



Joint Task Force National Capital Region Medical INSTRUCTION

6025-01
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J-3

SUBJECT: Clinical Case Management

References: See Enclosure 1

1. **PURPOSE.** This Instruction is written under the authority of the Commander, Joint Task Force National Capital Region Medical (JTF CapMed) in order to establish guidance in the delivery of case management (CM) services within Joint Operations Area (JOA).

2. **APPLICABILITY.** This Instruction applies to all personnel functioning or hired as a case manager and applicable support elements within the JOA. CM is recognized as an essential component to optimize quality, service, and clinical and resource efficiency.

3. **DEFINITIONS.** The DoD Medical Management Guide has adopted the Case Management Society of America definition of Case Management and the National Committee for Quality Assurance (NCQA) qualifiers for complex CM.
 - a. A collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet and individual's health needs, through communication and available resources to promote quality cost-effective outcomes. (CMSA)
 - b. The coordination of care and services provided to members who have experienced a critical event or diagnosis requiring the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. (NCQA)

4. **POLICY.** As hereby delineated in this Instruction all Case Managers in the JOA will adhere to the standard Case Management model. CM interventions result in integration, patient care coordination, and continuum of care, thereby enhancing the quality of health care.

a. **CM Goals and Objectives:** The goals and objectives of CM must be in alignment with the Department of Defense (DoD), appropriate directive authorities, and military treatment facility (MTF) strategic plans. The goals of CM are to:

1. Manage the TRICARE Prime health care of beneficiaries with multiple, complex, chronic, and catastrophic illnesses or known conditions.
2. Provide the appropriate level of care (e.g., care coordination, discharge planning, and other CM) for those individuals requiring special assistance (e.g., wounded warriors, children, and elderly population).
3. Coordinate transfer of information with the managed care support contractor (MCSC) case managers when patients require CM outside the Direct Care System.
4. Ensure case managers communicate with other medical management personnel (utilization management, referral management, and disease management).
5. Use CM to ensure a seamless transition from one duty station to the next for selected family members enrolled in the Exceptional Family Member Program (EFMP).
6. Enhance continuity of care and decrease fragmentation by providing education, developing strategies, and intervening when required to restore or maintain optimal health functions.

b. **Case Manager- Services include:**

1. Identification/Case Finding

(a) Sources of identification may include:

(1) Review of:

- a. Admission and disposition lists.
- b. Daily inpatient census.
- c. Obtain Armed Forces Health Longitudinal Technology Application (AHLTA) and Composite Health Care System (CHCS) ad hoc reports from the information technology department.
- d. Emergency department/urgent care rosters.
- e. Wounded warrior reports.
- f. Population health navigator.
- g. Medical transition company, medical hold, and medical holdover

(Reserve) units.

(2) Communication with multi-disciplinary team after daily inpatient ward rounds.

(3) Communication with EFMP coordinators.

(4) Referrals may be from:

- a. Primary care manager or specialty care providers (network or non-network).
- b. Patient.
- c. Family.
- d. Utilization management, disease management, and/or discharge planners.
- e. Recovery care coordinator, Wounded Warrior Program representative, i.e., non-clinical case manager.

(b) Beneficiaries in any of the following categories may be case managed:

- (1) Wounded warrior: ill or injured.
- (2) Multiple medical providers.
- (3) Catastrophic illnesses or injury.
- (4) Chronic or terminal illness.
- (5) Multiple medical problems.
- (6) Lack of family/social support.
- (7) Non-adherence to treatment.
- (8) Multiple visits to the emergency department.
- (9) Transplant, high-risk or high-cost.
- (10) Special interest.
- (11) Functional/physical deterioration.
- (12) Medical claims i.e., multiple visits to an emergency department.
- (13) Frequent utilizer of health care resources.

(c) Wounded Ill and Injured (WII) who meet the following criteria:

- (1) High-risk, multiple complex conditions or diagnosis.
- (2) Catastrophic, extraordinary conditions (e.g., serious head injury, spinal cord injury, complicated fractures, amputation, visual impairment, post-traumatic stress disorder (PTSD), and cancer).
- (3) Requirements for extensive monitoring or coordination of needs.
- (4) Complex psychosocial or environmental factors (family or military obligations) that impact the ability to achieve health or maintain function.

2. Assessment is a systematic, ongoing process of collecting comprehensive bio-psychosocial information about a beneficiary's situation (including all relevant sources military and civilian) to identify needs.

3. Planning, in collaboration with the patient and family, specific goals, objectives, and actions are determined to meet the particular needs of the patient. Key elements include:

- (a) Designing care plans with goals that are individualized for the beneficiary, action oriented, and time and goal specific.
- (b) Identifying immediate patient support systems.
- (c) Advocating for patient and family as needed.
- (d) Identifying actual and potential resources.

4. Implementation

- (a) Communicating with the patient and family to understand their specific needs and concerns, and to provide targeted education.
- (b) Communicating with the health care team members.

(c) Documenting in AHLTA and/or Essentris the treatment progress and modifying the plan as appropriate.

(d) Communicating the patient's medical care plan to the recovery care coordinator for inclusion into the comprehensive recovery plan.

5. Coordination

- (a) Avoiding duplication of services.
- (b) Ensuring timely and appropriate provision of services.
- (c) Identifying barriers to care delivery and exploring alternatives.
- (d) Matching patient needs with available resources.
- (e) Optimizing health care resources in the MTF and community to address targeted needs.
- (f) Organizing and managing the activities outlined in the care plan.

6. Monitoring

- (a) Ensure timely and appropriate care is provided based on the patient's changing health status and/or environment.
- (b) Ensure timely patient/family contact and follow-up.
- (c) Establish and document outcome measurements.
- (d) Identify variance(s) from the treatment plan.
- (e) Monitor results of interventions and care delivery.
- (f) Monitor utilization of health care resources.

7. Evaluation

- (a) Appropriateness of patient needs and plan of care.
- (b) Clinical outcomes.
- (c) Cost savings and/or cost avoidances for the patient, family, and MTF.
- (d) Customer and health care team satisfaction.
- (e) Effectiveness of the CM program.
- (f) Impact of CM interventions on population health.
- (g) Stability of the patient/family home environment.

8. The CM shall coordinate with the TRICARE regional operations, case managers, Wounded Warrior Program Recovery Care Coordinators and Non-Clinical Case Managers, Veteran Affairs Medical Facilities, other MTFs, civilian health care facilities, and Military Medical Support Office where TRICARE Prime beneficiaries receive care.

c. **Case Transfer:** When a beneficiary under CM transfers to another facility or region, it is the responsibility of the transferring and gaining case managers to ensure a smooth transition. Prior to transfer, an accepting physician must be identified and accept the patient. As the patient transitions to an outpatient, it is highly encouraged not only to identify the accepting physician, but also to obtain an appointment with the identified physician, coordinate the medical record transfer, and communicate the date/time of the appointment to the patient/family. When the

patient is case managed and transferred to a different medical facility, a gaining case manager is identified and informed of the pending transfer. If a gaining case manager cannot be identified, the case must be maintained within the originating CM program.

1. Criteria for consideration of case transfer include:

- (a) Permanent change of station orders, temporary assigned duty orders, and assignment to another MTF.
- (b) Change of catchment area or primary care manager (PCM) which may result in reassignment of case manager.
- (c) Patient request for different case manager.
- (d) Patient's care needs exceed that of MTF and is transferred to another level of care to maintain continuity.
- (e) Change in eligibility status, such as discharge/retirement with follow-on medical care obtained from the Veteran Affairs Medical Facility or change from MTF PCM to civilian network PCM. For patients who are pending medical retirement or medical discharge from the services and already under CM, the case manager must ensure the patient is connected to the appropriate Veteran Affairs Medical Facility resources, civilian resources, when applicable the MCSC CM (especially traumatic brain injury, spinal cord injury, transplant, and medically complex cases).

2. Responsibilities of the case managers during transfer: Transferring/gaining case managers shall collaborate with social workers, discharge planners, and non-clinical case managers, Federal Recovery Care Coordinators (FRCs) and Recovery Care Coordinators (RCCs) as appropriate, to perform responsibilities listed below based upon organizational structure and policy.

d. **Documentation Guidelines:** Documentation shall follow the standards of practice for CM per reference (b). Additionally the following is required:

- 1. All CM documentation will be placed into AHLTA using the standardized advanced integration module (AIM) template or Essentris as appropriate.
- 2. Each patient note will be coded per TRICARE Management Activities Guidelines.
- 3. Upon transfer, the transferring case manager communicates with the gaining case manager at the accepting facility and documents within the CM notes in AHLTA or Essentris as appropriate.

4 Transferring case manager responsibilities do not stop until the gaining case manager accepts the responsibility of the patient. The following shall be documented within the case manager's notes in AHLTA or Essentris:

- (a) Diagnosis or medical condition that prompted the need for CM services. Include a summary of the patient's current medical status.
- (b) Date of transfer.
- (c) Reason for transfer.
- (d) Mode of transfer.
- (e) Accepting case manager and physician.

(f) A brief summary of the care received and potential future needs identified. Include copy of Discharge Summary Form, administrative requirements (Physical Evaluation Board (PEB) etc.), change in benefits, and forward electronic copy of diagnostic studies as appropriate.

(g) Inter/Intraregional Transfer Documentation Active Duty Service Member (ADSM) or Inter/Intra regional Transfer Documentation Non-Active Duty Service Member (Non-ADSM).

(h) Education given to the patient/family member to include notation of references provided.

(i) Case Management Discharge Planning Assessment and Checklist for Operation Iraqi Freedom/ Operation Enduring Freedom (OIF/OEF).

e. **Workload Management:** Per the DoD Medical Management Guide, reference (a), the case load for CM ranges between 10 to 50 patients per case manager depending on acuity.

f. **Case Manager Training and Competencies:** MTFs shall provide appropriately trained case managers to support WII service members and all TRICARE Prime beneficiaries.

1. **Education.** Case managers must be either licensed registered nurses with a bachelors degree or licensed social worker.

2. **Certification.** It is recommended that case managers become certified in CM within 2 years and certification is mandatory within 3 years of hire. The nurse or social worker case manager has the option to obtain certification by the Commission for Case Management Certification (CCMC) the Certified Care Manager (CCM), American Nursing Credentialing Center (ANCC) the Registered Nurse-Board Certified (RN-BC), the National Academy of Certified Care Managers (NACCM), CCM, the National Association of Social Workers (NASW), Certified Social Work Case Manager (C-SWCM). All other certification shall require approval and waiver based on level of education required, work experience, and continuing education requirements for recertification.

3. **Basic CM training.** to be completed within 3 months of hire and prior to the assignment of a full patient case load. Contents of the basic training shall include:

- (a) Completion of the Basic Case Manager Competency.
- (b) Training in proper documentation in AHLTA, Essentris, and appropriate coding.
- (c) Training in the role of the case manager in utilizing a patient-centered approach to clinical CM (including the involvement of the WII service member and their family in developing a multi-disciplinary plan of care).
- (d) Gaining an understanding of common combat-related injuries.
- (e) Transition coordination.

4. All clinical case managers shall complete the following required education and training modules within 3 months hire, or as they become available, using the MHS Learn training platform, available at: <https://mhslearnsatx.disa.mil>:

- (a) Suicide Awareness.
- (b) Homicide Awareness.
- (c) Substance Abuse.
- (d) Introduction to Department of Veteran's Affairs.
- (e) Traumatic Brain Injury.
- (f) Post-Traumatic Stress Disorder.
- (g) TRICARE Fundamentals for Case Managers.
- (h) Clinical Decision Support Tools (Inpatient and Ambulatory Care).
- (i) Federal Recovery Care Coordination Program.
- (j) Service-specific Medical Case Management Orientations.
- (k) Case Management.
- (l) Disability Evaluation System.
- (m) Military Medical Support Office.
- (n) Clinical Decision Support Tools (Inpatient and Ambulatory Care).

5. Specialty departments are responsible for the provision of specialty specific training.

6. Competencies shall be reviewed on an annual basis. The organization must have education and training plans to provide initial and subsequent competency review. It is recommended that the newly oriented case manager conducts a self-assessment at the beginning of orientation.

f. **Supervisor Oversight/Review:** It is required that a minimum of 10 percent of active cases or 5 records, whichever is greater, be reviewed monthly for 6 months of hire, then reviewed quarterly. Peer review reports shall be maintained by the department head or CM supervisor for a period of 7 years.

g. **Recovering Service Member (RSM) Coordination:** As appropriate, CM shall support the Recovering Care Coordinator Program by:

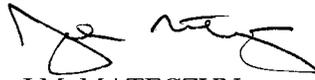
1. Identifying and timely communicating issues to the recovery care coordinator.
2. Providing the results of the medical CM assessment of each RSM who meets the Category 2 or Category 3 criteria to the NMCM and the RCC for inclusion into the RCP.
3. Coordinating with the RCC and the NMCM multi-disciplinary teams.
4. Being available as a resource for the NMCM and the RCC, the medical care team, and the Multi-disciplinary team.
5. Including the NMCM and the RCC in MTF operations optimizing support for the seriously WII service members.

5. **RESPONSIBILITIES.** See Enclosure 2

6. **RELEASABILITY.** UNLIMITED. This Directive is approved for public release and is available on the Internet from the JTF CAPMED Web Site at <http://www.jtfcapmed.mil>.

JUL 13 2010

7. EFFECTIVE DATE. This Instruction is effective immediately.



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Enclosures

1. References

2. Responsibilities

Acronyms

Enclosure 1

- Ref: (a) DoD TRICARE Management Activity, Medical Management Guide, Section II, Case Management, 2009
(http://www.tricare.mil/ocmo/download/MM_Guide_2006.pdf)
- (b) Case Management Society of America, Standards of Practice, 2002
(<http://www.cmsa.org/MARKETPLACE/StandardsofPractice/tabid/118/Default.aspx>)
- (c) DoD Population Health Improvement Plan and Guide, Dec 2001
- (d) Utilization Review Accreditation Commission (URAC), Case Management Standards (http://www.urac.org/programs/prog_accred_CM_po.aspx)
- (e) Joint Commission Standards (<http://www.jointcommission.org/Standards/>)
- (f) National Defense Authorization Act
- (g) Under Secretary of Defense for Personnel and Readiness Directive-Type Memorandum (DTM) 08-049, Recovery Coordination Program: Improvements to the Care, Management, and Transition of Recovery Service Members (RSMs)
(<http://www.dtic.mil/whs/directives/corres/pdf/DTM-08-049.pdf>)

Enclosure 2

Responsibilities

1. JTF CAPMED (Program Manager)

- (a) Provides program oversight, support, and resources.
- (b) Develops CM Policy:
 - (1) Determines and issues standards of care for CM.
 - (2) Outlines required training and education.
 - (3) Establishes standards for documentation.
 - (4) Establishes standards for workload management.
 - (5) Develops process and outcome metrics to accurately report CM activity across the JOA.
- (c) Serves as subject matter expert (SME).
- (d) Collaborates with TRICARE Management Activity, civilian organizations, Veteran Affairs Medical Facilities, and other DoD activities.

2. MTF Commanders

- (a) Shall ensure the provisions of this instruction are followed.
- (b) Shall facilitate collaboration between Regional MTFs, TRICARE Regional Office, and their network, VA, civilian organizations, and DoD activities.
- (c) Ensures CM activities are centralized within the organization with clear authority delineation.
- (d) Shall collect and forward monthly the following data to JTF CM Program Manager:
 - (1) Total number of case managers.
 - (2) Number of patients receiving facility-based CM services.
 - (3) Number of active duty personnel receiving CM services through Service-specific wounded warrior programs (e.g., Navy Safe Harbor, Marine Corps Wounded Warrior Program, and Army Wounded Warrior Program).
 - (4) Acuity.
 - (5) Case-mix (reference (a)).
 - (6) Number of WII service members receiving CM services.
 - (7) Outcome reports showing the effectiveness of clinical CM.
 - (8) The report showing timeliness of intake and transfer transitions.
 - (9) The report of effectiveness of CM interoperability with all service personnel systems.

3. Deputy Commander

- (a) Provides logistical support, staffing, and funding to meet the mission requirements.

(b) Ensures that comprehensive care, treatment, and administrative services are provided in a multidisciplinary, collaborative manner.

(c) Prioritizes the populations to be served by CM based upon MTF business plan or Regional policy and patient requirements.

4. MTF CM Department Head/Division Officer

(a) Ensures CM activities and standard operating procedures (SOPs) meet policy requirements.

(b) Evaluates the effectiveness of CM from clinical, quality, and economic perspective.

(c) Prepares a variety of workload and administrative reports as related to CM efforts.

(d) Functions as SME for command on CM issues.

(e) Keeps MTF commander and higher authority informed of activities, trends, and issues to include data to be reported to higher authority:

(1) Total number of case managers.

(2) Number of patients receiving facility based CM services.

(3) Number of active duty personnel receiving CM services through Service-specific wounded warrior programs e.g., Navy Safe Harbor, Marine Corps Wounded Warrior Program, Army Wounded Warrior Program).

(4) Acuity.

(5) Case mix (reference (a)).

(f) Educates members of health care team on CM program benefits and outcomes.

(g) Supervises case managers to ensure standards of practice are being met per policy.

(h) Serves as resource/educator and consultant to command about CM program.

(i) Identifies and appropriately monitors WII service members receiving CM services.

(j) Monitors the precision and timeliness of intake and transfer transitions.

(k) Provides documentation oversight/review for all MTF CM.

(l) Develops and deploys comprehensive performance measures to ensure appropriate and effective implementation of clinical CM.

(m) Monitors the effectiveness of CM interoperability with all service personnel systems. Service-specific CM programs shall be interoperable with apparent seamlessness for the WII service member.

(n) Ensures all training and competencies are completed as required.

(o) Ensures all required reports are completed and forwarded in a timely manner.

Acronyms:

AANC	American Nursing Credentialing Center
ADSM	Active Duty Service Member
AHLTA	Armed Forces Health Longitudinal Technology Application
AIM	Advanced Integration Module
C-SWCM	Certified Social Work Case Manager
CCM	Certified Care Manager
CCMC	Commission for Case Management Certification
CHCS	Composite Health Care System
CM	Case Management
CMSA	Case Management Society of America
DoD	Department of Defense
DON	Department of Navy
DTM	Directive-Type Memorandum
EFMP	Exceptional Family Member Program
MCSC	Managed Care Support Contractor
MTF	Military Treatment Facility
NACCM	National Academy of Certified Care Managers
NASW	National Association of Social Workers
NCQA	National Committee for Quality Assurance
NMCM	Non-Medical Case Manager
OIF/OEF	Operation Iraqi Freedom/Operation Enduring Freedom
PCM	Primary Care Manager
PEB	Physical Evaluation Board
PTSD	Post-Traumatic Stress Disorder
RN-BC	Registered Nurse-Board Certified
SME	Subject Matter Expert
SOP	Standard Operating Procedures
URAC	Utilization Review Accreditation Commission
WII	Wounded, Ill, or Injured