

Case Management and the Active Duty Service Member

Case Management of the Active Duty Service Member (ADSM) poses unique challenges and opportunities for the case managers. Case management of the ADSM must be viewed as a shared responsibility between the military and the case management vendor. The article addresses the following considerations as they relate to the case management process in a military setting: communicating with the family, medical boards, line of duty investigations, competency evaluations, convalescent leave, military transportation, and discharge planning.

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Health care reform has sent shock waves throughout the health care industry and the military health care system is not exempt from the challenges of declining funds, shrinking resources, and escalating health care costs.¹ In response to the challenge of maintaining medical combat-readiness while providing optimal health care for all eligible Military Health System (MHS) beneficiaries, the Department of Defense (DoD) began to remodel military health care with the phased-in implementation of TRICARE and the Managed Care Support Contract (MCSC). TRICARE combines the health care resources of the Tri-services and supplements them with a network of civilian health care professionals to enhance access to care and to strengthen quality service while maintaining the capability to support military operations. It is a regionally managed health care program for the active duty and retired members of the uniformed services, their families, and survivors. Regionally, a senior military health care officer, the Lead Agent, manages implementation of the TRICARE triple option health care plan. The triple options are TRICARE Prime (similar to a Health Maintenance Organization), TRICARE Extra (a net

work of preferred providers), and TRICARE Standard (Standard CHAMPUS, a fee for service option).

A vital component of TRICARE is Utilization Management (UM). In October 1994, the Department of Defense (DoD) set in motion the Utilization Management (UM) Policy for the Direct Care System (Military Hospitals). This policy was designed to "provide guidance in support of a uniformed resource management system based on systematic business and clinical decision processes."² It offered Lead Agents working in coordination with the Military Treatment Facility (MTF) Commanders flexibility in developing cost-efficient, multidisciplinary processes, consistent with National Committee of Quality Assurance (NCQA) and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards, which are aimed at improving patient care. The DoD Utilization Management policy was revised in April 1998 allowing increased flexibility in performing UM functions at the local and regional levels. This is to ensure that the highest quality of care is provided in a timely, cost-effective manner and delivered in the most appropriate setting to Military Health System (MHS) beneficiaries.³

Case Management Arrives

Case management services were introduced in 1992 to military beneficiaries in the TRICARE Mid-Atlantic Region DoD Expanded Home Health Care Case Management Demonstration Project.⁴ The purpose of the Demonstration Project was to test the extent to which individualized coordination of health care needs and resources could affect the cost of care for beneficiaries with extraordinary, complex, potentially high cost conditions. The Demonstration Project showed the benefits of CM and served as the foundation for case management in the Managed Care Support Contract.

The Managed Care Support Contract was implemented in the TRICARE Mid-Atlantic Region in May 1998. Case Management services for eligible TRICARE beneficiaries, including the Active Duty Service Member, were purchased as part of the Region's Managed Care Support Contract.

Case Management of the active duty military population has posed unique challenges and opportunities. A major lesson learned was that military-unique issues can impact benefits and must be considered and incorporated when providing discharge planning and case management services to the Active Duty Service Member (ADSM)

In this context, discharge planning and case management of the ADSM must be viewed as a shared responsibility between the government and the Managed Care Support Contractor. Failure to understand and recognize the significance of differences between providing services to the ADSM and the civilian population can have a negative impact on the ADSM and the member's family, resulting in a potential loss of benefits, while also impacting military readiness.

Acting as a liaison between the patient, the military system, and Tricare

Policies, the case manager's goal is to provide a seamless transition from one level of care to another. The case manager is responsible for ensuring and facilitating the achievement of quality care, appropriate care costing, and clinical outcomes. He or she is responsible for negotiating, procuring, and coordinating services and resources needed by the patient or the patient's family and intervening appropriately when the patient deviates from the anticipated progression through the military or civilian health care system.⁵

ADSM Case Management

Discharge planning and case management for the ADSM can be a challenging, frustrating, and difficult process. The ADSM has Service specific rules and regulations, which must be addressed before any discharge planning or case management plan can be implemented. Managing active duty cases requires fortitude, persistence, perseverance, and a sense of humor, because no matter how well you have planned, if something can go awry, it will.

The Case Manager must pay special attention to Uniformed Services specific policies, procedures and regulations as well as the patient's medical, surgical and/or psychological needs prior to transitioning the ADSM to the next level of care. Each of the five Uniformed Services (Air Force, Army, Coast Guard, Marine Corps, and Navy) has military-specific parameters that need to be addressed before a service member can progress to another level of care.

Case Managers for Active Duty Service Members must be knowledgeable about military requirements and have information concerning all applicable military regulations prior to formulating case management interventions. Developing a working relationship with each branch of the uniformed services, key staff at military hospitals,

Department of Defense staff, and other government agencies is a must for successful case management of the ADSM. Case Managers must evaluate the ADSM for the diverse military-specific policies and coordinate with the appropriate uniformed service to see that military issues have been addressed, if required, prior to transitioning the service member to the next level of care. When assessing, coordinating, and implementing case management for the ADSM the following issues if not examined can have a negative impact on the ADSM's outcome:

I. Communication with the Family

Numerous writers have documented the importance of early communication with the family in the CM process.^{6,7} Families affected by the injury or illness of an ADSM often will experience role changes, dependency shifts, anxiety, anger, and an inability to make decisions.⁸ Thus early contact is crucial when working with the active duty population. By virtue of the nature of their military obligations, the military population is very mobile. When a traumatic or catastrophic illness or injury occurs, the ADSM may be miles away from the

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Table 1

**Military Hospital and VA Regional
Traumatic Brain Injury Rehabilitation Centers**

East Coast, USA

Hunter Holmes McGuire Medical Center
Richmond, Virginia

Southern USA

James A. Haley Medical Center
Tampa, Florida

Middle USA

Minneapolis VA Medical Center
Minneapolis, Minnesota

West Coast, USA

VA Palo Alto Health Care
Palo Alto, California

Military Hospital

Walter Reed Army Medical Center
Washington, DC

support of family, friends, or the service member's home of record. The family may have no knowledge of military specific requirements or military benefits. Therefore, it is critical that the Case Manager involves the family as quickly as possible and provides linkage to the appropriate military personnel and resources. Early intervention identifies barriers to successful management of the ADSM and ensures that families are supported with information and resources throughout the episode of care.⁹

II. Medical Evaluation Board

The purpose of the Medical Evaluation Board is to determine the service member's military readiness and fitness for continued full duty. Active Duty Service Members who have medical, surgical, or psychiatric conditions that incapacitate them for a protracted period of time must have a review by a military physician who determines their fitness for full duty. If the military physician determines the ADSM's illness/injury will exceed the Uniformed Service's specific timeframe, then a medical board is initiated.

Each branch of the Military has Medical Evaluations Boards whose requirements vary slightly based on the branch of Service.¹⁰⁻¹³ For the most part, the first level is initiated when the service member's activity is restricted, but it is determined that the service member will be able to return to full duty within the Uniformed Service's specific time frame. A Physical Evaluation Board (PEB) is initiated when a military physician recommends to the Uniformed Service's specific Physical Evaluation Board that the service member may not be fit for full duty. Generally, three military officers (two line officers and a medical officer) determine if the ADSM should be retained on active duty, reclassified for another job, or separated from the service with or without benefits. An

Table 2

VA Spinal Cord Centers

California

Long Beach VA Medical Center
Long Beach, California

Palo Alto VA Medical Center
Palo Alto, California

San Diego VA Medical Center
San Diego, California

Florida

James A. Haley Medical Center
Tampa, Florida

Miami VA Medical Center
Miami, Florida

Georgia

Augusta VA Medical Center
Augusta, Georgia

Illinois

Great Lakes Health Care System
Great Lakes, Illinois

Massachusetts

Brockton VA Medical Center
Brockton, Massachusetts

West Roxbury VA Medical Center
West Roxbury, Massachusetts

Missouri

St Louis VA Medical Center
St Louis, Missouri

New Jersey

East Orange Campus of the VA New Jersey
Health Care System
East Orange, New Jersey

Lyons Campus of the VA New Jersey
Health Care System
Lyons, New Jersey

Ohio

Louis Stokes VA Medical Center
Cleveland, Ohio

Tennessee

Memphis VA Medical Center
Memphis, Tennessee

Texas

South Texas Veterans Health Care System
San Antonio, Texas

Virginia

Hunter Holmes McGuire Medical Center
Richmond, Virginia

Imminent Death Board is initiated when a service member's medical condition is such that death is anticipated within 72 hours. Survivor's benefits may be reduced if the ADSM is not retired prior to death. Therefore it is imperative that a service member whose medical condition is considered severe or critical and imminent death is anticipated be reported immediately to the Head of Patient Administration or designee at the nearest MTF so that an Imminent Death Board can be initiated.

Each branch of the Uniformed Service has specific requirements for medical evaluation boards; therefore, each Uniformed Service initiates and reviews the recommendations for their service members.

III. Line of Duty Investigation

A line of duty investigation is a military process conducted to clarify whether an ADSM's injuries occurred in the line of duty, not due to the member's own misconduct, or not in the line of duty, due to the member's misconduct.¹⁴ If the investigation reveals that the ADSM's injuries were "not in the line of duty," the ADSM might be held financially responsible for any and all necessary care related to the injury or illness. Case Managers need to be aware of the implications of financial responsibility and the impact that negative findings can have on the ADSM. This is of utmost importance when transitioning the military member to another level of care outside of the direct military health care system. In addition, a determination of "not in the line of duty" will have a negative impact on any possible PEB proceedings and could result in the ADSM not receiving disability or compensation.

IV. Competency Evaluation

A military psychiatrist conducts a competency evaluation to assess the ADSM's mental capacity to handle financial and personal affairs. A competency exam is required for patients who have suffered a serious head injury, an anoxic event, or any medical condition that causes impaired thinking. Active Duty Service Members who have been found to be

incompetent to handle financial matters will have a trustee appointed by the military. This appointee is responsible for the service member's military financial resources until such time as the ADSM is deemed competent to handle his/her financial affairs.¹⁵

V. Traumatic Brain Injury (TBI), Spinal Cord Injury (SCI), or Blindness

Active Duty Service Members who have been diagnosed with a traumatic brain injury, spinal cord injury (paralyzed), or blindness may be placed, expeditiously, in a Department of Veteran's Affairs (VA) Facility, which specializes in Traumatic Brain Injury, Spinal Cord Injury, or loss of sight rehabilitation. Active Duty Service Members who are being transferred to a VA facility must have a Physical Evaluation Board initiated prior to the move. The Case Manager should contact the nearest Uniformed Service MTF and speak with the Chief of Patient Administration if there are issues or concerns about the status of the ADSM's medical board.¹⁶

There is one military hospital and four VA regional centers, which evaluate the ADSM for admission to TBI rehabilitation. Table 1 lists the one military hospital and the four regional TBI facilities. SCI patients may go to one of the VA Medical Facilities specializing in SCI rehabilitation listed in Table 2. Phone numbers and addresses of Veteran's Affairs facilities for blindness rehabilitation or for any Veteran's Affairs facility may be obtained from the VA web address (www.va.gov).

VI. Convalescent Leave

Convalescent leave for the ADSM is similar to sick leave for a civilian. However the ADSM's parent command has final approval for any and all convalescent leave. Therefore all Active Duty Service Members receiving care in civilian hospitals must report back to their parent command for approval of convalescent leave. Convalescent leave is generally limited to 30 days (42 days for uncomplicated maternity leave).¹⁷ Any request for an extension beyond the original

time limit must also be forwarded to the ADSM's parent command for approval.

VII. Military Medical Transportation: Medevac/Air Evacuation

The Global Movement Requirements Center (GPMRC) at Scott Air Force Base is responsible for coordinating the movement of all DoD beneficiaries from point of injury to definitive care, including rehabilitation but not convalescent leave. The goal of the aeromedical evacuation system is to provide continuity of care for the patient and a smooth transition to the receiving facility.¹⁸

When transitioning an ADSM from one local or regional inpatient setting to another, ground transportation is arranged through the local military hospital's MEDEVAC office.

The Air Force Form 3839, Aeromedical Evacuation Patient Record, AMC Form 805, Aeromedical Evacuation Inpatient Nursing Summary, AF Form 3838, Do not Resuscitate (DNR) if applicable, certification for Aeromedical Evacuation, (if applicable); and DD Form 2239, Consent for Medical Care and Transportation in the Aeromedical Evacuation System must be completed when requesting aeromedical evacuation through the military system.

Close coordination of arrangements with the Medevac office is a must when preparing an ADSM for air evacuation. There are critical details, which must be addressed to prevent delays and provide for a smooth transition of care.

VIII Discharge Planning

The ADSM who resides in a barracks or on board a ship requires special discharge planning consideration. Contagious conditions or incapacitating illnesses (i.e. chicken pox, measles, casts, etc.), which in the civilian sector would be managed in an outpatient setting, may require an acute inpatient admission or other special arrangements. This is to prevent the spread of disease to other service members and to assure the safety of the ADSM.

The Case Manager or Discharge Planner can contact the Military Medical Support Office (MMSO) for

support and guidance when an ADSM, residing in a different TRICARE region, is hospitalized. MMSO serves as the Service Point of Contact (SPOC) for the Air Force, Army, Navy, and Marine Corps. MMSO was established to provide the means to identify, manage, and provide medical oversight of civilian health care furnished to members of these branches of Service. MMSO provides 24 hours, 7 days per week, customer service to facilitate access to TRICARE Managed Care Support Contractor and other medical/dental treatment facilities. MMSO can be reached by calling 1-800-876-1131. The Coast Guard SPOC may be reached by calling 1-800-942-2422.²¹

Conclusion

The Department of Defense through the Managed Care Support Contract in the TRICARE Mid-Atlantic region provides case management benefits to the ADSM. Case Managers for the ADSM must understand military unique policies, rules and/or regulations, as well as the patient's diagnosis when formulating a care plan. The Case Manager must actively collaborate with the ADSM's Uniformed Service to assure that military-specific requirements are met prior to transitioning the ADSM to another level of care. Failure to identify and comply with military specific issues can have a major impact on the quality of life and financial resources of the ADSM and/or the member's family. To avoid putting the ADSM at financial or career risk, the Case Manager is obligated to have knowledge of military requirements and to utilize all available military resources. **GM**

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