Defense Health Agency

PROCEDURAL INSTRUCTION

NUMBER 6025.20
August 27, 2019

DAD-MA

SUBJECT: Medical Management (MM) Program within the Military Health System (MHS)

References: See Enclosure 1.

1. PURPOSE. This Defense Health Agency-Procedural Instruction (DHA-PI), based on the authority of References (a) and (b), and in accordance with the guidance of References (c) through (t), establishes the Defense Health Agency's (DHA) procedures for MM program requirements to support standard and integrated care management implementation within the MHS.

2. APPLICABILITY. This DHA-PI applies to:

a. The Military Departments, the markets, and the military medical treatment facilities (MTFs).

b. Healthcare practitioners and facilities within the MHS that are involved in the delivery of Direct Care MM program support to eligible MHS beneficiaries. For the purposes of this DHA-PI, a Clinical Case Manager will be referred to as a Case Manager.

3. POLICY IMPLEMENTATION. It is DHA's instruction, pursuant to References (c) through (s), to:

a. Establish integrated and standardized MM program documentation, coordination processes, and multidisciplinary care team communication to promote seamless care transitions and reduce fragmentation of MM activities across varied treatment settings to include direct care, purchased care and Department of Veterans Affairs (VA).

b. Promote interdependent MM system coordination between DHA Medical Affairs (MA) MM, MTFs within the Direct Care System (DCS), DHA Headquarters Healthcare Operations, and VA to improve the delivery and quality of health care for eligible beneficiaries, to include wounded, ill, and injured (WII) Service members (SM). This DHA-PI does not direct the VA

Federal Recovery Coordination Program or the DoD Recovery Coordination Program. The Federal Recovery Coordination Program is defined in Reference (k) and DoD Recovery Coordination Program as defined in Reference (l).

c. Assign responsibilities, standardize reporting, and promote integration between clinical and non-clinical interdisciplinary team members to reduce fragmentation and improve patient outcomes in alignment with the MHS High Reliability Organization (HRO) model.

4. RESPONSIBILITIES. See Enclosure 2.

5. PROCEDURES. See Enclosure 3.

6. RELEASABILITY. **Cleared for public release**. This DHA-PI is available on the Internet from the Health.mil site at: http://www.health.mil/DHApublications.

7. EFFECTIVE DATE. This DHA-PI:

a. Policy effective immediately with full implementation within 6 months of publication date.

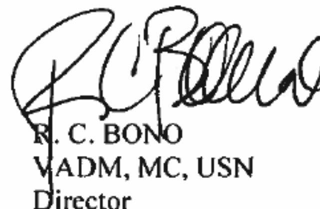
b. Will expire 10 years from the date of signature if it has not been reissued or cancelled before this date in accordance with Reference (c).

8. FORMS. The following DHA forms are available at: https://info.health.mil/cos/admin/DHA_Forms_Management/Lists/DHA%20Forms%20Management/AllItems.aspx#.

a. DHA Form 112, Case Management Core Competency Assessment.

b. DHA Form 113, Disease Management Competency Assessment.

c. DHA Form 114, Utilization Management Core Competency Assessment.



Enclosures
1. References
2. Responsibilities
3. Procedures
4. Required Military Health System Education and Training Modules

Glossary

ENCLOSURE 1

REFERENCES

(a) DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs (ASD(HA))," September 30, 2013, as amended
(b) DoD Directive 5136.13, "Defense Health Agency (DHA)," September 30, 2013
(c) DHA-Procedural Instruction 5025.01, "Publication System," August 24, 2018
(d) DoD Instruction 6025.20, "Medical Management (MM) Programs in the Direct Care System (DCS) and Remote Areas," April 9, 2013, as amended
(e) Military Health System Coding Guidance: "Professional Services and Specialty Coding Guidelines: Appendix D: Case Management Services," August 2017
(f) Case Management Society of America, "Standards of Practice for Case Management," 2016
(g) United States Code, Title 10, Section 1073c
(h) DoD Instruction 1010.10, "Health Promotion and Disease Prevention," April 28, 2014, as amended
(i) DoD Instruction 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)," February 17, 2011, as amended
(j) DoD, TRICARE Management Activity, "Medical Management Guide," Version 3.0
(k) Federal Recovery Coordination Program, "VA HANDBOOK 0802," March 23, 2011
(l) DoD Instruction 1300.24, "Recovery Coordination Program," December 1, 2009
(m) Health Affairs Policy 09-015, "Policy Memorandum Implementation of the 'Patient-Centered Medical Home' Model of Primary Care in MTFs," September 18, 2009
(n) National Defense Authorization Act for Fiscal Year 2008, Section 1611
(o) National Defense Authorization Act for Fiscal Year 2017, Section 702
(p) National Defense Authorization Act for Fiscal Year 2019, Section 717
(q) Agency for Healthcare Research and Quality (AHRQ), "Re-Engineered Discharge (RED) Toolkit," March 2013
(r) Memorandum of Understanding between Department of Veterans Affairs (VA) and Department of Defense (DoD) for "Interagency Complex Care Coordination Requirements for Service Members and Veterans," July 29, 2014
(s) DoD Instruction 6010.24, "Interagency Complex Care Coordination," May 14, 2015
(t) DoD Manual 6025.13, "Medical Quality Assurance and Clinical Quality Management in the Military Health System," October 29, 2013

ENCLOSURE 2

RESPONSIBILITIES

1. DIRECTOR, DHA. Under the authority, direction, and control of the Under Secretary of Defense for Personnel and Readiness, Assistant Secretary of Defense for Health Affairs, and in accordance with Reference (d), the Director, DHA will:

a. Oversee implementation of uniform MM policy guidance and ensure standardized processes are established.

b. Support MM program implementation through dedicated and standardized program evaluation and reporting.

2. DEPUTY ASSISTANT DIRECTOR (DAD), MA. The DAD-MA will:

a. Direct and oversee the establishment and implementation of a comprehensive and standardized MM program and processes within the MHS in accordance with this DHA-PI.

b. Monitor the implementation and tracking of required program and reporting implementation outlined within this DHA-PI.

c. Recommend and evaluate interdependent MM program support necessary to improve the delivery and quality of care outcomes between the DCS, Purchased Care System (PCS), and VA, when appropriate.

d. Evaluate and recommend outcome measurements in support of standardized and uniform process evaluation for MHS MM programs.

e. Provide MM input to the DAD, Healthcare Operations on current and future TRICARE contracts and policy manuals to support an integrated MM approach between MTFs and PCS.

f. In collaboration with DAD, Healthcare Operations, identify opportunities to improve MTF MM care coordination between the DCS, Managed Care Support Contractors (MCSC), and VA to standardize programs and support transitions of care.

g. Advocate for the development and dissemination of educational products, decision support tools, and applications to assist in training staff, evidence-based decision making, and standardized MM activities.

h. Coordinate recommendations as an integrating function to advisory boards and MHS clinical communities that are condition-based networks of clinicians, organized by high-volume, high-risk groups of care processes to align clinical specialties and report to the Enterprise Solutions Board on compliance with this DHA-PI.

3. FUTURE DHA MARKETS AND SERVICES. The future DHA markets and Services will:

a. Identify future DHA market and Service MM leads to support full implementation and compliance with this DHA-PI.

b. Implement MM program requirements within the MTFs, markets, enhanced Multi-Service Markets, and within joint DoD/VA facilities as outlined in this DHA-PI.

c. Monitor and implement the required MM program-specific education and training (E&T) activities within the local and regional areas.

d. Ensure MTF Commanders and Directors develop and integrate MM program coordination between DHA Headquarters (MA and Healthcare Operations), to reduce fragmentation.

4. MTF COMMANDERS AND DIRECTORS. MTF Commanders and Directors will:

a. Identify a dedicated MTF MM lead(s) to support full compliance with this DHA-PI and integrated MM program requirements and reporting.

b. Implement required MM program activities, training, and reporting requirements to support standardized and integrated MTF program implementation.

(1) Develop an organizational-wide interdisciplinary MM program to include integration of Case Management (CM), Disease Management (DM), and Utilization Management (UM). The program will complement the MTF business and MHS Quadruple Aim strategic performance plans.

(2) Provide semi-annual reports to future DHA markets, and DHA MA MM on measures no later than the last business day of January and June.

c. Identify opportunities to enhance MM coordination between DHA Headquarters (MA and Healthcare Operations) to improve integrated care processes for eligible beneficiaries in need of MM program support.

ENCLOSURE 3

PROCEDURES

1. OVERVIEW. Establishment of this DHA-PI supports the execution of standardized and integrated MM program activities, processes, collaboration, and communication with multidisciplinary care teams and clinical communities to reduce fragmentation of care coordination across varied treatment settings. In addition, this DHA-PI aims to improve MM collaboration between the DHA Headquarters (MA and Healthcare Operations), VA, and clinical and non-clinical programs to improve the delivery and quality of healthcare management and care coordination for eligible beneficiaries, to include WII SM, in alignment with MHS and the accrediting agency on the journey to an HRO.

2. TIMELINE. Policy effective immediately with full implementation within 6 months of publication date.

3. GOVERNANCE. DHA MA MM will coordinate program requirements with the MHS advisory boards, clinical communities, and report to the Enterprise Solutions Board on program implementation.

4. STANDARDIZED REQUIREMENTS AND PROCESSES FOR MTF MM SERVICES. Implement required MM program activities, training, and reporting requirements to support standardized MTF program implementation.

a. Develop an organization-wide interdisciplinary MM program to include integration of CM, DM, and UM.

b. Support coordination with advisory boards and clinical communities that improve patient-centric care and outcomes, reduce variability, and support MHS Quadruple Aim strategic performance plans.

5. STANDARDIZED REQUIREMENTS AND PROCESSES FOR MTF CM SERVICES

a. Education. Case Managers must, at least, be either licensed registered nurses or licensed social workers and graduated from a program accredited by a nationally recognized accreditation agency recognized by the U.S. Department of Education and must hold an active, valid, current, and unrestricted license to practice nursing as a registered nurse or to practice social work as a licensed clinical social worker in any U.S. State or jurisdiction.

b. Certification. It is highly recommended that Case Managers obtain certification by a nationally recognized CM organization.

c. Coordination. Case Managers will:

(1) Manage TRICARE eligible beneficiaries enrolled in CM that may require special assistance, including participation in required discharge planning and care coordination for those with complex care needs.

(2) Utilize analytic tools, predictive analytics, and CM registry to identify and screen eligible TRICARE beneficiaries for CM services.

(3) Coordinate with the MCSC's Case Managers when eligible beneficiaries require clinical CM outside the DCS.

(4) Facilitate communication and coordination between healthcare teams and programs, to include Patient Centered Medical Home (PCMH) and clinical communities, for eligible beneficiaries enrolled in CM.

(5) Provide coordination with non-clinical partners, to include Recovery Care Coordinators, when necessary to support patient care needs.

(6) Participate in MTF MM, population health, quality, and care coordination meetings.

d. Required Documentation and Reporting

(1) Documentation

(a) Case Managers will utilize the dedicated Adult and Pediatric CM Tri-Service Workflow (TSWF) form to document CM encounters which includes prompts for comprehensive CM interventions and support. These forms are currently located within the outpatient Electronic Health Record (EHR), Armed Forces Health Longitudinal Technology Application (AHLTA), and MHS GENESIS system when available. Utilization of a dedicated TSWF form within the DCS facilitates standardized screening, documentation, multidisciplinary team communication, and clinical content.

(b) The Adult and Pediatric CM TSWF form is intended to support CM documentation of face-to-face, telephonic, or virtual engagement to ensure all encounter needs and requirements are documented.

(c) Utilization of the Adult and Pediatric CM TSWF form supports clinical CM embedded in primary and/or specialty care clinics, as well as stand-alone clinical CM.

(d) DHA MA MM will collaborate with the DHA TSWF team concerning content change recommendations and training needs.

(2) Referrals

(a) MTF provider and clinical staff requesting CM services for a patient will generate a referral in the EHR. Case Managers will document referral source and engagement on the Adult and Pediatric CM TSWF form within AHLTA, EHR, and MHS GENESIS system, when available.

(b) Through the screening process, Case Managers will document the patient's referral source (how the patient came to CM), to include patient requested self-referrals, on the Adult and Pediatric CM TSWF form.

(c) Through the screening process, Case Managers will document whether the patient is a candidate, or not, for CM on the Adult and Pediatric CM TSWF form. Should the patient not be a candidate, or the patient declined or refused services, rationale for exclusion must be documented on the Adult and Pediatric CM TSWF form.

(3) Reporting

(a) MTF Case Managers will identify performance improvement opportunities in alignment with MHS Quadruple Aim strategic performance plans.

(b) Case Managers will communicate recommendations through their MM leads to DHA MA MM.

e. Required Coding and Data Capture

(1) Case Managers, in all settings, will use MHS standardized coding guidance (Reference (e)), for CM in order to track eligible beneficiaries receiving clinical CM services. Utilization of common MTF coding will support standardization and maximize use of analytic tools, predictive analytics, and CM registry to identify and screen eligible TRICARE beneficiaries for CM services.

(2) Regardless of MTF site location, Case Managers will document and code their services in the EHR/AHLTA, and MHS GENESIS system, when available, using DoD CM unique codes currently outlined in Reference (e), to maintain standardized coding documentation and reporting capabilities.

(3) To document in AHLTA, a provider profile must be established in the Composite Health Care System and EHR/and MHS GENESIS system, when available, for each Case Manager.

(a) Provider Codes. Use of standardized CM unique codes and the Health Insurance Portability and Accountability Act taxonomy codes, in alignment with Reference (e), will be used in the Case Manager’s provider profile. These provider specialty codes and their mapping to default the Health Insurance Portability and Accountability Act taxonomy codes will be implemented to separately identify Social Worker Case Managers and Registered Nurse Case Managers.

(b) Primary Diagnosis. Document primary diagnosis code using DoD CM unique codes currently outlined in Reference (e), for clinical CM encounters and DoD extender codes to indicate if the patient entered into (i.e., initiated, started) clinical CM services during the month, received ongoing clinical CM services, or no longer required clinical CM services.

(c) Secondary Diagnosis. If an Active Duty member is entered into or receives clinical CM services related to a deployment related issue, a secondary diagnosis code will be assigned in accordance with established guidelines outlined in Reference (e).

f. Establish MTF Webpage Location for CM Service Availability

(1) All MTF sites, both inside and outside the continental United States, will update dedicated outward facing MTF websites. Each MTF website will identify the location, hours, and contact information for CM services, by clinic. Each MTF and Market will be responsible for the update, management, and sustainment of this information.

(2) Semi-annual Market reporting will be provided to the DHA MA MM to support validation of requirement and ensure up-to-date MTF clinic CM support and services are maintained on MTF locator sites.

g. Training Requirements and Reporting

(1) Training. Case Managers will complete the required MHS-approved E&T modules outlined in this DHA-PI (see Enclosure 4) and ensure course updates are completed and reported as they become available.

(a) Training modules can be accessed via Joint Knowledge Online (JKO) at: https://jkodirect.jten.mil/.

(b) Once online at JKO, Case Managers can locate required training in the Community Tab under 'Case Management Required Training.' Request for access to Clinical Decision Support Tool (CDST) training should submitted to the DHA Medical Management Mailbox (dha.ncr.clinic-support.mbx.mhs-medical-management@mail.mil) by the case manager's supervisor. The subject line for all e-mails for CDST training registration should be titled, "CDST Registration."

(2) Reporting

(a) MTF and future DHA market MM will be responsible to ensure compliance with CM training requirements.

(b) MTF semi-annual documentation and reporting of required training completion and reporting requirements to DHA MA MM no later than the last business day of January and June.

h. CM Competencies

(1) MTF Case Managers will utilize the DHA Form 112, CM Core Competency Assessment to ensure they are competent in performing the required Knowledge, Skills, and Abilities (KSA) needed to manage the health care of eligible beneficiaries to include WII SMs.

(a) Standardized competencies provide guidance to improve the capability of the medical community to support a consistent level of quality care to beneficiaries.

(b) Standardized competencies provide supervisors the ability to verify Case Managers have the KSAs needed to effectively perform CM.

(2) When a Case Manager reports to the MTF, the supervisor identifies the Case Manager's level of competency utilizing DHA Form 112.

(a) No Prior Experience (NPE)

(b) Needs Review (NR)

(c) Experienced (E)

(d) Not Applicable (NA)

(3) Revalidation of core competencies will be assessed at a minimum of every 3 years.

(4) MTF and future DHA market MM will validate and report required competency implementation on a semi-annual basis to DHA MM no later than the last business day of January and June.

6. <u>STANDARDIZED REQUIREMENTS AND PROCESSES FOR MTF DM SERVICES</u>

a. <u>Certification</u>. It is highly recommended that Disease Managers obtain certification by a nationally recognized DM, chronic care management, or quality management organization.

b. <u>Coordination</u>

(1) MTF Disease Managers will proactively collaborate with the patient and healthcare teams, and utilize predictive analytics to identify patients who would benefit from disease-specific education and patient-centered care designed to promote self-management and prevent or delay the progression of disease.

(2) MTF Disease Managers will coordinate with MCSCs DM representatives to promote communication and collaboration for eligible MTF enrolled members utilizing PCS DM programs.

(3) Disease Managers will participate in MTF MM, population health, quality, and care coordination meetings.

c. Required Documentation. Document DM patient care in the EHR/AHLTA and MHS GENESIS, when available.

d. Establish MTF DM Services and Reporting. The MTF's MM program will establish, implement, and integrate DM processes in accordance with the information and guidelines in (1) through (5) below. The program will:

(1) Assess the population and disease prevalence to determine the need for specific DM engagement by evaluating MTF health data.

(2) Utilize evidence-based tools, such as predictive analytics and VA/DoD Clinical Practice Guidelines (CPG).

(3) Coordinate, communicate, and collaborate with other members of the MTF healthcare team, MCSC MM, and DHA MA MM staff as necessary, to ensure continuity of care for patients with chronic illness.

(4) Utilize available DM, education, and information platforms that empower patients and establish self-management techniques that enhance shared decision-making skills.

(5) Identify performance improvement opportunities in alignment with MHS Quadruple Aim strategic performance plans.

e. Training Requirements and Reporting

(1) Training. Disease Managers will complete the required MHS-approved E&T modules outlined in this DHA-PI (Enclosure 4) and ensure course updates are completed and reported as they become available.

(a) Training modules can be accessed via JKO at: https://jkodirect.jten.mil/.

(b) Once online at JKO, Disease Managers can locate required training in the Community Tab under 'Case Management Required Training.'

(c) Request for access to CDST training should submitted to the DHA Medical Management Mailbox (dha.ncr.clinic-support.mbx.mhs-medical-management@mail.mil) by the case manager's supervisor. The subject line for all e-mails for CDST training registration should be titled, "CDST Registration."

(2) Reporting

(a) MTF and future DHA market MM will be responsible to ensure compliance with DM training requirements.

(b) Semi-annual documentation and reporting of required training completion and reporting requirements to DHA MA MM no later than the last business day of January and June.

f. DM Competencies

(1) MTF Disease Managers will utilize a standardized DHA Form 113, DM Core Competency Assessment to ensure Disease Managers are competent in performing the required KSAs needed to provide DM services to eligible beneficiaries to include the WII SMs.

(a) Standardized competencies provide guidance to improve the capability of the medical community to support a consistent level of quality care to beneficiaries.

(b) Standardized competencies provide supervisors the ability to verify Disease Managers have the KSAs needed to effectively perform DM.

(2) When a Disease Manager reports to the MTF, the supervisor identifies the Disease Manager's level of competency utilizing the DHA Form 113.

(a) NPE

(b) NR

(c) E

(d) NA

(3) Revalidation of core competencies will be assessed at a minimum of every 3 years.

(4) MTF and future DHA market MM will validate and report required competency implementation on a semi-annual basis to DHA MA MM no later than the last business day of January and June.

7. STANDARDIZED REQUIREMENTS AND PROCESSES FOR MTF UM SERVICES

a. Coordination. Utilization Managers must:

(1) Utilize systematic, data driven processes to proactively identify and improve clinical and business outcomes, as well as define target populations for focused interventions that will promote ideal resource utilization, and optimal patient outcomes.

(2) Use available predictive analytics and registries to identify beneficiaries utilizing health care at higher rates than average and who may benefit from intervention and more intense care coordination.

(3) Leverage MHS evidence-based CDSTs available to support optimal level of care determinations, promote ideal resource utilization, and promote optimal patient outcomes.

(4) Facilitate communication and coordination between healthcare teams and programs.

(5) Participate in MTF MM, population health, quality, and care coordination meetings.

b. UM Oversight for Required Discharge Planning Documentation and Reporting

(1) Discharge planning should be conducted in accordance with the accrediting agency's standards for all eligible beneficiaries.

(2) At a minimum, MTF personnel will conduct and document dedicated discharge interventions for those beneficiaries identified as high risk. MTF will identify beneficiaries at high risk for readmission utilizing the Military Health System Population Health Portal (MHS PHP) High Risk Admissions Registry.

(3) MTF will document discharge interventions (described below in paragraphs 7.b.(4)(a) through 7.b.(4)(d)) for beneficiaries identified as high risk using the following systems.

(a) A care management note will be completed for each intervention outlined in paragraph 7.b.(4)(a) through 7.b.(4)(c) below per beneficiary. Documentation of care management notes will be completed utilizing the MHS PHP, until transition to MHS GENESIS system when available.

(b) A Post Discharge Follow-up TSWF, located in AHLTA, will be completed to document follow-up post discharge contact (intervention paragraph 7.b.(4)(d) below). All fields must be completed on the Post Discharge Follow-up TSWF.

(c) In accordance with the accrediting agency's standards, clinical documentation of discharges is still required within Essentris and MHS GENESIS system when available.

(4) The dedicated interventions are:

(a) Medication Reconciliation to include a complete and comprehensive medication review and reconciliation and documented in the medical record prior to discharge. Per paragrahp 7.b.(3)(a), a care management note must also be completed.

(b) Multidisciplinary rounds prior to discharge must be documented in the medical record to support key information necessary post discharge to ensure safe and effective transition of care. Per paragraph 7.b.(3)(a), a care management note must also be completed. This intervention will include a focused team review discussion and validation of discharge requirements that include, but are not limited to:

1. Validate beneficiary understanding of reason for hospitalization.

2. Confirm outpatient services required post discharge have been ordered and coordinated to ensure timely completion and notification back to medical team and provider.

3. Need for physical profile documentation or sick slip for individual or unit readiness requirements.

(c) Follow-up primary care appointment prior to discharge. Per paragraph 7.b.(3)(a), a care management note must be completed.

1. Follow-up appointment with Primary Care Provider will be coordinated with input from the patient and/or caregiver, if required, regarding the best date and time for the appointments.

2. Confirm the patient knows where to go and has a plan regarding how to get to appointments and address other barriers to keeping appointments.

3. The follow-up appointment will be documented in the medical record and provided to the patient prior to discharge.

(d) Follow-up post discharge contact.

1. Follow-up phone calls after discharge support reduced readmission, increased patient satisfaction, attendance at scheduled follow-up visits, increased adherence to treatment, and fewer adverse post-discharge outcomes.

2. A follow-up phone call will be made within 48-72 hours post inpatient discharge and documented in the Post Discharge Follow-Up TSWF per paragraph 7.b.3(b). MTF facilities will ensure that if a discharge occurs on the weekend or over holidays, a follow-up phone call still occurs within 48-72 hours of discharge.

3. If the patient does not already have a Primary Care Provider, coordinate a follow-up appointment with an MTF provider for continuity of post discharge care services following an MTF admission.

(5) Compliance of interventions will be monitored through MHS data capture.

(6) Discharge dates for MTF enrolled members will be included on the PCMH Team Huddle tool on the MHS PHP to support visibility and improved communication between inpatient and outpatient teams.

c. Training Requirements and Reporting

(1) Training. Utilization Managers will complete the required MHS-approved E&T modules outlined in Enclosure 4 and ensure course updates are completed and reported as they become available.

(a) Training modules can be accessed via JKO at: https://jkodirect.jten.mil/.

(b) Once online at JKO, Utilization Managers can locate required training in the Community Tab under "Case Management Required Training."

(c) Request for access to CDST training should submitted to the DHA Medical Management Mailbox (dha.ncr.clinic-support.mbx.mhs-medical-management@mail.mil) by the case manager's supervisor. The subject line for all e-mails for CDST training registration should be titled, "CDST Registration."

(2) Reporting

(a) MTF and future DHA market MM will be responsible to ensure compliance with UM training requirements MM.

(b) Semi-annual documentation and reporting of required training completion and reporting requirements to DHA MA MM no later than the last business day of January and June.

d. UM Competencies

(1) MTF Utilization Managers will utilize a standardized DHA Form 114, UM Core Competency Assessment to ensure Utilization Managers are competent in performing the required KSAs needed to provide UM services.

(a) Standardized competencies provide guidance to improve the capability of the medical community to support a consistent level of quality care to beneficiaries.

(b) Standardized competencies provide supervisors the ability to verify Utilization Managers have the KSAs needed to effectively perform UM.

(2) When a Utilization Manager reports to the UM department, the supervisor identifies the Utilization Manager's level of competency utilizing the DHA Form 114.

(a) NPE

(b) NR

(c) E

(d) NA

(3) Revalidation of core competencies will be assessed at a minimum of every 3 years.

(4) MTF and future DHA market MM will validate and report required competency implementation on a semi-annual basis to DHA MA MM no later than the last business day of January and June.

ENCLOSURE 4

REQUIRED MILITARY HEALTH SYSTEM EDUCATION AND TRAINING MODULES

1. CM E&T MODULES

a. CDST

b. Clinical CM

c. DoD Recovery Coordination Program

d. DHA Great Lakes Overview

e. Introduction to the Disability Evaluation System for CM

f. TRICARE Fundamentals

g. Veterans' Health Administration (VHA) Overview

h. DHA Mental Health Training

2. DM E&T MODULES

a. CDST

b. DoD Recovery Coordination Program

c. TRICARE Fundamentals

d. VHA Overview

e. DHA Mental Health Training

3. UM E&T MODULES

a. CDST

b. TRICARE Fundamentals

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

AHLTA	Armed Forces Health Longitudinal Technology Application
CDST	Clinical Decision Support Tool
CM	Case Management
CPG	Clinical Practice Guideline
DAD	Deputy Assistant Director
DCS	Direct Care System
DHA	Defense Health Agency
DHA-PI	Defense Health Agency-Procedural Instruction
DM	Disease Management
E	Experienced
EHR	Electronic Health Record
E&T	education and training
HEDIS	Healthcare Effectiveness Data and Information Set
HRO	high reliability organization
JKO	Joint Knowledge Online
KSA	Knowledge, Skills, and Abilities
MA	Medical Affairs
MCSC	Managed Care Support Contractor
MHS	Military Health System
MHS PHP	Military Health System Population Health Portal
MM	Medical Management
MTF	military medical treatment facility
NA	Not Applicable
NPE	No Prior Experience
NR	Needs Review
PCMH	Patient-Centered Medical Home
PCS	Purchased Care System
SM	Service member
TSWF	Tri-Service Workflow

UM	Utilization Management
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
WII	wounded, ill, and injured

PART II. DEFINITIONS

These terms and their definitions are for the purposes of this DHA-PI.

Care Coordination. 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 healthcare services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care (Reference (f)).

Case Manager. A healthcare professional who is responsible for coordinating the care delivered to a group of patients based on diagnosis or need. Other responsibilities may include patient and family education, advocacy, management of delays in care, UM, transitional planning, and outcomes monitoring and management. Case Managers work with people to get the healthcare services and other community resources they need, when they need them, and for the best value (quality, safety, and cost).

CDST. MHS centrally licensed tool accessible at vendor website that provides actionable, evidence-based clinical intelligence that helps optimize care management decisions, support the appropriateness of care, and foster appropriate utilization of resources.

CM. A collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost-effective outcomes (Reference (f)).

CPG. Systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances. CPGs define the role of specific diagnostic and treatment modalities in the diagnosis and management of patients. The statements contain recommendations based on evidence from a rigorous systematic review and synthesis of the published medical literature. DoD, VHA, Evidence Based practice, CPGs are based on a systematic review of both clinical and epidemiological evidence and are developed by a panel of multidisciplinary experts. The guidelines provide a clear explanation of the logical relationships between various care options and health outcomes while rating both the quality of the evidence and the strength of the recommendations.

DCS. Hospitals and clinics that are operated by military medical personnel.

Disease Manager or DM specialist. A healthcare professional who uses a collaborative approach in identifying patient and disease specific education and care needs, to provide comprehensive, patient-centered, proactive strategies promoting prevention, health, and wellness concepts that support the provider's Plan of Care. In the DCS, the Disease Manager delivers DM services to eligible TRICARE beneficiaries at the MTF. The DM specialist in PCS provides individualized, one-on-one telephonic education and resource health information services designed to empower the beneficiary to better self-manage their disease and communicate with their provider.

DM. An organized effort aimed at achieving desired health outcomes in populations with prevalent, often chronic, diseases from which healthcare delivery is subject to considerable variation. DM programs use evidenced-based guidelines to provide information and tools in promoting self-management activities with MHS Quadruple Aim goals of increasing patient and provider satisfaction and improving clinical and financial outcomes, while advocating the appropriate utilization of resources.

Enhanced Multi-Service Market Office. Links Tri-Service MTFs in a given TRICARE area to form an integrated network under one health plan to optimize healthcare delivery.

Healthcare Effectiveness Data and Information Set. A tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Altogether, Healthcare Effectiveness Data and Information Set (HEDIS) consists of 75 measures across eight domains of care; because so many plans collect HEDIS data, and the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis.

HRO. High Reliability Organizations. Organizations which experience fewer than anticipated accidents or events of harm, despite operating in highly complex, high-risk environments. HROs are focused on the elimination of harm and mitigation of errors through fundamental culture change.

MCSC. An organization with which DHA has entered into a contract for delivery of and/or processing of payment for health care services, and the performance of related support activities, such as, pharmacy services, quality monitoring and/or customer service.

MHS Quadruple Aim. The MHS Quadruple Aim represents the MHS leadership's commitment to delivering value to all they serve and is aligned with the MHS strategic goals and value proposition to include: Better Health, Better Care, Lower Cost, and Increased Readiness.

MM. An integrated managed care model promoting UM, clinical CM, and DM programs as a hybrid approach to managing patient care. It includes a shift to evidenced-based outcome-oriented UM, and a greater emphasis on integrating CPGs into the MM process, thereby holding the system accountable for patient outcomes.

PCS. Civilian hospitals or clinics or physician or provider offices where healthcare is provided to TRICARE beneficiaries.

Population Health. Improving the health of a defined group by assessing determinants of health and enabling optimal health outcomes. Population health's purpose is to address opportunities and gaps in needed care, generally involving identification of indicated evidence-based interventions lacking in individuals.

TRICARE. The DoD's managed health care program for active duty service members, military families, military retirees and their families, survivors, and other TRICARE-eligible beneficiaries. TRICARE is a blend of the military's system of hospitals and clinics and civilian providers.

UM. A methodology that addresses the issue of managing the use of resources while also measuring the quality of the care delivered. UM is an organization-wide, interdisciplinary approach to balancing cost, quality, and risk concerns in the provision of patient care. UM is an expansion of traditional Utilization Review activities to encompass the management of all available healthcare resources, transitions of care to other health settings, including referral management.

Utilization Manager. Provides UM activities and functions by using MTF-specific quality improvement processes to identify areas for review from data, suspected problem areas, and input from departments or services within the facility. The Utilization Manager prioritizes accordingly based on high dollar, high volume, or problem prone diagnoses.