundaries of agreements between the United States and other NATO countries. Depending on the healthcare utilization patterns and practices (medical and/or dental) of an individual NATO member country, case requirements can quickly escalate. The case manager needs to manage the access and utilization of care while liaisoning with the ADSM's embassy staff for authorization.

In non-NATO cases, only ADSMs are eligible for care; their family members are not covered. However, because ADSMs often move between various theaters of operation and because international agreements continually change, it is recommended that case managers consult with their Patient Administration departments on a case-by-case basis.

THE CASE MANAGEMENT PROFESSIONAL

Qualifications

The job description of the employee working in the CM department of an MTF will vary depending on the size of the organization and its internal resources. Titles include Case Manager, Health Care Integrator (HCI), Nurse Clinical Case Manager, Medical Care Case Manager (MCCM), and Licensed Clinical Social Worker (LCSW).

The following resources can aid in understanding the essential skill sets required for successful case managers:

- *Nursing Case Management from Essentials to Advance Practice Applications*, 4th Edition.
- *The Case Manager's Survival Guide, Winning Strategies for Clinical Practice*, 2nd Edition.
- *CMSA Core Curriculum for Case Management*, 2nd Edition.

See **Appendix A, References**, for publication information.

Knowledge of key CM skill sets and assistance from the Human Resources and/or Personnel departments can help case managers prepare appropriate interview questions to determine whether your candidates possess these skill sets.

The CM professional:

- Should have sufficient clinical knowledge and breadth of patient care experience to identify the clinical rationale for procedures or tests.
- Should be able to gather necessary information and determine the medical necessity of services and the appropriateness of care.
- Must have knowledge in the area of CM and expertise applying his/her professional skills to the full range of bio-psychosocial health-related problems in the provision of CM services.
- Must have a patient- and family-centered approach to performing assessments and plans of care.

The case manager will have knowledge of human behavior/dynamics and motivation, healthcare service delivery, healthcare financial systems and funding sources, professional ethics, and clinical standards and outcomes. He/she should also possess knowledge of accreditation standards from organizations such as TJC and privacy and confidentially requirements as detailed in the Health Insurance Portability and Accountability Act (HIPAA). ▶ **CD-ROM Resource CM-38** is a Privacy Act Statement for Health Care Records form. (See also **Section I, Medical Management Essentials**; and **Appendix C, Definitions**.)

Education and Experience Requirements

CM professionals must possess the following specific education and experience credentials:

- Licensed Registered Nurse (RN) – i.e., graduate of an accredited nursing program, Bachelor of Science in Nursing (BSN) preferred; or bachelor's (or higher) degree in a healthcare-related field from an accredited educational institution (position typically occupied by an RN with a BSN).

- Valid unrestricted clinical license to practice.
- Social worker case managers — current license from a U.S. jurisdiction and must be Licensed Master's Social Worker (LMSW).
- A minimum of two years of recent experience (within the last four years) in professional nursing, social work, or CM for adults, children, families, seniors, or groups.
- Employed for the past 12 months in a healthcare-related field.
- Current basic life support (BLS) certification.
- Knowledge and experience, or comprehension during training, in the performance of core CM activities (i.e., patient advocacy, assessment, planning, implementation, coordination, monitoring, evaluation).
- Demonstrated expertise in resolving complicated healthcare, social, interpersonal, and financial patient situations.
- Experience in program planning and conducting individual, family, group, and community assessments.

Certification

Valid desirable qualifications are certification by a CM-specific program upon hire or within 24 months of employment. Refer to the following resources:

- Commission for Case Manager Certification (CCMC): http://www.ccmcertification.org/.
- American Nurse Credentialing Center (ANCC): http://www.nursecredentialing.org/.
- CMSA: http://www.cmsa.org.

Ethical Practice Standards

Ethics address the judgment of right and wrong and good or bad. Per the CMSA's 1996 statement on ethical CM practice, case managers adhere to the code of ethics for their profession of licensure. CM is guided by the ethical principles of autonomy, beneficence, non-maleficence (not harming others), justice, and veracity (Beauchamp and Childress, 1994/2008).

The patient is always the primary consideration when making CM decisions. This means the patient must be involved in all aspects of decision-making, including being informed of options and consequences prior to making decisions. The case manager works closely with the patient during this process in order to help him/her achieve self-management.

The case manager is obliged to promote for the good of the patient (beneficence) and refrain from doing harm to the patient (maleficence). The case manager is intimately involved with the dissemination of services and resources on an individual basis (justice). Truth-telling (veracity) is imperative for development of trust with a patient, and must be built among patients, case managers, and healthcare providers.

The case manager must follow the regulations set forth in his/her state licensing body, as well as those practice guidelines published by nationally recognized organizations in the industry of managed care, particularly the CMSA and URAC. In 2002, the CMSA published standards of practice delineating guidelines for the CM profession.

The standards require that the case manager provide services within the scope of practice defined by their community, licensure, and published practice standards. Case managers are potentially liable if they do not follow these CM standards of practice. DoD and Service Branch-specific policies and directives concerning the provision of health care also apply.

Resources for Orienting and Training the New Case Manager

Web-based learning modules to assist in orienting and training newly hired staff are available at MHS Learn: https://mhslearn.csd.disa.mil. MHS-required CM training includes the following topic areas:

1. Case Management
2. TRICARE Fundamentals
3. Military Medical Support Office
4. Traumatic Brain Injury
5. Post-Traumatic Stress Disorder
6. Suicide Awareness
7. Homicide Awareness
8. Substance Abuse
9. Clinical Decision Support Tools
10. Introduction to the Veterans Administration
11. Disability Evaluation System
12. Federal Recovery Coordination Program
13. Recovery Care Coordinators

As part of the CM orientation process, case managers are required to complete and pass *all* relevant MHS Learn modules prior to providing patient care. It is also vital for personnel to have a basic knowledge of each position within their department, as MM roles are often interdependent.

Each Service and MTF may offer its own required or optional training opportunities. For more information, contact your Education and Training manager.

A "continuity binder" — also called a standard operating procedure (SOP), orientation, or resource manual — specific to individualized CM role(s) can be a useful tool. The binder may be in paper or electronic form, and can help personnel covering another staff member's position in his/her absence understand the responsibilities of that staff member's position(s). The binder provides:

- Descriptions of daily, weekly, and monthly responsibilities and related tasks.
- A list of personnel in the organization and their counterparts within the TMA region.
- A hard copy of any forms or logs used, in case of computer system failures.
- A list of scheduled meetings.
- Other relevant information.

The continuity binder should be updated on a regular basis.

In addition to possessing the basic educational background for the position, it is also crucial for CM personnel to maintain practice competency. (▶ **CD-ROM Resource CM-39** provides a Sample Case Manager Core Competencies Form.)

SUMMARY

Clinical CM moves beyond the historical practice of coordinating systems and brokering for cost reduction. It is a personal involvement in the medical, behavioral, psychosocial, and functional aspects of a patient's health care. The case manager's span of influence encompasses the continuum from health to impairment, requiring an integrated approach that involves collaboration with utilization managers and disease managers for effective coordination across healthcare settings.

Military CM practice requires licensed healthcare professionals who are experienced in Population Health, the MHS and related benefits, payor mechanisms, community resource models, and disease states. With appropriate education and training, nursing or social work professionals are well equipped to support patients and their family members in the pursuit of optimal wellness.

Case managers seek to promote self-management education and an optimal quality of life while implementing cost-effective resourcing and the timely resolution of clinical and system issues.

Specifically, case managers serve as catalysts, facilitators, and communicators when advocating for patients who are unable to meet or unsuccessful in meeting their own healthcare needs. Case managers serve not only as "connectors" of fragmented systems; they also function as the "hub" in a wheel of coordinated, multiple-care delivery systems, acting as a central POC for patients.

Case managers facilitate and ensure that "one hand knows what the other hand is doing." This visibility fosters timely and appropriate interventions from a myriad of providers who may be delivering care to complex and chronic care patients.

CM plays a crucial role in supporting the MHS despite a financially challenging environment and the high operational tempo of military missions. As such, it is an excellent resource for patients, families, providers, and military Commands when advanced MM interventions are required to meet healthcare and mission goals.

CD-ROM RESOURCES

CM-1 Article: Reineck, C. A., Farris, P.: Case Management: Conserving the Fighting Strength in the U.S. Military — *Care Management* (August 2003)

CM-2 Article: Lewis-Fleming, G., Laing, D., Whiting, D. (CDR), Dawe-Gillis, C. (CAPT): Case Management and the Active Duty Service Member — *Care Management* (February 2001)

CM-3 Standard Form (SF) 513 – Blank

CM-4 Standard Form (SF) 513 – Completed

CM-5 Case Management Screening Criteria

CM-6 Severity/Complexity Index – Army

CM-7 Sample Introductory Letter

CM-8 Sample Authorization Form for Disclosure of Medical Information – Army

CM-9 Original Informed Consent

CM-10 Non-Acceptance Letter

CM-11 Inability to Contact

CM-12 Sample Case Closure Summary Letter

CM-13 AIM Screenshot, CM Plan of Care – Air Force

CM-14 AIM Screenshot, Initial Assessment – Air Force

CM-15 Patient/Family Satisfaction Survey – Sample

CM-16 Provider Satisfaction Survey – Sample

CM-17 CM Measurement Reporting Tool – Sample

CM-18 CM Caseload Log Sample #1

CM 19 CM Caseload Log Sample #2

CM-20 CM Caseload Log Sample #3

CM-21 Directive-Type Memorandum (DTM) 08-033, Interim Guidance for Clinical Case Management for the Wounded, Ill, and Injured Service Members in the Military Health System – DRAFT

CM-22 CMSA CM Caseload Concept Paper

CM-23 Sample CM Marketing Brochure – Patient/Provider

CM-24 Directive-Type Memorandum (DTM) 08-049 – Recovery Coordination Program: Improvements to the Care, Management, and Transition of Recovering Service Members (RSMs)

CM-25 Federal Recovery Coordination Program – Overview

CM-26 Federal Recovery Coordination Program – Care Coordination Office (Mission)

CM-27 Federal Recovery Coordination Program – Description

CM-28 Federal Recovery Coordination Program – Care Coordination Office (National Resources Directory)

CM-29 Federal Recovery Coordination Program – Enrollment Form

CM-30 Federal Recovery Coordination Program – Comprehensive Needs Assessment

CM-31 Federal Recovery Coordination Program – Comprehensive Recovery Plan

CM-32 Federal Recovery Coordination Program – Category Assignment Tool

CM-33 Transitions of Care Implementation Plan

CM-34 Inter/Intra-Regional Transfer Form – ADSMs

CM-35 Inter/Intra-Regional Transfer Form – non-ADSMs

CM-36 VHA Liaison Contact List

CM-37 VHA Liaison Referral Form

CM-38 Privacy Act Statement for Health Care Records Form

CM-39 Sample Case Manager Core Competencies Form

CM-40* Wounded Warrior Regiment Brief for New Personnel (February 2008)

CM-41* Department of the Army Warrior Transition Unit (WTU) Consolidated Guidance (July 18, 2008)

CM-42* Frequently Asked Questions (FAQs) and answers pertaining to the Army Medical Action Plan (AMAP) and United States Army Europe (USAEUR) WTUs

**Not referenced in text*

DISEASE MANAGEMENT

DISEASE MANAGEMENT

TRICARE

Department of Defense

Disease Management

SECTION IV

INTRODUCTION

Disease Management (DM) is focused on optimizing health in specific populations. It should be noted that all components of MM — Utilization Management (UM), Case Management (CM), and Disease Management (DM) — blend together when they are operationalized. The lines of distinction between UM, CM, and DM programs may become less defined as UM, CM, and DM personnel collaborate with Military Treatment Facility (MTF) providers and staff to achieve the best healthcare benefit possible for the patient and the organization.

Fig. 27 highlights the role of DM over the various stages of health care (see also **Section I, Medical Management Essentials**). Specifically, as the focus of healthcare delivery moves along the Population Health continuum, when the focus of health care is primary prevention, interventions are most effective for groups of people with similar characteristics. The same is true when providing healthcare services at the level of secondary prevention for people who

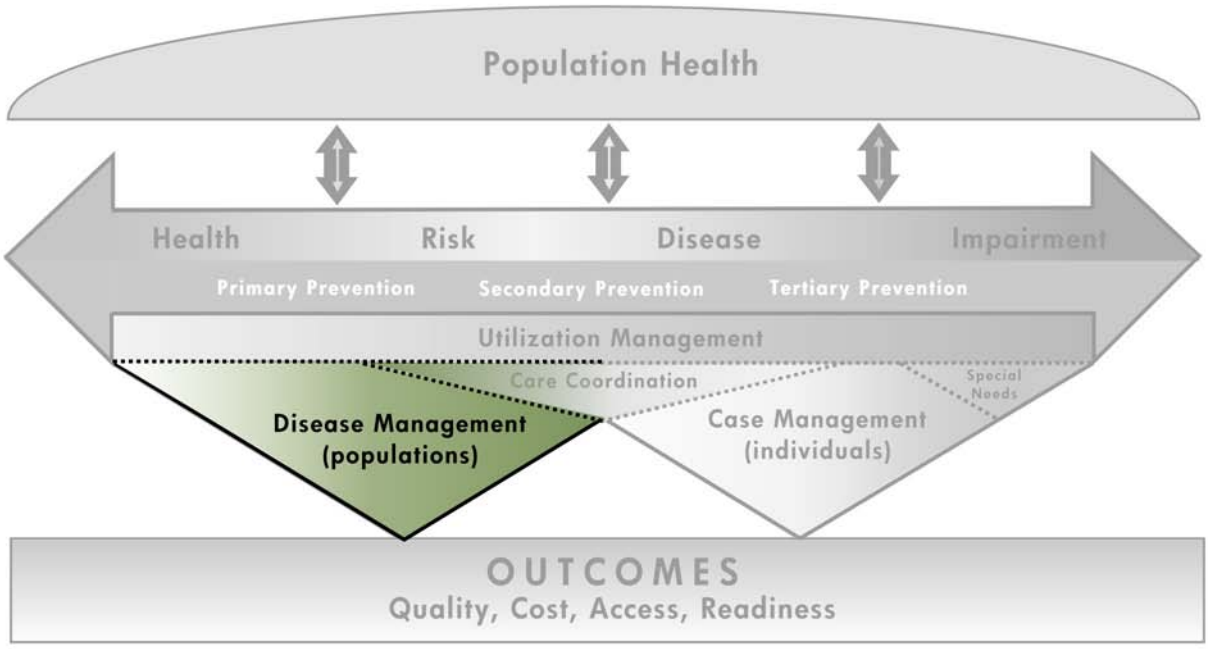

Fig. 27 – Disease Management within the Integrated Medical Management Model

*See also Section I, Medical Management Essentials: Fig. 4, Integrated Medical Management Model (IM3) with Key info, page 14.

are at risk for exacerbating or complicating their disease.

In the Department of Defense (DoD), MTFs have successfully implemented DM programs for a number of conditions and disease states. In accordance with the National Defense Authorization Act (NDAA) of 2007, the Military Health System (MHS) was tasked with developing DM programs for a variety of diseases and chronic conditions including asthma, chronic obstructive pulmonary disease, diabetes, depression and anxiety disorders, cancer, and heart disease. Thus, MTFs and Managed Care Support Contractors (MCSCs) have begun to systematically incorporate these disease states into their DM programs.

Definition, Goals, and Purpose

DM is an organized effort aimed at achieving desired health outcomes in populations with prevalent, often chronic, diseases for which healthcare delivery may be subject to considerable variation (Kongstvedt, 2007) (see also **Appendix C, Definitions**). In contrast to CM's focus on individual patients, DM is aimed at sub-populations of patients with a specific condition, disease, or set of co-morbidities (e.g., the metabolic syndrome associated with diabetes, hypertension, and hyperlipidemia). The principles of DM are applicable to all venues of healthcare delivery, including the inpatient and outpatient settings in both the primary and specialty care arenas.

According to the Disease Management Association of America (DMAA, 2009): The Care Continuum Alliance (hereafter referred to as DMAA), DM is "a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant." The DMAA has broadened its focus from strictly DM to a Population Health model, of which DM is a component. This model promotes a proactive, accountable, patient-centric approach featuring a "physician-guided" healthcare delivery approach designed to "develop and engage informed and activated patients over time to address both illness and long term health" (DMAA, 2009). The MHS Population Health model (see **Section I, Medical Management Essentials**, Fig. 3) is based on a healthcare delivery approach that incorporates six key components illustrating this paradigm from a provider-guided approach.

DM program goals are to improve clinical outcomes, increase patient and provider satisfaction, and promote appropriate utilization of resources throughout the MHS. The purpose of DM is to improve the quality of life for individuals by preventing or minimizing the impact of a disease or chronic condition. This purpose is accomplished by activities such as implementing more standardized care and improving patients' ability to care for themselves.

Per the DMAA (2009), a DM program:

- Emphasizes prevention of exacerbations and complications by using evidence-based practice guidelines and patient empowerment strategies.
- Supports the healthcare provider/patient relationship and plan of care.
- Evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

The Current State of Disease Management

Providers have long strived to return patients to optimum health. It has only been since the mid-1990s that DM became the program of choice for managing patient populations (Sprague, 2003). Several driving forces (e.g., congressional mandates, TMA policy, increasing costs) have influenced the MHS' move to adopt more robust DM practices. There is strong evidence for efficacy of health promotion, disease prevention, and condition management programs in both the MHS and the civilian healthcare arena.

Effective DM is a cost-effective approach to enhancing quality of life, postponing the development of complications, and consistently improving health outcomes for all beneficiary populations in the MHS. DM should no longer be viewed as a burden to healthcare teams but rather as an effective means for improving the future health of defined populations.

Managing Chronic Disease in the Military Health System

In the MHS, the incidence of chronic disease in Active Duty Service members (ADSMs) is approximately 21 percent (Armed Forces Health Surveillance Center, 2009). However, the vast majority of chronic illnesses in the MHS are present in the retiree and family member population. Approximately 30 percent of military members remain in the Service until retirement and become lifetime beneficiaries (Force Readiness and Manpower Information System, 2003). Therefore, the long-term care coordination and resulting program benefits for this population can be maximally realized in the MHS by leveraging MM resources.

In 2005, 133 million people — almost half of all Americans — lived with at least one chronic condition (e.g., heart disease, cancer, diabetes). These diseases cause major limitations in daily living for almost 1 in 10 Americans (Agency for Healthcare Research and Quality [AHRQ], 2009). In fact, chronic diseases account for 70 percent of all deaths in the U.S., or about 1.7 million each year (National Center for Chronic Disease Prevention and Health Promotion [NCCDPHP], 2008). These diseases have a severe impact on quality of life, resulting in significant increases in individual healthcare costs and the development of conditions that lead to a high rate of morbidity.

Supporting the link between clinical and business operations and evidence-based health care (e.g., asthma, diabetes, and cancer screening) is included as one of eight critical initiatives in Tri-Service business planning (described in **Section I, Medical Management Essentials**). In accordance with the NDAA of 2007, the MHS placed a greater emphasis on integrating DM programs for a variety of diseases and chronic conditions with enterprise activities. Consequently, the incorporation of evidence-based medicine practices and programs has assumed a higher priority in the administration of current TRICARE contracts. (For more on the link between clinical and business operations, see **Section I, Medical Management Essentials**. For more information on Tri-Service business planning, see **Section V, Medical Management Tools**.) To support the objectives of their business plans,

MTFs have implemented the clinical practice guidelines (CPGs) established by the Department of Veterans Affairs (VA) and the DoD for numerous high-cost and high-volume conditions, including diabetes and asthma. However, significant gaps in quality still exist for conditions covered by these CPGs, requiring further emphasis and continued evaluation.

Employer-Funded Health Plans

Employer funding of healthcare plans has been a driving force in civilian DM efforts, as employers seek to control healthcare program costs.

According to a study in the *American Journal of Managed Care* (Welch et. al., 2002), DM programs were most likely to focus on three main diseases: diabetes, asthma, and congestive heart failure. The study found that medical directors perceived their DM programs to be highly effective not only in reducing mortality and morbidity and improving the functional status of patients, but also in lowering costs. This highlighted the need for DM programs to undergo critical evaluation for quality and cost effectiveness. In a survey by the Kaiser Family Foundation (KFF) and the Health Research and Educational Trust, 55 percent of large employers (those with 200 or more employees) offering health benefits included one or more DM programs. The same survey found that 62 percent of large firms had one or more wellness programs, including injury prevention, fitness, smoking cessation, and weight loss (KFF, 2006).

A report by America's Health Insurance Plans (AHIP) examined a variety of civilian health programs aimed at improving the quality of life for members with chronic disease (AHIP, 2007). Important trends in chronic care included:

- Providing health coaching for behavior change: Healthcare professionals, usually nurses or health promotion staff, coach high-risk members on lifestyle changes.
- Harnessing advancements in information technology (IT): Technology, such as electronic medical records and electronic registries, is used to improve effective care.
- Caring for the whole person: Rather than targeting individual diseases (such as one program for asthma, one for diabetes, and one for depression), the needs of the whole person are addressed.
- Offering a continuum of care: Health outcomes are improved by the provision of a variety of services, ranging from wellness and prevention to acute, chronic, and end-of-life care.

Cost Savings for Disease Management

As previously discussed, cost control is an important focus for DM. Medical expenditures in 2006 for individuals with one or more chronic diseases totaled about $1.58 trillion, or 75 percent of total U.S. health spending (Partnership to Fight Chronic Disease, 2008).

An analysis on the economic burden of chronic disease in 2003 demonstrated:

- The highest treatment expenditures for chronic diseases were $64 billion for heart disease, $45.8 billion for mental disorders, and $45.2 billion for pulmonary conditions.

- Direct costs per person were $3,381 for heart disease, $1,977 for diabetes, $1,509 for mental disorders, and $919 for pulmonary conditions (DeVol, Bedroussian, 2007).

As recently as 2003, costs for seven common chronic diseases, cancer, diabetes, heart disease, hypertension, stroke, mental disorders, and pulmonary conditions, were $277 billion with lost productivity totaling $1.1 trillion (DeVol, Bedroussian, 2007). This lost productivity included absenteeism, missed work days, and presenteeism. Presenteeism, defined as being at work but not performing optimally, was identified as causing the largest share of lost economic output (Partnership to Fight Chronic Disease, 2008).

According to the Centers for Disease Control and Prevention (CDC), the approach of focusing on various risk factors not only helps prevent chronic disease; it is cost effective. Reducing cholesterol levels for U.S. adults by 10 percent can reduce the number of heart attacks and stroke overall by 30 percent. U.S. adults lowered blood pressure and high cholesterol during the 1980s, which reduced costs associated with coronary heart disease by about 9 percent — from about $240 billion in 1981 to about $220 billion in 1990 (CDC, 2009).

For Americans with diabetes, foot care examinations and improved self-care as a result of patient education could prevent up to 85 percent of diabetes-related amputations. Blood pressure control among people with diabetes reduces the risk of heart disease and stroke by up to 50 percent and the risk of eye, kidney, and nerve diseases by approximately 33 percent. Blood pressure control alone for this population can result in a concomitant cost savings of $1,200 over a lifetime for a person with Type 2 diabetes. In addition, self-management training for diabetics prevents hospitalizations: every $1 invested in training reduces healthcare costs by up to $8.76 (Capital District Physicians' Health Plan [CDPHP], 2008).

DISEASE MANAGEMENT COMPONENTS

There are six essential components to effective DM:

1. Population identification processes.
2. Evidence-based clinical practice guidelines (CPGs) to reduce practice variation and improve care.
3. Collaborative practice models, including providers and interdisciplinary healthcare team members.
4. Patient self-management education.
5. Process and outcome measurement, evaluation, and management.
6. Feedback and reporting to stakeholders, including patients, the healthcare team, and Command leadership.

Full-service DM programs must include all of the aforementioned elements. Programs not inclusive of all six components are considered "DM support services" (DMAA, 2009).

1. Population Identification Processes

DM begins with a thorough assessment and analysis of the population served by the healthcare system. This assessment includes, at a minimum, knowledge

of population age distribution, gender, beneficiary category, risk factors, and disease burden. Disease managers will also be interested in any known healthcare utilization patterns (e.g., high utilizers, inpatient admissions, Emergency Department [ED] visits).

Tools to identify population demographic characteristics include:

- Defense Eligibility Enrollment Reporting System (DEERS)
- MHS Management Analysis and Reporting Tool (M2)
- MHS Population Health Portal (MHSPHP)
- Armed Forces Health Longitudinal Technology Application (AHLTA)

For more information, refer to **Section V, Medical Management Tools**.

Armed with a thorough knowledge of their population, disease managers can risk-stratify that population and its healthcare needs in order to determine the priority of interventions. This risk stratification includes identifying chronic disease conditions and required treatment along with defining unhealthy behaviors within specific sub-populations or cohorts.

2. Evidence-Based Clinical Practice Guidelines

Fundamentals

Evidence-based practice forms the foundation of DM. DM programs use CPGs to guide patient care.

What is the Military Health System Population Health Portal (MHSPHP)?

The MHSPHP is a centralized, secure, Web-based Population Health management system used by Army, Navy, and Air Force healthcare teams. The MHSPHP transforms Department of Defense (DoD) and Network healthcare administrative data into actionable information.

Military Treatment Facility (MTF) TRICARE Prime enrollees in need of potential clinical preventive services, Disease Management, or Case Management are identified on healthcare action lists. MHSPHP documentation defines specific data sources and methodologies that are based on HEDIS® parameters. Using the MHSPHP, all MTF healthcare teams can proactively manage the health status of their patients over the Web.

(CM and UM may also use CPGs as part of their work flow and patient care processes.)
CPGs are systematically developed, evidence-based, nationally recognized statements to assist practitioners and patients in making decisions about appropriate healthcare services for specific clinical circumstances (Field & Lohr, 1990). Using CPGs as a tool is an important strategy in any healthcare organization, particularly where there is an opportunity to improve the quality of care and individual patient quality of life, reduce variation in clinical practice, and decrease costs. CPGs help standardize DM processes and may be used as a framework for evaluating interventions by specifying treatment goals and outcome measures (i.e., metrics). When successfully implemented, CPGs offer the opportunity for improving both patient clinical outcomes (by decreasing the rate of complications) and financial outcomes (by reducing inappropriate utilization of healthcare services).

In contrast to practices reflecting expert consensus or the anecdotal experiences of individual providers, evidence-based CPGs are explicitly linked to the strength of evidence established after extensive and systematic review of all relevant literature. CPGs must be:

- Clinically applicable and flexible.
- Developed through an interdisciplinary process.
- Reviewed on a scheduled basis.
- Based on valid, reliable, and reproducible evidence.
- Well documented.

CPGs are frequently displayed as an algorithm — a flowchart format providing step-by-step decision support and care guidance for a specific disease or condition. CPGs are seen by many as a potential solution to inefficiency and inappropriate variations in the quality of care. However, it is acknowledged that the use of guidelines must always be applied in conjunction with a provider's clinical judgment for the care of a particular patient. For that reason, CPGs may be viewed as an educational tool analogous to textbooks and journals but presented in a more user-friendly format.

The MHS rationale for adopting CPGs is that they provide practitioners with a clinical decision-support tool for determining appropriate evidence-based health care for specific clinical conditions. A well-designed guideline offers a broad approach to supporting interdisciplinary, coordinated care for patients with a variety of conditions. However, providers should be able to deviate from a guideline without incurring sanctions or jeopardizing coverage for services when, in their judgment, the healthcare needs or desires of the individual patient indicate such a deviation.

The Joint Commission (TJC, 2009) acknowledges that CPGs can "improve the quality, utilization, and value of healthcare resources." The Commission has incorporated their use into its standards for 2009, which state that leaders in hospitals (LD.4.240 through LD.4.270) and ambulatory care facilities (LD.4.280) will use CPGs to design or improve processes that evaluate and treat specific diagnoses, conditions, and/or symptoms.

The 2006 Department of Defense Instruction (DoDI) 6025.20, *Medical Management Programs in the Direct Care System (DCS) and Remote Areas* (see **Section I, Medical Management Essentials,**

▶ **CD-ROM Resource MME-1**) describes the requirement for MTFs to identify and select at least one clinical process each year for improvement through the application of a CPG. Furthermore, one of the critical initiatives informing Tri-Service business planning (see **Section I, Medical Management Essentials** and **Section V, Medical Management Tools**) calls for increasing the use of evidence-based health care (EBHC), including the incorporation of CPGs, to address clinical quality and outcomes for specific diseases and conditions. (▶ **CD-ROM Resources DM-1** and **DM-2** provide Service-specific policy guidance on incorporating CPGs.)

Department of Defense/Department of Veterans Affairs Clinical Practice Guidelines

MTFs are encouraged not to create CPGs themselves, but rather to adopt or adapt an existing CPG, ideally with a rigorous, evidence-review foundation. Creating a CPG is a labor- and time-intensive process. CPGs created at the national level are developed by well-supported teams of subject matter experts (SMEs) who are experienced in the evidence review process.

The VA and DoD have partnered since 1998 to develop evidence-based CPGs that are pertinent to the DoD population's needs while also free from pharmaceutical and industry bias. In effect, these CPGs serve to standardize care for specific conditions across federal healthcare systems. The VA/DoD Evidence-Based Practice Working Group develops CPGs for select high-volume, high-cost conditions specific to VA and DoD populations. The Working Group reports to the Assistant Secretary of Defense for Health Affairs (ASD [HA]) and the Under Secretary for Health, Veterans Health Administration (VHA). The Army Medical Department (AMEDD) has assumed the responsibilities as Executive Agent for the DoD.

The scientific rigor of the VA/DoD evidence review process has been acknowledged by a multitude of civilian healthcare organizations that have volunteered to collaborate with the two agencies on federal CPG development. The rigorous process for selecting and developing a VA/DoD CPG is outlined below.

1. *Selection* — A condition for CPG development is selected by the VA/DoD Work Group based on relevant high-volume, high-cost conditions.
2. *Development* — Reviewing guidelines already in existence, a VA/DoD CPG is developed or revised based on a current review of research-based literature, with a focus on implementing that guideline in primary care settings.
3. *Toolkit* — Educational materials specific to providers and patients are developed and packaged in a toolkit to aid in CPG implementation.
4. *Dissemination* — The CPG is launched to MTFs using a variety of modalities, such as direct mail, Web-based programming, and site assistance visits.
5. *Implementation* — MTF facility champions and action teams are identified and empowered to implement the CPG.
6. *Maintenance* — CPGs and toolkits are updated every two to four years based on current evidence and feedback from VA and DoD facilities. Patient outcomes are monitored at the local, Service, and MHS levels to assess the impact of CPG implementation on patient health.

CPG and toolkit development involves bringing together VA and DoD SMEs as well as patients, providers, and support staff to develop process tools that support patients, providers, and the healthcare system as a whole. By developing and deploying the toolkits centrally, items are standardized throughout the MHS and resources are conserved. Resources supporting CPG implementation include:

- *Patient self-management tools* encompassing a variety of resources, such as self-care brochures, wallet cards, care cards, posters, videos, and CD-ROMs.
- *Clinical support tools* that streamline and standardize clinician assessment, documentation, and treatment of patients (e.g., algorithms, medical education videos, posters, exam room cards, and pocket cards).
- *System support tools,* including AHLTA templates, disease registries such as the MHS Population Health Portal (MHSPHP), Service-specific scorecards, and suggested process outcome measures (refer to **Section V, Medical Management Tools**).

CPGs developed by the VA/DoD collaboration are displayed in Fig. 28. These CPGs, available supporting materials, and ordering information are available at the U.S. Army Medical Command (USA MEDCOM) Quality Management Office (QMO): https://www.qmo.amedd.army.mil/ (see also **Appendix D, Resources**). VA/DoD CPGs are frequently under development or undergoing routine updates, so it is important to check the website regularly for the most current version.

VA/DoD Clinical Practice Guidelines (CPGs)

- Amputation*
- Asthma*
- Chronic Heart Failure*
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease
- Diabetes Mellitus*
- Disease Prevention
- Dyslipidemia*
- Dysuria
- Gastroesophageal Reflux Disease
- Hypertension in Primary Care*
- Ischemic Heart Disease*
- Low Back Pain*
- Management of Pregnancy* (formerly Uncomplicated Pregnancy)
- Major Depressive Disorder* (includes Substance Use Disorder and Suicide Prevention)
- Medically Unexplained Symptoms (Chronic Pain and Fatigue)*
- Mild Traumatic Brain Injury (mTBI)
- Obesity*
- Opioid Therapy for Chronic Pain
- Post-Deployment Health Evaluation and Management*
- Post Traumatic Stress Disorder (PTSD)*
- Post-Operative Pain*
- Psychoses*
- Stroke Rehabilitation*
- Substance Use Disorder*
- Tobacco Use Cessation*

**Supporting toolkit available*

Fig. 28 – VA/DoD Clinical Practice Guidelines

The AMEDD enlisted the assistance of the RAND Corporation in developing the best method for implementing VA/DoD CPGs (Nichols, 2001). That collaboration resulted in an implementation guide published in 2001, titled *Putting Practice Guidelines to Work in the Department of Defense Medical System: A Guide for Action* (► **CD-ROM Resource DM-3**). This document is also available at the Army QMO website: https://www.qmo.amedd.army.mil (see also **Appendix D, Resources**).

From its work with RAND, the AMEDD developed the current plan for implementing CPGs within primary care. That plan, the *VA/DoD Manual for Facility Clinical Practice Guideline Champions* (refer to ► **CD-ROM Resource DM-4**) includes the following steps:

1. Know the Guideline (CPG)
2. Assess Current MTF Practice Patterns
3. Compare Practice Patterns with CPG Recommendations
4. Identify "Gaps" in MTF Practice Patterns
5. Develop an "Action Plan" to Close the Gaps
6. Implement the Plan
7. Develop a System to Monitor Practice Change

National Guideline Clearinghouse™ – http://www.guideline.gov/

The National Guideline Clearinghouse (NGC) is a joint effort among the AHRQ, the American Medical Association (AMA), and AHIP. The NGC is a comprehensive database of evidence-based CPGs and related documents. The NGC website provides an easily accessible mechanism for obtaining objective, detailed information on CPGs and furthering their dissemination, implementation, and use. A template of attributes is completed for each guideline included in the NGC; and the NCG verifies the currency of all guidelines represented in the database. The NGC website allows users to view more than 2,000 guidelines by clinical specialty, disease/condition, target population, treatment/intervention, or issuing organization. The website also features comprehensive structured summaries, full-text guidelines, guideline syntheses, guideline comparisons, and PDA downloads.

U. S. Preventive Services Task Force – http://odphp.osophs.dhhs.gov/pubs/guidecps/uspstf.htm

The U. S. Preventive Services Task Force (USPSTF) is an independent panel of primary care and prevention experts who systematically review current evidence for effectiveness and develop recommendations for clinical preventive services. USPSTF recommendations, while not technically CPGs, are firmly based in evidence and deserve mention because of their common use and acceptance. USPSTF recommendations and their evidence reviews are routinely used by the TMA as the basis for determining TRICARE benefits.

The USPSTF aims to:

- Create age-, gender-, and risk-based recommendations regarding services that should be a routine part of primary care.
- Evaluate the benefits of individual services.
- Identify a research agenda for clinical preventive care.

The USPSTF has provided recommendations for preventive interventions related to screening,

counseling, immunizations, and chemoprophylactic treatments for more than 80 conditions and disorders, including in the following areas:

1. Cancer (oncology)
2. Cardiovascular
3. Infectious disease
4. Injury and violence
5. Mental health and substance abuse
6. Metabolics, nutrition, and endocrinology
7. Musculoskeletal
8. Obstetrics and gynecology
9. Pediatrics
10. Vision and hearing

Clinical protocols and pathways are tools that delineate the optimal sequencing and timing of interventions by providers for a particular diagnosis or procedure. They are designed to minimize delays and resource utilization and maximize the quality of care. (Refer also to **Appendix C, Definitions**.) They often have a role in the clinical setting, in both the inpatient and outpatient arenas. Although they may be evidence-based, these protocols are distinguishable from CPGs in that they do not have the full complement of support resources. They are adjunct tools that may be leveraged by healthcare teams to streamline patient care processes.

3. Collaborative Practice Models

The MHS has a wide variety of practice models in place. The most effective are those that foster collaboration and communication among healthcare team members, including providers, support/ancillary staff, and Command leadership, as well as patients and their families. Examples of ancillary staff who may be involved in patient care include pharmacists, nutritionists, physical therapists; and dental, health promotion, health benefits, and laboratory staff. Deployment health services, health promotion, and medical counterparts in the field should also be considered as potential partners. Other military and civilian resources include organizations such as family support services, local health departments, and local fitness centers. To maximize the use of resources and increase efficiencies, it may be advantageous to collaborate with MCSCs, the Multi-Service Market Office (MSMO), and the TRICARE Regional Office (TRO) (see **Appendix D, Resources**).

The United States are divided into three **TRICARE regions**. Each of the regions has a regional civilian care partner, the **Managed Care Support Contractor (MCSC)**, who helps administer the TRICARE benefit plan. The MCSC works with the **TRICARE Regional Offices (TROs)** to manage the benefit at the local level and receives overall guidance from TRICARE Management Activity (TMA) headquarters.

A **Multi-Service Market Office (MSMO)** is a TRICARE area with more than one Service with a Military Treatment Facility (MTF). A designated MTF Commander is appointed to serve as Senior Market Manager for each MSMO. This role is responsible for developing a single, consolidated, integrated business plan for the Direct Care System (DCS) and Purchased Care System (PCS) for all services located within the MSMO. There are currently 12 MSMOs.

The most effective processes have been demonstrated in teams whose members exercise joint accountability. This means that qualified staff are expected to be involved in direct care activities and patient/family education, and in adding patient information to the medical record and correcting such information. Commanders assist team members by clarifying expectations, prioritizing responsibilities, and allocating resources to provide care. Providers should strive to know the healthcare needs of their entire panel, document their interventions accurately in AHLTA, and provide leadership in the clinical arena.

In addition to providing patient care and education, providers, nurses, and support staff within the clinic should critically evaluate their program and take action, as necessary, to improve clinical processes. These stakeholders should be involved not only in direct care activities but also in MTF outreach and marketing activities to promote patient education and awareness.

> **The good physician treats the disease; the great physician treats the patient who has the disease.**
>
> *Sir William Osler*

Open and ongoing communication among team members enhances the effectiveness of team activities and allows all members to be involved in patient care to the fullest extent possible. Communicating with patients and families clearly and consistently serves to strengthen the patient-healthcare team relationship and to maximize patient safety. Communication patterns must be clear — not only in the clinic, but also during patient transitions to other clinics, facilities, healthcare services, or the inpatient setting.

Clinic reengineering to facilitate patient flow and patient care activities is integral to the success of collaborative practice models. Strategies to streamline patient care and improve communication among healthcare team members can include utilizing group visits, promoting standard order sets, and implementing nurse-run clinics.

4. Patient Self-Management Education

Self-management (also referred to as self-care) is a broad term describing interventions targeted toward patients with a chronic disease and condition and their families. The goal of self-management is to help patients with chronic disease(s) learn to incorporate the skills to lead an active and satisfying life (Loring, 1993). DM programs empower patients with information and self-management plans to enable them to participate directly in decisions related to their own health care. Because individual patients live within a context that includes their families and/or their immediate environment, self-management includes the family as an integral participant in the patient's education and skill-building process.

Self-management may include:

- Health promotion activities (e.g., tobacco cessation) and clinical preventive services (e.g., cancer screenings) as recommended by the USPSTF.
- Behavior modification, where indicated, to reduce chronic disease complications (e.g., dietary monitoring for patients with diabetes or obesity). Examples of specific programs targeting behavior modification include healthy eating and menu planning and exercises for managing blood glucose.
- Compliance monitoring (e.g., review of hypertension daily blood pressure logs).

The benefits of patient self-management are many and include reduced hospital admissions, reduced demand for clinical services, improved clinician and patient satisfaction, improved health outcomes and standard of living, and improved medication adherence. Clinical outcomes for diseases such as depression, asthma, hypertension, and diabetes only improve when patients are involved in their own care (Weingarten, 2002).

While patient education may teach disease-specific information and skills, self-management education implies that the patient not only learns the information but also acquires the skills to better manage his/her health. It includes exposing patients to problem-solving skills that will help them handle issues that affect their lifestyle, regardless of whether or not those issues are directly related to their condition or disease. Whereas the goal of general patient education is compliance with treatment regimes, the goal of self-management education is to increase a patient's confidence in the ability to manage his/her own health.

The underlying assumption in patient education is that knowledge will create a change in behavior, possibly because it is demanded by the educator. In contrast, self-management education empowers the patient to achieve a change based on a strategy that combines knowledge and his/her own self-care skills. A patient's health is more likely to improve when the patient is confident of his/her ability to adapt to change.

To support patients in managing their lifestyle choices to better adapt to living with a condition or disease, the healthcare professional needs to assess a patient's self-management knowledge, behaviors, abilities, confidence, and barriers. Armed with this assessment, the healthcare professional can provide behavior change information and ongoing support. This allows the patient to understand the effect of personal behavior on his/her own health, enabling that patient to develop strategies for health improvement to meet his/her lifestyle expectations.

According to the Institute for Healthcare Improvement (2008), typical failures found in patient/family self-management education include:

- Assumptions that the patient is the key learner.
- Confusion regarding self-care instructions, particularly medication use.
- Non-compliance, resulting in repeat clinic visits or hospitalizations.

When developing, selecting, and providing specific patient self-management education, it is critical that education efforts target both the patient and his/her family. Challenges in working toward patient self-management include low patient education level, language barriers, cultural barriers, low socio-economic status, and lack of family support.

Each of these should be considered when planning care with patients.

Education materials should reflect an appropriate level of understanding for the patient/family and be presented in their preferred modality and learning style. Education strategies include:

- Individual and group classes on wellness or on specific diseases or chronic conditions.
- Patient-friendly written handouts.
- Audio and video libraries.
- Disease-specific telephone information centers.
- Telephone prompts for screening or healthcare needs.

▶ **CD-ROM Resource DM-5** shows the WISE Disease Self-Care Model, which was developed by the HealthSciences Institute (HSI) as a framework for patient self-management.

5. Process and Outcome Measurement, Evaluation, and Management

The critical evaluation of current programs and processes is an important element of both MM and Population Health. This evaluation can be applied to all clinical departments within MTFs as disease managers assess the health of the population, the impact of clinical practices on care rendered, and the quality and cost effectiveness of the delivery system.

Quality of care can be measured by any number of means, including:

- Inpatient admission rates.
- Emergency Department (ED) utilization.
- Surgical outcomes.
- Immunization rates.
- Patient satisfaction.
- Compliance with preventive health assessments.
- Provision of recommended clinical preventive services.

Process and outcome measures allow the disease manager to understand how the DM program is performing and to evaluate the impact of implemented actions on patient health.

- *Process measures* evaluate specific aspects of the healthcare delivery practice, such as the percentage of patients with diabetes with an A1c test completed in the past 12 months or the percentage of patients with asthma who are on long-term controller medication.
- *Outcome measures* assess the results of a specific test or how many patients are experiencing a particular outcome (e.g., the number of patients with diabetes who had an LDL level less than 100 mg/dl).
  Clinical outcome measurements, such as process or outcome measures help gauge the progress of a DM program by improving specific aspects of healthcare quality in the MTF. They are especially useful in determining the effectiveness of a new program or of a specific *aspect* of that program. Tracking outcomes within an organization provides a basis for modifying processes to improve future outcomes and offers a mechanism for identifying barriers to desired outcomes.

Disease managers should use standard, nationally recognized measures to enable goal-setting and benchmarking — the review of processes, services, and clinical practices to compare performance and gauge whether and where clinical processes

may need to be improved (see also **Appendix C, Definitions**). Benchmarking enables the following comparisons:

- Among clinics/MTFs/services throughout an organization.
- Between the MHS and its civilian counterparts.
- Against individual DM programs over time.

These comparisons often allow for ready identification or adoption of best practices which may prompt the re-engineering of clinical processes to ultimately improve the health of a population.

Tools to readily collect healthcare information for specific diseases or preventive services include the MHSPHP, M2, AHLTA, and Clinical Data Mart, as well as Service-specific sites (see **Section V, Medical Management Tools**).

Clinical Quality Measures

A longstanding approach within the MHS has been to leverage nationally recognized measures to make comparisons to civilian benchmarks and organizations. Numerous civilian organizations and governmental agencies have developed measures of clinical quality and business efficacy. These organizations include the CDC, TJC, National Committee for Quality Assurance (NCQA), and Agency for Healthcare Research and Quality (AHRQ).

The requirements for centralized MM measures are developed through the MHS Clinical Measures Steering Panel, which includes representatives from the Services, MCSCs, and TMA.

Healthcare Effectiveness Data and Information Set (HEDIS®) —http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2009/2009_Measures.pdf

HEDIS® is sponsored by the NCQA. As the most widely utilized set of measures of clinical quality in health care, HEDIS® is used by more than 90 percent of managed care organizations throughout the United States. Using very explicit methodology (including age/gender/enrollment restrictions and inclusion/exclusion criteria), this set of standardized measures specifies how health plans collect and report data on quality of care. HEDIS® measures are frequently utilized by organizations to create a "report card" on the quality of services and care provided by healthcare plans. These measures do not necessarily reflect the standard of care; rather, they serve to provide objective comparisons across organizations.

The HEDIS® measures assess various dimensions of care and services and are organized in eight different domains encompassing more than 70 different measures (refer to Fig. 29).

The category the MHS leverages most to report on the quality of care delivered to DoD beneficiaries is the Effectiveness of Care (EOC) dataset. Measures of interest to the MHS, including cancer screening, comprehensive diabetes care, and asthma management, have been incorporated into the quality and business plans of all three Services and MCSCs. For a list of HEDIS® EOC topics, refer to Fig. 30.

ORYX — http://www.jointcommission.org/AccreditationPrograms/Hospitals/ORYX/facts_oryx.htm

ORYX is a set of objective measures to assess the clinical quality provided by inpatient facilities. Implementation of ORYX is a requirement for hospital accreditation with TJC. Under MHS Clinical Quality Management (CQM — https://www.mhs-cqm.info/), ORYX data are abstracted from medical records in all bedded (inpatient) MTFs. MTFs must choose a combination of applicable core and non-core measure sets. **The USAF may not exclusively use TJC for MTF accreditation, but ORYX data are still collected and reported.*

Core measure sets generally reflect inpatient processes and outcomes, and include the following:

- Acute myocardial infarction
- Heart failure
- Pneumonia
- Pregnancy and related conditions

HEDIS® Domains of Care

- Effectiveness of Care
- Access/Availability of Care
- Satisfaction with the Experience of Care
- Use of Services
- Cost of Care
- Health Plan Descriptive Information
- Health Plan Stability
- Informed Health Care Choices

Source: http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2009/2009_Measures.pdf

Fig. 29 – HEDIS® Domains of Care

List of HEDIS® Effectiveness of Care Measure Topics

- ADHD
- Asthma
- Cancer Screening
- Chlamydia Screening
- Cholesterol Management
- COPD
- Diabetes
- Geriatrics
- Glaucoma Screening
- Hypertension
- Immunizations
- Lead Screening
- Low Back Pain
- Medication Management
- Mental Illness
- Myocardial Infarction
- Osteoporosis
- Rheumatoid Arthritis
- Smoking Cessation
- Upper Respiratory Infections
- Urinary Incontinence
- Weight/Activity Assessments

Source: http://www.ncqa.org/Portals/0/HEDISQM/HEDIS2009/2009_Measures.pdf

Fig. 30 – HEDIS® Effectiveness of Care Measure Topics

- Hospital-based inpatient psychiatric services (DoD does not report this data to TJC)
- Children's asthma care
- Surgical Care Improvement Project (SCIP)
- Hospital outpatient measures

Non-core measures are generally ambulatory care measures and include diabetes, asthma, and hypertension. For more information, visit the MHS CQM website or contact a local QM representative. The MHS publishes MTF performance data for HEDIS® and ORYX measures on publically available portals, including the Hospital Compare and MHS CQM websites.

Healthy People 2010 (HP 2010) — http://www.healthypeople.gov/

The Healthy People 2010 measure set was developed by the CDC to serve as a road map for improving the health of all people in the United States. HP 2010 consists of 28 focus areas containing 467 objectives with measures to assess the health of American communities. A limited set of 10 objectives, the Leading Health Indicators (Fig. 31), reflects the major health concerns in the United States for the beginning of the 21st century. Indicators were selected based on their ability to motivate action and their importance as public health issues, and on the availability of data to measure progress.

HP 2010 provides measure definitions and current baseline data with epidemiologic stratifications, along with desired targets. The HP 2010 website provides additional resources and helpful strategies for implementing programs to meet the HP 2010 goals. Every 10 years, the Department of Health and Human Services (HHS) revises this document to account for major risks to health and wellness, evolving public health priorities, and emerging technologies related to our nation's health preparedness and prevention. Healthy People 2020 is anticipated to be published in early 2010. Additional information is available at the CDC website at http://www.cdc.gov/.

The MHS has recently focused on the 10 Leading Health Indicators identified by HP 2010 (Fig. 32), with an emphasis on tobacco use, alcohol abuse,

Healthy People 2010 Leading Health Indicators

- Physical Activity
- Overweight and Obesity
- Tobacco Use
- Substance Abuse
- Responsible Sexual Behavior
- Mental Health
- Injury and Violence
- Environmental Quality
- Immunization
- Access to Health Care

Fig. 31 – Healthy People 2010 (HP 2010) Leading Health Indicators

and overweight/obesity. Some of these indicators have been integrated into corporate and strategic documents, including the MHS Values Dashboard.

National Quality Measures Clearinghouse (NQMC)™ — http://www.qualitymeasures.ahrq.gov/

The NQMC, which is sponsored by the AHRQ, is a public archive for evidence-based quality measures and measure sets. It was developed to promote widespread access to quality measures by the healthcare community (NQMC, 2009). The NQMC website allows users to view measures by disease/condition, treatment/intervention, domain, or issuing organization. Users can also explore measures endorsed by the National Quality Forum (NQF) or those associated with related guidelines, housed on the National Guidelines Clearinghouse™ website (refer to DM Component 2, Evidence-Based Clinical Practice Guidelines). Other features of the NQMC website include measure summaries, tutorials, expert commentary, measure comparisons, and resources to correctly assess and apply quality measures.

Other measure sets are available for disease-specific conditions. Various consortia have created a nationally-recognized set of measures for assessing DM programs. These consortia include the National Diabetes Quality Improvement Alliance (DQIA) and the American College of Cardiology (ACC)/American Heart Association (AHA) Task Force on Performance Measures, which have addressed various cardiac conditions. Since these measure sets are the product of collaborative efforts, they are generally endorsed and supported by agencies such as the AHRQ, TJC, NQF, and other physician-based organizations.

MHS CQM Fact Sheets

- Asthma Care
- Birth Trauma
- Breast Cancer Screening
- Cervical Cancer Screening
- Childhood/Adolescent Immunizations
- Chiropractic Health Care Services
- Chlamydia Screening
- Clinical Practice Guidelines Use
- Depression
- Depressive Disorder
- Diabetes Mellitus Care
- Dyslipidemia
- Healthcare Acquired Infections
- Heart Failure
- Hypertension (also Pre-hypertension and Blood Pressure Measurement)
- Ischemic Heart Disease
- Obesity
- Prenatal Access to Care
- Post Deployment Health Care
- Postpartum Depression
- Post-Traumatic Stress Disorder
- Tobacco Use Cessation

For access to all NQMP Fact Sheets, please go to: https://www.mhs-cqm.info/Open/Education/Factsheets.aspx

Fig. 32 – MHS CQM Fact Sheets

Every year, MHS CQM performs special studies to critically evaluate clinical outcomes to assess the quality of care rendered in the MHS. CQM summarizes these special studies in fact sheets and provides educational opportunities for MHS staff. Fig. 32 provides a list of fact sheet topics published since 2001.

MM may use other Service-level, corporate, and strategic measures, as well as national benchmark measures, but the aforementioned measures highlight the MHS' current priorities (see also **Section I, Medical Management Essentials, Medical Management Goals and Approach**).

6. Feedback and Reporting

The complete outcomes management process requires not only defining data requirements and obtaining outcomes, but analyzing data and reporting results. Without obtaining feedback on the effectiveness of the current program and processes, it is difficult to appreciate the need for change. Program assessments and subsequent modifications allow for effective process improvement using the Plan-Do-Check-Act (PDCA) cycle (Fig. 33).

While some MM staff may not possess the skill sets or expertise to obtain and analyze appropriate data, they should communicate and collaborate with MTF personnel experienced in those areas to acquire the information they need.

Fig. 33 – The PDCA Cycle

Stakeholder Reporting

Reporting outcome measures serves to inform MHS stakeholders of the progress of DM activities on improving the health of the population. Reporting should be performed on a periodic interval determined by the DM and MTF leadership. It should include communication with patients, healthcare providers, ancillary and interdisciplinary support staff, and Command leadership to facilitate prioritization of resources and planning for future DM efforts. Reporting of individual provider or clinic outcomes to the healthcare team encourages ownership and refinement of care delivery practices.

MTF-specific data and performance on HEDIS® measures for many outpatient diseases and preventive screenings are available on the MHSPHP. Disease registries, AHLTA, and the Clinical Data Mart are other tools that can be leveraged to generate clinical data (see **Section V, Medical Management Tools**).

The MHS and Services display Aggregate performance data on MHS and Service-specific websites (some are CAC-enabled or password-protected), including:

- MHS — CQM: https://www.mhs-cqm.info/
- Army — Command Management System (CMS): https://cms.mods.army.mil/cms
- Air Force — Surgeon General's Executive Global Look (EGL): https://egl.afms.mil
- Navy — Population Health Navigator Dashboard: http://www-nehc.med.navy.mil/Data_Statistics/Clinical_Epidemiology/pophealthnav.aspx (restricted access, CAC card required)

See also **Section V, Medical Management Tools**. MTF leadership and the DM team should refer to their DM plan on an ongoing basis to determine whether their goals have been attained and to identify opportunities for process improvement.

ESTABLISHING A DISEASE MANAGEMENT PROGRAM

In the MHS, the DM program directly supports the strategic priority of promoting patient choice and accountability, building healthy communities, and demonstrating the MHS' commitment to safety and quality outcomes. To build an effective DM program in the MTF, a disease manager must be cognizant of the six components of DM as identified earlier in this chapter. Healthcare team members involved in planning a DM program must consider certain questions to provide direction for their MTFs (see Fig. 34).

Implementing a Disease Management Plan

Once the DM program components are analyzed and aligned to meet the needs of the MTF's population and Service-specific mission, the disease

Questions to Ask During Development of a DM Program

- What are the MTF's population demographics?
- Which risk factors are most prevalent in your population? Which subpopulations require clinical preventive services?
- What are the disease burdens/chronic conditions of the population served?
- Which MTF resources are currently available?
- Which disease or conditions should the MTF focus on? Could a CPG be adapted/applied as a tool for better management?

Fig. 34 – Questions to Ask During Development of a DM Program

Fig. 35 – The Phases of Implementing a Disease Management Plan

manager is ready to focus on implementing a specific plan. An eight-phase approach provides a systematic construct to help stakeholders become comfortable with the processes of plan implementation. Fig. 35 summarizes the phases involved in setting up a DM plan.

Let's break each phase down to get a more precise appreciation of what the disease manager should do at each level:

1. Assess the Target Population

For example, consider a chronic disease such as diabetes mellitus: How many patients are enrolled and to which providers are they assigned? The disease manager may further risk-stratify the population to examine glycemic control, overdue lab tests, and associated co-morbidities.

2. Assemble a Team

This phase allows the disease manager to present the clinical data identified in Phase 1 to the healthcare team that will be managing the diseases/conditions. Collaboration and communication are crucial in identifying the best way to assist a patient/group of patients in adhering to the treatment plan(s) and in taking more control and responsibility for their own health care. Phase 2 teams should be interdisciplinary, including providers, nursing staff, MM, and ancillary support personnel (see Fig. 36).

Based on contractual agreements, the MTF may also collaborate with the local MCSC in providing a seamless program between the DCS and PCS. Implementation must be a healthcare team effort that incorporates all available resources to avoid "reinventing the wheel."

3. Adopt Guidelines and Protocols

The healthcare team may decide to implement a disease-specific guideline and adapt it to facilitate local policies, business plan initiatives, or Command directives. Prior to implementing a CPG, team members will need education and training in the application of the algorithm(s) and toolkits. This will most likely involve reengineering MTF processes to mobilize the entire healthcare team. Roles will need to be assigned so that all personnel understand their role(s) in the process (e.g., appointing a provider champion). Other methods — such as the use of flow charts, lists, and the PDCA cycle (refer to Fig. 33) — can help in designing, tracking, and communicating the processes to all participants. The steps taken in developing and/or choosing an appropriate CPG should be documented in Service-specific executive/leadership functional minutes, Population Health committee minutes, or MTF policy.

4. Establish Goals and Target Outcomes

In establishing goals and targets, it may be helpful to look at prior performance, MTF trends, Command expectations and available resources. Targets should mirror the common project management approach SMART — that is, be specific, measureable, achievable, realistic, and time-bound. The disease manager, in collaboration with the interdisciplinary healthcare team, may develop a timeline for monitoring the status of the population selected by the team. For example, a desirable goal may begin with notifying patients overdue for diabetic hemoglobin A1C testing and encouraging them to complete laboratory tests within 60 days of DM plan implementation.

Example of an Interdisciplinary Healthcare Team

- Providers (physicians, physician assistants, nurse practitioners)
- Registered Nurses (RNs)
- Health educators
- Technicians, medics, medical assistants/clerks
- Utilization management (UM) and Case Management (CM) staff
- Any ancillary and allied healthcare staff who participate in managing the targeted disease/condition (e.g., pharmacists, nutritionists, dental hygienists/dentists)
- Command leadership
- Information management/technology specialists

Fig. 36 – Example of an Interdisciplinary Healthcare Team

5. Create a Prioritized Plan

6. Implement the Plan

In these two phases, the disease manager focuses on selected patient groups previously identified by the healthcare team and helps the team determine the decisions and tasks that need to occur and the order in which they should be executed. Individual and family education is just one type of intervention a disease manager can use to promote patient self-management in an effort to minimize complications and avoid unnecessary and inefficient healthcare utilization. Other strategies are to send reminder postcards or use automated telephone messaging systems to notify patients of the need for healthcare visits, medication changes, or recommended behavior changes. These techniques offer a simple yet effective way to collaborate with patients in reaching their desired treatment goals.

7. Collect and Analyze Outcomes Data

This phase should be accomplished at regular intervals to track progress. The disease manager is encouraged to liaison with other members of his/her Command (e.g., business office, quality management, IT) to determine whether this data collection is already occurring at the MTF, or to leverage existing resources or expertise.

8. Evaluate and Refine the Program

During this phase, the disease manager may identify barriers that are preventing the MTF from reaching its goals and determine the necessity of developing a plan to remove those barriers. It is critical that the MTF perform annual reviews to determine next steps and follow-on goals. Benchmarking against internal and external outcomes (e.g., applying HEDIS® measures) is a good method for tracking performance and progress.

Accreditation

Organizations such as URAC, the NCQA, and TJC provide accreditation to DM programs. Other disease-specific organizations, such as the American Diabetes Association (ADA), provide certifications that recognize outstanding educational programs based on national standards. (Based on the NDAA 2007, it is the MHS' policy to promote meeting the standards for program accreditation but not necessarily for programs to become accredited. The topic is included here to increase awareness of accreditation possibilities.)

URAC has established accreditation standards for DM programs. According to URAC, DM standards promote evidence-based practice, collaborative relationships with providers, consumer education, and shared decision-making with consumers. These standards apply to all types of entities providing services for individuals with chronic illnesses, including health plans and freestanding DM or MM organizations.

The URAC accreditation process occurs in four phases:

1. Application
2. Desktop Review
3. On-site Review
4. Committee Review

The NCQA offers program accreditation options to include various patient- and practitioner-oriented programs. The NCQA's DM standards address key areas for which organizations are reviewed. The standards are based on patient service, practitioner service, program content, clinical systems, measurement and quality improvement, and program operations.

TJC certifies DM programs as a complementary process to MTF accreditation. TJC's Disease-Specific Care (DSC) Certification Program is designed to evaluate DM and chronic care services that are provided by health plans, DM service companies, hospitals, and other care delivery settings. The evaluation and resulting certification decision is based on an assessment of the following:

- An organized approach to performance measurement and improvement activities.
- Compliance with consensus-based national standards.
- Effective use of evidence-based CPGs to manage and optimize care.

For organizations, TJC accreditation is available for virtually any chronic disease or condition. Advanced accreditation is available for chronic kidney disease, inpatient diabetes, primary stroke centers, and other specialized disease states/procedures.

THE DISEASE MANAGEMENT PROFESSIONAL

Qualifications

The job description of the DM professional will vary depending on the size of the MTF and the availability of resources. DM professionals should possess sufficient clinical knowledge and patient care experience to identify appropriate use of and compliance with CPGs, as well as conduct and/or arrange patient care. The DM professional also needs excellent communication skills, as he/she works in collaboration with a range of healthcare personnel to promote delivery of appropriate, cost-effective care to patient populations.

Typically, a candidate for the disease manager role can best succeed with the following qualifications or commensurate experience:

- A bachelor's degree (or higher) in a health-related field from an accredited institution.
- A valid unrestricted healthcare license.
- Current basic life support (BLS) certification.
- Experience with software and databases currently employed at the MTF.
- Strong communication and organizational skills.

Desirable qualifications include:

- Certification by the HealthSciences Institute (HSI) through its Chronic Care Professional (CCP) certification program or another disease-specific, patient-education certifying institution (e.g., American Diabetes Association [ADA]). (See **Certification**, next page.)

- Familiarity with evidence-based CPGs and USPSTF recommendations.
- Familiarity with clinical quality measures (e.g., HEDIS®, ORYX).
- Three years of broad-based clinical healthcare experience.
- Full-time employment in a healthcare role for the previous 12 months.
- Previous DM experience.

The disease burden of the MTF's enrolled population will determine the size and specificity of any DM program. ▶ **CD-ROM Resource Item DM-6** provides a list of sample contract tasks for a DM nurse, which could be adapted to either a statement of work or another type of job description. ▶ **CD-ROM Resources DM-7, DM-8**, and **DM-9** provide sample Service-specific DM position descriptions.

It should be noted that, depending on the particular Service or MTF, DM responsibilities or oversight may be included as part of roles such as Clinical Staff Nurse, Physician, or Health Care Integrator (HCI) — an Air Force-specific position (▶ **CD-ROM Resource DM-10** provides a description of the HCI role).

Certification

The HSI has offered a CCP certification program since 2004. In October 2007, the DMAA partnered with the HSI and endorsed the program, which encompasses 25 chronic diseases and late-life conditions. The program promotes an evidence-based approach to leveraging Population Health strategies, DM practices, and health coaching.

CCP certification is valid for three years. Recertification through re-examination or documentation of 15 hours of continuing DM or chronic care education may be obtained. Additionally, organizations that require CCP for their professional staff may include the CCP seal on their promotional materials, proposals, and website documentation to demonstrate to patients and customers that their staff have completed specialized training and passed a national examination (i.e., to show the organization is CCP-accredited).

SUMMARY

Closely linked to Population Health, DM focuses on fostering consistent, evidence-based care for beneficiaries with one or more chronic diseases or conditions. While the role of DM may have been underappreciated in the past, expanded IT capabilities and a renewed appreciation for the impact of chronic disease on the individual and the healthcare system have served to highlight the proactive role DM plays in improving the future health of defined populations.

To promote program goals and reduce duplication of efforts, DM must be accomplished in concert with both UM and CM staff and the entire healthcare team. Strategies for implementing DM should incorporate other policies and program documents, such as the 2006 Department of Defense Instruction (DoDI) 6025.20, *Medical Management Programs in the Direct Care System (DCS) and Remote Areas* (see **Section I, Medical Management Essentials,** ▶ **CD-ROM Resource MME-1**), and the current edition of the *DoD Population Health Improvement Plan and Guide* (see **Executive Summary,** ▶ **CD-ROM Resource ES-1**).

CD-ROM RESOURCES

DM-1 DM Policy Guidance – Navy

DM-2 DM Policy Guidance – Air Force

DM-3 *Putting Practice Guidelines to Work in the Department of Defense Medical System: A Guide for Action* – RAND

DM-4 *VA/DoD Manual for Facility Clinical Practice Guideline Champions*

DM-5 WISE Self-Care Model – HealthSciences Institute

DM-6 Sample Contract Tasks for the Disease Management Nurse

DM-7 Army Disease Management Position Description – Sample

DM-8 Navy Disease Management Position Description – Sample

DM-9 Air Force Disease Management Position Description – Sample

DM-10 Healthcare Integrator Job Description – Air Force

DM-11* Disease Management Road Map – Narrative Overview

DM-12* Disease Management Road Map – Assessment Form

DM-13* Disease Management Road Map – Action Plan (Blank)

**Not referenced in text*

MEDICAL MANAGEMENT TOOLS

MEDICAL
MANAGEMENT TOOLS

Department of Defense

TRICARE

Medical Management Tools

SECTION V

INTRODUCTION

This section focuses on tools and resources for successful Medical Management (MM) programs. It complements the *2001 Population Health Improvement Plan and Guide*, Section IV, p. 67, Analyze Performance and Health Status (see **Executive Summary, ▶ CD-ROM Resource ES-1**).

As discussed in **Section I, Medical Management Essentials** and throughout this Guide, the MHS emphasizes enhanced collaboration between clinical and business practices within Military Treatment Facilities (MTFs), since much of the same data are used to derive both clinical and business plans. Specifically, the priorities and measures (i.e., metrics) set for the local MM plan may directly affect the assumptions and data for the local business plan, and vice versa.

The tools described in this section are meant to help support this collaborative approach to MM.

USING INFORMATION SYSTEMS AND DATA MARTS

Accessing the Data

Many of the tools described here require passwords and/or are only accessible at ".mil" domains. Health Insurance Portability and Accountability Act (HIPAA) standards require security training and justification for system access. Some tools presented here advise the user of "*Restricted access." In such cases, please follow up with your supervisor or department head for more information on accessing and utilizing these tools.

Note that some Web links may take you to a page warning you of a problem with the website's security certificate. This is a standard message prior to accessing sensitive websites that may have restricted access. To access the site when this occurs, click on the red shield icon with the X and proceed.

Also note that some tools are presented without Web hyperlinks, as website addresses are often updated or rendered inactive due to domain name changes.

Understanding the Methodology and Limitations

Each system or data mart has detailed data dictionaries, defined methodologies, and business rules for its respective applications. It is imperative for MM teams to understand the applicability and limitations of the system or mart being used. The TRICARE Management Activity (TMA) sponsors and conducts training to assist MM staff in using these tools, including:

- Data Quality Training
- TRICARE Fundamentals
- TRICARE Financial Management Education Program (TFMEP)
- TRICARE Uniform Business Office (UBO)/Unified Biostatistical Utility (UBU) Conference
- Working Information Systems to Determine Optimal Management (WISDOM)

Courses are listed under the training section on the TMA conference website at http://www.tricare.mil/conferences.cfm.

Data Quality Concerns

Several coding validation studies conducted within the MHS have corroborated concerns about coding accuracy, especially regarding outpatient care. However, initiatives to establish training programs, involve leadership in more direct oversight, employ certified coders, and deploy the 3M Coding Compliance Editor (CCE) software should significantly improve the quality of MHS data over time. Still, it is advisable to scrutinize analyses that have been conducted using MHS data, to identify and minimize inconsistencies.

INFORMATION SYSTEMS AND DATA MARTS

Military Health System-Level Decision Support Tools and Executive Information Systems

Armed Forces Health Longitudinal Technology Application: http://www.health.mil/ahlta/

The MHS' electronic healthcare record system is the Armed Forces Health Longitudinal Technology Application (AHLTA), which interfaces with the Composite Healthcare System (CHCS) for patient record management. ▶ **CD-ROM Resource MMT-1** provides step-by-step instructions on accessing AHLTA in a user-friendly visual format.

Clinical Data Mart (CDM) is the clinical reporting tool for AHLTA. It allows users to measure, analyze, and manage performance of direct patient care, wellness, prevention, and DM of the MHS patient population. The CDM can be used to create ad hoc queries to help measure quality, safety, and efficiency. CDM accounts are created by the local MTF system administrator. Types of account (based on demonstrated need) include MTF Access (non-Protected Health Information [PHI] and PHI levels), Enterprise Access (non-PHI and PHI levels), and Provider Access (PHI level). Contact your supervisor or department head for more information.

Executive Information and Decision Support: https://dhss.csd.disa.mil/MX/Common/EIDS/mxAppHome.cfm?subMenuItem=about

The Executive Information and Decision Support (EI/DS) Web portal provides a centralized data store

for the MHS. EI/DS tools help provide complete, accurate information to MM staff, including beneficiary, provider, financial, and healthcare use data. These data are evaluated, integrated, and made available to MHS users through a variety of EI/DS tools and specialized data sets developed to meet business requirements. EI/DS actively interfaces with more than 260 systems around the globe and is comprised of a data warehouse and seven operational data marts supporting nearly 3,000 users, including MHS managers, clinicians, and analysts.

EI/DS includes the following tools, many of which are discussed in this section:

1. Military Health System Data Repository (MDR)
2. MHS Management Analysis and Reporting (M2)
3. Prospective Payment System (PPS)
4. ESSENCE Medical Surveillance
5. CDM
6. TRICARE Encounter Data (TED)
7. Patient Encounter Processing and Reporting (PEPR) and its reporting applications.

All tools and resources provided by EI/DS require an account. The various tools have a limited number of licenses; therefore, accounts must be approved by a Service representative. To become a user, contact EI/DS via email at: eids.access@tma.osd.mil.

TOOLS FOR UTILIZATION, CASE, AND DISEASE MANAGEMENT COLLABORATION

Fig. 37 provides a summary of information systems that may be helpful for UM, CM, and DM collaboration. (For more information on collaboration between MM components, see **Section I, Medical Management Essentials; Integrating Utilization, Case, and Disease Management Functions**.)

Multiple source systems feed the MHS Data Repository (MDR) to create various data marts and applications. These source systems include:

- The Composite Health Care System (CHCS) — where data are gathered directly from the MTFs.
- The Medical Expense & Performance Reporting System (MEPRS) Executive Query System (MEQS).
- The Defense Eligibility Enrollment Reporting System (DEERS).
- Managed Care Support Contractor (MCSC) systems.

The data from these systems are reviewed, analyzed, and aggregated in the MDR to create the various marts and applications listed in Fig. 38.

Be sure to see the companion CD-ROM for more important Medical Management Tools and Resources.

Summary of Data Systems for Use in Medical Management				
Data Source	**Utilization Management**	**Case Management**	**Disease Management**	**Population Health**
DMSS			X	X
M2	X	X	X	X
MCFAS	X			
CDM	X	X	X	X
MEWACS	X			
MHS Portal	X	X	X	X
PDTS	X	X	X	X
SADR	X			
SIDR	X			
TMA Purchased Care	X			
TMA-RT	X			
TOC	X			X
Service Sources: AFP2R2	X	X	X	X
Army PASBA	X			

Fig. 37 – Summary of Data Systems for Use in MM

MHS Data Repository

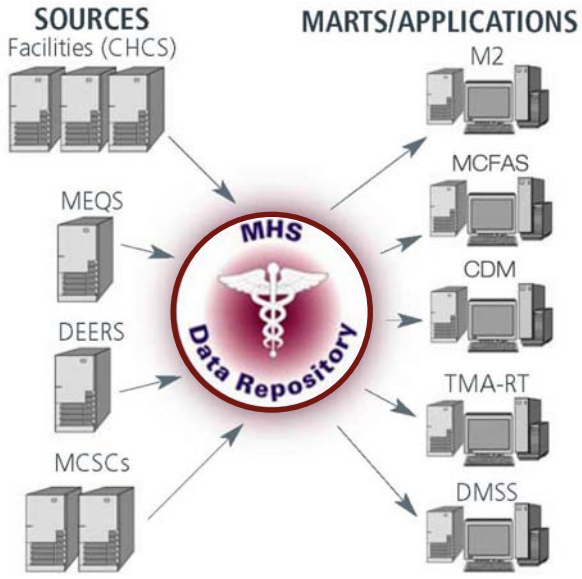

Fig. 38 –MHS Data Repository

TRICARE Management Activity Reporting Tools

TMA Reporting Tools (TMA-RT) comprise the following seven applications:

1. Military Health System Management Analysis and Reporting Tool: http://www.mhs-helpdesk.com/Pages/m2.asp

The Military Health System Management Analysis and Reporting Tool (M2) is used to obtain summary and detailed views of population, clinical, and financial data from all MHS regions. Access is granted at six levels of report from Level 1 (MTF-level data) through Level 6 (personally identifiable information).

M2 includes MTF and commercial network claims data integrated with eligibility and enrollment data. It allows users to perform trend analyses, conduct patient and provider profiling studies, and conduct business case analyses to maximize health plan efficiency. Many corporate measures are derived from M2.

Comprehensive data sets are compiled from various sources including, but not limited to:

- MTF data sets.
- Expense Assignment System, Version 4 (EAS IV).
- Standard Ambulatory Data Record (SADR).
- Standard Inpatient Data Record (SIDR).
- World Wide Workload Reports (WWRs).
- External data sets.
- Health Care Service Record (HCSR) — Network institutional and professional services claims. The name HCSR has been changed to "TRICARE Encounter Data" (TED); however, any claims submitted prior to contract changes remain an HCSR record.
- Pharmacy Detail Transaction Service (PDTS) — A centralized data repository that allows the DoD to build a common patient medication profile for all DoD beneficiaries, regardless of the point of service they use (excluding Standard TRICARE).
- National Mail Order Pharmacy (NMOP).
- Patient (i.e., beneficiary) demographic data.
- DEERS eligibility data.
- TRICARE enrollment data.
- TRICARE longitudinal enrollment data.
- TRICARE Mail Order Policy (TMOP).

2. Defense Medical Surveillance System: *Restricted access

3. Defense Medical Epidemiology Database: http://afhsc.army.mil/

The Defense Medical Surveillance System (DMSS) and Defense Medical Epidemiology Database (DMED) are operated by the Armed Forces Health Surveillance System (AFHSC).

As the DoD's premier epidemiologic resource, DMSS provides the MHS with a longitudinal record of up-to-date historical data related to:

- Medical events (e.g., hospitalizations, ambulatory visits, immunizations, reportable medical events, health risk appraisals, deployment health assessments).
- Individual/demographic characteristics.
- Military experiences (assignments, deployments, casualty information) spanning a Service member's entire career.

The DMSS is an excellent source for processing Tri-Service epidemiologic queries on disease burdens and injury rates, and can be used to demonstrate Service trends and potential for disease/condition management initiatives. Features include the ability to create results in tabular, line graph, or bar graph formats. DMSS also has the ability to save, export, and print query results.

The DMED application enables Web-based, user-definable queries of de-identified DMSS data subsets. Its user-friendly interface provides data on population statistics, disease summaries, detailed queries, and Top 10 diagnoses for Active Duty populations. Data can be obtained for inpatient

and ambulatory encounters, reportable events, and demographic data elements.

4. Medical Expense & Performance Reporting System Early Warning and Control System: http://www.meprs.info/mol3

The Medical Expense & Performance Reporting System (MEPRS) Early Warning and Control System (MEWACS) is a robust, interactive, user-friendly data quality surveillance tool developed by the MEPRS Management Improvement Group (MMIG) to proactively identify, investigate, resolve, or correct MEPRS data anomalies in a timely manner using systematic, repeatable processes. It is a valuable MM tool for monitoring resource consumption and clinic productivity. MEWACS provides detailed information at the MTF level and does not require a password for access.

MEWACS currently contains up to 24 months of Tri-Service MTF activity-level measures, including:

- EAS IV Repository data status and compliance with 45-day reporting suspense.
- Interactive MTF MEPRS data profiles by third-level functional cost code.
- MTF-specific summary data outliers and variance assessments.
- A WWR vs. EAS IV Repository total ambulatory visit comparison.
- Ancillary and support expense allocation tests.

MEWACS is updated monthly and is available for download at the end of each month.

5. TRICARE Operations Center: http://mytoc.tma.osd.mil/

This tool is an MHS healthcare information Web portal providing decision-makers at all levels of the organization with meaningful, easy-to-use, Web-based operational tools and reports. The Center provides useful MM resources, such as a template analysis tool, inpatient daily summaries, length-of-stay (LOS) analysis, provider schedules, and appointment cancellations by MTFs. General access is available through the TRICARE website; direct access to the tool requires a username and password.

6. Patient Administration Systems and Biostatistics Activity: *Restricted access

The Patient Administration Systems and Biostatistics Activity (PASBA) offers a wealth of valuable information for preparing MM plans. The Army uses PASBA to post utilization reports for the MHS that are stratified by Service, fiscal year, current procedural terminology (CPT) code, diagnosis-related group (DRG), and International Classification of Diseases-Ninth Edition-Clinical Module (ICD-9-CM) codes. (See also **Appendix C, Definitions**.)

The following is a list of available reports:

- Top 100 CPT for Non-Same Day Surgery
- Top 100 CPT for Same Day Surgery Report
- Top 100 DRG by Case Weighted Product
- Top 100 DRG by Frequency
- Top 100 ICD-9-CM for Non-Same Day Surgery
- Top 100 ICD-9-CM for Same Day Surgery
- Top 25 CPT for Non-Same Day Surgery for Active Duty

- Top 25 CPT for Same Day Surgery for Active Duty
- Top 25 DRG by Case Weighted Product for Active Duty
- Top 25 DRG by Frequency for Active Duty
- Top 25 ICD-9-CM for Non-Same Day Surgery for Active Duty
- Top 25 ICD-9-CM for Same Day Surgery for Active Duty

These reports are available for all DoD and VA regional commands and medical facilities. Data are posted once a year, usually in January or February, for the previous fiscal year.

7. Military Health System Population Health Portal:
*Restricted access

The Military Health System Population Health Portal (MHSPHP) allows MM professionals to identify and assess their populations, forecast and manage demand, and provide evidence-based care to individuals needing clinical preventive services and DM. Although the tool has a common log-in page, each Service has a unique name and home page for its application — the Army Population Health Information Connection, the Navy Population Health Navigator, and the Air Force Population Health Portal.

This tool provides patient demographic information and identifies patients requiring clinical preventive services, including but not limited to:

- Cancer screening
  - Breast cancer
  - Cervical cancer
  - Colon cancer
- Chlamydia screening
- High cardiovascular risk
- Lipid risk

By generating provider-level action lists of patients, the Portal enables risk stratification and targeting of provision of services to the enrolled population. The ability of the Portal to identify individuals who are considered "high utilizers" directly supports MM activities and encourages collaboration between UM, CM, and DM.
The Portal also assists in the evaluation of the MM program by providing:

- Aggregate measures (e.g., HEDIS®) to assess the performance of a branch clinic or MTF.
- Action lists to enable other critical analyses at the patient, provider, clinic, or MTF level.

Health Assessment Review Tool — formerly Health Enrollment Assessment Review

The Health Assessment Review Tool (HART), formerly known as the Health Enrollment Assessment Review (HEAR), is a DoD automated health assessment tool. Information from the HART can be used to help establish prevalence of health risk behaviors and to set MM priorities accordingly. ▶ **CD-ROM Resource MMT-2** describes various aspects of the tool, and ▶ **CD-ROM Resource MMT-3** records the change from HEAR to HART per the Assistant Secretary of Defense for Health Affairs (ASD [HA]) in 2005.

MHS Insight

MHS Insight is an exceptionally powerful yet easy-to-use MHS performance management tool to support the periodic review of performance measures to actively manage business, operational, and clinical activities from the ASD (HA); the TMA; and the Army, Navy, and Air Force medical departments (including local MTFs, intermediate Commands, and headquarters). This Web-based solution improves the ability of the MHS to set, monitor, and achieve strategic performance goals; and to quickly and accurately communicate performance information to all levels of the MHS. Contact your supervisor or department head for more information.

Prospective Payment System

The Prospective Payment System (PPS) is a modular, performance-based budgeting system that facilitates the ability of the MHS to provide incentives and financial rewards for efficient management. Each module of the application is designed to leverage information technology that has already been built by the Services as part of their business planning.

Protected Health Information Management Tool

The Protected Health Information Management Tool (PHIMT) is a Web-based application that assists in complying with the HIPAA Privacy Disclosure Accounting requirement. It enables the MHS to simplify its compliance tasks and reduce associated costs through the use of sophisticated HIPAA process automation features and centralized data management.

Information on the PHIMT is available through the TRICARE website at http://www.trow.tma.osd.mil/TMAPrivacy/hipaa/hipaacompliance/tools-training/PHIMT.htm.

To obtain access to the tool, contact EIDS@mhs-helpdesk.com.

SERVICE-LEVEL INFORMATION SYSTEMS

The Army, Navy, and Air Force have developed Service-specific websites that provide measures supporting the Defense Health Program (DHP), as well as other measures of interest for MM. The tools described below allow Service-, regional-, and MTF-level views of their respective measures, to assist MM teams in extracting relevant measures to support their MTFs' MM and business plans.

- ***Army*** — The Army's Office of the Surgeon General (OTSG) maintains a dashboard of clinical and business measures on the Command Management System (CMS), and the Medical Operational Data System (MODS). MODS provides the Army Medical Department (AMEDD) with an integrated automation system supporting all phases of human resource life cycle management during both peacetime and mobilization. It provides Commanders, staff, and functional managers of AMEDD organizations with a real-time source of information on the qualifications, training, special pay, and readiness of AMEDD personnel. Measures are available from the MEDCOM level to the child Defense Medical Information System (DMIS)

level and are presented in a red-amber-green stoplight with contributing data available for download. Access to the site is restricted to those with a CAC: https://cms.mods.army.mil/.

- ***Navy*** — In direct support of Tri-Service business planning, and of the Navy's Performance-based Budget (PBB) and current MM policy, the Population Health Navigator (PHN) dashboard displays clinical quality performance data generated by the MHSPHP. In addition to the HEDIS-like performance measures, other clinical PBB measures are also displayed. The PHN dashboard design allows for benchmarking with Navy and external standards as well as for comparisons with children's healthcare clinics, Navy Medicine regions, or similar MTF types. Access is restricted to those with a CAC: http://www-nehc.med.navy.mil/Data_Statistics/Clinical_Epidemiology/pophealthnav.aspx.

- ***Air Force*** — The Air Force Medical Service (AFMS) offers the Surgeon General Executive Global Look (SG/EGL) and the SG/EGL Virtual Analyst, which provide performance measures for all Air Force MTFs. Each of the SG/EGL measures directly supports the objectives and initiatives of the Air Force SG and Major Command (MAJCOM) Surgeons General (SGs) for each MTF in the AFMS. The tool tracks measures such as:
  - Readiness (dental and individual readiness)
  - Quality HEDIS® measurements on cancer screenings, diabetic management, and childhood immunizations)
  - Efficiency (access and coding)
  - External customer service (delivery assessment)
  - Financials (business plan, prime containment).

A significant innovation is the "Push Report," a feature on the SG/EGL website that allows custom reports to be pushed directly to Air Force customers' email inboxes. These reports contain the same information as what is available on the EGL website, but the data are sent in an attachment so users receive updated information when the site is refreshed.

SG/EGL and Virtual Analyst have become the benchmarks of Web-based performance measurement improvement efforts within the AFMS. Access is granted through a ".mil" domain. A username and password are required to enable full navigation: https://www.egl.afms.mil and https://eglva.afms.mil.

BUSINESS PLANNING TOOLS

As discussed throughout this Guide, developing a clear and coherent business plan is a central function of today's MM programs (see also **Section I, Medical Management Essentials**).

Tri-Service Business Plans

Business plans consist of the following four primary sections:

1. Enrollment Forecasts
2. Inpatient Demand and Workload
3. Outpatient Demand
4. Workload and Manpower Requirements

In 2005, the MHS introduced an automated format for Tri-Service business plans. This format is:

- Focused on MTFs that are able to receive input and validation from MSMOs and TROs.
- Automated and standardized with easy, on-screen access guidance.
- Mapped to HA and Service-level measures.
- Comprised of measures that relate to critical initiatives approved by all Services (modes of execution may vary).

Fig. 39 is a sample MTF enrollment template. The template is stratified by patient (i.e., beneficiary) categories, gender, and age. The demographics of the enrolled population can be an indicator of future demand.

Fig. 40 is a sample MTF inpatient demand and workload template, which forecasts total relative weighted products (RWPs) by major diagnostic categories (MDC) and is stratified by treatment locations. Normative demand (third column) indicates the expected RWP workload based on the MTF's enrolled population. The data under the Enrollee columns show the MTF's actual workload for care provided in house, in other MTFs, and in the network.

Fig. 41 is a sample MTF outpatient demand and workload template, which forecasts total relative value units (RVUs) by Service and product lines, stratified by treatment locations.

The final section of the business plan is the manpower template (Fig. 42).

The manpower template displays historical full-time equivalents (FTEs) by source (i.e., contract staff,

Enrollment

DMISID

	Enrollees			Plan				Enrollees			Plan				Enrollees			Plan			
Bencat	Gender	Age Group	History	FY03	FY04	FY05	Bencat	Gender	Age Group	History	FY03	FY04	FY05	Bencat	Gender	Age Group	History	FY03	FY04	FY05
AD	M		0				ADFM	M	0 to 4	6,484	6,330	6,347	6,348	Ret/Others	M	0 to 4	129	122	113	109
			0						5 to 14	8,799	9,022	8,969	8,996			5 to 14	737	756	728	701
		15 to 17	17	17	17	18			15 to 17	1,348	1,346	1,337	1,317			15 to 17	417	450	448	443
		18 to 24	13,377	16,416	16,506	16,496			18 to 24	958	983	983	979			18 to 24	520	630	634	633
		25 to 34	13,589	15,196	15,170	15,115			25 to 34	407	410	408	401			25 to 34	84	84	85	89
		35 to 44	6,816	8,017	7,929	7,815			35 to 44	273	242	244	245			35 to 44	787	752	694	648
		45 to 64	772	1,001	926	874			45 to 64	107	107	104	99			45 to 64	2,870	3,290	3,402	3,512
									65+	0	0	0	0			65+	0	0	0	0
	F							F	0 to 4	6,199	6,019	6,023	6,058		F	0 to 4	104	108	104	101
									5 to 14	8,630	8,759	8,763	8,804			5 to 14	711	708	678	656
		15 to 17	5	1	2	4			15 to 17	1,410	1,428	1,420	1,406			15 to 17	414	457	446	429
		18 to 24	2,002	2,393	2,384	2,377			18 to 24	5,767	5,507	5,531	5,540			18 to 24	586	659	663	663
		25 to 34	1,869	2,216	2,167	2,111			25 to 34	9,675	9,123	9,172	9,135			25 to 34	203	208	202	198
		35 to 44	682	892	843	799			35 to 44	4,843	4,859	4,833	4,815			35 to 44	1,070	1,057	1,000	944
		45 to 64	87	121	113	107			45 to 64	935	928	930	918			45 to 64	3,015	3,469	3,551	3,624
			0						65+	0						65+	0	0	0	0
		Total	39,215	46,270	46,057	45,716			Total	55,835	55,063	55,063	55,063			Total	11,649	12,750	12,750	12,750
Empanelled TRICARE Plus			4,188	4,188	4,188	4,188		Enrollees													
								Plan													
								Histor	FY03	Chang	FY04	Chang	FY05	Change							
					All Bencats			106,700	114,083	7,383	113,870	(212)	113,530	(341)							

Fig. 39 – Sample MTF Enrollment Template

Health Care Plan												
				DMISID	=							
		DOD										
History		Normative	Enrollee				Care for Othe	Space-A	Space-A	Plus Care	TFL Care	Total
		Demand	Demand	In-house	Other DC	Purchase	Enrollees	AD	Non-AD	<65	(65+)	In-house
RWPs	OB - 14	1,516	1,418	1,286	27	106	291	31	116	0	0	1,725
	GYN - 13	304	245	160	30	56	52	3	16	0	11	243
	Newborn - 1	771	700	57	0	643	22	0	929	0	0	1,008
	Respiratory	410	385	221	20	143	93	21	90	0	206	632
	Ortho - 8	690	792	488	144	159	138	163	42	0	111	942
	Mental Healt	146	119	93	11	16	23	38	6	0	10	170
	Digestive - 6	548	429	307	45	77	122	38	77	0	138	682
	Circulatory -	630	470	131	43	297	44	12	66	0	249	502
	Nervous - 1	375	313	106	33	174	39	17	30	0	41	232
	ENT -3	144	266	217	15	34	49	111	13	0	9	400
	Other	1,245	1,169	770	104	295	273	98	160	0	236	1,537
	Total	6,780	6,307	3,836	472	1,998	1,147	533	1,546	0	1,011	8,074
FY03		Normative	Enrollee				Care for Othe	Space-A	Space-A	Plus Care	TFL Care	Total
		Demand	Demand	In-house	Other DC	Purchase	Enrollees	AD	Non-AD	<65	(65+)	In-house
RWPs	OB - 14	1,500	1,433	1,298	27	107	294	32	118	0	0	1,742
	GYN - 13	310	248	162	30	56	53	3	16	0	12	245
	Newborn - 1	751	707	58	0	650	22	0	938	0	0	1,018
	Respiratory	429	389	224	20	145	94	21	91	0	208	638
	Ortho - 8	762	800	493	146	161	139	164	43	0	112	952
	Mental Healt	162	120	94	11	16	23	39	6	0	10	172
	Digestive - 6	583	433	310	46	77	123	39	78	0	139	689
	Circulatory -	675	475	132	44	300	45	13	66	0	252	507
	Nervous - 1	398	316	107	34	175	39	17	30	0	41	235
	ENT -3	159	269	220	15	34	50	112	14	0	9	404
	Other	1,313	1,180	778	105	298	276	99	162	0	238	1,552
	Total	7,041	6,370	3,875	477	2,018	1,158	538	1,561	0	1,021	8,154

Fig. 40 – Sample MTF Inpatient Demand and Workload Template

Health Care Plan												
				DMISID								
History		Normative	Enrollee				Care for Other	Space-A	Space-A	Plus Care	TFL Care	Total
		Demand	Demand	In-house	Other DC	Purchase	Enrollees	AD	Non-AD	<65	(65+)	In-house
RVUs	Primary Care	289,511	245,260	222,874	13,029	9,357	17,940	20,051	21,329	62	15,679	297,936
	Emergency	48,441	38,175	28,417	2,774	6,984	9,360	6,166	7,139	10	3,448	54,541
	Mental Health/Social Work	129,359	164,550	113,233	6,047	45,270	11,954	24,351	4,575	4	1,451	155,567
	Ortho/Phys Ther	102,590	92,021	79,117	7,201	5,703	15,339	15,092	7,142	0	4,317	121,007
	Internal Med Sub	3,746	40,118	29,579	2,521	8,018	9,154	2,966	3,188	4	7,652	52,543
	Surgery	13,369	23,109	17,481	1,627	4,000	5,623	1,741	1,825	28	3,774	30,473
	Surgery Sub	12,632	10,665	6,876	1,233	2,556	2,124	532	975	26	2,466	12,999
	Ophthalmology/Optometry	54,875	61,801	43,847	3,011	14,943	9,579	9,963	1,815	5	4,652	69,860
	OB/GYN	67,563	59,890	52,759	2,364	4,767	13,821	1,300	4,803	2	480	73,166
	ENT	14,005	12,788	6,929	366	5,493	1,647	559	441	0	483	10,059
	Dermatology	8,834	6,888	5,271	334	1,283	1,470	482	383	0	375	7,981
	Facility	28,749	21,206	0	0	21,206	0	0	0	0	0	0
	Radiology	5,204	2,425	0	0	2,425	0	0	0	0	0	0
	Anesthesiology	1,220	790	0	0	790	0	0	0	0	0	0
	Pathology	1,516	599	0	0	599	0	0	0	0	0	0
	Home Health Care	755	657	0	0	657	0	0	0	0	0	0
	Other	27,253	34,694	27,925	2,781	3,988	7,860	6,667	1,826	1	2,679	46,958
	Total	809,622	815,636	634,308	43,289	138,038	105,871	89,872	55,440	142	47,457	933,090
Plan		Normative	Enrollee				Care for Other	Space-A	Space-A	Plus Care	TFL Care	Total
FY03		Demand	Demand	In-house	Other DC	Purchase	Enrollees	AD	Non-AD	<65	(65+)	In-house
RVUs	Primary Care	305,521	250,165	227,332	13,289	9,544	18,299	20,452	21,756	63	15,993	303,894
	Emergency	50,307	38,939	28,985	2,830	7,124	9,548	6,290	7,282	10	3,517	55,632
	Mental Health/Social Work	140,238	167,841	115,497	6,168	46,176	12,193	24,838	4,666	4	1,480	158,679
	Ortho/Phys Ther	114,296	93,861	80,699	7,345	5,817	15,646	15,394	7,285	0	4,404	123,427
	Internal Med Sub	4,133	40,921	30,170	2,572	8,179	9,337	3,025	3,252	4	7,805	53,594
	Surgery	14,244	23,571	17,831	1,660	4,080	5,735	1,776	1,862	29	3,850	31,083
	Surgery Sub	13,553	10,878	7,013	1,258	2,607	2,166	543	995	26	2,515	13,259
	Ophthalmology/Optometry	60,085	63,037	44,724	3,071	15,242	9,770	10,162	1,852	5	4,745	71,258
	OB/GYN	68,052	61,088	53,814	2,411	4,863	14,097	1,326	4,899	2	490	74,629
	ENT	14,833	13,044	7,068	374	5,603	1,680	571	450	0	492	10,260
	Dermatology	9,478	7,026	5,377	341	1,308	1,500	492	390	0	382	8,141
	Facility	30,275	21,630	0	0	21,630	0	0	0	0	0	0
	Radiology	5,538	2,474	0	0	2,474	0	0	0	0	0	0
	Anesthesiology	1,310	805	0	0	805	0	0	0	0	0	0
	Pathology	1,500	611	0	0	611	0	0	0	0	0	0
	Home Health Care	782	670	0	0	670	0	0	0	0	0	0
	Other	29,495	35,388	28,484	2,836	4,068	8,017	6,800	1,862	1	2,733	47,897
	Total	863,638	831,948	646,994	44,155	140,799	107,988	91,670	56,549	144	48,407	951,752

Fig. 41 – Sample MTF Outpatient Demand and Workload Template

Manpower Plan									
					DMISID				
History		Assigned FTEs	Available Contract FTEs	Available Mil/Civ FTEs	Available Other FTEs	Borrowed Military	Borrowed Other	Loaned Military	Loaned Other
Inpatient	General Surgeon	0	1	8	0	2	0		
	Surgery Sub-specialists	0	0	6	0	1	0		
	Internists	0	0	2	0	0	0		
	Family Practice	0	0	2	0	0	0		
	Radiologists	0	0	0	0	0	0		
	Anesthesiologists	0	0	0	0	0	0		
	Nurse Anesthetists	0	0	0	0	0	0		
	Residents/Interns	0	0	1	0	0	0		
	Other Providers	0	3	9	0	0	0		
	Nurses	86	19	75	0	4	0		
	Other Nonproviders	72	16	68	0	12	0		
	Total	158	41	170	0	19	0		
Outpatient	Providers								
	Primary Care								
	Physicians	44	19	28	0	10	0		
	NP/PA	23	3	19	0	11	0		
	Other Prof	2	5	2	0	0	0		
	Residents/Interns	5	0	17	0	0	0		
	Emergency	19	5	9	0	0	0		
	Mental Health/Social Work	16	1	17	0	1	0		
	Ortho/Phys Ther	27	5	20	0	4	0		
	Internal Med Sub	13	1	9	0	1	0		
	Surgery	11	1	4	0	2	0		
	Surgery Sub	2	0	2	0	1	0		
	Ophthamology/Optometry	10	2	7	0	2	0		
	OB/GYN	20	2	15	0	1	0		
	ENT	2	0	2	0	0	0		
	Derm	2	1	1	0	0	0		
	Other	21	0	16	0	0	0		
	Support Staff	343	73	284	0	43	5		
	Total	558	119	452	0	77	5		
Other	Providers								
	Radiologist	10	1	9	0	0	0	0	0
	Anesthesiologists	4	3	4	0	0	0	0	0
	All Other Providers	197	29	190	0	28	0	2	0
	NonProviders	1,155	320	1,091	0	204	25	1	1
	Total	1,366	353	1,293	0	232	25	3	1
Total	Providers	426	84	398	0	64	0	2	0
	NonProviders	1,655	429	1,518	0	264	29	1	1
	Total	2,082	512	1,915	0	328	30	3	1

Fig. 42 – Sample MTF Manpower Template

civilian, and military personnel). It also documents whether personnel are borrowed or loaned out to other facilities. The number of FTEs should correlate to productivity measures.

▶ **CD-ROM Resource MMT-4** shows a screenshot of a Tri-Service business planning tool from the Army. ▶ **CD-ROM Resource MMT-5** offers a TRICARE conference presentation on business planning.

Tri-Service business plans should also offer MTFs the opportunity to validate historical clinical information regarding elements such as eligibility, enrollment, outpatient/inpatient workload, and outpatient/inpatient utilization.

CD-ROM RESOURCES

MMT-1 AHLTA Step-by-Step Instructions

MMT-2 Assistant Secretary of Defense for Health Affairs Memorandum, Policy for TRICARE Health Enrollment Assessment Review (HEAR) Survey (Oct. 11, 1996)

MMT-3 Assistant Secretary of Defense for Health Affairs Memorandum, Policy Memorandum for Name Change of the DoD Automated Health Assessment Tool from HEAR to HART (Oct. 28, 2005)

MMT-4 Tri-Service Business Planning Tool Screenshot (Army)

MMT-5 MHS Business Planning, TRICARE Conference (Jan. 26, 2005)

APPENDICES


TRICARE
Department of Defense
DEPARTMENT OF DEFENSE
UNITED STATES OF AMERICA

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CD-ROM RESOURCES

AppendixA-Ref1 TMA Medical Management Guide References

Appendix B – Acronyms

A&D	Admissions and Disposition
AAAHC	Accreditation Association for Ambulatory Health Care
AC	Active Component
ADAMHA	Alcohol, Drug Abuse, and Mental Health Administration
ADFM	Active Duty Family Member
ADL	Activity of Daily Living
ADM	Ambulatory Data Module (formerly Ambulatory Data System [ADS])
ADME	Active Duty Military Extension
ADSM	Active Duty Service Member
AE	Aeromedical Evacuation
AFHSC	Armed Forces Health Surveillance Center
AFI	Air Force Instruction
AFPD	Air Force Policy Directive
AFPHSD	Air Force Population Health Support Division
AHLTA	Armed Forces Health Longitudinal Technology Application (formerly CHCS II)
AHRQ	Agency for Healthcare Research and Quality
AIM	Access Improvement Model (Air Force)
ALC	Assignment Limitation Code
ALOS	Average Length of Stay
AMEDD	Army Medical Department
ANG	Air National Guard
APHIC	Army Population Health Information Connection
AR	Army Regulation
ARMP	Anesthesia Report and Monitoring Panel
ARNG	Army National Guard
ASAM	American Society of Addiction Medicine
ASD (HA)	Assistant Secretary of Defense (Health Affairs)
BCAC	Beneficiary Counseling and Assistance Coordinator
BLS	Basic Life Support
BUMED	Bureau of Medicine and Surgery (Navy)
CBHCO	Community-Based Healthcare Organization
CCE	Coding Compliance Editor
CCM	Certified Case Manager
CCP	Chronic Care Professional
CCTP	Custodial Care Transitional Policy
CDC	Centers for Disease Control and Prevention
CDIS	Care Detail Information System
CDM	Clinical Data Mart
CDR	Clinical Data Repository
CDW	Clinical Data Warehouse
CHCC	Cooperative Health Care Clinic

CHCS	Composite Health Care System
CM	Case Management
CMAC	Champus Maximum Allowable Charge
CMG	Clinical Management Group
CMI	Case Mix Index
CMIS	CHAMPUS/TRICARE Medical Information System
CMS	Centers for Medicare & Medicaid Services
CMSA	Case Management Society of America
COE	Center of Excellence
CONUS	Continental United States
COR	Contracting Officer's Representative
COTR	Contracting Officer's Technical Representative
CPG	Clinical Practice Guideline
CPT	Current Procedural Terminology
CQI	Clinical Quality Improvement/ Continuous Quality Improvement
CTP	Comprehensive Transition Plan
CURES	CHAMPUS/TRICARE Utilization Reporting and Evaluation System
DA	Department of the Army
DCAO	Debt Collector Assistance Officer
DCS	Direct Care System
DEERS	Defense Enrollment Eligibility Reporting System
DES	Disability Evaluation System
DHIMS	Defense Health Information Management System
DHSS	Defense Health Services Systems
DIGMAS	Drop-in Group Medical Appointments
DM	Disease Management
DMAA	Disease Management Association of America: The Care Continuum Alliance
DME	Durable Medical Equipment
DMED	Defense Medical Epidemiology Database
DMIS	Defense Military Identification System
DMSS	Defense Medical Surveillance System
DoD	Department of Defense
DQ	Data Quality
DRG	Diagnosis Related Group
EASIV	Expense Assignment System, Version IV
ECHO	Extended Care Health Option
ED	Emergency Department
EFMP	Exceptional Family Member Program
EGL	Executive Global Look (formerly Privilege, Pleasure, Relevant, Reasonable [P2R2])
E/M	Evaluation and Management
EOC	Episode of Care
FHI	Family Health Initiative
FIRP	Federal Individual Recovery Plan
FRC	Federal Recovery Coordinator
FTE	Full-time Equivalent
FY	Fiscal Year
GPM	Group Practice Manager
GWOT	Global War on Terrorism (see also Overseas Contingency Operations – OCO)
HA	Health Affairs
HART	Health Assessment Reporting Tool (formerly Health Enrollment Assessment Review [HEAR])

HAWC	Health and Wellness Center
HBA	Health Benefits Advisor
HCI	Health Care Integrator
HCIL	Healthcare Information Line
HCPCS	Healthcare Common Procedure Coding System
HCSR	Healthcare Service Record
HEDIS®	Healthcare Effectiveness Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act (of 1996)
HSI	HealthSciences Institute
HSS	Health Service Support
HSSC	Health Service and Support Contractor
ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification
ICDB	Integrated Clinical Database
IOP	Improving Organizational Performance
JPTA	Joint Patient Tracking Application
JTF	Joint Task Force
LCSW	Licensed Clinical Social Worker
LIMDU	Limited Duty
LOD	Line of Duty
LOS	Length of Stay
M2	MHS Management Analysis and Reporting Tool
MAJCOM	Major Command (Air Force)
MCFAS	Managed Care Forecasting and Analysis System
MCSC	Managed Care Support Contractor
MDC	Major Diagnostic Category
MDR	MHS Data Repository
MEB	Medical Evaluation Board
MEDCEN	Medical Center
MEDCOM	Medical Command (Army)
MEDDAC	Medical Department Activity (Army)
MEPRS	Military Expense and Performance Reporting System
MEQS	MEPRS Executive Query Summary
MEWACS	MEPRS Early Warning and Control System
MHO	Medical Holdover
MHS	Military Health System
MHS CQM	Military Health System Clinical Quality Management
MHSPHP	Military Health System Population Health Portal
MM	Medical Management
MMIG	MEPRS Management Improvement Group
MMSO	Military Medical Support Office
MRP/MRP2	Medical Retention Processing
MSA	Medical Savings Account
MSIP	Modeling and Simulation (M&S) Investment Plan
MSMO	Multi-Service Market Office
MSMP	Modeling and Simulation (M&S) Master Plan
MSW	Master of Social Work
MTF	Military Treatment Facility
NAS	Non-availability Statement
NATO	North Atlantic Treaty Organization
NCM	Nurse Case Manager
NCQA	National Committee for Quality Assurance
NDAA	National Defense Authorization Act
NED	National Enrollment Database
NMCPHC	Navy and Marine Corps Public Health Center
NGC	National Guideline Clearinghouse™
NAVMISSA	Navy Medical Informatic Systems Support Activity

NMOP	National Mail Order Pharmacy
NPIC	National Perinatal Information Center
NQF	National Quality Forum
NQMC	National Quality Measures Clearinghouse™/National Quality Monitoring Contractor
NRD	National Resource Directory
NSQIP	National Surgical Quality Improvement Program
OCMO	Office of the Chief Medical Officer
OCO	Overseas Contingency Operations (see also Global War on Terrorism – GWOT)
OCONUS	Outside of the Continental United States
ODPHP	Office of Disease Prevention and Health Promotion
OEF	Operation Enduring Freedom
OHI	Other Health Insurance
OIF	Operation Iraqi Freedom
OIG	Office of the Inspector General
OSHA	Occupational Safety Health Act
P4P	Pay for Performance
PASBA	Patient Administration Systems and Biostatistical Activity
PBAM	Performance-based Adjustment Model (Army)
PBB	Performance-based Budget
PCE	Primary Care Element
PCM	Primary Care Manager
PCO	Primary Care Optimization
PCP	Primary Care Provider
PCS	Purchased Care System
PDCA	Plan, Do, Check, Act
PDES	Physical Disability Evaluation System
PDHRA	Post Deployment Health Risk Assessment
PDTS	Pharmacy Data Transaction Service
PEB	Physical Evaluation Board
PEBLO	Physical Evaluation Board Liaison Officer
PEC	Pharmacoeconomic Center
PHA	Periodic Health Assessment
PHI	Protected Health Information
PHMMD	Population Health and Medical Management Division
PHN	Population Health Navigator
PII	Personal Identifying Information
PKC	Problem Knowledge Couplers
PPS	Prospective Payment System
QA	Quality Assurance
QM	Quality Management
RAP	Recruitment Assessment Program
RC	Reserve Component
RCC	Recovery Care Coordinator
RCP	Recovery Coordination Program
REFRAD	Released from Active Duty
REFRADT	Released from Active Duty for Training
RITPO	Resource Information Technology Program Office
RM	Referral Management
RMC	Referral Management Center
ROFR	Right of First Refusal
ROI	Return on Investment
RVU	Relative Value Unit
RWP	Relative Weighted Product
SADR	Standard Ambulatory Data Record
SECNAV	Secretary of the Navy
SG	Surgeon General
SIDR	Standard Inpatient Data Record
SJA	Staff Judge Advocate

SME	Subject Matter Expert
SNIAC	Special Needs Identification and Assignment Coordination (formerly USAF EFMP)
SSDI	Social Security Disability Index
SSI	Supplemental Security Income
SWII	Severely Wounded, Ill, and Injured
TAMP	Transitional Assistance Medical Program
TDY	Temporary Duty
TJC	The Joint Commission
TLD	Temporary Limited Duty
TMA	TRICARE Management Activity
TMA-RT	TMA Reporting Tools
TMIP	Theater Medical Information Program
TOA	Theater of Operations
TOC	TRICARE Operations Center
TOL	TRICARE Online
TPC	Third Party Collection
TPL	Third Party Liability
TPR	TRICARE Prime Remote
TSC	TRICARE Service Center
TRO	TRICARE Regional Office
UBU	Unified Biostatistical Utility
UBO	Uniform Business Office
UFR	Unfunded Request
UM	Utilization Management
UR	Utilization Review
URAC	Utilization Review Accreditation Commission
USA	United States Army
USACHPPM	U. S. Army Center for Health Promotion and Preventive Medicine
USAF	United States Air Force
USAFR	United States Air Force Reserve
USAR	United States Army Reserve
USCG	United States Coast Guard
USMC	United States Marine Corps
USN	United States Navy
USNR	United States Navy Reserve
USPSTF	United States Preventive Services Task Force
VA	Department of Veterans Affairs
VBA	Veterans Benefits Administration
VHA	Veterans Health Administration
WII	Wounded, Ill, and Injured
WT	Warrior Transition
WTB	Warrior Transition Battalion
WTU	Warrior Transition Unit (Army)
WISDOM	Working Information Systems to Determine Optimal Management
WWR	Wounded Warrior Regiment
WWWR	World Wide Workload Reports

CD-ROM RESOURCES

AppendixC-Def2	TRICARE Operations Manual 6010.51-M, Appendix A, Acronyms and Definitions

Appendix C - Definitions

Absent Sick

An Active Duty (Army, Navy, Air Force, and Marine Corps) member hospitalized in other than a U.S. Military Treatment Facility and for whom administrative responsibility has been assigned to an MTF. Includes "absent sick moved to an MTF" and "total absent sick."

Resources:

DoD Manual 6015.1-M, Glossary of Healthcare Terminology (January 1999): http://www.dtic.mil/whs/directives/corres/pdf/601501m.pdf.

See **CD-ROM Resource AppendixC-Def1**

Accreditation

A formal process by which an agency or organization evaluates and recognizes an institution or program of study as meeting certain predetermined criteria or standards.

Resources:

DoD Manual 6015.1-M, Glossary of Healthcare Terminology (January 1999): http://www.dtic.mil/whs/directives/corres/pdf/601501m.pdf.

See **CD-ROM Resource AppendixC-Def1**

Appeals

An administrative review of program determinations made under the provisions of law and regulation. An appeal cannot challenge the propriety, equity, or legality of any provision of law or regulation.

Resources:

Code of Federal Regulations (CFR), Title 32 — National Defense, Section 199, Part 10 (199.10): Appeal and hearing procedures: http://www.tricare.mil/FR05/C10.PDF.

Benchmark/Benchmarking

Benchmark: A TRICARE clerical and automated systems test using claims and other documents created or approved by TMA and processed by the contractor. The contractor's output is compared to predetermined results prepared or approved by TMA to determine the accuracy, completeness, and operational characteristics

of the contractor's clerical and automated systems components. The purpose of the benchmark is to identify clerical and automated systems deficiencies which must be corrected before claims can be processed in accordance with TMA requirements. The comprehensiveness of the benchmark will vary depending on the number and type of conditions tested.

Benchmarking:

- The practice of comparing outcomes against local, Service, or national industry standards. Benchmarking allows for the identification of areas for improvement and goal-setting as well as recognition of best practices.
- The comparison of like provider's performance. It is a standard from which to establish what "quality" medical care is and to develop measurements from which to evaluate providers and patient outcomes.

Resources:

TRICARE Operations Manual 6010.51-M, Appendix A, Acronyms and Definitions (Aug. 1, 2002): http://www.tricare.mil/to02/APPA.PDF.

See **CD-ROM Resource AppendixC-Def2**

DoD Manual 6015.1-M, Glossary of Healthcare Terminology (January 1999): http://www.dtic.mil/whs/directives/corres/pdf/601501m.pdf.

See **CD-ROM Resource AppendixC-Def1**

General definition as provided in **Section IV, Disease Management**

Care Coordination

A comprehensive method of client assessment by Registered Nurses, designed to identify client vulnerability, needs identification, and client goals which results in the development plan of action to produce an outcome that is desirous for the client. The goal is to provide client advocacy, a system for coordinating client services, and providing a systematic approach for evaluation of the effectiveness of the client's Life Plan.

Resources:

TRICARE Operations Manual 6010.51-M, Appendix A, Acronyms and Definitions (Aug. 1, 2002): http://www.tricare.mil/to02/APPA.PDF.

See **CD-ROM Resource AppendixC-Def2**

Case Management (CM)

- 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.
- A collaborative process *under the population health continuum* which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes.

- A method of managing the provision of health care to members with catastrophic or high cost medical conditions. The goal is to coordinate the care so as to both improve continuity and quality of care as well as lower costs. This generally is a dedicated function in the utilization management department.

Resources:

Case Management Society of America www.cmsa.org

DoDI 6025.20, Medical Management Programs in the Direct Care System (DCS) and Remote Areas: http://www.dtic.mil/whs/directives/corres/pdf/602520p.pdf.

See **CD-ROM Resource MME-1**

Code of Federal Regulations (CFR), Title 32 — National Defense, Section 199. Part 2 (199.2): http://www.tricare.mil/CFR/C2.PDF. See **CD-ROM Resource AppendixC-Def3**

Case Mix

Categories of patients, classified by disease, procedure, method of payment, or other characteristics, in an institution at any given time, usually measured by counting or aggregating groups of patients sharing one or more characteristics.

Resources:

DoD Manual 6015.1-M, Glossary of Healthcare Terminology (January 1999): http://www.dtic.mil/whs/directives/corres/pdf/601501m.pdf

See **CD-ROM Resource AppendixC-Def1**

Certification

The process by which a governmental or non-governmental Agency or association evaluates and recognizes a person who meets predetermined standards; it is sometimes used with reference to materials or services. "Certification" is usually applied to individuals and "accreditation" to institutions.

Resources:

DoD Manual 6015.1-M, Glossary of Healthcare Terminology (January 1999): http://www.dtic.mil/whs/directives/corres/pdf/601501m.pdf See **CD-ROM Resource AppendixC-Def1**

Clinical Pathways/ Protocols

Tools that delineate the optimal sequencing and timing of interventions by providers for a particular diagnosis or procedure designed to minimize delays and resource utilization and maximize quality of care. They often have a role in the clinical setting, in both the inpatient and outpatient arenas. Although they may be evidence-based, these protocols are distinguished from clinical practice guidelines (CPGs) in that they do not have the full complement of additional resources to support them.

Resources:

Open Clinical: http://www.openclinical.org/clinicalpathways.html

Clinical Practice Guidelines (CPGs)

Systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances (Institute of Medicine, 1990). CPGs define the role of specific diagnostic and treatment modalities in the diagnosis and management of patients. The statements contain recommendations based on evidence from a rigorous systematic review and synthesis of the published medical literature.

Resources:

Department of Health & Human Services (HHS), National Heart Lung and Blood Institute (NHLBI): http://www.nhlbi.nih.gov/guidelines/about.htm.

Department of Veterans Affairs (VA): http://www.healthquality.va.gov/index.asp.

National Guideline Clearinghouse (NGC): http://www.guideline.gov/index.aspx.

U.S. Army Quality Management Office (QMO): https://www.qmo.amedd.army.mil/pguide.htm.

Code of Federal Regulations (CFR)

The codification of the general and permanent rules published in the *Federal Register* by the executive departments and agencies of the federal government. It is divided into 50 titles that represent broad areas subject to federal regulation. Each volume of the CFR is updated once each calendar year and is issued on a quarterly basis.

Resources: Government Printing Office: http://www.gpoaccess.gov/CFR/.

Convalescent Leave

An authorized leave status, not chargeable to the individual, granted to active duty Uniformed Service members while under medical or dental care that is part of the care and treatment prescribed for a member's recuperation or convalescence. Convalescent leave days are not counted as occupied bed days but are counted as sick days when the convalescent leave occurs before the disposition of the patient. Convalescent leave occurring after disposition of the patient while en route to a new command or convalescent leave granted by a line commander after patient discharge from the hospital is not counted as occupied bed days or sick days.

Resources: DoD Manual 6015.1-M, Glossary of Healthcare Terminology (January 1999): http://www.dtic.mil/whs/directives/corres/pdf/601501m.pdf. See **CD-ROM Resource AppendixC-Def 1**

Cooperative Health Care Clinic (CHCC)

In cooperative health care clinics (CHCC), health care is provided to older patients in a group setting. The CHCC concept, which was developed under a research grant by Kaiser Permanente in Colorado in 1991, showed improvement in patient and provider satisfaction, as well as improved quality of care and cost effectiveness.

Resources:

Scott, J., Gade, G., McKenzie, M., Venohr, I. Cooperative health care clinics: a group approach to individual care. *Geriatrics*, May 1998, 53(5):68-70, 76-8, 81. National Center for Biotechnology Information (NCBI): http://www.ncbi.nlm.nih.gov/pubmed/9597981?dopt=Abstract.

Cost-Benefit Analysis

The process of weighing the total expected costs vs. the total expected benefits of one or more actions in order to choose the most profitable option. This often involves monetary calculations of initial expense vs. expected return. It is usually done to decide whether to make a change or to determine how well, or how poorly, a planned action (e.g., implementation of a program) will turn out. Also known as "running the numbers."
A cost-benefit analysis finds, quantifies, and adds all the positive factors. These are the benefits. Then it identifies, quantifies, and subtracts all the negatives, the costs. The difference between the two indicates whether the planned action is advisable. The real trick to doing a cost benefit analysis well is making sure you include all the costs and all the benefits and properly quantify them.

Resources:

About Business Management: http://management.about.com/cs/money/a/CostBenefit.htm.

Covered Entity

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), any entity that is:

- A healthcare provider that conducts certain transactions in electronic form (called here a "covered healthcare provider").
- A healthcare clearinghouse.
- A health plan.

Resources:

Centers for Medicare & Medicaid Services (CMS): http://www.cms.hhs.gov/HIPAAGenInfo/06_AreYouaCoveredEntity.asp.

Current Procedural Terminology® (CPT)

A coding system that describes the procedures, services, or supplies provided to patients within the outpatient setting.
Current Procedural Terminology® (CPT), 4th Edition, is a listing of descriptive terms and identifying codes for reporting medical services and procedures. The purpose of CPT is to provide a uniform language that accurately describes medical, surgical, and diagnostic services, and thereby serves as an effective means for reliable nationwide communication among physicians, and other healthcare providers, patients, and third parties.

Resources:

American Medical Association (AMA):
http://www.ama-assn.org/ama/no-index/physician-resources/3882.shtml.

Custodial Care

The treatment or services, regardless of who recommends treatment or services or which such treatment or services are provided, that a) can be rendered safely and reasonably by a person who is not medically skilled or b) is/are designed mainly to help the patient with the activities of daily living.

Resources:

DoD Manual 6015.1-M, Glossary of Healthcare Terminology (January 1999): http://www.dtic.mil/whs/directives/corres/pdf/601501m.pdf

See **CD-ROM Resource AppendixC-Def 1**

Custodial Care Transition Policy, TRICARE: http://manuals.tricare.osd.mil/.

Demand Management

A collection of proactive interventions focused on reducing unnecessary healthcare utilization while simultaneously encouraging the appropriate use of healthcare resources.

Resources:

DoD Population Health Improvement Plan and Guide, p. 43 (December 2001): http://www.tricare.mil/ocmo/download/mhs_phi_guide.pdf.

See **CD-ROM Resource ES-1**

Diagnosis-Related Group (DRG)

A patient classification system that relates demographic, diagnostic, and therapeutic characteristics of patients to length of inpatient stay and amount of resources consumed. It provides a framework for specifying hospital case mix and identifies classifications of illness and injury for which payment is made under prospective pricing programs.

Resources:

DoD Manual 6015.1-M, Glossary of Healthcare Terminology (January 1999): http://www.dtic.mil/whs/directives/corres/pdf/601501m.pdf.

See **CD-ROM Resource AppendixC-Def 1**

Disability Evaluation System (DES)

The purpose of the DES is to maintain a fit and vital force. According to DoD regulations, the DES should include a Medical Evaluation Board (MEB), a Physical Evaluation Board (PEB), an appellate review process, and a final disposition. Service members should be assigned a Physical Evaluation Board Liaison Officer (PEBLO) to help them navigate the system.

Resources:

Deployment Health Clinical Center: http://www.pdhealth.mil/hss/des.asp.

See **Section III, Case Management**

Discharge Planning

The development of an individualized discharge plan for the patient prior to leaving an institution for home, with the aim of improving patient outcomes, reducing the chance of unplanned readmission to an institution, and containing costs.

Resources:

TRICARE Operations Manual 6010.51-M, Appendix A, Acronyms and Definitions (Aug. 1, 2002): http://www.tricare.mil/to02/APPA.PDF.

See **AppendixC-Def2**

Disease Management (DM)

- A system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant.
- An organized effort to achieve desired health outcomes in populations with prevalent, often chronic diseases, for which care practices may be subject to considerable variation.

An organized effort to achieve desired health outcomes in populations with prevalent, often chronic diseases, for which care practices may be subject to considerable variation. DM programs manage populations and use interventions that are evidence-based. The term "condition management" is also used to include non-disease states, such as pregnancy.

Resources:

Disease Management Association of America (DMAA): The Care Continuum Alliance: http://www.dmaa.org/dm_definition.asp.

DoDI 6025.20, Medical Management (MM) Programs in the Direct Care System (DCS) and Remote Areas: http://www.tricare.mil/ocmo/download/mhs_phi_guide.pdf.

Kongstvedt, P.R. Essentials of Managed Health Care, 5th ed. Jones and Bartlett Publishers, 2007.

DoD Population Health Improvement Plan and Guide, p. 43. December 2001: http://www.tricare.mil/ocmo/download/mhs_phi_guide.pdf.

Exceptional Family Member Program (EFMP)

See also Military OneSource

The Military Services use the term Exceptional Family Member Program (EFMP) to refer to two different functions: a personnel function and a family support function. The EFMP family support function is not mandatory. DoD policy allows, but does not require, the Services to offer family support services to EFMs within their family support systems.

In the Army and Marine Corps, EFM support staff are called EFMP Managers (Army) or EFMP Coordinators (Marine Corps).

In the Navy, the EFMP staff that support the personnel function may also provide family support services, but the Navy does not staff their family centers with EFMP Coordinators. In the Air Force, special needs staff are located in the Military Treatment Facility (MTF) only.

Resources:

DoDI 1342.22, Family Centers, Dec. 30, 1992: http://www.dtic.mil/whs/directives/corres/pdf/134222p.pdf.

Extended Care Health Option (ECHO)

See also Program for Persons with Disabilities (PFPWD)

A supplemental program to the basic TRICARE program. ECHO provides financial assistance for an integrated set of services and supplies to eligible active duty family members (including family members of activated National Guard or Reserve members). There is no enrollment fee for ECHO; however, family members must:

- Have an ECHO-qualifying condition.
- Enroll in the Exceptional Family Member Program (EFMP) as provided by the sponsor's Service Branch.
- Register in ECHO through ECHO case managers in each TRICARE region.

Resources:

Code of Federal Regulations (CFR), Title 32 — National Defense, Section 199, Part 5 (199.5): www.tricare.mil/cfr/C5.PDF.

See **CD-ROM Resource AppendixC-Def5**

TRICARE: www.tricare.mil/mybenefit/Download/Forms/ECHO_Flyer_v3_09_L.pdf.

Factual Determinations (nonmedical necessity)

Determinations issued in cases involving coverage issues, provider authorization (status) requests, hospice care, foreign claims, denials based on sections other than National Defense Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), Title 32, Section 199, Part 4 (199.4), and both medical necessity and factual determinations.

Resources:

TRICARE Operations Manual 6010.51-M, Chapter 13, Section 5, Appeal of Factual (Nonmedical Necessity) Determinations: http://www.tricare.mil/TO02/C13S5.pdf.

Code of Federal Regulations (CFR), Title 32 — National Defense, Section 199, Part 4 (199.4): www.tricare.mil/cfr/C4.PDF.

See **CD-ROM Resource AppendixC-Def4**

Federal Recovery Coordinator (FRC)

The DoD/VA federal Recovery Coordination Program (RCP) provides senior-level clinical nurses and social workers through the VA designated as Federal Recovery Coordinators (FRCs). These staff provide oversight of the recovery plan for catastrophically injured Service members. The FRC works with the Service member, his/her family, and the recovery team to develop a Federal Individual Recovery Plan (FIRP). The FRC continues to work with the Service member and his/her family throughout the recovery, rehabilitation, and transition process to meet their needs. The FRC remains available to the Service member and his/her family for life as long as they need.

Resources:

Department of Veterans Affairs (VA): http://www.oefoif.va.gov/.

Federal Individual Recovery Plan (FIRP)

See Federal Recovery Coordinator (FRC)

Resources:

Department of Veterans Affairs (VA): http://www.oefoif.va.gov/.

Global War on Terrorism (GWOT)/Overseas Contingency Operations (OCO)

Following the terrorists attacks of Sept. 11, 2001, the U.S. began military operations to combat terrorism both in the United States and overseas. Military operations to defend the United States against further attacks are known as Operation Noble Eagle. Ongoing military operations in Afghanistan and Iraq are known as Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), respectively. Together, these three military operations are identified as the Global War on Terrorism (GWOT).

In a memorandum from the Office of Management and Budget (OMB) in March 2009, which was forwarded to Pentagon staff members from the Defense Department's Office of Security Review, the Obama administration noted that it "prefers to avoid using the term 'Long War' or 'Global War on Terror' [GWOT]." It asked that the term "Overseas Contingency Operation" be used instead.

Resources:

Government Accountability Office (GAO) publication GAO-05-822, Global War on Terrorism — DoD Needs to Improve the Reliability of Cost Data and Provide Additional Guidance to Control Costs, p. 1: http://www.gao.gov/new.items/d05882.pdf.

U.S. Department of Defense, Officer of the Inspector General: http://www.dodig.mil/gwot_iraq/index.htm.

Wilson, S., Kamen, A. "Global War On Terror" Is Given New Name — Bush's Phrase Is Out, Pentagon Says. *The Washington Post*, March 25, 2009: http://www.washingtonpost.com/wp-dyn/content/article/2009/03/24/AR2009032402818.html.

Grievance

In the DCS, filing a grievance is the proper method for addressing beneficiary concerns (i.e., complaint) when there is a perceived inequity of the benefit, rather than a question of medical necessity.

Resources:

DoDD 6000.14, Patient Bill of Rights and Responsibilities in the Military Health System (July 30, 1998): http://www.dtic.mil/whs/directives/corres/pdf/600014p.pdf.

See also **Section II, Utilization Management**

Group Visit

A relatively new model in healthcare delivery where a number of patients meet on a prescribed basis in an expanded office visit that includes care delivery, education, socialization, and one-to-one physician-patient time, as needed. Group visits offer staff a new and more satisfying way to interact with patients that makes efficient use of resources, improves access, and uses group process to help motivate behavior change and

improve outcomes. The Group Visit Starter Kit describes the Cooperative Health Care Clinic (CHCC) model developed by the Kaiser Colorado staff. Group visits were pioneered with frail elderly patients who were high utilizers of primary care.

In this model, the healthcare team facilitates an interactive process of care delivery in a periodic group visit program. The team empowers the patient, who is supported by information and encouraged to make informed healthcare decisions. The group visit can be conceptualized as an extended doctor's office visit where not only physical and medical needs are met, but education, social, and psychological concerns can be dealt with effectively.

Resources:

Institute for Healthcare Improvement: http://www.ihi.org/IHI/Topics/ChronicConditions/AllConditions/Tools/GroupVisitStartKit.htm.

Improving Chronic Care:

- http://www.improvingchroniccare.org/downloads/groupvisitmodelcomparison.pdf
- http://www.improvingchroniccare.org/downloads/group_visit_starter_kit_copy1.doc

Health Promotion

Any combination of health information, education, diagnostic screening, and healthcare interventions designed to facilitate behavioral alterations that will improve or protect health. It includes those activities intended to influence and support individual lifestyle modification and self-care.

MHS population health initiatives often follow guidance from Healthy People (e.g., Healthy People 2010).

Resources:

DoD Manual 6015.1-M, Glossary of Healthcare Terminology (January 1999): http://www.dtic.mil/whs/directives/corres/pdf/601501m.pdf.

See **CD-ROM Resource AppendixC-Def 1**

DoDD 1010.10, Health Promotion and Disease Injury Prevention (Aug. 22, 2003): http://www.dtic.mil/whs/directives/corres/pdf/101010p.pdf.

Healthy People 2010: http://www.healthypeople.gov/.

Health Insurance Portability and Accountability Act (of 1996) (HIPAA)

A law that includes provisions for health insurance portability, fraud and abuse control, tax-related provisions, group health plan requirements, revenue offset provisions, and administrative simplification requirements.

It addresses the use, disclosure, and security of private health information. It affects health care in terms of patient privacy and confidentiality. The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, healthcare clearinghouses, and those healthcare providers that conduct certain healthcare transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information (PHI) and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also

gives patients rights over their PHI, including the right to examine and obtain a copy of their health records and request corrections.

Resources:

TRICARE:

- http://www.tricare.osd.mil/hipaa/faq_ans.htm
- http://www.tricare.osd.mil/tmaprivacy/hipaa/hipaacompliance/images/pdf/Documentation_Jan03.pdf

Department of Health and Human Services (HHS):

- http://www.hhs.gov/ocr/hipaa/
- http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/index.html

International Classification of Diseases – 9th Revision – Clinical Modification (ICD-9-CM)

The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is based on the World Health Organization's Ninth Revision, International Classification of Diseases (ICD-9). ICD-9-CM is the official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States. The ICD-9 is used to code and classify mortality data from death certificates. The ICD-9-CM consists of:

- A tabular list containing a numerical list of the disease code numbers in tabular form.
- An alphabetical index to the disease entries.
- A classification system for surgical, diagnostic, and therapeutic procedures (alphabetic index and tabular list).

Resources:

Centers for Disease Control and Prevention (CDC) — Classifications of Diseases and Functioning and Disabilities: http://www.cdc.gov/nchs/about/otheract/icd9/abticd9.htm.

Inter/Intraregional Care

Care received in a region other than the region in which the beneficiary is enrolled, which includes both continental U.S. and overseas locations.

Intraregional care is care received within a region where a beneficiary is enrolled but outside their MTF's catchment area. Care may be received from any branch of Service.

Resources: N/A

Light Duty

Time spent performing "light duty" work does not count against an employee's FMLA leave entitlement. The employee's right to restoration is held in abeyance during the period of time the employee performs light duty (or until the end of the applicable 12-month FMLA leave year). An employee who is voluntarily performing a light duty assignment is not on FMLA leave.

Presumes frequent provider/patient interaction to determine whether return to full duty status or more intensive therapeutic intervention is appropriate in any given case; therefore, light duty will be ordered in

periods not to exceed 30 days to ensure appropriate patient clinical oversight. Consecutive light duty for any "new condition" up to 90 days may be ordered by the provider (in maximum 30-day periods), but in no case will light duty exceed 90 consecutive days, inclusive of any convalescent leave periods. The Federal Employees' Compensation Program (FECA) for the Army requires that light duty assignments be provided to employees faced with job-related injuries or occupational illnesses or diseases. When medical care is authorized under the Federal Employees' Compensation Act (FECA), the supervisor, in coordination with the Civilian Personnel Assistance Center (CPAC), offers the employee light duty work in his/her assigned position, or in another position, compatible with medically imposed restrictions/limitations. Any position offers made must be evaluated by the employee's attending physician to ensure the modified work assignment can safely be performed by the employee based upon the limitations of his/her medical condition.

Resources:

Department of Labor, Wage and Hour Division, Final Rule under the Family and Medical Leave Act (FMLA) (effective Jan. 16, 2009):

- http://www.dol.gov/esa/whd/fmla/
- http://www.dol.gov/esa/whd/fmla/finalrule.htm

Army Civilian Personnel Online
http://www.cpol.army.mil/library/permiss/2904e.html
http://www.cpol.army.mil/library/permiss/2904.html

Limited Duty (LIMDU)

See also Temporary Limited Duty (TLD)/Permanent Limited Duty (IPLD)

Limited Duty status allows a Marine to remain on Active Duty when they are not currently fit for full duty, but there is high likelihood that, with appropriate treatment, they can be restored to ongoing full and productive duty in a reasonable amount of time (defined as 6-14 months). This status will usually prevent them from being deployable and has some other administrative ramifications.

Resources:

U.S. Marine Corps (USMC): http://www.usmc-mccs.org/LEADERSGUIDE/keyterm_display.cfm?anchor=LimitedDuty.

Line of Duty (LOD)

An inquiry into the circumstances surrounding the injury or disease of an Active Duty Service member (ADSM). LOD is used to determine the status of an ADSM for indemnity and compensation purposes. LOD investigations answer three primary questions:

1. Did the member's injury or disease occur while performing military duty in a duty status?
2. If not, was it aggravated by military duty?
3. Was the occurrence or aggravation due to the ADSM's intentional injury or willful negligence?

Resources:

Army: AR 635-40, Physical Evaluation for Retention, Retirement, and Separation: http://www.army.mil/usapa/epubs/pdf/r635_40.pdf.

Air Force: AFI 36-2910, Line of Duty (Misconduct) Determinations: http://www.e-publishing.af.mil/.

Air Force: AFI 48-123, Medical Examinations and Standards: http://www.e-publishing.af.mil/.

Managed Care Support Contractor (MCSC)

The 50 United States are divided into three TRICARE regions. Each of the regions has a regional contractor that helps administer the TRICARE benefit plan. These roles are defined as Managed Care Support Contractors (MCSCs). The regional contractors provide a variety of functions, including:

- Establishing TRICARE provider networks.
- Operating TRICARE service centers.
- Providing customer service call centers.
- Providing administrative support, such as enrollment, care authorization, and claims processing.
- Communicating and distributing educational information to beneficiaries and providers.

MCSCs work with their TRICARE Regional Offices to manage the benefit at the local level, and receive overall guidance from TMA headquarters.

Resources:

TRICARE:

- http://www.tricare.mil/factsheets/viewfactsheet.cfm?id=92
- http://www.tricare.mil/tp02/C12S11_1.PDF

See **Section I, Medical Management Essentials.**

McKesson® InterQual® Evidence-based Clinical Decision Support Criteria

Criteria that assist in determining the appropriate level of clinical care for adult and pediatric patients in the acute, long-term, rehabilitation, subacute, home care, and skilled nursing facility settings. They provide evidence-based clinically appropriate decision-making support to promote care management and facilitation, quality improvement, and beneficiary satisfaction.

The criteria are designed to screen for cases that warrant medical review. Used as a UM tool for managing care, it is not intended to deny care, but can function as a decision support tool. TMA purchases an enterprise-wide license annually for a variety of McKesson InterQual criteria sets for use within MTFs.

Resources:

McKesson: http://www.mckesson.com/.

Medicaid

A healthcare coverage program for certain low-income individuals and families who meet state and federal eligibility requirements. Medicaid does not pay money to patients directly; instead, it sends payments directly to healthcare providers. Depending on a state's rules, patients may also be asked to pay a small part of the cost (co-payment) for some medical services. Medicaid is a state administered program, with each state setting its own guidelines regarding eligibility and services. Many groups of people are covered by Medicaid, but certain requirements must be met related to age; whether an individual is pregnant, disabled, blind, or aged; income and resources; and a U.S. citizenship or an immigration status. The rules for counting income and resources vary from state to state and from group to group. There are special rules for those who live in nursing homes and for disabled children living at home.

Resources:

Centers for Medicare & Medicaid Services (CMS): http://www.cms.hhs.gov/home/medicaid.asp.

Medical Department Activity (MEDDAC)

The Army's medical department.

Resources:

Go Army – Army Health Care: http://www.goarmy.com/amedd/.

Medical Evaluation Board (MEB)

The MEB is a board to identify members whose physical or mental qualification for full duty is in doubt or whose physical or mental limitation precludes return to full duty within a reasonable period of time; speaks to the degree to which a member can perform his or her duties.

Resources:

Army: AR 40-400, Patient Administration: http://www.army.mil/usapa/epubs/pdf/r40_400.pdf.

Army: AR 40-501, Standards of Medical Fitness: http://www.army.mil/usapa/epubs/pdf/r40_501.pdf.

AFI 36-3209, Separation and Retirement Procedures for Air Force National Guard and Air Force Reserve Members: www.af.mil/shared/media/epubs/AFI36-3209.pdf.

Navy: SECNAVINST 1850.4E — Disability and Evaluation Manual:

- http://doni.daps.dla.mil/default.aspx Search for: 1850.4E
- http://www-nmcphc.med.navy.mil/LGuide/Medical/Medical_Boards.htm

Medical Hold

- Mobilized RC soldiers who were unable to deploy with their units due to a medical condition, and were not REFRAD within 30 days of mobilization. These soldiers remain on Active Duty awaiting medical/ administrative disposition.
- Redeployed/Demobilizing RC soldiers who sustained injury, disease, or aggravated pre-existing conditions that require medical/administrative resolution before REFRAD/ demobilization.

Medical Retention Processing (MRP) - Medical holdover soldiers mobilized under Title 10 USC 12302 ISO GWOT. All RC soldiers with medical conditions that require more than 60 days for resolution will be asked to volunteer to transition to a Medical Retention Processing Unit (MRPU). Soldiers who do not volunteer will be released from active duty and briefed on follow-on medical entitlements such as VA hospitals.

Resources:

Fort Carson the Mountain Post: http://www.carson.army.mil/Moblas/Medical%20Hold.htm.

Medical Management (MM)

An integrated managed care model that promotes Utilization Management (UM), Case Management (CM), and Disease Management (DM) programs as a hybrid approach to managing patient care. It includes a shift to evidence-based, outcome-oriented UM, and a greater emphasis on integrating clinical practice guidelines into the MM process, thereby holding the system accountable for patient outcomes.

Resources: DoD Instruction 6025.20, Medical Management (MM) Programs in the Direct Care System (DCS) and Remote Areas (Jan. 5, 2006): http://www.dtic.mil/whs/directives/corres/pdf/602520p.pdf.

Medical Necessity

Accepted healthcare services and supplies provided by healthcare entities, appropriate to the evaluation and treatment of a disease, condition, illness, or injury and consistent with the applicable standard of care. Whether services or supplies are deemed "medically or psychologically necessary," depends on the frequency, extent, and types of medical services or supplies which represent appropriate medical care and that are generally accepted by qualified professionals to be reasonable and adequate for the diagnosis and treatment of illness, injury, pregnancy, and mental disorders or that are reasonable and adequate for well-baby care.

Resources:

American College of Medical Quality (ACMQ), Policy 8: Definition and Application of Medical Necessity: http://www.acmq.org/policies/policy8.pdf.

Code of Federal Regulations (CFR), Title 32 — National Defense, Section 199, Part 2 (199.2): http://www.tricare.mil/CFR/C2.PDF. See **CD-ROM Resource AppendixC-Def3**

Medicare

A health insurance program for people age 65 or older, people under age 65 with certain disabilities, and people of all ages with End Stage Renal Disease (permanent kidney failure requiring dialysis or transplant). Medicare has Part A (Hospital Insurance), Part B (Medical Insurance), and Prescription Drug Coverage.

Resources:

Centers for Medicare & Medicaid Services (CMS):

- http://www.cms.hhs.gov/MedicareGenInfo/
- http://www.cms.hhs.gov/home/medicare.asp

Medicare: http://questions.medicare.gov/cgi-bin/medicare.cfg/php/enduser/std_alp.php.

Military Medicine

Every Service's delivery of health care within their departments, under the leadership of the Surgeon General, varies in its administration (i.e., different programs and services). Refer to each command/headquarters' references for more specific information. Military medicine within the DoD collaborates closely with the VA.

Resources:

Army Medicine—Army Medical Command (AMEDD): http://www.armymedicine.army.mil/index.html.
Air Force Medicine—Air Force Medical Service (AFMS): http://www.airforcemedicine.afms.mil/.
Navy Medicine—Bureau of Medicine and Surgery (BUMED): https://navymedicine.med.navy.mil/.
Department of Veteran's Affairs (VA): http://www.va.gov/.

Milliman Care Guidelines®

Published by Milliman USA, these guidelines are a set of standardized criteria used in Medical Management programs, such as UM. The Guidelines are valuable management tools for treatment that span the continuum of patient care, describing best practices for treating common conditions in a variety of care settings. Used in conjunction with the healthcare professional's clinical judgment, they define the assessment and treatment modalities that should occur at the primary care level prior to referral for specialty care.

TMA maintains an enterprise-wide license annually for use by MTF personnel within the DCS and is user/password protected.

Milliman Care Guidelines produces annually updated, evidence-based clinical guidelines that span the continuum of care, including chronic care management. The *Milliman Care Guidelines*® provide much more than just authorization criteria, driving high-quality care through such tools as care pathway tables, flagged quality measures, and integrated medical evidence.

The current best evidence is optimal only when it allows healthcare professionals to make decisions about the care of individual patients in an efficient and timely manner. To that end, the *Care Guidelines* are incorporated into easy-to-use software. From Web-based applications, to interactive software producing real-time management reports, to handheld versions, *Care Guidelines* software makes the current best evidence readily available for use where it matters: *at the point of care.*

Resources:

Milliman™ USA: http://www.milliman.com/.
Milliman Care Guidelines: http://www.careguidelines.com/.
CareWeb (Client Access): http://www.careguidelines.com/login-careweb.htm.

National Defense Authorization Act (NDAA) 2008/NDAA 2007

The National Defense Authorization Act (NDAA) 2008, Title XVI — Wounded Warrior Matters, acknowledges challenges associated with caring for wounded, ill, and injured (WII) ADSMs and their families. Under Title XVI, the law outlines specific screening, referral, and management requirements for PTSD, TBI, and behavioral health conditions.

In September 2008, the DoD and VA released their response to requirements in the *Report to Congress on the Comprehensive Policy Improvements to the Care, Management, and Transition of Recovering Service Members* (*NDAA Section 1611 and 1615*). The DoD/VA report outlines provisions implemented by the two Departments that affect medical case managers in the MTF.

Resources:

Government Printing Office (GPO): http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_cong_public_laws&docid=f:publ181.110.

See **Executive Summary, CD-ROM Resource ES-3**.

Overseas Contingency Operations (OCO)

See Global War on Terrorism (GWOT)

Permanent Disability Retirement List (PDRL)

See also Temporary Disability Retirement List (TDRL)

If a Service member has been found to be unfit by reason of disability that is found to be of a permanent nature and has been rated at 30 percent or greater, or if rated at less than 30 percent but the Service member has 20 or more years of service, that Service member will be placed on the PDRL under authority of Title 10 of the U.S. Code, Section 1201 or 1204. This is a permanent status. A member of the Temporary Disability Retirement List (TDRL) whose disability is now considered to be of a permanent nature will be transferred to the PDRL.

Resources:

Defense Finance and Accounting Service (DFAS): http://www.dfas.mil/retiredpay/disabilityretirements.html.

Permanent Limited Duty (PLD)

See Limited Duty (LIMDU)

(DoD) Pharmacoeconomic Center (PEC)

A DoD customer-oriented center of expertise (COE) implementing recognized state of the art pharmacoeconomic analysis for the purpose of improving readiness by increasing value, quality, and access to medical care and pharmacotherapy within the MHS' available resources.

Resources:

http://www.pec.ha.osd.mil/

Physical Evaluation Board (PEB)

A fact-finding body (informal and formal board) that investigates the nature, origin, degree of impairment, and probable permanence of the physical or mental defect or condition of an ADSM; speaks to the member's fitness for continued service based on limitations identified in the MEB.

Resources:

Army: AR 635-40, Physical Evaluation for Retention, Retirement, and Separation (Feb. 8, 2006): http://www.army.mil/usapa/epubs/pdf/r635_40.pdf.

Army: AR 600-60, Physical Performance Evaluation System (Feb. 28, 2008): http://www.army.mil/usapa/epubs/pdf/r600_60.pdf.

Air Force: AFI 36-3212, Physical Evaluation for Retention, Retirement, and Separation (Feb. 2, 2006): http://www.af.mil/shared/media/epubs/AFI36-3212.pdf.

DoDD 1332.18, Separation or Retirement for Physical Disability (Jan. 5, 2006): http://www.dtic.mil/whs/directives/corres/pdf/133218p.pdf.

Population Health

Population-based health care improves the health status of all our beneficiaries by delivering proactive, efficient, and effective evidence-based interventions in partnership with our patients.

Resources:

2001 DoD Population Health Improvement Plan and Guide: http://www.tricare.mil/ocmo/download/mhs_phi_guide.pdf.

See **CD-ROM Resource ES-1**

Predictive Modeling

A set of tools used to stratify a population according to its risk of nearly any outcome. Ideally, patients are risk-stratified to identify opportunities for intervention before the occurrence of adverse outcomes that result in increased medical costs.

A technological tool that functions as an electronic claims canvasser searching for predefined variables of interest. This tool is used to identify high-cost diagnoses that, in turn, provide a risk score indicative of the likelihood to utilize more healthcare resources and dollars than persons of the same age and gender.

Resources:

Cousins, Michael S., Shickle, Lisa M., Bander, John A. An Introduction to Predictive Modeling for Disease Management Risk Stratification. *Disease Management*, September 2002 — 5(3): 157-167.

Kongstvedt, P.R. Essentials of Managed Health Care, 5th ed., 378-379. Jones and Bartlett Publishers, 2007.

See **CD-ROM Resources MME-1** and **MME-2**

Carlson, B. Predictive Modeling, Sharp Lens on Near Future. *Managed Care*, July 2003. MediMedia USA: http://www.managedcaremag.com/archives/0307/0307.predictive.html.

Hodgman, S.B., BS, MSc, RN, CPUM. Predictive Modeling & Outcomes. *Professional Case Management*, 13:1, 19–23, January/February 2008: http://www.nursingcenter.com/prodev/ce_article.asp?tid=765747.

Primary Prevention

(see also Secondary Prevention, Tertiary Prevention)

A stage of Medical Management that occurs when the goal is to avert or slow the onset or incidence of disease.

Resources:

2001 DoD Population Health Improvement Plan and Guide: http://www.tricare.mil/ocmo/download/mhs_phi_guide.pdf.

See **Executive Summary, CD-ROM Resource ES-1**

Wilson, W., Carneal, G., Newman, M.B. Documenting Case Management Outcomes, *Case in Point*, 15. Case Management Society of America, February/March 2008: http://www.schoonerhealth.com/files/32736223.pdf.

Profiling

The collection and analysis of clinical utilization data to produce specific information on resource consumption and outcomes of care.

Resources:

Kongstvedt, P.R. Essentials of Managed Health Care, 5th ed. Jones and Bartlett Publishers, 2007.

Kongstvedt, P. R. The Managed Health Care Handbook. Aspen, 2007.

Program for Persons with Disabilities (PFPWD)

See Extended Care Health Option (ECHO)

Recovery Care Coordinator (RCC)

See also Federal Recovery Coordinator, Recovery Care Plan, Recovery Coordination Program

The ultimate resource for wounded, ill, and injured Service members and veterans, and their families. This role oversees the development and delivery of services/resources through the comprehensive recovery care plan in conjunction with multi-disciplinary teams (MDTs), to ensure quality care and accountability.

Resources:

National Resource Directory: http://www.nationalresourcedirectory.gov/.

Department of Veterans Affairs (VA): http://www.va.gov/JOBS/Fed_Recover_Coord.asp.

See **CD-ROM Resources CM-25, CM-26, CM-27, CM-28, CM-29, CM-30, CM-31, CM-32**

Recovery Care Plan

See also Recovery Care Coordinator, Recovery Coordination Program

An individualized, integrated, longitudinal, medical/nonmedical service plan across the continuum of care to meet personal and professional goals of wounded, ill, and injured Service members and veterans, and their families.

Resources: See Recovery Coordination Program

Recovery Coordination Program (RCP)

See also Recovery Care Coordinator, Recovery Care Plan

NDAA 2008 requires the Services (Army, Navy, AF, Marines) to establish a federal Recovery Care Program (RCP) for wounded, ill, and injured Service members who may be medically retired or separated from the military. Referral for the program is through a screening process performed by the Service that considers acuity in both medical and nonmedical (e.g., financial, housing, family support) areas.

Resources:

National Resource Directory: http://www.nationalresourcedirectory.gov/.

Department of Veterans Affairs: http://www.va.gov/JOBS/Fed_Recover_Coord.asp.

See **CD-ROM Resources CM-25** through **CM-32**.

Referral Management (RM)

The process by which primary care managers (PCMs) determine if they need to refer a member either to a specialist or for services to be performed outside of the PCM's office (e.g., diagnostic tests, outpatient surgery, home health care). If a referral is necessary, the PCM also needs to decide to whom the referral is made, for how long, and for which services.

Resources:

Milliman Care Guidelines®: http://www.careguidelines.com/login-careweb.htm.

TRICARE Operations Manual 6010.51-M, Appendix A, Acronyms and Definitions (Aug. 1, 2002): http://www.tricare.mil/to02/APPA.PDF.

See **CD-ROM Resource AppendixC-Def2**

Respite Care

Short-term care for a patient in order to provide rest and change for those who have been caring for the patient at home, usually the patient's family. Respite care is an essential part of the overall support that families may need to keep their child with a disability or chronic illness at home.

Resources:

TRICARE Operations Manual 6010.51-M, Appendix A, Acronyms and Definitions (Aug. 1, 2002): http://www.tricare.mil/to02/APPA.PDF.

See **CD-ROM Resource AppendixC-Def2**

Autism and PPD Support Network: http://www.autism-pdd.net/respite.html.

Secondary Prevention

(see also Primary Prevention, Tertiary Prevention)

A stage of Medical Management that occurs when the goal is to detect disease.

Resources:

2001 DoD Population Health Improvement Plan and Guide: http://www.tricare.mil/ocmo/download/mhs_phi_guide.pdf.

See **Executive Summary, CD-ROM Resource ES-1**

Wilson, W., Carneal, G., Newman, M.B. Documenting Case Management Outcomes, *Case in Point*, 15. Case Management Society of America, February/March 2008: http://www.schoonerhealth.com/files/32736223.pdf.

Self-Management/Self-Care Programs

The provision of information and services to members of a healthcare plan to assist them to maintain personal health and make appropriate decisions concerning medical care.

Resources:

HealthWise Handbook: http://www.healthwise.org/p_selfcare.aspx.

Vickery, D.; Fries, J. Take Care of Yourself, 8th ed. Da-Capo Press, 2004.

Self-Management Education

When patients are involved in their own care, have increased knowledge of their condition, and confidence in their ability to adapt to change; and their ability to reach treatment goals is realized. Self-care may include:

- Health promotion activities.
- Clinical preventive services.
- Behavior modification.
- Compliance monitoring.

Resources:

Institute for Healthcare Improvement (IHI): http://www.ihi.org/IHI/Topics/ChronicConditions/AllConditions/Changes/Self-Management.htm.

Healthnet Federal Services: https://www.hnfs.net/bene/healthyliving/self-care.htm.

California HealthCare Foundation: http://www.chcf.org/topics/chronicdisease/index.cfm?subtopic=CL613.

Social Security Disability Income (SSDI)

SSDI is paid to individuals who have worked in the recent years, usually 5 out of the last 10 years. For individuals under 31 years old, the requirements are a little different since they may have not been in the work force as long.

Resources:

Social Security Administration (SSA): http://www.ssa.gov/disability/.

Social Security Disability Claims: http://www.social-security-disability-claims.org/.

Supplemental Security Income (SSI)

SSI is a federal income supplement program funded by general tax revenues (not Social Security taxes). It is designed to help aged, blind, and disabled people who have little or no income. It provides cash to meet basic needs for food, clothing, and shelter.

Resources:

Social Security Administration (SSA): http://www.socialsecurity.gov/ssi/.

Temporary Disability Retirement List (TDRL)

See also Permanent Disability Retirement List (PDRL)

If, as the result of a Physical Evaluation Board finding, a Service member is found unfit to perform his/her duties by reason of a disability which may not be of a permanent nature, that Service member may be placed on the Temporary Disability Retired List under the authority of Title 10 of the U.S. Code, Section 1202 or 1205.

Resources:

Defense Finance and Accounting Service (DFAS): http://www.dfas.mil/retiredpay/disabilityretirements.html.

Temporary Limited Duty (TLD)

See Limited Duty (LIMDU)

Tertiary Prevention

(see also Primary Prevention, Secondary Prevention)

A stage of Medical Management that occurs when the goal is to prevent further suffering at end the stage of the disease.

Resources:

2001 DoD Population Health Improvement Plan and Guide: http://www.tricare.mil/ocmo/download/mhs_phi_guide.pdf.

See **Executive Summary, CD-ROM Resource ES-1**.

Wilson, W., Carneal, G., Newman, M.B. Documenting Case Management Outcomes, *Case in Point*, 15. Case Management Society of America, February/March 2008: http://www.schoonerhealth.com/files/32736223.pdf.

Transitional Assistance Management Program (TAMP)

TAMP offers transitional TRICARE coverage to certain separating ADSMs and their eligible family members. Care is available for a limited time. Under the National Defense Authorization Act for Fiscal Year 2005, effective Oct. 28, 2004, TRICARE eligibility under the TAMP has been permanently extended from 60 or 120 days to 180 days.

The four categories for TAMP are:

- Members involuntarily separated from active duty and their eligible family members.
- National Guard and Reserve members, collectively known as the Reserve Component (RC), separated from

Active Duty after being called up or ordered in support of a contingency operation for an Active Duty period of more than 30 days, and their family members.

- Members separated from Active Duty after being involuntarily retained in support of a contingency operation, and their family members.
- Members separated from Active Duty following a voluntary agreement to stay on Active Duty for less than one year in support of a contingency mission, and their family members.

Resources:

TRICARE: http://www.tricare.mil/factsheets/viewfactsheet.cfm?id=317.

Traumatic Injury Protection under Service members' Group Life Insurance (TSGLI)

A traumatic injury protection rider under Service members' Group Life Insurance (SGLI) that provides for payment to any member of the Uniformed Services covered by SGLI who sustains a traumatic injury resulting in certain severe losses. Effective Dec. 1, 2005, every member who has SGLI also has TSGLI. This coverage applies to ADSMs, Reservists, National Guard members, funeral honors duty, and one-day muster duty. This benefit is also provided retroactively for members who incur severe losses as a result of traumatic injury between Oct. 7, 2001 and Dec. 1, 2005 if the loss was the direct result of injuries incurred in Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF).

Resources:

Department of Veterans Affairs (VA): http://www.insurance.va.gov/SGLISITE/legislation/TSGLIFacts.htm.

Utilization Management (UM)

A methodology that addresses the issue of managing use of resources in the delivery of health care, while also measuring the quality associated with the delivery of that care.

Resources:

McKesson Certified Professional in Healthcare Management (CPHM) Study Guide 2, 148. September 2009.

Utilization Review (UR)

The process of determining whether all aspects of a patient's care, at every level, are medically necessary and appropriate.

Resources:

McKesson Certified Professional in Healthcare Management (CPHM) Study Guide 2, 148. September 2009.

Variance Analysis

Variance analysis is the variation or differences in quality and cost (underuse or overuse of services) in care that identifies opportunities for cost reduction and quality improvement. Variations can be negative or positive and may occur in six sources:

1. Patient/family
2. Clinical status
3. Practitioner
4. Community
5. Service delays
6. System delays

There are two types of variance data: patient care activity is not performed as ordered and expected outcomes are not achieved. Variance analyses may include both cost and statistical variances.

Resources:

Rossi, P. A. Case Management in Healthcare: A Practical Guide. (2nd ed.). W.B. Saunders, 2003: http://www.ramex.com/title.asp?id=9606.

StatGraphics: http://www.statgraphics.com/analysis_of_variance.htm.

CD-ROM RESOURCES

AppendixC-Def1	DoD Manual 6015.1-M, Glossary of Healthcare Terminology
AppendixC-Def2	TRICARE Operations Manual 6010.51-M, Appendix A, Acronyms and Definitions
AppendixC-Def3	Code of Federal Regulations (CFR), Title 32 — National Defense, Section 199, Part 2 (199.2)
AppendixC-Def4	Code of Federal Regulations (CFR), Title 32 — National Defense, Section 199, Part 4 (199.4)
AppendixC-Def5	Code of Federal Regulations (CFR), Title 32 — National Defense, Section 199, Part 5 (199.5)

Appendix D – Resources

Agency for Health Care Research and Quality (AHRQ)
A federal agency whose mission is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. Information from AHRQ research helps people make more informed decisions and improve the quality of healthcare services. The website supports evidence-based practice, clinical practice guidelines (CPGs), the National Guideline Clearinghouse, healthcare outcomes and efficacy, quality, and patient safety.
***Resources*:** http://www.ahrq.gov/

Air Force Wounded Warrior (AFW2)
The Air Force facilitates enhanced assistance for airmen/women and their families through AFW2. An AF wounded warrior is any airman/woman with a combat or hostile-related injury or illness requiring long-term care that will require a Medical Evaluation Board (MEB) or Physical Evaluation Board (PEB) to determine fitness for duty. A combat or hostile-related injury results from hazardous service or performance of duty under conditions simulating war or through an instrumentality of war.
Resources: http://www.woundedwarrior.af.mil/ VA: http://www.veteransforamerica.org/woundedwarrior/
DoD/MHS: http://mhs.osd.mil/WoundedWarrior.aspx

Armed Forces Health Surveillance Center (AFHSC)
A center designated by Health Affairs and the Secretary of Defense as the central epidemiological resource for medical surveillance of military and military-associated populations. Via the DMSS and DMED databases, the AFHSC provides regularly scheduled and customer-requested analyses and reports to policymakers, medical planners, and researchers.
***Resources*:** http://afhsc.army.mil/

Army Wounded Warrior Program (AW2) — U.S. Army Human Resources Command
See also Warrior in Transition (WT) Program
The Army facilitates enhanced assistance for soldiers and their families through AW2. An Army wounded warrior is any soldier with a combat or hostile-related injury or illness requiring long-term care that will require a Medical Evaluation Board (MEB) or Physical Evaluation Board (PEB) to determine fitness for duty. A combat or hostile-related injury results from hazardous service or performance of duty under conditions simulating war or through an instrumentality of war.

Resources: https://www.aw2.army.mil/index.html
VA: http://www.veteransforamerica.org/woundedwarrior/
DoD/MHS: http://mhs.osd.mil/WoundedWarrior.aspx

BNET Business Library
Resources: http://jobfunctions.bnet.com/Industries/Healthcare+and+Medical/

Case Management Society of America (CMSA)
An international, non-profit organization dedicated to the support and development of the profession of Case Management through educational forums, networking opportunities, and legislative involvement. CMSA offers membership discounts for military personnel, as well as a military forum during its annual national conference.
***Resources*:** http://cmsa.org/

Center for Case Management
***Resources*:** http://www.cfcm.com/

Centers for Medicare & Medicaid Services (CMS)
A federal agency within the Department of Health and Human Services (HHS). CMS programs/initiatives include Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and Clinical Laboratory Improvement Amendments (CLIA).
***Resources*:** http://www.cms.hhs.gov/

Community Based Warrior Transition Unit (CBWTU) Program
A program initiated in 2004 that allows Reserve Component (RC) soldiers placed in Medical Retention Processing (MRP) status to return home and complete their medical care in their local communities, rather than being required to remain on an installation that may be thousands of miles from their homes and families. It is the policy of the U.S. Army Medical Command (MEDCOM) that all RC WT soldiers be assessed for referral to the CBWTU. When referred by the WTU nurse case manager (NCM) and accepted by the CBWTU, the WT soldier is transferred and attached to the CBWTU that covers the region where that soldier lives. There are nine CBWTU regional headquarters, located in the states of Alabama, Arkansas, California, Florida, Illinois, Massachusetts, Utah, and Virginia; and in Puerto Rico. WT soldiers at the CBWTU normally receive their medical care from civilian network providers and are managed by their assigned CBWTU NCM. WT soldiers who live within the TRICARE catchment area of an MTF are enrolled Prime to that location but continue to be managed by the CBWTU NCM.
***Resources*:**
U.S. Army Medical Department (AMEDD), North Atlantic Regional Medical Command: http://www.narmc.amedd.army.mil/Pages/default.aspx

Defense Health Services Systems (DHSS)

The office that provides decision support information and tools used by managers, clinicians, and analysts to manage the business of health care within the MHS. DHSS is comprised of a data warehouse and operational data marts to support *clinical practice, medical logistics, and the business of military medicine.* Among the deployed applications supported by DHSS are the MCFAS, M2, Clinical Data Mart (CDM), EAS-IV, TRICARE Online (TOL), and the TMA reporting tools (CDIS, CMIS, and CURES) — see **Section V, Medical Management Tools**.

***Resources*:** http://www.health.mil/DHSS/

Department of Veterans Affairs (VA)

Established March 15, 1989 as the federal agency succeeding the Veterans Administration. It is responsible for providing federal benefits to veterans and their families. Headed by the Secretary of Veterans Affairs, the VA is the second-largest of the 15 Cabinet departments and operates nationwide programs for health care, financial assistance, and burial benefits.

***Resources*:** http://www.va.gov/

Journals

A list of current journals and other general website publication resources.

***Resources*:**

Medical Management

American Journal of Managed Care (AJMC): http://www.ajmc.com/

Frontiers of Health Services Management — American College of Healthcare Executives (ACHP), Health Administration Press: http://www.ache.org/

Group Practice Journal — American Medical Group Association: http://www.amga.org/

Health Care Management Review — Wolters Kluwer Health/Lippincott, Williams & Wilkins: http://journals.lww.com/

Health Care Management Science — Springer: http://www.springer.com/

Health Care Risk Report: http://www.healthcareriskreport.com/

Health Economics: http://www.healtheconomics.com/journals.cfm

Healthcare Executive — American College of Healthcare Executives (ACHP), Health Administration Press: http://www.ache.org/

HealthLeaders Media: http://www.healthleadersmedia.com/

International Journal of Healthcare Quality Assurance: http://info.emeraldinsight.com/products/journals/

Journal for Healthcare Quality — National Association for Healthcare Quality: http://www.nahq.org/journal/

Journal of Health Care Finance — Wolters Kluwer/Aspen Publishers: http://www.aspenpublishers.com/

Journal of Healthcare Information Management — Healthcare Information and Management Systems Society (HIMSS): http://www.himss.org/

Journal of Healthcare Management — American College of Healthcare Executives (ACHP), Health Administration Press: http://www.ache.org/
Managed Care Magazine: http://www.managedcaremag.com/
Managed Care Interface — Medicom International/Managed Care Online: http://www.mcol.com/
Managed Healthcare Executive: http://managedhealthcareexecutive.modernmedicine.com/
Case Management
American Journal of Medical Quality — SAGE JOURNALS Online: http://ajm.sagepub.com/
Care Management Journals (Journal of Case Management/Journal of Long Term Home Health Care) — Springer Publishing Company: http://www.springerpub.com/
International Journal for Human Caring (IJHC): http://www.humancaring.org/journal/
Case Management Advisor — AHC Media, LLC: http://www.ahcpub.com/
Collaborative Case Management — American Case Management Association: http://www.acmaweb.org/
The Health Care Manager — Wolters Kluwer/Lippincott, Williams & Wilkins: http://journals.lww.com/
Home Healthcare Nurse — Home Healthcare Nurses Association: http://www.homehealthcarenurseonline.com/
Medical Disability Advisor
Professional Case Management — Wolters Kluwer/Lippincott, Williams & Wilkins: http://journals.lww.com/. Official journal of:

- Case Management Society of America: http://www.cmsa.org/
- National Case Management Network of Canada: http://www.ncmn.ca/

Social Work in Healthcare — Routledge, Taylor and Francis Group: http://www.routledge.com/
The Case Manager: http://www.thecsmgr.com/
Disease Management
Disease Management — Mary Ann Liebert, Inc. Publishers: http://www.liebertpub.com/ — Official journal of the Disease Management Association of America: The Care Continuum Alliance (DMAA): http://www.dmaa.org/
Disease Management and Clinical Outcomes — Elsevier Science: http://www.elsevier.com/
Disease Management and Health Outcomes — ADIS Data Information/Wolters Kluwer: http://pharma.wkhealth.com/
International Journal of Evidence-Based Healthcare — Joanna Briggs Institute: http://www.joannabriggs.edu.au/about/home.php — Wiley: http://www.wiley.com/
Evidence-Based Medicine: http://ebm.bmj.com/

MHS Clinical Quality Management (CQM)

The MHS portal offering information and educational resources for MHS staff in the areas of clinical quality, patient safety, and quality assurance.
***Resources*:** https://www.mhs-cqm.info/

Military OneSource

Military OneSource is a Tri-Service, 24/7 information and referral program for participating Service families. It offers resources to help families address a wide range of everyday issues, including parenting and child care, older adults, education, and financial and legal matters. Assistance may be obtained via phone or online. Each Service has its own home page and log-on tool.

***Resources*:** http://www.militaryonesource.com

Army: http://www.armyonesource.com/

Air Force: http://www.airforceonesource.com/

Navy: http://www.navyonesource.com/

Military Medical Support Office (MMSO)

A TRICARE office that provides a variety of functions, as follows:

- Acts as a liaison between MCSCs, Services, Commanders, and MTFs for ADSMs not enrolled to MTFs on military-unique issues.
- Provides customer service for Commanders, HBA, MTF and TPR ADSMs.
- Identifies ADSMs with serious medical conditions for the Services.
- Assists MCSC/MTF on care management coordination, as needed.
- Authorizes care for National Guard/Reserve members not eligible in DEERS (i.e., line-of-duty injuries/ illnesses).
- Provides claims payment determinations for MCSCs unable to pay.
- Coordinates appeals for denied claims and debt collection cases.

***Resources*:** http://www.tricare.mil/tma/MMSO/index.aspx

Multi-Service Market Office (MSMO)

A TRICARE office that serves areas with more than one Service with an MTF and in which the markets overlap. A Senior Market Manager — a designated MTF Commander — is appointed to each MSMO. This role is responsible for developing a single, consolidated, integrated business plan for the DCS and PCS for other Services located in the MSMO. There are 12 MSMOs, located in the following geographic areas: National Capital Area (NCA), Tidewater, Ft. Bragg/Pope, Charleston, Ft. Jackson/Shaw, Gulf Coast, San Antonio, Colorado Springs, San Diego, Puget Sound, Hawaii, and Alaska. All other MTFs are considered single market managers.

***Resources*:** http://www.tricare.osd.mil/

National Committee on Quality Assurance (NCQA)

A private, non-profit organization that is dedicated to improving healthcare quality. NCQA also provides accreditation for organizational health plans that report performance on quality of care, access, service, and member satisfaction.

***Resources*:** http://www.ncqa.org/

National Guideline Clearinghouse™ (NGC)
A public resource for evidence-based clinical practice guidelines. NGC™ is sponsored by the AHRQ and provides an easily accessible mechanism for obtaining objective, detailed information on CPGs and furthering their dissemination, implementation, and use.
***Resources*:** http://www.guideline.gov/

National Quality Forum (NQF)
Promotes change through development and implementation of a national strategy for healthcare quality measurement and reporting.
***Resources*:** http://www.qualityforum.org/

National Quality Measures Clearinghouse™ (NQMC)
A public archive for evidence-based quality measures and measure sets sponsored by the AHRQ. It was developed to promote widespread access to quality measures by the healthcare community.
***Resources*:** http://www.qualitymeasures.ahrq.gov/

National Transition of Care Coalition (NTOCC)
A coalition formed in 2006 that brings together thought leaders, patient advocates, and healthcare providers from various care settings who are dedicated to improving the quality of care coordination and communication when patients are transferred from one level of care to another.
***Resources*:** http://www.ntocc.org

Navy Safe Harbor
The Navy facilitates enhanced assistance for seamen/women and their families through Navy Safe Harbor. A Navy wounded warrior is any seaman/woman with a combat or hostile-related injury or illness requiring long-term care that will require a Medical Evaluation Board (MEB) or Physical Evaluation Board (PEB) to determine fitness for duty. A combat or hostile-related injury results from hazardous service or performance of duty under conditions simulating war or through an instrumentality of war.
***Resources*:** http://www.npc.navy.mil/CommandSupport/SafeHarbor/
VA: http://www.veteransforamerica.org/woundedwarrior/ DoD/MHS: http://mhs.osd.mil/WoundedWarrior.aspx

Population Health and Medical Management Division (PHMMD)
(formerly MHS Optimization and Population Health Support Center [OPHSC])
The PHMMD is the division within the TRICARE Office of the Chief Medical Officer (OCMO) that provides a single point of access for reference materials, tools, Service links, MHS innovations, discussion forums, and accredited Web-based learning modules that support and promote essential transformation, cultural change, and knowledge transfer.
***Resources*:** http://www.tricare.mil/ocmo/OCMO_PHMM.cfm

Social Security Administration (SSA)/Social Security Online
A federal program to assist with the economic security of U.S. citizens. Social Security assists with retirement benefits for the primary worker, as well as survivor benefits and benefits for the retiree's spouse and children. Social security also provides for disability benefits through Medicare (see Centers for Medicare & Medicaid Services).
***Resources*:** http://www.ssa.gov/

The Joint Commission (TJC)
An independent, non-profit organization that is the predominant standard-setting and accrediting body in U.S. health care. TJC develops state-of-the-art, professionally based standards and evaluates the compliance of healthcare organizations against these criteria. TJC's mission is to continuously improve the safety and quality of care provided to the public through the provision of healthcare accreditation and related services that support performance improvement in healthcare organizations.
***Resources*:** http://www.jointcommission.org/

TRICARE
The DoD's worldwide healthcare program for Active Duty and retired Uniformed Services members and their families. Consists of:
- TRICARE Prime (managed care option)
- TRICARE Extra (preferred provider option)
- TRICARE Standard (fee-for-service option)
- TRICARE For Life (for Medicare-eligible beneficiaries age 65 and over effective 1 Oct 01)

Eligible MHS beneficiaries receive certain benefits based on their chosen health plan.
***Resources*:** http://www.tricare.osd.mil/ e-mail: questions@tma.osd.mil

TRICARE Area Office (TAO) — see TRICARE Regional Office (TRO)
In overseas locations, TRICARE Regional Offices (TROs, see below) are called "area offices." The TAOs consist of Europe, Pacific, Alaska, and Latin America/Canada.
***Resources*:** See TRICARE Regional Office (TRO)

TRICARE Online (TOL)
An enterprise-wide, secure Internet portal for use by DoD beneficiaries, providers, and managers worldwide. TOL provides access to health and contact information for hospitals, clinics, and providers. It provides links to information on TRICARE services and benefits, as well as helpful resources, such as DM tools, a drug interaction checker, and a Personal Health Journal. TOL enables TRICARE Prime and Plus members to make appointments with a PCM online. TOL is maintained by the Clinical Information Technology Program Office (CITPO) at the Defense Health Services Systems (DHSS).
***Resources*:** http://www.tricareonline.com/

TRICARE Regional Office (TRO)
TRICARE has three regional offices: North, South, and West.
***Resources*:** http://www.tricare.osd.mil/

Uniformed Biostatistical Utility (UBU) Working Group
The group responsible for the detailed analysis required to standardize biostatistical data elements, definitions, data collection processes, procedure codes, diagnoses, and algorithms across the MHS. The UBU Working Group consists of multi-disciplinary functional experts from each Service. The UBU also consists of a sub-workgroup of Service coders who develop and publish DoD Coding Guidelines when coding patient care in the MHS.
***Resources*:** http://www.tricare.mil/ocfo/bea/ubu/index.cfm

Uniformed Business Office (UBO)
An office within the TRICARE Office of the Chief Financial Officer (OCFO) Management Control & Financial Studies (MCFS) Division. It supports TRICARE managed care programs by providing tools and policies to enhance and improve the effectiveness of the financial and collection operations. This includes providing support for managing and expediting collections from patients and third-party insurers; consistent and uniform reporting of expense, manpower, and workload data; and enhancing third-party reimbursements. These efforts are coordinated by the charted UBO Advisory Working Group, which includes members from each Service.
***Resources*:** http://www.tricare.mil/ocfo/mcfs/ubo/index.cfm

U.S. Army Medical Command (MEDCOM) Quality Management Office (QMO)
***Resources*:** https://www.qmo.amedd.army.mil/

U.S. Preventive Services Task Force (USPSTF)
An independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive services.
***Resources*:** http://www.ahrq.gov/clinic/uspstfix.htm

Utilization Review Accreditation Commission (URAC) (formerly American Accreditation Healthcare Commission [AAHC])
A not-for-profit organization founded to promote the accountability of healthcare organizations with the establishment of utilization review accreditation standards. Individual states often require utilization management organizations to be URAC-accredited before they can operate.
***Resources*:** www.urac.org

Warrior in Transition Program (WT) — see also Army Wounded Warrior Program (AW2)

As a result of Global War on Terrorism (GWOT) missions, including Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), the highest rate of transition resource need has occurred in the Army. A unique responsibility for case managers working in the MHS involves caring for Army Service members in Warrior Transition (WT) status.

A WT member is defined as a Service member from any component (Active Compo [1], Army National Guard [2], or USAR [3]) who has been assigned to a WT unit.

- Active Compo soldiers who require at least six months of significant care and rehabilitation and intensive CM are assigned to a WTU.
- Reserve Component (RC) WT soldiers are assigned to a WTU when they:
  - Have experienced injury or illness during training prior to mobilization (e.g., during training).
  - Have sustained injuries during deployment and were Medevaced.
  - Upon redeployment, were identified with an injury or illness that was caused by mobilization or aggravated during mobilization.

RC soldiers are placed on Medical Retention Processing (MRP), MRP2, or Active Duty Medical Extension (ADME) orders when they are assigned to the WTU.

WTU Nurse Case Manager (NCM)

The WTU nurse case manager (NCM) in the WTU is involved not only with the medical care and execution of the treatment plan, but also with the WT soldier's transition back to duty; or to civilian life, if separated from the Service. As part of the Triad of care (the primary case manager [PCM], NCM, and squad leader), the NCM plays a key role in the development of the Comprehensive Transition Plan (CTP). He/she is responsible for documenting the clinical aspects of the CTP, coordinating with the VA for post-WTU care and follow-on services, and ensuring the family is aware and engaged to the extent possible in the WT soldier's care and transition. The NCM also works closely with other members of the recovery team, including AW2 advocates, FRCs, and RCCs.

While in WT status, a soldier is on a Temporary or Permanent profile and receives the appropriate medical care until he/she is determined to fall under one of the following statuses:

- Found fit for duty and returned to his/her unit.
- Released from Active Duty (REFRAD) Reserve Component (RC) soldier.
- Has achieved optimal medical benefit according to the PCM (and therefore does not meet retention standards), has been referred to and completed a Medical Evaluation Board (MEB), and has completed the Physical Disability Evaluation System (PDES) process.

The Army has instituted the following enhanced access standards to improve the medical treatment process:

- Seventy-two hours for initial specialty referrals.
- One week for magnetic resonance imaging and other diagnostic studies.
- Two weeks for surgery (from decision time to day of surgery).

In addition, the ratio of WT soldiers to NCMs is 1:20, to facilitate close monitoring and assistance for the WT

and his/her family. These standards exceed TRICARE standards and are only applicable to care within MTFs. The MEDCOM standard for completing the MEB is 90 days. It is critical that the NCM work closely with the assigned Physical Evaluation Board Liaison Officer (PEBLO) to make the process as expeditious as possible.
***Resources*:** https://www.aw2.army.mil/index.html

Wounded Warrior Regiment (WWR) – Marines
Established in April 2007 as a result of Planning Guidance created in 2006 by the 34th Commandant of the Marine Corps, the WWR grew out of a combination of the 2005 Marine for Life Ill/ Injured Support Section and the 2004 wounded warrior barracks in Camp Lejeune, North Carolina. Its mission is to provide and facilitate assistance to wounded, ill, and injured Marines and sailors attached to or in support of Marine units throughout the phases of recovery; as well as assisting their family members. The WWR is headquartered in Quantico, Virginia, with Wounded Warrior Battalions on both the East and West Coasts.
***Resources*:** http://www.woundedwarriorregiment.org/WWR.aspx

CD-ROM RESOURCES

AppendixD_Res1 Army G-1 WTU Consolidated Guidance

Department of Defense

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MEDICAL MANAGEMENT GUIDE, Version 3.0