UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND
READINESS

JAN 1 2 2021

The Honorable James M. Inhofe
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The Department's report in response to section 744 of the National Defense Authorization Act for Fiscal Year 2020 (Public Law 116-92), which requires the Secretary of Defense to conduct a study on the effectiveness of Case Management practices in the Military Health System, is enclosed.

The report highlights specific Department of Defense and Military Department provisions and standardization of Case Management services resulting in uniformity of clinical processes between military medical treatment facilities. In particular, the report evaluates processes before and during the transition of military medical treatment facility administration to the Defense Health Agency (DHA) and identifies Military Department-specific practices incorporated in the respective regulations.

Thank you for your continued strong support for our Service members, civilian workforce, and families. I am sending an identical letter to the House Committee on Armed Services.

Sincerely,

//SIGNED//

Matthew P. Donovan

Enclosure:
As stated

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PERSONNEL AND
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JAN 1 2 2021

The Honorable Jack Reed
Ranking Member
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Senator Reed:

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PERSONNEL AND
READINESS

JAN 12 2021

The Honorable Adam Smith
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

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PERSONNEL AND READINESS

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

JAN 12 2021

The Honorable Michael D. Rogers
Ranking Member
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Representative Rogers:

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As stated

Report to Congress

Study on Case Management in the Military Health System

Requested by: Section 744 of the National Defense Authorization Act for Fiscal Year 2020 (Public Law 116-92)

January 2021

The estimated cost of this report or study for the Department of Defense (DoD) is approximately $64,000.00 for the 2020 Fiscal Year. This includes $7,000.00 in expenses and $57,000.00 in DoD labor.
Generated on 2020 Sep 02 Ref ID: 5-359EF69

TABLE OF CONTENTS

EXECUTIVE SUMMARY

This report is in response to section 744 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2020 (Public Law 116-92). This submission provides a report on a "Study of Case Management in the Military Health System." Key elements include: a standardized definition of Case Management (CM); an evaluation of CM practices provided by the Military Departments (MILDEPs) before and during the transition of the administration of military medical treatment facilities (MTFs) to the Defense Health Agency (DHA) pursuant to section 1073c of title 10, United States Code (U.S.C.); a discussion of the metrics used in determining CM effectiveness and cost; an evaluation of CM and outreach provided by managed care support contractors (MCSCs) supporting DHA; a review of CM best practices in the private sector; and the results of discussions with covered beneficiaries at no less than four public forums held in different geographic areas, relating to the satisfaction of such covered beneficiaries with CM and outreach provided by DHA and the MILDEPs in MTFs.

The Department of Defense (DoD) Military Health System (MHS) is engaging in an organizational health care transformation to manage care within DHA, including the delivery of CM services to members of the Armed Forces and other covered beneficiaries. DHA has made great progress in the provision and standardization of CM services, resulting in higher reliability in health care delivery and uniformity of clinical processes within MTFs. Expanded engagement and collaboration between DHA and the MILDEPs, as a result of the required transition of MTF authority, direction, and control (ADC) to DHA, has improved the standardization of these clinical practice efforts. Data collected to date has informed DHA's transformation and is the basis for further metric development. In addition, current and future data collection will inform DHA's approach to a more integrated system of care, consolidating and standardizing programs around the supported population. Military MHS collaboration remains critical to many accomplishments in the development and implementation of dedicated policies and procedure standardization. This tri-Service collaboration resulted in reduced practice variation, decreased fragmentation in care processes, and enhanced delivery of an integrated enterprise-wide approach to CM practice and services.

INTRODUCTION

Through advocacy and education functions, the Case Management Society of America (CMSA) has been an organizing force in setting the practice direction for CM. CMSA promotes evidence-based practices and discourages the use of practices which, though popular or widely accepted, are either not beneficial or are contrary to the CMSA CM Standards of Practice. The underlying premise of CM is that everyone benefits when an individual reaches the optimum level of wellness and functional capability: the individuals being served, their support systems, the health care delivery systems, and the various reimbursement sources. CM is a mechanism for achieving patient wellness and independence through support, education, identification of service resources, and service facilitation. The case manager helps identify appropriate providers and facilities throughout the continuum of services, while ensuring available resources in a timely and cost-effective manner to obtain optimum value for the beneficiary and the reimbursement source. CM services should be offered in an environment which allows for direct communication between the case manager, the beneficiary, and the appropriate service personnel (www.cmsa.org, July 2020).

As defined by the CMSA, "CM is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost effective outcomes" (www.cmsa.org, July 2020). With the transition of MTF ADC from the MILDEPs to DHA, the MHS CM program incorporates both the CMSA's CM definition and its Standards of Practice, across the MHS CM health care continuum. The MHS CM program is dedicated to promoting patient goal setting and encourages optimal wellness through advocacy, ongoing communication, health education, coordination, and facilitation of necessary care services and resources.

To achieve these objectives, the MHS has continued to identify and execute enterprise-wide process improvements on behalf of Service members, Veterans, and their families, to include the development and execution of standardized program guidance, utilization of evidence-based tools to support proactive identification and engagement, and improved collaboration and integration with interdisciplinary care teams. These examples will be highlighted in more detail below. Enhanced enterprise-wide programmatic improvements have also reinforced the need for CM integration and services across various MHS care platforms. Case managers support the identification of individuals with chronic, complex, high-risk, and / or high-cost conditions that would benefit from engagement and coordination with dedicated health care teams to reduce fragmentation across the MHS. This transformation supports the MHS Quadruple Aim to optimize health system performance.

EVALUATION OF CASE MANAGEMENT PRACTICES PROVIDED BY THE MILITARY DEPARTMENT

Section 702 of the NDAA for FY 2017 directed the transition of MTFs from the MILDEPs to DHA in support of a more integrated system of readiness and health. The transition to DHA was

initiated on October 1, 2018; the time after this date to the present is referenced in this report as the "during" timeframe. The time prior to October 1, 2018 is considered "before" the transition to DHA. MTFs located Outside the Continental United States (OCONUS), Region Europe and Region Indo-Pacific, are scheduled to transition in FY 2021, and are excluded from this report. This report is in response to Section 744 of the NDAA for FY 2020, requiring the evaluation of CM practices provided by the military before and during the transition to DHA, pursuant to Section 1073c of Title 10, U.S.C. Timelines are distinguished to provide a meaningful comparison of CM practices before and during the transition to DHA.

Before DHA Transition (September 30, 2017 – September 30, 2018)

The following section highlights the MILDEPs CM programs prior to the initiation of MTF ADC transitioning from the MILDEPs to DHA.

Department of the Army

Before transitioning to DHA, Army CM operated under the following policies:

- Department of Defense Instruction (DoDI) 6025.20, "Medical Management (MM) Programs in the Direct Care System and Remote Areas," (April 09, 2013)
- Army Medical Command (MEDCOM) Operations Order (OPORD) 13-25, "Nursing Case Management Guidance" (January 02, 2013)

The Army MEDCOM OPORD served to consolidate and clarify guidance outlined within DoDI 6025.20 for Army-centric Active Duty and civilian CM in all clinical practice settings across the Army. Army case managers were required to hold a current unrestricted state license as a registered nurse, complete the standardized DHA baseline competency assessment checklist and unit specific checklists within 30 days of employment prior to accepting a caseload, and complete a minimum of 20 hours of CM-related continuing education credits annually. The Army Nurse Case Manager course was mandatory for nurses working in the Warrior Transition Unit (WTU), and optional for case managers in all other practice settings. The course satisfied the requirement for the CM Additional Skill Identifier representing extra skills, training, and qualifications for Army nurses. Students became course graduates upon completion of preceptorship and a validated competency assessment. In addition, local, regional, and national conferences were made available to support continued learning and professional development.

The quality of work performed by case managers was assessed utilizing the Electronic Health Record (EHR) with audits performed by peers, supervisors, region leads, and headquarters-level staff members during Staff Assistant Visits and Organizational Inspection Programs. Army case managers implemented dedicated and standardized CM documentation in the outpatient medical record, Armed Forces Health Longitudinal Technology Application (AHLTA), utilizing the standardized DHA Tri-Service Workflow Forms (TSWFs)/Alternate Input Method (AIM) Forms. Army case managers applied the CM Acuity Calculator to monitor the quality of CM work and provide timely feedback to case managers. The care setting and complexity of care

determined the frequency and volume of documentation of CM services based on the emerging patient care needs, an approach that aligned with CMSA practice standards. Specific elements for CM documentation requirements were inclusive of consent or declination for CM services, comprehensive assessment information, and the CM care plan. CM coding was required for clinical case managers. This encompassed primary and secondary diagnosis codes, an Evaluation and Management code, five acuity level codes, and various procedure codes. This coding requirement directed the status of the case and the time associated in direct and indirect coordination of care for the encounter by the case manager. Additionally, the Medical Expense Performance Reporting System codes were required to ensure accurate cost accounting for Army CM activities.

Army CM focused on readiness within the Warrior Transition Battalion (WTB)/WTU/Warrior Transition Command (WTC), resource utilization complexity of care, over utilization (predominately within the Emergency Room (ER), Intensive Care Unit, and Pharmacy), care across multiple agencies, catastrophic events/conditions, and at-risk populations. Behavioral Health (BH) case managers identified at-risk/high-risk Service members, in conjunction with embedded BH teams. Anecdotally, Connect Care Program Managers (PMs) provided specialized care coordination for Active Duty Service Members (ADSMs) who required higher levels of BH and substance use care to ensure medically and psychologically necessary care at the least restrictive level using direct care resources prior to TRICARE referral. Initially, MTFs transitioned to DHA were in a direct support relationship with the intermediate management organizations. Reorganizational efforts were focused on providing beneficiaries with standardized services and high quality care.

Department of the Navy

Before transitioning to DHA, the Bureau of Medicine and Surgery (BUMED) utilized the following policies to ensure CM services aligned to industry standards:

- DoDI 6025.20
- DoD MM Guide, Version 3.0, (2009)
- BUMED Instruction 6300.19, Primary Care Service in Navy Medicine, (May 26, 2010)
- BUMED Instruction 6300.17A, Navy Medicine Clinical Case Management, (September 23, 2016)

BUMED policy and procedures for CM services refers to best practice standards from The Joint Commission (TJC) Provision of Care (see https://foh.psc.gov/tjc/provisioncts.html) and are described within the Department of Veterans Affairs (VA) and DoD Clinical Practice Guidelines (see https://www.healthquality.va.gov/). Unique to Navy, BUMED Note 6300, "Case Management," offers policy guidance to standardize and implement best practices in MM services at OCONUS MTFs, ensure seamless health care delivery to beneficiaries in direct care and private sector care settings, and maintain medical readiness of the force.

Navy case managers were required to complete online educational development training in the knowledge share MHS Learn platform. Completion of mandatory training courses was required for case managers to access records and provide CM services. Training courses included: CM TSWF/AIM Form Recorded Training; Health Artifact and Image Management Solutions; Privacy and Personally-Identifiable Information Awareness Training; Health Insurance Portability and Accountability Act and Privacy Act Training; EHR Training: AHLTA, Composite Health Care System, and MHS GENESIS. BUMED shared additional opportunities for training with all Navy Medicine case managers at planned monthly meetings.

Case manager competency assessments were conducted within three months of hire, utilizing "Navy Medicine (NAVMED) FORM 6317/1" and included a self-assessment at the beginning of orientation as well as a post-assessment after an orientation period, which ensured case managers had the competency and skills needed to provide services independently. Competency reassessment was conducted at least once every two years, or as required by MTF policy. Both initial competency and reassessment were documented using the approved NAVMED form and maintained in the case manager's training record.

To identify patients who needed CM, case managers reviewed and screened different sources, including all Navy and Marine Corps Service members placed into Limited Duty status, MTF inpatient admission and disposition lists, Wounded Warrior reports, and ER/urgent care clinic patient rosters. Multi-disciplinary teams and case managers met frequently following inpatient ward rounds. Case managers also screened case referrals from primary care and specialty care providers, self-referrals from patients and families, cases from nonmedical case managers, and VA Federal Recovery Coordinators.

BUMED CM EHR documentation was standardized utilizing the DoD AIM Form. New case managers had monthly documentation reviews performed by their supervisors during the first six months of being hired, and quarterly reviews thereafter. Case managers were required to obtain document consent on NAVMED 6317/2 Clinical CM & Care Coordination Program Patient Consent Form to provide CM services. Documentation had to comply with standards of practice set forth by the CMSA and the MHS Coding Guidelines. The transition of BUMED to DHA has streamlined and standardized how the Navy approaches CM, resulting in a more collaborative and effective process.

Department of the Air Force

Before transitioning to DHA, Air Force (AF) CM practices were aligned with DoDI 6025.20 and the DoD MM Guide, Version 3.0. Service-specific policies were then further delineated and guided by:

- Air Force Instruction (AFI) 44-173, Population Health, (November 19, 2014)
- AFI 44-102, Medical Care Management, (March 17, 2015)
- Air Force Policy Directive 44-1, Medical Operations, (June 9, 2016)

These AF policies provided instruction for organizational provision of medical care in association with DoD publications and provided professional best practice standards and guidelines for defining case managers' role and responsibilities in the health care delivery model.

Training of AF case managers included completion of an AF initial clinical competency assessment tool, and an annual competency review. To meet clinical competency standards, case managers completed online education in the knowledge share MHS Learn platform. To ensure ongoing currency of CM knowledge, skills, and abilities, completion of standardized training courses in MHS Learn was mandatory. Additional educational opportunities and evaluation activities were conducted in collaboration with Tri-Service CM consultants and through internal and external peer reviews. Completion of educational requirements by individual case managers was tracked and reported for continuous program improvement.

Following new recommendations outlined in the 2014 Secretary of Defense MHS review, the AIM form was replaced with an enterprise-wide TSWF, developed through collaborative efforts with DHA and the MILDEPs, which expanded CM documentation and capture and aligned with TJC and the Agency for Healthcare Research and Quality (AHRQ). The TSWF exceeded the Secretary of Defense MHS Review recommendations. The transition of AF to DHA has streamlined and standardized how AF approaches CM, and the process is now more collaborative and effective.

During DHA Transition (October 1, 2018 – Present)

The transition of MTF ADC to DHA has provided an opportunity to bring the MILDEPs together in the development of a standardized approach. Beneficiaries across the enterprise now have the same standards of care, which strengthens the quality of care being provided and aligns with the goals of the Quadruple Aim. The following section describes the current MHS CM program and highlights Service-specific differences.

MHS CM Program

As part of the transition, and in coordination with the MILDEPs, DHA participated in strategic policy development and collaboration to initiate policy directives to support the MHS transformation and health care delivery standardization. DHA Procedural Instruction (PI) 6025.20, "MM Program within the MHS" (August 27, 2019), was developed and is now the standard used for CM throughout DHA. Based on this policy, DHA now monitors delivery of evidence-based care and patient outcomes throughout the MTFs.

To achieve an integrated approach, DHA and the MILDEPs began a collective transition to a comprehensive and consistent MHS-wide CM practice model, which is outlined in DHA-PI 6025.20. This instruction directs MHS use of standardized documentation, training, MTF-based competency assessments, and evidence-based predictive analytics (see more details below) to proactively identify beneficiaries in need of CM services.

Additionally, DHA implemented a CM competency checklist in alignment with the CMSA Standards of Practice. This checklist is applicable to all CM disciplines, along with common processes and procedures for CM point of care, to facilitate screening, documentation, multidisciplinary team communication, and clinical content across the MHS.

Historically, CM targeted complex high-risk patients and beneficiary populations with high resource utilization. Today, the MHS has improved capabilities in utilization of evidence-based tools with proactive identification management of those beneficiaries that may benefit from CM services using predictive analytics. Specifically, the MHS leverages the evidence-based Johns Hopkins Adjusted Clinical Groupings (ACG) to identify patients through a population-based approach, rather than a single diagnosis. Patients identified as high-risk are listed on the web-based MHS Population Health Portal (MHSPHP) utilized by CM personnel at the point of care. Utilization of the MHSPHP tool provides CM personnel the capability to identify and intervene for at-risk populations proactively, as opposed to retroactively. "Unlike many traditional methods for case identification (such as hospital concurrent review and emergency department (ED) utilization reports), the ACG Predictive Model identifies many persons in need of care management intervention before they become high utilizers" (Johns Hopkins, 2015). Standardizing CM processes benefits military health care beneficiaries and closes the gap on operational variance, in addition to promoting identification of best practices. Dedicated education and training modules are now accessible to Service CM personnel on the MHS training platform Joint Knowledge Online (JKO) and are available 24 hours a day.

As a result of the transition to DHA, CM now falls under MM, increasing CM accountability and the ability to provide more well-rounded CM services to beneficiaries, including wounded Service members. Overall, MHS now better aligns with industry-based best practices, and military CM and health care has moved forward on the journey to high-reliability, improving beneficiary health outcomes and positively impacting overall military readiness.

Service-Specific Differences

Army

Before the transition, the Patient Centered Medical Homes and the Soldier Centered Medical Homes, although guided by the same policy, had different mission requirements for their case managers. Since the transition, many of the Army CM programs align with the "readiness mission" under the Army Training and Doctrine Command with MEDCOM governing case managers. This helps to maintain communication and ensures the same level of care is provided by all case managers across the enterprise. MEDCOM continues to maintain military health workforce readiness in addition to delivering health care operationally in support of deployed forces. Additionally, Army MM now leverages monthly meetings with senior leaders to scale and spread the new enterprise-wide CM practice model, outlined in DHA-PI 6025.20.

Navy

Navy CM is guided by DHA-Interim Procedures Memorandum 19-004, "Utilization of the Case Management (CM) Registry (Active and Screening) for Military Health System (MHS) Beneficiaries" (April 23, 2020), as well as DHA-PI 6025.20. BUMED participates with MHS efforts.

Air Force

With collaboration from the Services and DHA, AF case managers have developed targeted synergistic practices, procedures, and evidence-based tools aimed at reducing practice variance and improving efficiency and effectiveness. In addition, AF maintains a strong MM background with a focus on CM and Disease Management all falling under the same authority.

MHS CM CORONAVIRUS DISEASE 2019 (COVID-19) RESPONSE

In response to the COVID-19 pandemic, the MHS delivers ongoing CM services across the care continuum regardless of the MTF's transition status. Remaining sensitive to operations, high-risk CM patients are interviewed, screened, and consulted utilizing virtual modalities, strategically identifying critical elements of health conditions requiring follow-up with primary care managers or specialists limiting unnecessary exposure risk. These actions minimize gaps in health care delivery and documents encounters and interventions within the EHR. Telephonic communication now includes review of signs and symptoms, education of disease process and prevention, medication review, and outstanding appointments. Case managers support efforts in various capacities, to include follow-up with COVID-19 patients to monitor complications related to the virus. CM teams assist in rescheduling missed critical appointments, reducing negative impacts to Service members and beneficiaries. Based on these efforts, feedback from beneficiary and/or family members treated by the case managers report feelings of being reconnected and reassured. According to MM Service leads, case managers are further expanding their clinical expertise, many case managers took on the role of providing triage for the COVID-19 hotline, receiving calls and coordinating needed services in support of public health initiatives. Case managers who provide triage support attend COVID-19 roundtables focused on maintaining closed-loop information sharing and mission alignment.

BH case managers enhance provider efficiencies in the management of high-risk patients through regular communication (at least weekly) with the Army Service member's unit/command and the individual Service member. Additionally, Army Connect Care PMs provide specialized care coordination for ADSMs requiring higher levels of BH and substance use disorder care. This improves the communication of information regarding real-time COVID-19 testing requirements, quarantine restrictions, and requirements for ADSMs located in the continental United States (CONUS) and OCONUS. MHS CM supports engagement regardless of location or specialty within the MTF and focuses on continuity of CM practice to ensure ongoing provision of care.

METRICS USED IN DETERMINING EFFECTIVENESS AND COST

The MHS has made progress toward developing standard processes and tools to decrease practice variance across the enterprise in alignment with DHA's goal of providing consistent patient experiences and outcomes, wherever care is received. Specifically, for CM, the MHS has developed and implemented standardized competencies, training, and workflows aligned with industry based best practices to promote uniform care delivery across the enterprise. These efforts reflect a drive toward developing one cohesive framework for CM service provision across the MHS. Ultimately, the aim is to deliver reliable, efficient, high quality patient experiences to ensure optimal wellness in the MHS CM population (CMSA, 2016).

Incremental implementation of standards serves to move the program toward a cohesive strategy and concurred upon program goals, which will serve as the framework for measuring program effectiveness. One accomplished component of the CM standardization effort is the new implementation of patient registries specific to the CM population. Historically, case finding efforts varied among case managers and were targeted toward populations or diagnostic conditions where there was evidence of costly, high-risk, and high-resource consumption. To improve this variance and to facilitate case findings, DHA deployed a CM screening registry, powered by the Johns Hopkins ACG System predictive analytics algorithms, so MTF case managers could identify and proactively engage with persons that may need CM intervention (Johns Hopkins, 2015). In addition, DHA provisioned an active case registry to aid in workload tracking and facility level case viewing in a single electronic source.

The MHS CM registry program evaluation involved developing metrics to track registry utilization and practice standardization across the enterprise. Based on findings of accountability regarding electronic patient tracking and data support, registry tools were developed and adopted in the MHS in mid-May 2019, after which a 90-day period was granted for training and dissemination. As such, in this report, CM registry program metrics are new and limited to Quarter (Q) 4 FY 2019.

In Q4 FY 2019, the CM registry tool identified 9,271 direct care beneficiaries as potential candidates for CM services. Of those identified, 5,016 (54 percent) had been already screened and 1,568 (16.9 percent) entered into CM services as of the end of the reporting period. While not part of the metrics identified for reporting, a notable process observation was an increase in the use of the TSWF, a standardized electronic documentation template for CM in the MHS, designed to reflect CM practice standards (CMSA, 2016). A usage chart for the TSWF CM charting tool for the period of May 2019 through August 2019 is shown below in Figure 1. Of note, case manager use of the standardized charting form increased to over 90 percent of initial CM encounters by August 2019. This increase demonstrates improvement of patient tracking with a goal of tracking overall patient outcomes, which will inform practice changes. The framework provides for the deliberate documentation of the problem and can be adjusted based on data findings.

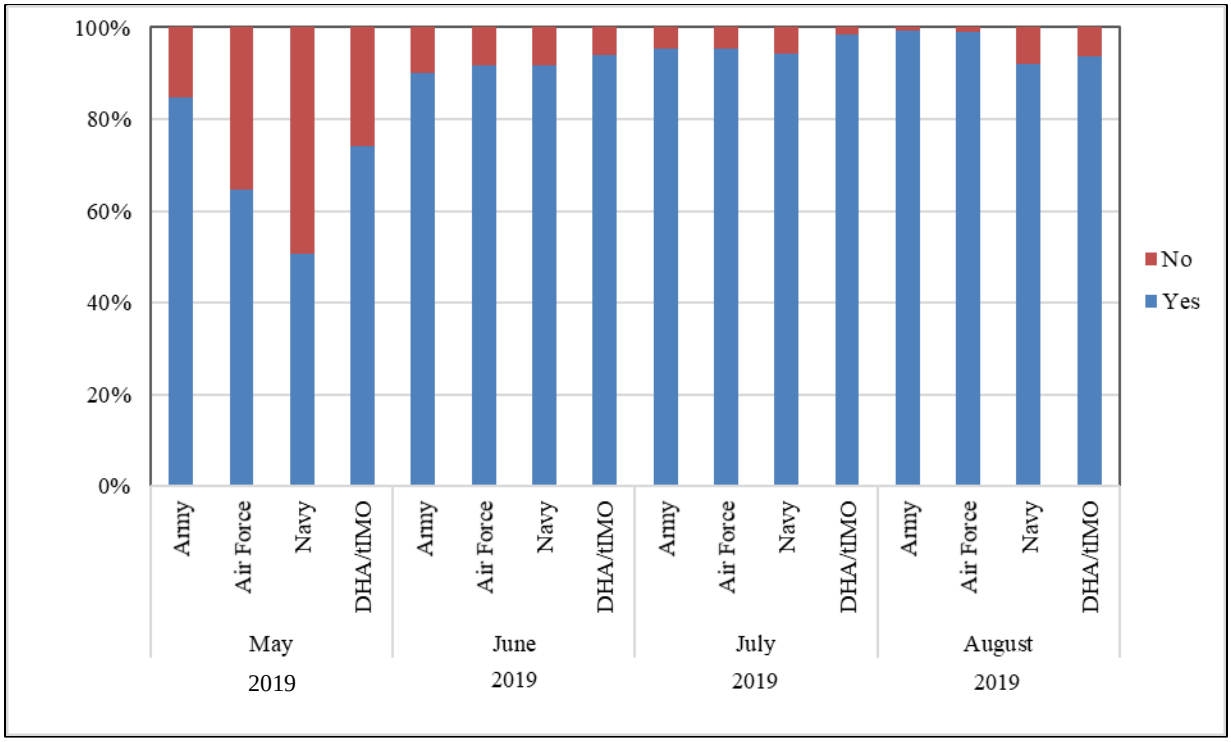

Figure 1. Percent of CM encounters documented in a TSWF, by Service, 2019.

In addition to the metric noted above, initial efforts are underway toward establishing shared outcome measures to demonstrate the impact of CM on beneficiary care and costs. Candidate outcome measures include ER utilization and private sector care costs. Measures of utilization and cost avoidance are the principal measures of CM effectiveness. For individuals with high medical and/or mental health complexity, an insurance carrier's CM program would measure the rates of medical/mental health services utilized and costs incurred in categories, such as ED, inpatient, clinician office, durable medical equipment, home health, lab, imaging, and prescriptions (AHRQ, 2014). Briefly, the candidate measure methods involve identifying all direct care beneficiaries receiving initial CM services in each month. Prospective and retrospective window periods of three months each were established based on the CM start date. All ER encounters (in direct and private sector care) and, separately, private sector care claims for each beneficiary entering CM were then identified, in each window period. The activities in the period before and after starting DHA harmonized CM interventions were compared and net change in activity was computed. The candidate outcome measures are presented below in pilot form. At the time of this report, the candidate measures are undergoing evaluation for enterprise use, a process that includes stakeholder input, goal development, refinement, baseline identification, and validation.

Outcome Measures

ER Utilization

Persons referred or self-selected into CM tend to have complex health care needs requiring intense management and coordination. Improved condition management and care coordination should reduce avoidable episodes requiring emergent care and improve patient understanding of where and when to seek the appropriate level of care (American Nurses Association, 2013). Overall, the frequency and cost of ER visits decreased in the three months following beneficiaries' entry into CM services. The amount paid for ER encounters averaged $563 per patient before initiating CM services, declining to $274 per patient in the post-initiation period. Both the average number of ER visits per patient (0.7 visits pre- to 0.4 visits post-; Figure 2) and the average cost per visit ($811 pre- to $727 post-; data not shown) decreased following entry into CM services. For the measure period, overall ER visit frequency and costs per patient declined by 46 percent and 51 percent respectively, in the pre- and post-CM initiation periods (Figure 3). Further operational refinement is needed to identify performance gaps and potential improvement goals around ER utilization in this population.

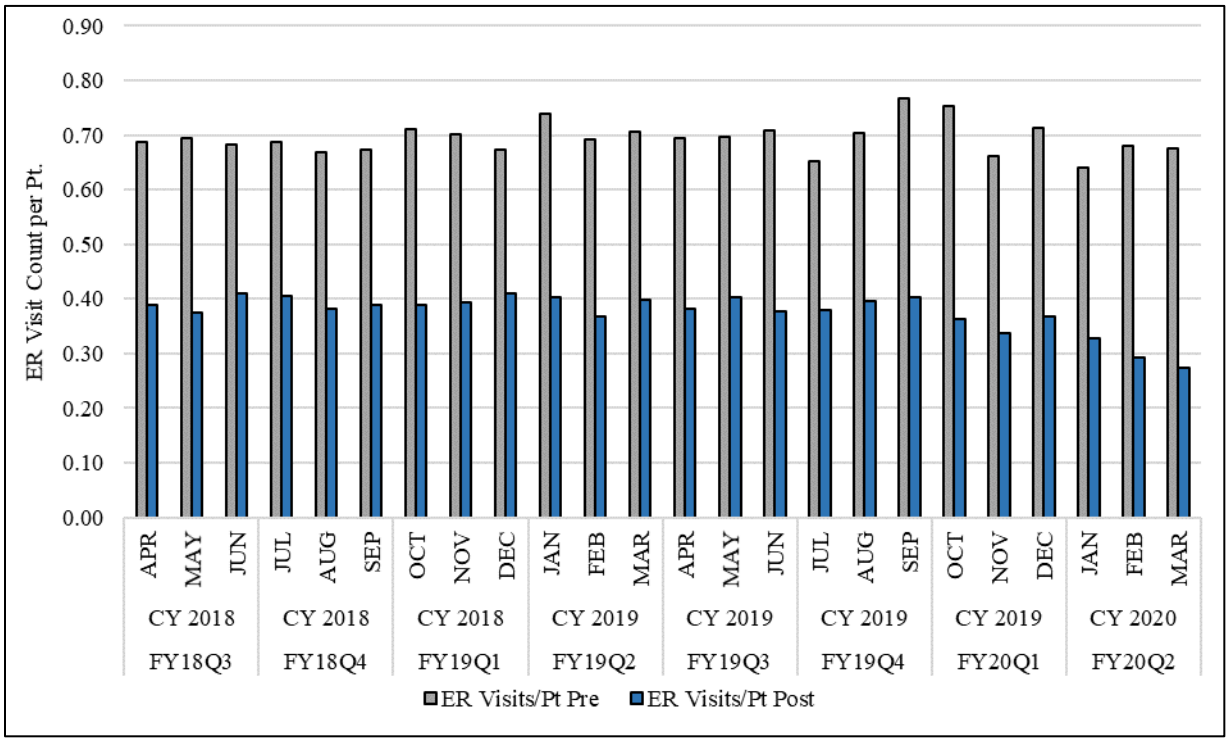

Figure 2. Average ER visit frequency before and after initial CM encounter, Q3 FY 2018 – Q2 FY 2020.

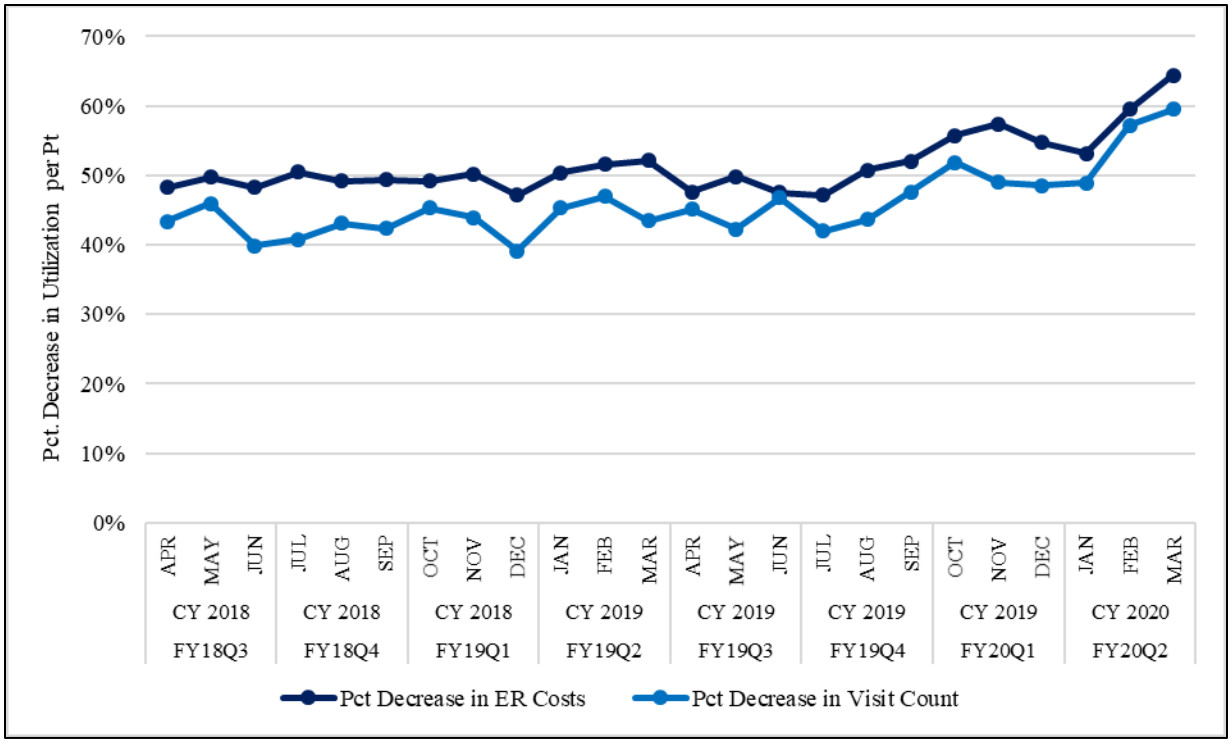

Figure 3. Average percent decrease in ER utilization among new CM patients, Q3 FY 2018 – Q2 FY 2020.

Private Sector Care Claim Costs

CM interventions aimed at reducing care fragmentation and improving coordination should ensure the right care is delivered to the right patient at the right time in the right place. For some patients, the right place may mean redirecting care sought in the private sector back to the direct care system. It is often challenging to show overall reduction in total costs for persons receiving CM services (Lee et al, 2018). For MHS beneficiaries, however, there are unique opportunities for care recapture. Reducing private sector care episodes often translates to reduced costs. Consistent reductions were demonstrated in total private sector care costs for patients entering CM across the measurement period. The average amount paid in private sector care claims per patient declined from $23,819 before initiating CM to $14,922 in the period following (Figure 4). Although reductions in private sector care claims costs were seen over the entire measure period, variation in percent reduction was noted (Figure 5). Further operational refinement is needed to identify performance gaps, reasons for variation, and potential improvement goals for this performance measure.

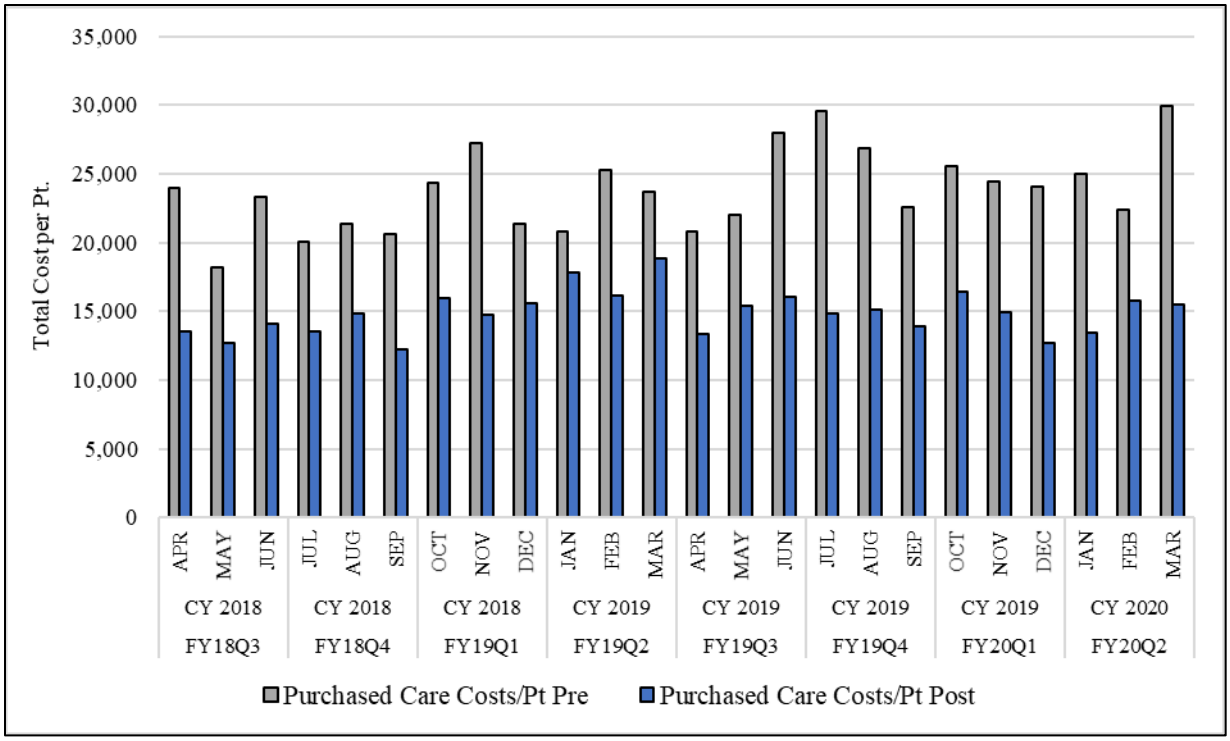

Figure 4. Average private sector care claim costs before/after initial CM encounter, Q3 FY2018 – Q2 FY 2020.

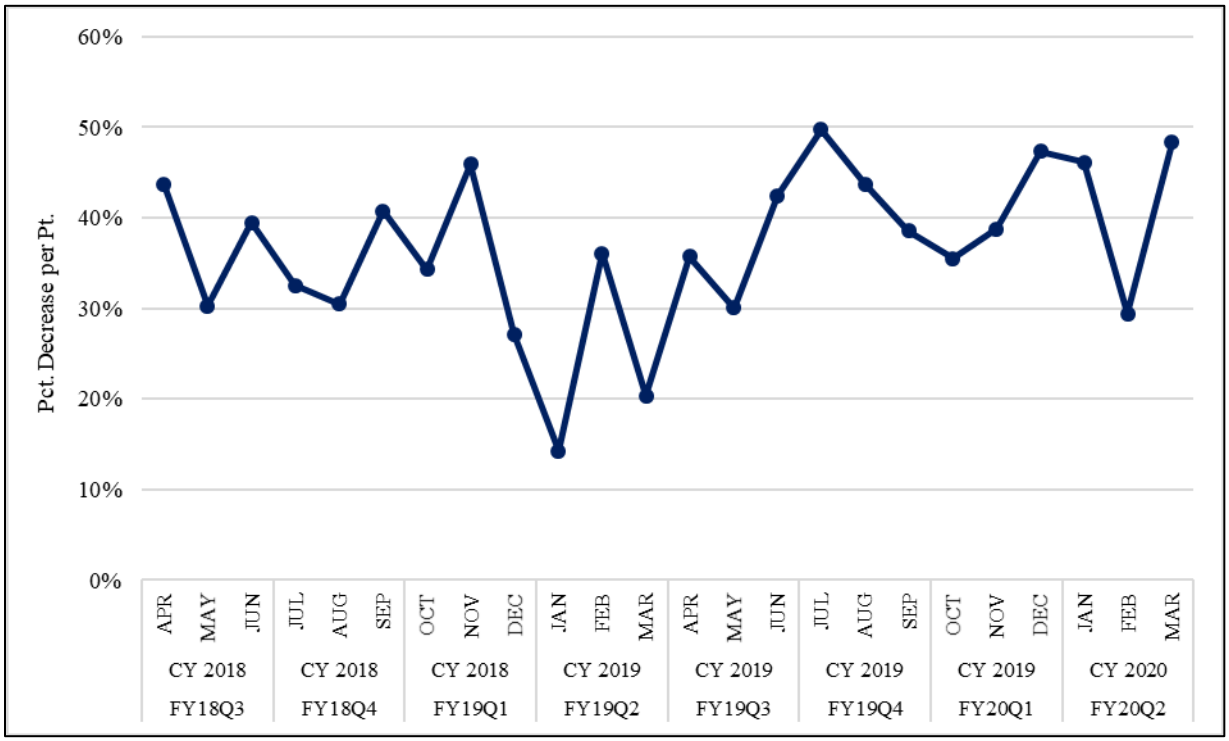

Figure 5. Average percent decrease in private sector care claim costs among new CM patients, Q3 FY 2018 – Q2 FY 2020.

CM AND OUTREACH PROVIDED BY MCSCs

TRICARE brings together the military hospitals and clinics worldwide with network and non-network TRICARE authorized civilian health care professionals, institutions, pharmacies, and suppliers to provide access to the full array of high-quality health care services while maintaining the capability to support military operations. In support of this mission, DHA is dedicated to improving the health of all MHS beneficiaries. Ongoing efforts promote an integrated and evidence-based approach that aims to optimize and encourage proactive engagement through interactive beneficiary participation. The MHS provides health care to TRICARE beneficiaries through direct and private sector care with the goal of meeting the MHS Quadruple Aim of improving readiness, better health, better care, and lower cost. MCSCs support DHA based on an overarching systems' view of MHS care and ensures alignment and established practices are guided by industry standards and expertise while also addressing the unique needs of the TRICARE population.

Following the CMSA Standards of Practice, beneficiaries are contacted at intervals based on the primary health care needs and socioeconomic conditions affecting the beneficiary. The caseload of individuals managed by a case manager at any given time varies based on these needs and complexities. MCSC CM teams provide specific interventions by connecting beneficiaries with the right provider, at the right time, and with the right care interventions. Addressing specific needs at the right time mitigates delays in care and enhances positive outcomes. For most beneficiaries, contact should be, at a minimum, on a monthly basis, with an increased frequency of contact based upon the medical condition(s) (e.g., acute vs. chronic, complex vs. short-term problems). MCSCs utilize risk stratification processes to determine levels of risk and the corresponding need for frequency and intensity of contacts and interventions (CMSA, 2016). CMSA policy recommends national standards of practice principles for CM, which are also endorsed and used by the DHA TRICARE Health Plan (THP) and MCSCs.

A CM foundational principle is the coordination of care, which facilitates reduction of delays in care by ensuring beneficiaries connect to the right service at the right time (CMSA, 2016). MCSCs offer educational opportunities providing beneficiary education on managing complex medical situations or support for chronic conditions. Case managers collaborate with physicians and other health care professionals to help patients continue to live at home safely while addressing their physical, behavioral, cognitive, social, and financial needs. Services vary on need but can include coordination of care between various providers, assessing risk for injury at home, medication safety/education, arranging transportation, and assisting with housing, insurance, and financial issues, especially for older beneficiaries.

According to AHRQ, "care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services" (AHRQ, 2014). Coordinating care involves strategic utilization of resources required in achieving and maintaining continuity of care. MTF and MCSC case managers collaborate in coordinating the transitioning of TRICARE eligible

beneficiaries from direct care to private sector care to facilitate continuity of care and avoid delays of medically necessary services. MTF and MCSC case managers also partner to assist, plan, and support coordination of care during Permanent Change of Station moves, both within and outside regions.

MCSCs utilize multiple variables to determine CM caseload, including but not limited to, acuity level, short-term and long-term needs, health literacy level, beneficiary's risk factors, and complexity of non-clinical socioeconomic issues. MCSCs are contractually required to obtain and maintain CM program accreditation by a nationally recognized accrediting organization. MCSCs receive and maintain Utilization Review Accreditation Commission (URAC) accreditation. URAC "promotes health care quality through the accreditation of organizations involved in medical care services" (URAC, 2020), and provides guidelines on case manager caseloads.

MCSCs function with a holistic beneficiary-focused approach to build trusting relationships, communicate consistent reliable information, and provide compassionate support. MCSCs' functional responsibility within the MHS is vital in providing all aspects of care coverage to TRICARE authorized beneficiaries, which improves MHS standardization. The MCSC approach complements recommendations from the AHRQ, which funded research on primary care practice transformation and found that "outreach is a critical service for managing patients with chronic conditions and those experiencing transitions of care" (AHRQ, 2014). Recommendations from MCSCs regarding cross-functional CM processes help to inform transition of care processes across direct and private sector care. MCSC CM teams aim to achieve early identification of all cases to facilitate appropriate and accessible provider specialist and primary care resources. The MCSCs' multidisciplinary team approach allows case managers' involvement as collaborators, acting as the liaison between the MCSC and the MTF, and influences successful, partnered relationships for the benefit of the patient.

PRIVATE SECTOR CARE BEST PRACTICES

The hospital industry is in the midst of major changes, from mergers and acquisitions among hospital and non-hospital entities. With increasing expansion of convenient centers for ambulatory services, health care systems are under pressure to improve patient outcomes and lower costs. To adapt and survive in this new marketplace, hospital leaders need to make changes that reflect the new reality. As a result, CM has suddenly caught the attention of hospital leaders. The role of the MHS and industry case managers and care coordinators is to align the patient with the right resources, whether it is human capital, services, and/or durable medical equipment. The case manager develops a care plan in conjunction with the patient and provider and updates the plan as the patient transitions from one care level or care setting to another.

The CMSA Standards of Practice for CM provides practical guidelines for CM and provides the basis of care within the MHS. According to the CMSA Standards of Practice, "the standards identify foundational knowledge, skills, and competencies for the professional Case Manager

within the spectrum of CM practice settings, specialties, and health and human service disciplines" (Tahan, 2016). Standardized processes minimize fragmentation in the health care system by applying evidence-based guidelines that promote collaborative care coordination and optimal navigation in transitions of care. Adherence guidelines and other standardized practice tools are valuable resources available to case managers; utilization of these tools improves the experience of care across the MHS and maintains alignment with industry standards. Standardized practice tools, such as CM registries, enable efficient identification of potential CM enrollees and comprehensive CM planning, documentation, and monitoring of outcomes. A review from various sources throughout the health care industry demonstrates that MHSs' practices are in alignment with the private sector's utilization of the CMSA's Standards of Practice. Examples of these primary principal sources consist of AHRQ, CMSA, and URAC, which are health care accrediting organizations that establish quality standards for the entire health care industry and promote health care quality.

Intervals at Which Patients Should Be Contacted

According to the CMSA, intervals at which patients are contacted is highly individualized, based upon beneficiary-centric care needs, and are intended to achieve optimal outcomes and maximum levels of functioning. Early identification of signs/symptoms of exacerbation is necessary in patients with complex, chronic conditions that have a goal to achieve self-management. Ongoing coordination and facilitation of care services between the beneficiary, family, and interdisciplinary health care team is required. Rather than assignment of a narrow interval or time span for contact, the CMSA Standards of Practice emphasize that contact is executed on a cyclical and recurrent basis, as opposed to linear and unidirectional. An evaluation of CM organizations also demonstrates that patient encounters for care vary between daily and monthly, but no less than once a month (CMSA Standards of Practice, 2016). This standard is followed by the MHS CM and aligns with the industry standard.

The intensity and frequency of CM interventions are greatest early in the care continuum and decrease as the patient's health care improves and the patient can independently direct his or her own health care. As described in the literature, frequency and intensity of CM encounters is based upon: 1) whether the patient has experienced a recent care transition; 2) the patient's health status and progress toward achieving the goals in the patient's individualized plan of care; and 3) the patient's confidence in self-care management (Wasson, 2018). Newly enrolled patients and those that have experienced a recent care transition typically require more frequent interaction than patients who have learned to self-manage and demonstrate improvement toward care goals. Furthermore, some patients may be able to effectively self-manage with only telephone support, while others may require face-to-face visits in the home or primary care practice. Importantly, care plans should be reviewed, discussed, and updated with each care manager interaction, including the patient, family, and multi-disciplinary care team, to determine continued relevance, importance, and progress, and to respond to any changes in the patient's needs or situation. This continual process improvement approach allows care teams to efficiently escalate or de-escalate care for optimal outcomes, facilitates progression of care

ideally to self-care management, and effectively integrates the efforts of the care team to accomplish care goals. This approach is implemented throughout the MHS.

Case Manager in Care Coordination

According to the AHRQ, the main goal of care coordination is to meet patients' needs and preferences in the delivery of high quality, high-value health care. Care coordination is a process that "ensures the patients' health care needs and preferences are known and communicated at the right time, to the right people, and that this information is used to guide the delivery of safe, appropriate and effective care (AHRQ 2014)."

Any activity that bridges gaps between providers, care team participants, settings, treatment plans and patients leads to improved care coordination. Furthermore, CM is designed to "assist patients and their support system in managing their medical/social/mental health conditions more efficiently and effectively" (AHRQ, 2014). The goal of the case manager is to educate patients, build their confidence, and empower them to direct their own health care. Case managers seek out care inefficiencies and redundancies, and work to eliminate them. In compliance with DHA PI 6025.20, case managers operate at the top of their license, leveraging capabilities to optimize provider availability and patient care supporting guidelines by AHRQ. Each MILDEP medically and administratively manages medical fitness matters with its own systems. Unique to CM within the MHS, case managers often need to involve the Command for matters specific to readiness. DHA is assuming management of the MTFs, but the MILDEPs control the definition of medical fitness and adjudicate retention decisions. Coordinating the medical care and administrative processes across the MHS organizational boundaries is ongoing.

Number of Patients Managed by a Case Manager

There is no single standardized way to measure CM caseloads; therefore, differences exist within the health care industry, in both assigned CM caseloads and CM assignment methods. Caseloads depend on numerous factors, including acuity, setting of health care delivery, care model, and degree of automation and technological support. Analyzing work product of case managers in a similar environment can help determine caseloads. Regardless of the method to determine CM caseload, industry consensus indicates the number of patients case-managed varies according to the acuity level of the patient. It is a linear relationship where the higher the acuity, the lower the caseload. Review of industry organizations demonstrates similar concepts and supports the caseload based on acuity rather than pre-specified caseload-based numbers. There is a developing trend in the civilian sector to work in care management teams rather than as a solitary nurse or social worker case manager (Tahan, 2016). The MHS models the civilian sector's best practices by using the CM Registry's predictive analytics to identify potential clients for CM. Any attempt to develop a caseload standard should be informed by empiric evidence in context of setting, population of interest, client needs, desired outcomes, case/care manager and team roles, level of training, externalities such as access to community services, administrative duties, client record keeping, decision support, and the model of care.

Other Best Practices Relating to CM Improving the Experience of Care Across the MHS

Organizations must understand the unique needs of their patient populations and the desired outcomes to execute CM effectively. Formal onboarding education and training contribute to the development of foundational CM knowledge and, ultimately, a sustainable workforce. Civilian sector best practices include use of analytic tools to identify potential cases, database case tracking, and electronic methods for tracking case manager workload. In keeping with industry best practices, DHA CM leverages a standardized CM Screening Registry in support of a comprehensive assessment and identification of care needs. The Screening Registry uses the Johns Hopkins ACG System, and utilizes dedicated registries to support the need for CM screening and active engagement. The MHS is currently refining the use of the Screening Registry tool to help inform CM practices based on trending data collection.

Measures of utilization and cost avoidance are the principal measures of CM effectiveness. For individuals with high medical and/or mental health complexity, an insurance carrier's CM program would measure the rates of medical/mental health services utilized and costs incurred in categories such as: ED, inpatient, clinician office, durable medical equipment, home health, lab, imaging, and prescriptions. Utilization and cost avoidance for a cohort of patients under active CM would be compared to a cohort of propensity-matched patients not under CM. Propensity matching is difficult to achieve as patients within CM programs may be unlike the matched cohort because of practical problems in case finding, referrals, and retention. Across the board, payers, health delivery organizations, patients and families, and external stakeholders have struggled with non-cost client-centered health outcomes as measures of effectiveness (Ehlenbach, 2020). Through utilization and data tracking measures with the Nurse Case Management Registry, currently undergoing additional evaluation, a process including stakeholder input, goal development, refinement, baseline identification, and validation with a goal to maximize Registry utilization.

BENEFICIARY SATISFACTION WITH CM SERVICES

As required in Section 1072 of Title 10, U.S.C., in accordance with DHA guidance, MTFs established Patient and Family Partnership Councils (PFPCs), consisting of shared overarching objectives focused on enhancement of the overall health care experience within MTFs for patients and their families. PFPCs facilitate on-going, bi-directional virtual communication between MTF PFPC members, MTF Command, and MHS governance regarding recommendations to improve care provided by CM to the beneficiary and family experience in support of High Reliability Organization (HRO) principles.

The DHA MM leveraged pre-existing PFPCs for the planning and execution of public forums in support of beneficiary outreach from each geographic region with consideration of the population and broad representation. As a result, five separate virtual forums were conducted with MTF representation from each of the Services and one large Market, to include: Carl R. Darnall Army Medical Center (AMC), Naval Medical Center Portsmouth, 99th Medical Group, Nellis Air Force Base (AFB), Womack AMC, and 375th Medical Group, Scott AFB.

Discussions from each geographic location with beneficiary engagement related to the satisfaction of CM performance, were facilitated by DHA and the MTFs. PFPCs utilized various communication channels to maximize participation, such as personal calls and secure messaging to current and recent CM enrollees and posting the forum poster on pre-existing PFPC social media channels. All beneficiaries willing to participate in the virtual forums joined by calling into the designated operator-supported conference line. Prior to and during the forum, participants were provided an Office of Management and Budget and DHA Privacy Office approved link to a tailored Interactive Customer Evaluation (ICE) Questionnaire on CM. The ICE Questionnaire was developed in alignment with Section 744 of NDAA FY 2020, which requires allowing participants to complete the ICE Questionnaire survey for feedback.

Case Management Forums were pre-planned and guided by an inquiry-based facilitation script, and conducted over a one-hour period. To protect the callers' identities, names and demographic information was not collected. An operator greeted each caller and gave instructions on participation. The facilitators asked for callers to indicate to the operator when they wished to make a comment about their satisfaction with CM, outreach, and recommendations for improvement. MTF leadership was present during the forums and a 30-minute post call discussion debrief ensuring correct information was received.

Overall, 95 respondents completed the ICE Questionnaire over a 72 hour period. Of the 95 respondents, 99 percent (n=94) indicated they were extremely satisfied with CM services. Additionally, 96 percent (n=91) of respondents were completely satisfied with being able to contact their case manager. Furthermore, 91 percent (n=86) of respondents indicated they were completely satisfied with getting the services needed. Overwhelmingly, respondents felt their case manager treated them with dignity and respect (97 percent, n=92) and listened to what they had to say (97 percent, n=92).

Patients were satisfied to a lesser extent with being included, "my case manager includes me in setting goals to manage my illness/injury or situation" (84 percent, n=80) and indicating their case manager assists with self-management, "my case manager assists me to identify self-management skills with my health care needs" (88 percent, n=84).

In summary, there is room for improvement with DHA and THP MCSC coordination. Respondents were also mostly satisfied with the CM services provided by the MCSC (77 percent). Representatives from THP MCSC assisted in forum development and post call brief, providing a better understanding on the importance of maintaining an organized working relationship between DHA, THP MCSC, and the Services which will better serve the participants and allow an opportunity for improvement and growth.

CONCLUSION

An evaluation of CM practice effectiveness provided by DHA and the MILDEPs demonstrates the MHS has made significant progress in the provision and standardization of CM services, resulting in higher reliability in health care delivery and clinical processes within MTFs.

Expanded engagement and collaboration during the transition between DHA and the MILDEPs enabled improvement efforts resulting in reduction of practice variation, enhanced delivery of an integrated enterprise-wide approach to CM training, identification of best practices, and implementation of industry standards and analytic tools, such as the Johns Hopkins ACG and CM Registry tools. Efforts toward the selection and management of higher acuity cases has resulted in moving the CM focus towards the most resource intensive beneficiaries. Case managers must be agents of change and drive the processes and policies that leverage the structure, the role and the practice workflow to promote achievement of the Triple Aim (CMSA, 2016). The case manager role is being restructured to support closing the gap on standardization and generate outcomes that will contribute to the well-being of the population served. The strategy for the MHS CM practice is built around three core principles. The three principles are 1) a shared vision of patient-centric care and an enterprise-wide commitment to quality and safety, 2) evidence of an enduring mutual interest which in CM organizational terms, means executive leadership supports the intent and goals of a CM program across the continuum as it parallels the organization's preparations for a value based environment, and 3) alignment around shared values and a shared spirit of cooperation, teamwork and respect. DHA remains committed to these three principles and harmonizing MHS CM policies and procedures. DHA will continue to coordinate with the MILDEPs throughout the duration of transition to standardize CM best practices and become a HRO and health care delivery system for Service members, Veterans, and their families.

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10 U.S.C. §1072 (2010)

10 U.S.C. §1073c (2010)

ACRONYMS

ACG	Adjusted Clinical Groupings
ADC	Authority, Direction, and Control
ADSM	Active Duty Service Members
AF	Air Force
AFB	Air Force Base
AHLTA	Armed Forces Health Longitudinal Technology Application
AHRQ	Agency for Healthcare Research and Quality
AIM	Alternate Input Method
AMC	Army Medical Center
BH	Behavioral Health
BUMED	Bureau of Medicine and Surgery
CM	Case Management
CMSA	Case Management Society of America
COVID-19	Coronavirus Disease 2019
DHA	Defense Health Agency
DHA-PI	Defense Health Agency-Procedural Instruction
DoD	Department of Defense
DoDI	Department of Defense Instruction
ED	Emergency Department
EHR	Electronic Health Record
ER	Emergency Room
FY	Fiscal Year
ICE	Interactive Customer Evaluation

JKO	Joint Knowledge Online
MCSC	Managed Care Support Contractor
MEDCOM	Medical Command
MM	Medical Management
MHS	Military Health System
MHSPHP	Military Health System Population Health Portal
MILDEP	Military Department
MTF	Military Medical Treatment Facility
NAVMED	Navy Medicine
NDAA	National Defense Authorization Act
OCONUS	Outside the Continental United States
OPORD	Operational Order
PFPC	Patient Family Partnership Counsel
PM	Program Manager
Q	Quarter
THP	TRICARE Health Plan
TJC	The Joint Commission
TSWF	Tri-Service Workflow Form
URAC	Utilization Review Accreditation Commission
USC	United States Code
VA	Department of Veterans Affairs
WTB	Warrior Transition Battalion
WTC	Warrior Transition Command
WTU	Warrior Transition Unit