DHA-IPM 17-009
December 11, 2017

MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY (MANPOWER AND
                  RESERVE AFFAIRS)
           ASSISTANT SECRETARY OF THE NAVY (MANPOWER AND
                  RESERVE AFFAIRS)
           ASSISTANT SECRETARY OF THE AIR FORCE (MANPOWER
                  AND RESERVE AFFAIRS)
           DIRECTOR OF THE JOINT STAFF
           DEPUTY ASSISTANT SECRETARY OF DEFENSE (HEALTH
                  READINESS POLICY AND OVERSIGHT)
           DEPUTY ASSISTANT SECRETARY OF DEFENSE (HEALTH
                  SERVICES POLICY AND OVERSIGHT)
           DEPUTY ASSISTANT SECRETARY OF DEFENSE (HEALTH
                  RESOURCES MANAGEMENT AND POLICY)
           DIRECTOR OF HEALTH, SAFETY, AND WORK-LIFE, UNITED
                  STATES COAST GUARD
           DIRECTOR, NATIONAL CAPITAL REGION MEDICAL
                  DIRECTORATE
           DIRECTORS OF THE DEFENSE AGENCIES
           DIRECTORS OF THE DOD FIELD ACTIVITIES

SUBJECT: Interim Procedures Memorandum 17-009, Nurse Advice Line (NAL) Program
                Operations Guidance

References: See Attachment 1.

        <u>Purpose</u>. This Defense Health Agency-Interim Procedures Memorandum (DHA-IPM), based on the authority of References (a) and (b), and in accordance with the guidance of References (c) through (h):

- Describes the mission and objectives of the NAL Program and provides guidance and direction on the expected roles and responsibilities at all levels of the Military Health System (MHS). Please disseminate this message to all Medical Treatment Facility (MTF) commanders.

- Is effective immediately; it must be incorporated into Military Service Department NAL policies and a future Defense Health Agency-Procedural Instruction for MTFs. This DHA-IPM will expire effective 12 months from the date of issue.

Applicability. This DHA-IPM applies to OSD, the Military Departments, the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the DoD, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD (referred to collectively in this DHA-IPM as the "DoD Components").

Policy Implementation. It is DHA's policy, pursuant to References (d) through (g), and in accordance with Reference (a), that this DHA-IPM provides guidance on the mission, management, and workflow of the NAL Program. Uniformed business practices minimize fragmentation and standardize processes to reduce cost and improve patient outcomes.

Responsibilities. See Attachment 2.

Procedures. See Attachments 3 through 5.

Information Collection Requirements. The NAL Program's registered nurses (RNs), customer service representatives (CSRs), and appointing clerks (ACs), document, store, and retrieve NAL caller encounter data from the NAL Web Reporting Repository (WRR) and the NAL Management System (NALMS) (effective March/April 2018). The NAL Program Management Office (PMO), the Services, enhanced Multi-Service Markets (eMSMs), Service Regional Commands, and MTFs designate NAL WRR or NALMS users to monitor NAL call encounter activity.

Releasability. **Cleared for public release**. This DHA-IPM is available on the Internet from the Defense Health Agency (DHA) SharePoint site at:
http://www.health.mil/dhapublications.

R. C. BONO
VADM, MC, USN
Director

Attachments:
As stated

cc:
Under Secretary of Defense for Personnel and Readiness
Assistant Secretary of Defense for Health Affairs
Surgeon General of the Army
Surgeon General of the Navy
Surgeon General of the Air Force
Medical Officer of the Marine Corps
Joint Staff Surgeon
Surgeon General of the National Guard Bureau

ATTACHMENT 1

REFERENCES

(a) DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs (ASD(HA))," September 30, 2013
(b) DoD Directive 5136.13, "Defense Health Agency (DHA)," September 30, 2013
(c) DHA-Procedural Instruction 5025.01, "Publication System," August 21, 2015
(d) Health Affairs Policy Memorandum 11-005, "TRICARE Policy for Access to Care," February 23, 2011
(e) Health Affairs Policy Memorandum 11-014, "TRICARE Policy for Continental United States Nurse Advice Line," September 30, 2001[1]
(f) TRICARE Operations Manual 6010.59-M, April 2015, as amended
(g) TRICARE Systems Manual 7950.3-M, April 2015, as amended
(h) Joint Commission Patient Centered Medical Home (PCMH) Certification for Accredited Ambulatory Health Care Organizations Question & Answer Guide, October 1, 2006

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[1] This reference can be found at:
https://info.health.mil/hco/clinicsup/hsd/pcpcmh/Documents/Forms/AllItems.aspx?RootFolder=%2Fhco%2Fclinicsup%2Fhsd%2Fpcpcmh%2FDocuments%2FPolicies&View=%7B87C81850%2DB4EC%2D489C%2D8C7D%2DE4CFB4B60A0D%7D

ATTACHMENT 2

RESPONSIBILITIES

1. <u>DIRECTOR, DHA</u>. The Director, DHA, will:

    a. Facilitate the implementation of the DHA-IPM.

    b. Provide strategic direction for the MHS to ensure proper alignment of the NAL Program.

    c. Provide leadership, engagement, and advocacy of the NAL Program.

    d. Ensure the Services are provided the necessary resources to implement this DHA-IPM.

2. <u>DIRECTOR, OPERATIONS (J-3)</u>. The Director, Operations (J-3), will:

    a. Provide oversight, monitoring, and guidance to the Clinical Support Division, Primary Care Office, NAL PMO.

    b. Coordinate and collaborate with the Service Deputy Surgeons General to identify the necessary improvements and future enhancements of the NAL Program to ensure that it continues to align with the MHS strategies.

3. <u>SURGEONS GENERAL OF THE MILITARY DEPARTMENTS</u>. The Surgeons General of the Military Departments will:

    a. Implement the NAL Program Operations Guidance outlined in this DHA-IPM.

    b. Monitor NAL Program performance data for their respective Service, and ensure compliance with responsibilities at the Service, eMSM, regional command, and MTF levels.

ATTACHMENT 3

NURSE ADVICE LINE PROGRAM OPERATIONS GUIDANCE

1. INTRODUCTION

    a. Purpose. The purpose of this DHA-IPM is to articulate the unified mission and objectives of the NAL Program, provide guidance and direction on the expected roles and responsibilities at all levels of the MHS, and establish standardized business practices resulting in a more consistent patient experience and a more effective and efficient system.

    b. Background. The NAL Program provides telephone access to an RN for triage services, self-care advice, and general health inquiries 24 hours a day, 7 days a week to eligible MHS beneficiaries. There are two NAL contracts managed by DHA providing this service: the continental United States (CONUS) NAL and outside continental United States (OCONUS) NAL.

        (1) MHS beneficiaries physically residing in the United States, except those enrolled to the U.S. Family Health Plan, can access the CONUS NAL by calling 1-800-TRICARE (1-800-874-2273), Option #1. If necessary, after NAL RN triage, the CONUS NAL also offers care coordination services to include MTF appointing services, civilian network Urgent Care (UC) referral submission, and provider locator support.

        (2) The OCONUS NAL is accessible through MTF phone trees in Europe, Africa, and the Middle East. Care coordination services are also offered, if necessary, after NAL RN triage. MHS beneficiaries residing in the Pacific Region are not currently covered under the OCONUS NAL.

        (3) Efforts are underway to establish a Global NAL in Fiscal Year 2018, which will replace both the CONUS and OCONUS NALs and provide service coverage to eligible MHS beneficiaries in countries with an established MTF, including the Pacific Region.

        (4) The goals for both NALs are to:

            (a) Direct patients to the most clinically-appropriate level of care.

            (b) Capture MTF-enrolled beneficiaries back to the direct care system in order to reduce purchased care costs.

            (c) Reduce unnecessary Emergency Department (ED) and UC utilization.

            (d) Enhance access to care, especially after hours and when the beneficiaries are traveling.

     (e) Improve the patient's continuous health care relationship with his or her MTF or civilian health care team and Primary Care Manager (PCM).

     (f) Maximize patient satisfaction.

2. <u>ORGANIZATION</u>

    a. As stated above, the NAL Program is a contracted service managed by the DHA and collaboratively led by the Uniformed Services (Army, Navy, Marines, Air Force, and Coast Guard) and the eMSMs.

    b. The CONUS NAL contract was awarded on September 26, 2013, to Leidos who sub-contracts various aspects of the NAL services to multiple sub-contractors. The NAL contractor must provide a pool of qualified and state licensed telehealth RNs that are readily available 24 hours a day, 7 days a week for all 50 states and the District of Columbia. The CONUS NAL contractor also manages two call centers located in Colorado and Tennessee where the CSRs and the ACs reside.

    c. The OCONUS NAL contract was competitively awarded for an additional year on January 1, 2017, to ensure covered beneficiaries do not experience a gap in service before the Global NAL is fully operational. Carenet is the prime contractor and provides telehealth RNs who work remotely within 14 different states. They also have two call centers located in San Antonio, Texas. Humana is the subcontractor providing MTFs appointing and care coordination services.

    d. The NAL PMO is aligned under the MHS's Patient-Centered Medical Home (PCMH) Advisory Board.

    e. Each Uniformed Service and eMSM has designated NAL points of contact (POCs), who work collaboratively with the NAL PMO to continuously improve the program, conduct program evaluations, and address systematic issues, concerns, and questions from the field. The NAL PMO, Service and eMSM leads, as well as representatives from the TRICARE Regional Offices meet monthly.

    f. The remainder of this DHA-IPM focuses on the CONUS NAL workflows and processes. However, the Roles and Responsibilities (Attachment 3, section 4), applies to both the CONUS and OCONUS NAL Programs. Once the Global NAL is fully operational in Fiscal Year 2018, the NAL Program operations guide will be updated in the form of a Defense Health Agency-Procedural Instruction.

3. <u>NAL PROCESS FLOW</u>

    a. The NAL Process Flow for callers adjusts based on which health care plan the caller is enrolled (i.e., MTF-enrolled TRICARE Prime and Plus, Managed Care Support Contractor

(MCSC) Prime enrolled, or TRICARE Standard), the reason the beneficiary is calling, the day and time of the call, and the triage disposition. However, most NAL calls have three distinct phases. Figure 1 provides a broad overview of a caller's process flow throughout the NAL Program. A more detailed description of the entire NAL process is provided in the sections below.
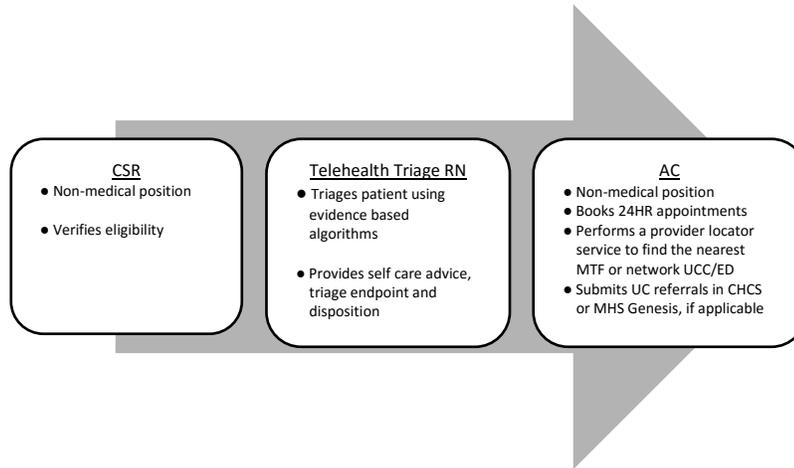

Figure 1: NAL Process Flow Overview

b. Phase 1: Verify Eligibility with CSRs.

(1) When a beneficiary calls 1-800-TRICARE (1-800-874-2273), they will hear the main NAL announcement.

(2) Once a caller selects Option 1, a subsequent NAL announcement will play, and the caller will be connected to a NAL CSR located in a secure call center in Tennessee or Colorado. All CSRs have Common Access Cards (CACs) and access to the 82 Composite Health Care System (CHCS/MHS GENESIS) hosts, which serve more than 300 MTFs in the United States. The CSR will obtain caller information and verify it via the official Defense Enrollment Eligibility Reporting System (DEERS) via General Inquiry of DEERS. The CSRs have "read" access only and are unable to update beneficiary information in DEERS.

(3) NAL CSRs record personal information including first and last name, sponsor(s)/individual(s) Social Security number, TRICARE enrollment status, DoD benefits number, the MTF or civilian enrolled (if Prime), a call-back number, and the state where the caller is physically located. This information is documented in the NAL encounter note stored in the real-time database.

(4) During the DEERS verification process, the caller is identified as TRICARE Standard, MCSC, or MTF Prime/Plus, and the reason for their call is obtained. The following four general categories—unrelated to chief complaint—depict rationale for calling the NAL:

(a) Cancel, meaning a 24HR primary care appointment was cancelled by the AC at the request of the caller.

(b) Reschedule, meaning a 24 HR primary care appointment was rescheduled by the AC at the request of the caller.

(c) Speak to a nurse, meaning the caller would like to speak to a NAL RN regarding a general health inquiry or be assessed by an RN for an acute health issue.

(d) Other, to capture anything not included in options (a) through (c).

(5) The call follows the applicable process based upon the enrollment status and reason for call. All "Speak to a Nurse" calls are transferred to the telehealth NAL RN. The CSR can cancel and, if appropriate, reschedule an MTF-enrolled caller's primary care appointment at the request of the beneficiary.

(6) If the beneficiary calls the NAL for a reason other than options (a) through (c), the call is documented as a "Not NAL" call in the NAL encounter report. Some examples include: prescription authorization/refills, pharmacy locator services, referrals for other services (e.g., specialty care), revision to DEERS information, transfer messages to providers, benefits and claims information (e.g., billing-related issues), MTF appointments without completing the initial nurse triage process, follow-up appointments (e.g., post ED treatment(s) or surgical procedure(s)), retroactive UC referrals for network UC visits that were not initiated by NAL, and a triage assessment when the patient is not present.

c. Phase 2: Telehealth Triage with an RN

(1) If the beneficiary wishes to speak to an RN, the CSR will connect the caller with an RN licensed in the state where the caller is physically located at the time of the call. The NAL RN does not have access to personally identifiable information, including the caller's demographic information. The CSR will provide the NAL RN with the following information: the caller's first name, who the caller is calling for (self or child), the patient's month and year of birth, and the encounter number (the patient is not providing any information during this time). The NAL RN ensures he/she is speaking with the right caller and/or beneficiary by verifying the information previously provided by the CSR with the caller and then proceeds with the telephone assessment.

(2) As part of the initial assessment, the NAL RN asks the caller what they would have done if they did not call the NAL (i.e., the caller's pre-intent). Table 1 outlines broad pre-intent categories.

Table 1. NAL Patient Pre-Intents

Pre-Intent Categories	Definition
Seek ED Care	Beneficiary planned to seek care at the ED before contacting NAL.
Seek UC Care	Beneficiary planned to seek UC before contacting NAL.
Call for professional advice	Beneficiary did not have alternative plans prior to contacting NAL.
Make appointment with a health professional	Beneficiary planned to make appointment with health professional before contacting NAL.

Self-care or non-professional advice	Beneficiary planned for self-care or to seek other non-professional advice before contacting NAL.
Not asked	Used for non-symptomatic and symptomatic calls that do not require algorithm assessment (e.g., unable to reach the patient's provider, needs reinforcement of prior instructions, the local UC center is closed, the patient is unavailable, or medication/refill-related issues.

(3) The NAL must speak to patients directly to provide beneficiaries the highest level of care, a quality assessment, and safe recommendations for care. If the caller is calling on behalf of a minor or another family member, the minor or family member must be present for the NAL RN to perform an accurate assessment. The NAL RN may ask the caller to perform one of the following: 1) "Look in the back of the throat"; 2) "Feel the skin for a temperature assessment", and/or 3) "Bring the child near the phone to listen for unusual breathing, wheezing, or coughing patterns". The age in which the NAL RN may ask to speak with a child directly is 14 years old and if the parent prefers, this can be done on a speaker phone with the parent present. The child does not make decisions about their health care; rather the child is participating in the description of his or her symptoms. There will always be special circumstances that do not require parental approval in order to protect the caller and they vary by state. Specifically, the definition of a minor, the circumstances under which a child is "emancipated" from his or her parents, the age at which consent is valid, and the medical care and treatment for which minors can consent without parental involvement varies by state. The minor's sole consent is binding when applicable law deems the minor legally capable of consenting.

(4) If the call is regarding something other than an acute symptom (i.e., non-symptomatic), the NAL RN provides the requested information and ends the call.

(5) If the call is regarding an acute symptom (i.e., symptomatic), the NAL RN determines if the beneficiary would be best served by self-care, UC, or emergency care. The NAL RN asks a series of questions based on the Axis Point Health (formerly McKesson) triage algorithms and provides a recommended endpoint. There are 17 different triage endpoints a symptomatic caller could receive. Please see Table 2 for examples.

Table 2. NAL Triage Endpoints

Access to Care Categories	Triage Endpoint	Time Frame
Emergency Care	Activate Emergency Procedures	Now
	UC/Emergency Department (UC/ED)	Now
	Speak to Provider (STP)	15 minutes
	STP	30 minutes
	UC-General (UC-GM)	1 hour
	UC-GM	3 hours
UC (Acute)	STP	4 hours
	UC-GM	6 hours
	STP	8 hours
	UC-GM	12 hours

Access to Care Categories	Triage Endpoint	Time Frame
	STP	18 hours
	UC-GM	24 hours
Routine Care	UC-GM	48 hours
	STP	72 hours
	Early Illness Appointment	72 hours
	Routine Illness Appointment	2 weeks
Self-care	Access self-care	Null

(6) Self-care. If the NAL RN determines that the caller would be best served by self-care, they advise the caller to an appropriate method for self-care. There are 42 triage algorithms that require the NAL RN to offer the beneficiary a call-back. If 1 of the 42 triage algorithms is used or based on NAL RN's critical thinking skills, the NAL RN inquires if the caller would like a call-back to reassess their symptoms and provide additional health care advice. Call-back timeframes and the number of call-backs are determined by the specific algorithm used by the NAL RN. If the beneficiary does not desire a call back, the NAL RN closes the case, and the beneficiary may pursue self-care independently. If the caller chooses to receive a call back, the NAL RN obtains information as to whom the NAL RN may speak with and obtains permission to leave a voicemail should the caller not answer. During the call-back, the NAL RN re-evaluates the beneficiary and determines whether to direct the beneficiary to a higher level of care or close the case as self-care.

(7) UC. If the telehealth NAL RN determines that the caller needs UC, the beneficiary is warm-transferred to the AC to assist the caller in care coordination. Care coordination services include booking an MTF appointment, locating an available MTF Urgent Care Clinic (UCC) or a UCC fast track within an MTF ED, or locating the nearest UCC and submitting a referral into CHCS/MHS GENESIS.

(8) Emergency Care. If the NAL RN determines that the caller would be best served by emergency care, the NAL keeps the caller on the phone and activates emergency management services on behalf of the caller for a warm transfer of care. If the caller declines the warm transfer, the RN instructs the caller to seek immediate care at the nearest ED.

(9) Not NAL. If the NAL RN determines that the call is categorized as a "Not NAL", the caller is given the necessary information for assistance and the call ends.

d. Phase 3: MTF Appointing or Provider Locator Service

(1) Once the caller is transferred from the NAL RN to the AC, the NAL AC attempts to book the MTF-enrolled beneficiary a primary care 24-hour appointment. The NAL AC attempts to warm transfer the caller to the MTF during the duty day when there are no appointments available at the MTF with the beneficiary's PCM, PCM Team, or PCM Clinic within the

required timeframe. This gives the MTF the right of first refusal to take care of their enrolled beneficiary's acute needs.

(2) The NAL AC calls the telephone number provided by the MTF and waits 45 seconds for the MTF to answer the phone. The NAL AC will only call the first number listed if more than one telephone number is provided in the MTF instructions. The non-clinical NAL AC is contractually limited in the amount of information to provide once the MTF responds to the call. The current NAL AC script states, "Good [morning/afternoon/evening], this is [Agent first name] from the NAL. I have Ms./Mr. X who has been triaged to need an appointment. Will you accept the patient at this time?"

(3) The two options for MTF staff who respond to the NAL AC calls are: Yes, we can take the beneficiary, or No, we cannot take the beneficiary.

(4) If the MTF accepts the beneficiary, the NAL AC provides the MTF staff member with the following information: the beneficiary's first and last name, the last four digits of the sponsor's social security number, the DoD benefits number, the beneficiary's date of birth and age in years, the chief complaint, and whether or not the beneficiary is active duty.

(5) If the MTF cannot take the beneficiary, the NAL AC will document the reason in the WRR or NALMS.

(a) The NAL AC utilizes provider locator services (or in some cases, a preferred network UC/ED listed in the MTF hand-off instructions) and submits a referral in the CHCS/MHS GENESIS to a civilian network provider. The place of care and the CHCS/MHS GENESIS referral number are documented in the NAL call encounter. This process, implemented in October 2016, reduces the administrative burden on the MTF staff, reduces variance, and reduces the risk of the beneficiary receiving a point of service charge.

(b) The above process is utilized in the following circumstances: When there are no available appointments with the beneficiary's PCM, PCM Team, or PCM Clinic; when an attempt to contact the caller's MTF failed; when the MTF is closed and there is no MTF UCC/ED; when the MTF requests no NAL clerk hand-off and there is no MTF UCC/ED; or, while the MTF Prime enrolled beneficiary is out-of-area from their primary residence and there is no MTF UCC/ED within 30 minute drive time.

(6) For all TRICARE Standard beneficiaries and those enrolled to a civilian PCM through the MCSC, the CONUS NAL provides only provider locator services via the MCSC websites.

(7) If an MTF-enrolled TRICARE Prime beneficiary (TRICARE Plus is non-transferrable to another MTF) is out-of-area from their home location and is in proximity (30 min drive time) of another MTF, the MTF-enrolled TRICARE Prime beneficiary can access an MTF-sponsored UCC/ED, which does not require an appointment.

(8) PCM On-call. The NAL does not transfer beneficiaries to a PCM On-call either during or after duty hours. In FY 2018, the NAL will have the enhanced ability to transfer beneficiaries to a PCM On-call.

e. NAL Dispositioning. At the end of the call, the outcome, after speaking to either a telehealth NAL RN or a NAL AC, is documented in the disposition section of the NAL Encounter Report. There are 11 possible dispositions. Please see Table 3.

Table 3. NAL Dispositions

Categories	Definition
Cancel	An appointment (Primary Care 24-hour) was cancelled by the AC at the request of the member/beneficiary/patient.
ED	NAL RN refers caller to the closest ED; RN Only - ED; stops at RN.
UC/ED - MTF	NAL AC advises caller to seek care at an MTF UC/ED and/or provided lookup services for an MTF UC/ED.
ED - Network	NAL AC provides provider locator assistance for an NAL RN Only emergency endpoint, resulting in Network ED or provided look-up services result in a Network ED due to MTF ED, Network UCC, or non-Network UCC not being available.
ED - non-Network	NAL AC provides provider locator assistance for an RN Only emergency endpoint, resulting in non-Network ED or provided look-up services result in a non-Network ED due to MTF ED, Network UCC, non-Network UCC, or Network ED not being available.
Empty	Empty or undefined entries can exist in the database and do not represent errors, but rather fields of data that are either *not applicable* or *not available*. For example, *disposition* is 1) *not applicable* to many non-symptomatic (non-SX) call types; and 2) is not asked therefore *not available* for calls involving life or limb emergencies.
MCSC	A MCSC beneficiary transferred from the NAL RN to the NAL AC instructed by the NAL RN to follow-up with their civilian PCM for further assistance.
MTF	NAL AC booked an appointment with the PCM, PCM Team, the PCM Clinic, the NAL AC performed a successful MTF hand-off, or the NAL AC instructed the caller to call their MTF for a routine primary care appointment.
Non-SX	Denotes non-symptomatic as determined by the NAL RN based on information captured during the NAL RN telehealth triage.
PCM	Only applies to a successful transfer to a PCM On-Call (at participating sites) during a PCM On-Call pilot from Oct 2016 through March 2017. This is no longer an active disposition used by NAL clerks, but may show up in data from that time period.
PCP	Indicates that the member was referred to their PCP. This disposition will only apply to Standard or Prime MCSC enrollees.
Referred to PCM	Member is an active duty MTF Prime enrollee and refused action either by an NAL RN or an NAL AC. They are provided the option to contact their PCM for an appointment or a UC referral.
Refused	Indicates that the service offered by the NAL AC was refused by the member/beneficiary/patient. For example, the member/beneficiary/patient may refuse the CHCS/MHS GENESIS appointments offered by the AC.
Reschedule	De-activated as of October 04, 2016. The previous definition was an appointment (24-hour) rescheduled by the NAL AC at the request of the Member.
Self-care	NAL RN advised self-care.

Categories	Definition
Transfer to NAL AC	Used for *Existing Call Types* when a member/beneficiary/patient is directly transferred to the NAL AC for NAL services (i.e. the directed UC was closed, the UC did not service pediatric patients, an appointment cancellation, rescheduling, etc.).
UC	Standard or MCSC-enrolled with an UC final resource chain, ending with the NAL RN.
UC - Network	NAL AC successfully enters the UC Referral in CHCS/MHS GENESIS and obtains a referral number, documents it, and provides it to the NAL caller or the NAL AC provides a lookup for either MCSC or standard enrollee resulting in network UC. NOTE: This disposition may also be used in cases in which the UC referral could not be entered (i.e., technical issues, no assigned PCM) but the caller is referred to a network UC.
UC - non-Network	NAL AC advised the caller to seek care at a non-Network UC and/or provided look-up services for a non-Network UC due to MTF UC/ED, the Network UC not being available, or the NAL AC provides a look-up for either MCSC or Standard enrollee resulting in non-Network UC. NOTE: This disposition may also be used when a UC referral is successfully entered in CHCS/MHS GENESIS, but there are no network UCs available or in cases in which the UC referral could not be entered (i.e. technical issues) but the caller is referred to a non-Network UC.
UC - Self-referred	NAL caller is non-active duty MTF Prime enrollee and has refused action either by an NAL RN or NAL AC. They were provided with a National Defense Authorization Act UCC Pilot option.
UC/ED - MTF	NAL AC referred member to an available MTF UC/ED.
Unknown	If a caller hangs up without accepting action or a caller never made it to NAL AC.

4. <u>ROLES AND RESPONSIBILITIES</u>

   a. <u>NAL PMO</u>

      (1) Provides oversight of the NAL Program by executing the following:

         (a) Monitors the existing NAL contracts, workflows, and processes

         (b) Conducts data analysis

         (c) Serves as a liaison between the Services, eMSMs, and the NAL Contractor

         (d) Conducts Quality Assurance (QA) audits

         (e) Performs NAL sustainment tasks, as follows:

            <u>1</u>. Performs CHCS/MHS GENESIS activation and deactivation notifications

            <u>2</u>. Coordinates NAL access to MHS Genesis

            <u>3</u>. Initiates and collects holiday closure notifications

            <u>4</u>. Collects NAL clerk hand-off instructions

<u>5</u>. Manages NAL WRR or NALMS user accounts

<u>6</u>. Provides NAL WRR or NALMS website assistance.

(2) Identifies systematic issues and provides recommended solutions for continuous process improvement based on Service, eMSM, MTF, and beneficiary feedback.

(3) Develops NAL policies, procedures, and guidelines, and represents and advocates for the NAL throughout the MHS Governance Process.

b. <u>Services and eMSM Leads</u>. Each Service and eMSM is responsible for identifying a lead representative to perform the following:

(1) Provide guidance and direction to the MTFs on current NAL processes and procedures.

(2) Monitor and analyze NAL WRR or NALMS encounter data (please see paragraph 7, Metrics)

(3) Review, validate, and collate MTF NAL instructions and holiday closure reports; and ensure MTFs activate CHCS/MHS GENESIS accounts for the NAL CSRs and ACs. Ensure NAL CSRs/ACs accounts are active within 30 days of notification.

(4) Ensure MTF staff and beneficiaries are educated on the current NAL processes and the proper use of the NAL.

(5) Identify Service or eMSM-specific systematic issues and provide recommended solutions to NAL PMO.

(6) Attend monthly NAL Service and eMSM Lead meetings with NAL PMO and TRICARE Regional Offices.

(7) Manage Service, eMSM, and MTF-level NAL WRR or NALMS user accounts.

c. <u>MTFs POCs</u>

(1) The NAL Program is designed to support and augment—but not replace—the MTF's PCMH services. It is intended to reduce the workload of MTFs, clinic nurses, and central appointment desks by providing beneficiaries an alternative route in seeking medical advice and obtaining only necessary appointments. The NAL is **not** intended to replace the MTF's central appointment desks. MTFs should continue to make appointments locally when beneficiaries contact the central appointment desk, and not refer or transfer beneficiaries to the NAL who call them for an appointment.

(2) The NAL is not intended to replace the MTF nurse triage process. If the MTF has a nurse triage process in place, they should continue to provide beneficiaries with local nurse

triage during the regular MTF business day, and not refer them to NAL for nurse triage. Beneficiaries may contact NAL directly. But, MTFs with a current nurse triage process in place should not transfer beneficiaries during duty hours for the purpose of nurse triage.

(3) Each MTF is responsible for identifying the proper NAL POC to perform the following tasks: Ensure the MTF-specific NAL instructions are in scope and up to date; review referrals submitted by NAL ACs for accuracy, follow-up with enrolled beneficiaries, and submit civilian UC referrals in CHCS/MHS GENESIS or MHS Genesis for beneficiaries who called the NAL and the NAL AC was unable to enter the referral due to system outages or for beneficiaries who do not have an assigned PCM. MTF NAL POCs must ensure CHCS/MHS GENESIS and MHS Genesis accounts for NAL CSRs/ACs are activated and completed within 30 days. This task requires coordination with the MTF's CHCS/MHS GENESIS POCs. Other responsibilities include the following:

(a) Monitor the NAL WRR or NALMS and review the MTF's beneficiary's demand (See paragraph 7, Metrics).

(b) Follow-up on crisis calls (please see Attachment 4: NAL Crisis Call Guidance).

(c) Review NAL Encounters and submit valid QA concerns (See Attachment 5).

(d) Upon notification of beneficiary feedback, contact beneficiary for an appropriate follow-up and educate them on the proper use of the NAL, as needed.

5. <u>STANDARDIZED BUSINESS PRACTICES</u>

   a. <u>MTF Telephone Trees</u>

(1) Many MTFs have chosen to add the NAL as an option on their phone trees. During normal business hours of the MTF appointment line or call center, the NAL may be placed on the telephone tree as an option other than Option #1. The NAL is recommended to be behind the options for making primary care, specialty care, and dental appointments, and the ability to leave a phone message for their PCM. The NAL may be moved to the first option when the appointment line is closed.

(2) Under no circumstances will MTFs, appointment lines, or call centers automatically transfer callers to the NAL without the caller being able to press an option.

(3) NAL PMO recommends MTFs add an option to their MTF phone tree connecting beneficiaries to their MTF for requests for medical records. In the event NAL PMO receives a request from a beneficiary for their NAL encounter record, the PMO will contact the NAL MTF POC and ask that they work with the MTF Patient Administration Office to coordinate any release of information regarding NAL encounters.

b. <u>Transferring to the MTF</u>. When no appointments are available in CHCS/MHS GENESIS, the NAL staff is required to transfer the caller to the MTF, clinic, or in some cases, the centralized appointing center for further action during duty hours. MTF POCs should not ask the NAL staff member to remain on the line once the transfer information has been provided, as the NAL staff members have post-call actions that must be completed immediately after being released.

c. <u>Primary Care Access to Care Requirement</u>

(1) MTFs can utilize the NAL to meet The Joint Commission (TJC) requirement to provide primary care access 24 hours a day, 7 days a week. The NAL meets the intent of TJC standards to obtain clinical advice for UC needs and a same or next day appointment (please see paragraphs (a) and (c) below). However, an on-site Joint Commission surveyor would make the final determination during the survey process. TJC PCMH standards state:

(a) The organization provides patients with the ability to do the following 24 hours a day, 7 days a week:

<u>1</u>. Contact the PCMH to obtain a same or next day appointment.

<u>2</u>. Request prescription renewals.

<u>3</u>. Obtain clinical advice for urgent health needs.

(b) The organization offers flexible scheduling to accommodate patient care needs. NOTE: This may include open scheduling, same-day appointments, group visits, expanded hours, and arrangements with other organizations.

(c) The organization has an established process to respond to patient UC needs 24 hours a day, 7 days a week.

(2) MTFs have other means of meeting TJC standard 2, via secure messaging and TRICARE On-Line.

6. <u>NAL WRR/NALMS FUNCTIONALITY</u>. The NAL WRR or NALMS:

a. Serves as the near real-time database, which contains all NAL call encounter information. Access is granted at the MTF, Service, eMSM, and NAL PMO level and the site is CAC-enabled. Site access is also restricted to approved-Internet Protocol addresses.

b. Can be accessed by clicking the following link using CAC access: https://conusnal.service-now.com/wrr/home.do.

c. Enables end users to do the following: Update MTF clinic information (e.g., MTF closures and telephone numbers); update personal account information; monitor beneficiary

activity; identify beneficiaries who received a network UC referral from the NAL; and conduct data analysis on beneficiary utilization.

7. <u>METRICS</u>. In order to measure the success and benefit of the NAL Program, corporate standardized metrics have been established. The NAL PMO and PCMH Branch use the following metrics within DHA on a regular basis.

   a. Process and Performance Metrics: NAL call volume by: enrollment type (e.g., MTF, MCSC, and Standard), Service and eMSM, the beneficiary's age, the day of week and month; NAL Call Utilization per 100 enrollees; booking analysis; percent of calls successfully booked directly into CHCS/MHS GENESIS/MHS Genesis or transferred to the MTF; percent of adult and pediatric triage algorithms used; top 10 reasons for calls; and percent of calls requiring Emergency Medical Service activation.

   b. Outcome Metrics: The NAL PMO provides a NAL Outcome Excel-based tool to assess the NAL caller's pre-intent in comparison to the assigned NAL RN's advice for care and the beneficiary's actual election of service. The MHS Mart (M2) is used to determine what the beneficiary did 24 hours after the beneficiary called the NAL. This Excel-based tool is located at: https://info.health.mil/hco/clinicsup/hsd/pcpcmh/nal/SitePages/Home.aspx. This tool also includes purchased care ED/UC cost avoidance.

ATTACHMENT 4

CRISIS CALL GUIDANCE

1. DEFINITION. A NAL call is considered a "crisis call" when the caller and/or concerned party states/verbalizes signs of distress, instability, and/or poses a danger to themselves or someone else. This definition includes the following call types, but is not limited to: suicide, homicide, incapacitated caller, violent crime/act, domestic abuse, elder or dependent abuse, sexual assault, and/or suspected child abuse.

2. NAL PROCESS FOR HANDLING CRISIS CALLS

    a. The NAL has internal processes for handling various types of crisis calls that include facilitating activation of emergency services to be sent to the beneficiary's location. As a secondary option, the NAL may choose to transfer appropriate beneficiaries with select behavioral crises to the Military Crisis Line, if the caller is agreeable to transfer.

    b. All steps taken will be documented clearly and completely in the NAL WRR or NALMS to the extent that the caller cooperates with the NAL RN's or CSR's attempts to provide assistance, and the caller provides information to support the documentation.

3. NAL CRISIS CALL MHS NOTIFICATION PROCEDURES

    a. NAL PMO. Upon notification of a crisis call, the NAL PMO will notify the Service designated authority, as directed by the Service-specific guidance.

    b. NAL Service Lead. As a representative of their respective Service, the NAL Service Lead will:

        (1) Provide the NAL PMO with specific guidance on who should be notified of NAL crisis calls originating from a beneficiary affiliated with their service and within what timeframe.

        (2)   Ensure the designated POC(s) are trained on whom to notify and in what timeframe as specified by their Service.

        (3) Send the post-crisis call information to the MTF NAL POC to ensure that the beneficiary received the appropriate follow-up care.

        (4) Provide the NAL PMO an update once the MTF has followed up with the beneficiary.

(5) Be responsible for providing the NAL PMO with a single telephone number or a list of telephone numbers that will be answered 24 hours a day, 7 days a week, if the Service requests immediate notification.

c. <u>MTF</u>. The MTF will:

(1) Reach out to the beneficiary to ensure that appropriate care was received and that the care is coordinated with the beneficiary's PCM.

(2) Provide an update to the NAL Service Representative once the MTF has followed up with the beneficiary.

ATTACHMENT 5

NURSE ADVICE LINE QUALITY ASSURANCE PROCESS

1. NAL QA PURPOSE

a. The NAL PMO is responsible for administering a QA Plan for evaluating all clinical and operational quality-related aspects of the NAL contractor performance. The NAL QA Plan demonstrates how the interaction between the government and the NAL contractor ensures high quality telehealth services for TRICARE beneficiaries throughout the United States is delivered by the NAL. QA calls provide an opportunity for Services, eMSMs, and MTFs to reflect on current clinical processes and provide feedback for improvement to the NAL contractors and NAL PMO.

b. The NAL QA Plan includes the review of recorded NAL calls to determine if triage algorithms are being used appropriately or need to be modified. It assesses whether or not the NAL RN performed accordingly in triaging the caller and the correct level of care was recommended, as well as determine if additional training of Telehealth NAL RNs is necessary. Calls are recorded and saved for 30 days. Older calls can be retrieved on a case-by-case basis.

c. Any MTF with clinical concerns regarding a NAL call may request a Quality Call Review submitted through their Service Lead to the NAL PMO at any time. Any interested party from the Service, eMSM, or MTF may call into the quality review.

d. NAL QA call reviews are bi-weekly and occur on Wednesdays. This bi-weekly teleconference includes listening to the encounters between the Telehealth NAL RN and the beneficiary by the NAL contractors, NAL PMO, and Service Leads/MTF Staff affected by the encounter. Audio reviews do not include the CSR or AC portion. However, CSR and AC QAs can be submitted for further investigation. After listening to the RN portion of the call, all parties have an opportunity to express concerns and offer recommendations. Lessons learned are documented and returned to the NAL Service and eMSM Leads.

2. NAL QA RESPONSIBILITIES

a. NAL PMO. The NAL PMO will:

(1) Consolidate QA Forms sent from NAL Service Leads onto the NAL PMO Extended QA Form each Monday.

(2) For each encounter, determine if the encounter requires an audio review for a more in-depth clinical evaluation based on the findings.

(a) Generally, a provider is present on the call for additional clinical evaluation. If a provider is available and an additional clinical review is necessary, NAL PMO will defer to the Tri-Service PCMH Advisory Board.

(b) NAL PMO may also request a clinical review on the contractor side as well.

(3) Be included on the NAL PMO Extended QA form for all encounters requiring audio review.

(4) Review the submissions and annotate their findings; the NAL PMO Extended QA Form will be forwarded to NAL Contract PMO for review. The Extended QA form is reviewed with the contractor, NAL PMO, Service Leads, eMSMs, and participating MTF representatives during the next regularly scheduled QA meeting. The NAL Contract PMO will document the highlights of the interview between the beneficiary and the NAL RN. The NAL Contract PMO areas of improvement will be documented and include the clinical content review, supervisory coaching of staff, and risk management review.

(5) Return the Final QA Extended Form via email to the eMSM/Service Lead by the Contractor PMO. The eMSM/Service Lead will use the sorting mechanism on the document to filter each MTF/eMSM to send out separate documents to each MTF/eMSM.

   b. Service or eMSM Lead. The Service or eMSM Lead will:

(1) Gather all QA Forms provided to them throughout the week from the sites and consolidate them into one document.

(2) Review each encounter and provide any form of commentary deemed necessary or appropriate (e.g., findings, recommendations, and comments) in their designated area of the QA Form (**only** the section labeled eMSM/Service Leads).

(3) Email their completed forms by close of business every Monday to the DHA NAL PMO QA representatives for review.

   c. MTF/Clinic. When an MTF/Clinic POC identifies a concern with an NAL encounter report, the member will document key findings on the QA form. Examples of QA concerns include: inappropriate bookings, clinical concerns, incomplete/incorrect documentation, or the contractor not abiding to clinic guidance as provided on the warm transfer instruction sheet. Once the designated areas are completed, the POCs will email the QA Form to their Service or eMSM NAL representative.

GLOSSARY

ABBREVIATIONS AND ACRONYMS

AC   appointing clerk

CAC   Common Access Card
CHCS   Composite Health Care System
CONUS   continental United States
CSR   customer service representative

DEERS   Defense Enrollment Eligibility Reporting System
DHA   Defense Health Agency
DHA-IPM   Defense Health Agency-Interim Procedures Manual

ED   Emergency Department
eMSM   enhanced Multi-Service Market

MCSC   Managed Care Support Contractor
MHS   Military Health System
MTF   Medical Treatment Facility

NAL   Nurse Advise Line
NALMS   Nurse Advice Line Management System

OCONUS   outside continental United States

PCM   Primary Care Manager
PCMH   Patient-Centered Medical Home
PMO   Program Management Office
POC   point of contact

QA   Quality Assurance

RN   registered nurse

STP   Speak to Provider

TJC   The Joint Commission

UC   Urgent Care
UC/ED   Urgent Care/Emergency Department
UCC   Urgent Care Clinic
UC-GM   Urgent Care-General

WRR   Web Reporting Repository