THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

NOV 0 2 2005

HEALTH AFFAIRS

The Honorable John Warner
Chairman, Committee on Armed Services
United States Senate
Washington, DC 20510-6050

Dear Mr. Chairman:

The enclosed report responds to House Report 108-491 requesting the Department of Defense evaluation of the elimination of the Nurse Triage and Health Information Line services. The Department affirms that the new service design for this purpose, inherent within the execution of our performance-based next generation of TRICARE contracts, facilitates better patient access and improved provider communication. It does so at a significantly reduced cost to the government. The requisite process changes subsequent to our transition last year, along with more attention to existing Military Health System (MHS) access policies and operational guidelines, has, in fact, provided a near-uniform approach for nurse advice and improved patient-provider relationships. This is accomplished without the more prescriptive design experienced in the former TRICARE 3.0 contracts.

The Department is committed to a continued assessment of present business practices related to nurse advice and healthcare information lines. We also remain engaged in identifying process improvements and relevant technology innovations that may shape future-state models and further enhance access, beneficiary satisfaction, patient-provider relationships, and improve efficiencies.

Thank you for your continued support of the Military Health System.

Sincerely,

William Winkenwerder, Jr., MD

Enclosure:
As stated

cc:
Senator Carl Levin

Report to Congress

Report on Nurse Triage and Health Care Information Line Services

Requested by: **House Report 108-491**

Prepared by:
Office of the Assistant Secretary of Defense (Health Affairs)/
TRICARE Management Activity

Report to Congress
Nurse Triage and Health Information Line Services

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EXECUTIVE SUMMARY

House Report 108-491 requested the Defense Department to provide a detailed explanation of its plan to fulfill nurse triage and health information lines services, specifically addressing: (1) the elements of the plan; (2) the timeline and current status for implementation; (3) an assessment of the military Services' abilities to perform the services; (4) any gaps in fulfilling these services; (5) how the Department will ensure uniformity within and across the TRICARE regions; and (6) the estimated cost of providing the service, but also the cost in terms of health care outcomes, provision of needed care, avoidance of unnecessary care, and redirection of care to a more appropriate level. The report language also expressed interest in discerning whether the elimination of nurse triage and health information line services from the previous generation of TRICARE contracts would significantly affect beneficiary access to quality health care services.

The Secretary of Defense, through the Office of the Assistant Secretary of Defense (Health Affairs), reviewed its policies, procedures and business planning relevant to the queries and concerns of the Committee and re-affirmed that the elimination of the requirement for the Healthcare Information Line (hereinafter HCIL), to include the requirement for nurse advice, has not adversely affected beneficiary access to quality healthcare services. Moreover, in our review of survey data from beneficiaries and military treatment facility (MTF) commanders, it is apparent that the clinical outcomes associated with appropriately triaging and scheduling care requirements is equally effective, and more efficient, when managed by the MTFs. Since none of the previously contracted nurse advice lines maintained the ability to appoint urgent care requests directly, our current business practice now facilitates enhanced patient-provider communications and relationships directly rather than through a remote entity. On average, the

contracted nurse advice line services cost the government about $25.00 - $27.00 a call. We have found that our new design facilitates better patient care and communication, and does so at a significantly reduced cost. Performance gaps have been systematically monitored, identified and reconciled throughout the transition to the new performance-based next generation of TRICARE contracts. The TRICARE Management Activity (TMA) and the military Services have discovered that the requisite process changes subsequent to this transition, and the strict adherence to Military Health System (MHS) access policies and operational guidelines has, in fact, provided a near-uniform approach for nurse advice and improved patient-provider relationships without the more prescriptive design under the former TRICARE contracts.

Our conclusions are founded upon an exhaustive review of data received from the Services, the new TRICARE Regional Offices, and our MHS beneficiaries through a retrospective analysis of the decision to eliminate the HCIL requirement from the TRICARE first generation contracts. A recent TMA-sponsored MTF data capture shows that, in the absence of the previously contracted HCIL requirement, nearly 90 percent of facilities continue to provide 24-hour, seven-day access to a privileged provider, either directly or on-call. The data also projected gaps in performance may still exist at certain MTFs with their ability to provide after-hours appointing. Although this issue is not directly relevant to the elimination of the previously contracted HCIL, it is nonetheless a very important consideration for the MHS towards our objective of more effectively executing front-end demand management of care. As identified later in the report, pending proposals by the Navy and the TRICARE Area Office in Europe offer some promising solutions to interface after-hours nurse advice with appointing. OASD(HA) anticipates that a thorough evaluation of these projects, and perhaps others, will assist the MHS leadership with identifying the optimal

design for enabling beneficiary access to care and services, as well as meeting the outcomes sought for achieving improved economies of scale.

OASD(HA) and TMA continues to maintain a forward focus on the issue of nurse advice and effectively communicating healthcare information to our beneficiaries. A joint and multi-disciplinary committee chartered by the Deputy Director, TMA and directed by the Assistant Secretary of Defense (Health Affairs) is evaluating different designs that incorporate advanced technologies and other innovations for this purpose. This effort, as well as the underlying decisional process on the elimination and subsequent transition of HCIL, is provided in response to the inquiry on Nurse Advice and Health Care Information in the Military Health System. An analysis of the Department's actions undertaken to effectively transition these services and any recommendations for enhancements and improvements to the MHS for these and related business processes is also included for consideration. In some cases, where noted, a retrospective assessment of relevant policies, surveys, or other guidance may be provided for context.

BACKGROUND

The Defense Department health care system covers a service population that includes active duty and reserve members, retirees, and their respective family members – a population of about 9.1 million. The Department delivers health care through its system of almost 500 military treatment facilities (MTFs) and through networks of contracted civilian healthcare providers worldwide. The MTFs include medical centers with tertiary care capabilities and graduate medical education (GME) programs, smaller community hospitals with less extensive service availability, and clinics offering outpatient services only. Pharmacy services are available to beneficiaries through one of three venues: MTFs, the

TRICARE Mail Order Program (TMOP) and contracted retail pharmacies. Regional health services support contractors are responsible for civilian provider network development, claims processing, and other support that supplements and complements the direct care system.

The TRICARE program is the Department's regional managed-care program. Congress has mandated that the program be modeled on Health Maintenance Organization plans offered in the private sector and other similar government health-insurance programs. Those beneficiaries who choose to enroll have reduced out-of-pocket costs and a uniform benefit structure.

The management of the direct care system is divided among the Office of the Secretary of Defense (Health Affairs) and the three Services with each Service having direct responsibility for its own MTFs. The Assistant Secretary of Defense (Health Affairs) is responsible to the Secretary of Defense for all programs, policies and activities of the Military Health System. As Director, TMA, the Assistant Secretary of Defense (Health Affairs) coordinates the development of the Defense Health Program budget, health care policy, and the development and implementation of health care support contracts in each of the TRICARE regions. Policy execution is delegated to the TMA and is shared with the Surgeons General of the three Services. In each TRICARE region, a TRICARE Regional Office (TRO) Director coordinates MTF and contractor services.

Prior to the implementation of the next generation of TRICARE contracts, the requirement for nurse advice and healthcare information services was executed as an administrative subcomponent of TRICARE managed care support contractor services. The recent elimination of this national contract requirement from the TRICARE portfolio of healthcare services has revised the oversight of this capability, placing operational and management responsibility in the direct care

system with the support and facilitation of the newly organized TRICARE Regional Offices (TROs).[1]

TRANSITION

The next generation of TRICARE contracts transition team was comprised of senior members from the military Services, civilian officials from TMA, transition leaders from the TROs, and other managed care experts. This team conducted an evaluation for more than two years of the contracts under the TRICARE first generation contract structure. In 2002, the team was sufficiently equipped with valid data to begin making informed recommendations to the Office of the Assistant Secretary of Defense, Health Affairs (OASD/HA) on healthcare services it believed the Department could procure locally to effectively optimize beneficiary access, quality and overall cost.

With regard to the specific details of the contracted HCIL, perspectives were varied on the following: the utility and cost effectiveness of HCIL as a managed care tool; its effective execution from region-to-region; its ability to enhance and/or sustain other MHS efficiencies (especially since empirical data from our operational experience did not appear to be particularly favorable to the proper management of demand and clinical outcomes as discussed later in this report). While some regional contractors emphasized the nurse advice component of the HCIL, others marketed their recorded "help line information" as a primary source of information. Nonetheless, during the business case analysis it was readily apparent that the variation in execution of HCIL under the prior contracts led to requisite variations in cost efficiencies, performance, and outcomes for MHS staff and beneficiaries.

[1] TROs were realigned from the former Lead Agent offices to address the revised regional structure of TMA's healthcare network and to more effectively manage healthcare markets and governance strategies.

Despite these concerns, however, the requirement for contracted HCIL remained a possible option to be included in the national suite of proposed TRICARE contracts. After a significant public comment period on the next generation concept, and upon the receipt and approval of recommendations on services to be purchased locally, an internal workgroup was chartered to assess gaps, identify risk mitigation strategies, and evaluate the benefits of procuring certain recommended services locally. The workgroup evaluated the following elements of the HCIL requirements under the old contracts:

1) Operation 24 hours a day, 7 days a week, toll free telephone access throughout the region;
2) Contractor use of nationally accepted algorithm-based protocols;
3) Answer 95 percent of calls within three (3) rings via an electronic message, and within two (2) minutes by a nurse at the conclusion of the electronic message:
    a. Determine if an emergent condition exists within one (1) minute of answering a call;
    b. Within three (3) minutes of terminating a call, nurse verifies with patient's local emergency service;
4) Contractor records all telephone calls and provides a monthly report of HCIL activities;
5) Nurse creates a record of all calls, and forwards a copy of the call record to the patient's PCM no later than 8:00 AM the following business day.

The workgroup partnered with a commercial actuary to provide a credible assessment of the requirements for HCIL under the previous contracts. The actuary was charged with providing an independent analysis to discern whether a

cost-effective acquisition or replacement strategy was feasible, with consideration to alternative options that may streamline MHS business processes and realign the core functions of HCIL internally to achieve a positive return on investment. Likewise, the results of the analysis would provide additional guidance to OASD(HA)/ TMA on the application of the resultant cost avoidance to other identified areas for enhancing care and supporting business practices within the MTFs.

An intergovernmental cost estimate (IGCE) was produced, which analyzed the total cost to OASD(HA)/ TMA for contracted nurse triage services. The criteria included the cost per call, staffing and productivity requirements, and other direct operational expenses for the delivery of this service to MHS beneficiaries. The estimate also included assumptions based on the number of users across the (then) twelve managed care support contractor regions and cost-avoidance outcomes. TMA conducted a concurrent analysis of its operational experience including the types and distribution of calls received across all regions.

Both analyses yielded nearly similar conclusions. The following summarizes the collective assessment of the MHS' operational experience with HCIL. For the first six months of 2002, the absolute number of calls to the HCIL service was 389,775, from a total beneficiary population of approximately 8.7 million. Annualizing this figure provided a reasonable projection of 779,550 calls, or 9.5 percent[2] of the beneficiary population. Specific use data showed that 63 percent of calls to the HCIL were those placed by first-time users; with 37 percent of those identified as repeat calls or users. Moreover, TMA's analysis[3] showed that the majority of calls for nurse advice were after-hours and weekend calls

[2] TMA notes that 9.5% does not represent accurate percentage of users since it is based on total calls, some of which may be repeat calls from the same user. (Brief: HCIL Usage and Cost Data)
[3] TMA's regional analysis showed that forty percent of calls were received after hours, with twenty-one percent of calls occurring on weekends.

primarily comprised of requests for assistance with pediatric and/or routine medical concerns.

The resulting low usage rate, disproportionate distribution of the usage after-hours and on weekends, the variation in execution across the managed care contracts, and the high cost per call (averaged at approximately $27.00 across all regions) provided reasonable justification in the cost-benefit analyses of proposed plans to discontinue the national contract requirement for HCIL. The analysis also gave OASD(HA)/ TMA the opportunity to review other in-house alternatives and more adequately align a $26 million projected cost avoidance. Additionally, it was believed that other private industry developments in the medical service market place (e.g., healthcare finders and *WebMD*) and the MHS' own TRICARE Online Internet website, could produce excellent patient information resources that further complemented a more efficient, beneficiary-centered approach without adding or duplicating costs.

During a Senior Military Medical Advisory Committee (SMMAC)[4] meeting, our Service representatives from each of the respective Surgeons General offices evaluated the findings of the workgroup, as well as the above-noted analyses and recommendations, and concurred that a national contract to procure HCIL services was neither cost-effective nor warranted for consideration as evidenced by the data. Moreover, the lack of standardized outcomes and varying degrees of MTF satisfaction with the quality of services reinforced the military Services' endorsement of a localized approach to procuring a "HCIL-like" alternative in healthcare service areas with a demonstrable and validated need. These, of course, could be executed through a national delivery order contract by

[4] The Senior Military Medical Advisory Council is the senior decision-making body within the MHS, which is chaired by the ASD (HA) and includes the membership from the Service Surgeons General, the Joint Staff Surgeon, the Deputy Director, TMA, and all Deputy Assistant Secretaries of the OASD(HA).

the newly established TRICARE Regional Offices, Market Managers and/or MTF commanders.

TMA expressed this decision in a letter to the Military Coalition and Alliance, stating, "TMA personnel analyzed current HCIL services across the Military Health System. A national HCIL contract was considered by TMA and the Services, but was not felt to be cost-effective. Each (military) Service will analyze their local markets and consider providing a HCIL service where it has been shown to be cost effective. Local contracting will provide flexibility and tailoring of services to local markets in order to better meet beneficiary needs. Beneficiaries health information needs will also be met (by) using the internet and TRICARE resources, such as, *WebMD*, *Healthfinder*, TRICARE Online and self care books."[5]

In consideration of all the facts regarding customer service, effective clinical care and the return achieved on our investment of resources, the senior MHS leadership determined that our MTFs were a more effective conduit for this function. It is worth noting, however, that MHS senior leadership has continued to challenge TMA and Service staff with assessing industry models and concepts that could further enhance our desire to improve front-end demand management for healthcare, enhance the patient-provider relationship, improve access to primary care and urgent care services, and ultimately create better informed healthcare consumers among our beneficiary population.

TMA is presently evaluating some concepts that would more effectively and efficiently enjoin the interface of requirements for after-hours care requests and appointing functions. Conceivably, the coupling of these two requirements in healthcare markets, where patient volumes are sufficient to support the cost, and

where these volumes might be predicted with reasonable certainty, could produce economies of scale and improve quality of access and clinical outcomes. The organization is currently evaluating the merits of this concept and will provide subsequent recommendations to MHS leadership. A pilot program in the TRICARE Europe Area Office (further discussed on pages 22-24, TRICARE Europe Aviano Air Base Pilot) has shown promise in coupling these fundamental functions, and the Navy Bureau of Medicine and Surgery leadership has engaged in the initial stages of implementing a similar design in the TRICARE West region. TMA will be following the progress and results of both these programs closely to determine if economies of scale can be realized on regional, national or even a global basis.

As TMA concluded its role in facilitating the management processes of the contract transition, the Services assumed responsibility for the proposed realignment of "HCIL-like" services. With responsibility of care management now redirected to the MTFs, the Services now had responsibility for the identification of program and pursuant funding strategies to enable implementation of the previously agreed-upon concept. MTFs are now immediately responsible for establishing appropriate venues or business practices to enable PCM access twenty-four hours a day.

The MTF responsibility for 24-hour PCM access had essentially been mandated since the After-Hours Care Policy was first published in 1996. The prior contracts further supplemented this MTF responsibility, but did so in a manner that was ultimately determined as duplicative. The determination of the TMA workgroup, with approval from the SMMAC, allowed the Services to establish local healthcare innovations for the purpose of nurse triage and health

[5] See, TMA Letter to Military Coalition and Alliance, March 3, 2003.

information services where business case analyses demonstrated an appropriate return in improving quality and efficiency.

To ensure beneficiaries were informed of changes in nurse advice services and other similar care management activities, TMA personnel commenced with a coordinated public affairs campaign to inform beneficiaries of the impending changes to the HCIL service. With the support of MTFs and the outgoing managed care support contractors, the marketing and education campaign informed beneficiaries of how they could obtain healthcare information services or more immediate clinical advice. Newsletters, web-sites and other marketing materials stressed the continuation of options within our MTFs, offered telephone and other contact information, and provided basic information on specific interim (or developing measures) to facilitate the delivery of nurse advice and healthcare information services. MHS beneficiaries were redirected to alternative sources, such as the use of web-based tools, to include: TRICARE Online, *WebMD*, and MTF Beneficiary Counseling and Assistance Coordinator (BCAC) web-pages.

MILITARY HEALTH SYSTEM SURVEYS AND ASSESSMENTS

Delphi Beneficiary Council Survey

A beneficiary survey administered to the Delphi Group[6] during the transition to our healthcare contracts found that it was "as easy" to identify proper telephone numbers and web addresses for alternative HCIL-like services in the MTFs as it was for the contracted HCIL. Further, in evaluation of the beneficiary "satisfaction rate" for the quality of advice provided, the MTFs actually received a higher assessment (85 percent v. 77 percent) from the group.

[6] The Delphi Group is a focus group comprised of retirees of the military Services often utilized as a barometer for assessing satisfaction with the TRICARE benefit.

In our more recent retrospective assessment of the beneficiary marketing and education campaign, we concluded that the communications plan was more heavily focused upon identifying sources for healthcare information rather than emphasizing the available local alternatives for nurse triage services during the transition period. In review of other surveys, there was clear evidence that our beneficiaries' primary demand for information did not include "clinical advice". Further, it was apparent from the data that our beneficiaries seemed relatively satisfied with their ability to contact MTF clinical staff when they required it. In retrospect, however, the communications approach may not have addressed the local alternatives for direct nurse advice or triage and perhaps contributed to the heightened interest immediately following the transition. Nonetheless, based upon our research, it appears that our public affairs and communication strategies served as a key venue for informing our beneficiary population of systemic changes; helping to avoid any dissonance regarding the perceived erosion of acute and preventive health care services and the continued availability of these 24 hours a day, seven days a week.

Use of TRICARE Toll-Free Call Centers

Beneficiary surveys conducted by TMA in 2004 and 2005 provided additional evidence that our beneficiaries' primary demand for information does not include nurse advice or clinical information lines. The 2004 beneficiary survey found that approximately 91 percent of TRICARE beneficiaries using TRICARE Toll-Free Call Centers identified this source of TRICARE information as the one with which they were "most aware." Moreover, they rated the contracted toll-free HCIL as the second best source for "ease in getting useful information". From a beneficiary satisfaction perspective, it was apparent that contracted HCIL offered some value to our beneficiaries. However, it is also clear

that although the contracted HCIL had been widely marketed (with an identified 91 percent "awareness" of its availability), the use of the line never exceeded more than 10 percent of the population in any of the TRICARE regions. Further, in more detailed assessment of beneficiary information sources, contracted HCIL was rated as the ninth most commonly used resource. This ranked far below other alternatives such as MTF clinical staff, beneficiary advisors, the TRICARE website, and even other toll-free telephone lines not related to the contracted HCIL service. When specifically evaluating our beneficiaries' "primary source of information for TRICARE", the contracted HCIL lines did not even rate within the top ten sources. Although our beneficiaries appreciated the contracted HCIL when it was used, the frequency of its use in combination with the excessive cost did not appear to offer value to the MHS. Although the front-end demand management of clinical care is clearly a means to improve efficiency, it seems equally apparent that the opportunity cost of executing this function within the MTFs was a more reasonable alternative.

The 2005 beneficiary survey was conducted from March – May of this year and was administered to 3,360 Active Duty Service Members, their family members, Reserve Component, and Retirees, both under and over age 65, from all three TRICARE regions. The survey, in part, assessed beneficiary usage of TRICARE Toll-Free Call Centers under the business practices of the performance-based TRICARE contracts. The results again affirmed the primary information demands of the TRICARE beneficiary population. The following were cited as predominant information needs among current users of TRICARE call center services: 1) to resolve claims or billing issues; 2) to obtain information about TRICARE; 3) to find a healthcare provider; 4) to schedule an appointment; or 5) to learn about benefit eligibility. These categories accounted for the significant majority of calls to the TRICARE Toll-Free Call Center, while the category for "obtaining medical or clinical advice" yielded a disproportionately small

percentage of the reasons identified by beneficiaries for contacting a TRICARE Toll-Free Call Center. These results also reaffirmed earlier business case analyses that, while contracted HCIL indeed was appreciated by our beneficiaries when used, the low volume of calls could not justify the expense. This was especially evident when evaluated against the option of executing this function from within the MTFs. Discontinuation of the contracted HCIL, especially in view of its under-usage for nurse advice, has proven to be a prudent fiscal decision. Use of the MTFs for this purpose has proven not only to be more efficient, but has encouraged greater patient-provider relationships. It has also more appropriately directed our beneficiaries towards use of TRICARE information resources such as the TRICARE On-line (TOL) website.

MTF Data Call

The significance of a less constrained approach to implementing nurse advice and healthcare information line services is also evidenced by the findings of a recent retrospective study[7] undertaken at the direction of the Deputy Director of TMA. The purpose of this review was to examine MTF commanders' perspectives regarding beneficiary access to health care information and nurse triage services following the November 2004 conclusion of regional Health Care Information Line (HCIL) contracts. The survey was administered to 114 of our largest U.S. MTFs, and in particular, looked at after-hours access to PCMs and gathered additional feedback on facilitating beneficiary access to healthcare information and services. These 114 MTFs are generally referred to as "parent" facilities, since all other facilities and clinics within the MHS are essentially subordinate to them. In effect, this survey captures the activities of the entire MHS; more specifically, however, the commanders queried have immediate responsibility for more than 2.2 million TRICARE Prime enrollees nationwide.

The data below provides a brief summary of the findings and indicators for further consideration as the MHS works to strengthen existing policies and protocols for 24-hour, seven day access and after hours care.

1) Of the 114 U.S. MTFs surveyed, 112 (98 percent) responded to this data call:
   a. 48 (43 percent) of the responding MTFs provide hands-on ambulatory care 24-hours a day, 7 days a week. These are generally larger MTFs, serving 60 percent of the TRICARE Prime enrolled beneficiaries in this study.

2) Of the 64 responding MTFs without 24-hour ambulatory care:
   a. 57 (89 percent) provide 24-hour access to a privileged provider, either directly or on-call. In the initial survey, 7 cited that they neither provide after-hours ambulatory care, nor access to a privilege provider via phone, although alternative arrangements may be in place. Since this survey, however, the activities within these MTFs were directed to the attention of the Services for corrective action. These MTFs support 4.9 percent of the Prime enrollees in this survey.
   b. 56 (88 percent) are confident their after-hours telephone consult number has been communicated to their enrollees. Phone numbers were provided in the survey as a validation of this service.
   c. 50 (78 percent) have the capability to arrange for patients to see promptly a provider. The remaining 22 percent of MTFs care for approximately 193,000 Prime enrollees.
   d. 53 (83 percent of MTFs without after-hours care and 47 percent of all responding MTFs) stated they did not have procedures in place to schedule directly urgent care appointments after-hours.

[7] Data Call for the Congressional Report on the Elimination of the National Health Care Information Line (HCIL), March 2005.

e. 47 (73 percent) of MTFs provide phone consultation service with in-house staff, and 35 percent have contracted for this service (some MTFs do both).

The results of this MTF Data Call and evaluation of other survey data relevant to nurse advice and health information yielded the following conclusions:

1) **The availability of local alternative arrangements or plans to rectify noncompliance with Health Affairs Policy should be further explored with local Commanders.** A revision of the urgent care and after-hours policy that more clearly affixes responsibilities and aligns MTF responsibilities with the requirements of the new contracts is presently in staff coordination for approval by the Director, TMA.

2) **Further assessment of MTF practices may be necessary to determine if policy clarification or operational guidance is warranted to ensure a more uniform approach for the provision of these services.** The ASD (Health Affairs) was presented with these findings and chartered an internal committee to explore other innovations that may provide regional, national or even global economies of scale. The TRICARE Regional Office Directors were also directed to continue to evaluate nurse advice and health information practices within their regions to ascertain those practices which may warrant further expansion throughout the MHS.

3) **Further cost benefit analysis is warranted since economies of scale could possibly be realized through either regional or national subscription to an existing national service or establishment of a TRICARE Nurse Advice Line.** The committee is closely following

the Nurse Advice Line program in Europe and the proposed concept in the TRICARE West Region.

4) **If a decision is made to implement either regional or national HCIL services, further data collection, to include feedback from MTFs with after-hours ambulatory care, would be helpful.**

5) **Further analysis of current local practices proven as successful need to be evaluated to determine if they are applicable in similar-sized facilities. MTFs may, in fact, be capable of implementing local solutions with minimal investment that would preclude a regional or national contracting solution.** This recommendation was to the TRO Directors by the TMA Director for continued collaborative review and evaluation with senior MHS leadership, MTF commanders and multi-service market managers.

Military Treatment Facility Experience

In view of what may have been possible gaps in coordinating the program requirements necessary to transfer this capability, the shift to local support contracting began a renewed effort to bring into alignment a Military Health System characterized by sound business incentives, fiscal and operational assessments, and one to be governed by MTF stakeholders able to establish and provide for healthcare driven by specific market requirements. The Services have continued their implementation of localized initiatives to enable beneficiary access to after-hours care; the execution of which, have been shaped by policy, contractual and outsourcing arrangements, memoranda of understandings (MOUs) with the new regional health services support contractors, and other network partnerships to replace effectively an otherwise costly, underutilized service.

Supported by firm MHS policy requirements[8], all MTFs are responsible for establishing local procedures that ensure consistent, reliable access to primary care managers (PCM) 24-hours-a-day, 7 days-a-week. If a beneficiary needs to contact their PCM after normal duty hours due to an urgent condition, the MTF must have the means to arrange for the patient to see a provider, schedule an appointment, or obtain a referral for the beneficiary to seek care from an available provider.

In a recent review of beneficiary survey data and inquiry responses from our MTFs, it was apparent that the clinical outcomes associated with appropriately triaging and scheduling care requirements were equally effective when managed by the MTFs. Furthermore, the process is more efficient since patient-provider communications are managed directly rather than through a remote entity. In fact, none of the previously contracted nurse advice lines maintained the ability to appoint urgent care requests. On average, the contracted nurse advice line services cost the government about $25.00 – $27.00 per call. OASD/HA has found that our new design facilitates better patient care and communication, and does so at a significantly reduced cost.

Our facilities in the North, South, and West regions have utilized the revised contract structure to improve clinical and operational outcomes in these healthcare service areas. The Naval Hospital (NH) at Cherry Point (NC), with an enrolled population of more than 22,000 has utilized access policy guidance to implement applicable measures believed to counter the unnecessary expense caused by the previous referral of too many patients to emergency services. Patients at NH Cherry Point have 24-hour access to a PCM and the facility has

[8] HA Policy 96-060, Policy for After-Hours Care for TRICARE Prime Enrollees

noted that beneficiary satisfaction with this level of access remains high, especially with the ability to receive nightly acute appointments, as needed. Moreover, the MTF at Fort Rucker (AL), with an enrolled population of more than 15,000, and no emergency room services, cites a significant per month savings by the ability to develop a contract for after-hours staffing and operational requirements which capture the exact needs and usage of its beneficiary population. Similarly, the 59th Medical Wing at Lackland Air Force Base (AFB) (TX), with an enrolled population of more than 58,000 and the ability to provide emergency services 24 hours a day, has established a contract which provides a needed after-hours nurse advice line where authorization(s) for care outside the facility may be given. In the TRICARE West region, the 60th Medical Group at Travis AFB (CA) with more than 44,000 enrollees provides PCMs in accordance with policy 24 hours a day, seven days a week throughout the year.

Thus, the design of a more localized model where healthcare requirements are assessed and met by MTF-specific and/or regional market factors has afforded these, and many of our other facilities, the ability to deliver more effectively and manage patient care while realizing a multitude of savings on previously absorbed, albeit misplaced, resources.

FUTURE CONSIDERATIONS

TRICARE Europe Aviano Air Base Pilot

As recommendations continue to be made for policy clarification or operational guidance to improve upon and ensure a more uniform approach to the

provision of these services, the MHS Access to Care Committee[9] is currently evaluating the TRICARE Europe (Aviano AB) model for applicability in streamlining processes within the MTFs, improving access for beneficiaries, managing front-end demand management to ensure appropriate levels of care, and strengthening the economies of scale for the MHS in the United States and, perhaps, globally.

TRICARE Europe has provided a nurse advice line service to DoD beneficiaries since 1996. While the overseas community has consistently utilized NAL services at a higher rate than CONUS beneficiaries, TRICARE Europe has, nonetheless, continued to seek improvements in the services. This has included several analytic studies to determine ways to better integrate the NAL with the PCM and clinic operations.

As a result of these analyses, TRICARE Europe implemented a pilot study linking the Nurse Advice Line function, via the Composite Health Care System (CHCS)[10], to the following sources: (1) Patient appointing/telephone consultations; (2) PCM after-hours notification; and (3) Provider/clinic information systems.

The Aviano AB NAL services were modified so that beneficiaries selecting the NAL service on the telephone tree were connected to the NAL nursing staff and provided the normal advice and triage services. If the NAL guidance recommended that a patient seek an appointment with their PCM, or speak with their PCM by telephone, they were immediately transferred to appointing

[9] The ATC committee was chartered at the direction of the TMA Deputy Director in 2004 to evaluate MHS corporate access initiatives.
[10] The Composite Health Care System (CHCS) is one of the largest medical systems in the world and the primary automated medical information system for the Department of Defense.

personnel who (using the relevant CHCS modules) either scheduled a clinic appointment or telephone consultation, as appropriate.

This service was available 24 hours per day, 7 days per week—a service that was previously unavailable to this beneficiary population as the clinic and local appointing functions closed at the end of each work day. In addition, if the guidance recommended that the caller speak with their PCM immediately, they were connected with their PCM by telephone, regardless of the day or time.

This one month pilot program was launched in September 2004 at Aviano AB, Italy with oversight from the TRICARE Europe Office (TEO). The findings were:

(1) Increased patient satisfaction with the customer service enhancements of after-hours appointing capabilities and the introduction of CHCS-facilitated telephone consultations and appointments;

(2) Increased overall patient call volume as the beneficiary-perceived value of nurse advice services also increased;

(3) Increased provider and MTF staff satisfaction with the quality of information prior to appointments, and for the opportunity for nurse screening/triage prior to appointments;

(4) Improved patient compliance with nurse advice – a three-fold decrease in clinic appointments, and a four-fold increase in self care; and

(5) A three-fold increase in the NAL return on investment (ROI) as calculated using the Medical Expense and Performance Reporting System (MEPRS) costs of the respective care venues.

The pilot study revealed that integration of nurse advice into patient appointing, telephone consultation, PCM after-hours notification, and provider feedback, all using CHCS, can be effectively accomplished at little additional cost, and will produce a substantial increased ROI for nurse advice services and an increase in both beneficiary and provider satisfaction. A TMA committee overseeing access programs is preparing a report for the Deputy Service Surgeons General before the conclusion of this calendar year. In addition to assessing the returns on investment, quality and customer service implications of this pilot, the committee must assess whether the positive results achieved in this overseas market have relevance and are exportable to our TRICARE health markets within the United States. There are marked differences in the delivery of healthcare in this overseas location as compared to the United States. Our MTFs overseas, for example, do not have contractual relationships with our new contractors and have very limited access to use of local civilian providers. Nonetheless, there are clearly aspects of this model that may provide the foundation for similar approaches in the United States.

The Department of the Navy

The Department of the Navy has recently issued a pre-solicitation notice to integrate the requirements for nurse advice and appointing, and to acquire nurse triage telephone-based clinical assessment and support services for the Naval Medical Center San Diego, California. This market provides healthcare for 114,071 TRICARE Prime beneficiaries and results in services to be provided 24 hours a day for nurse triage, clinical assessment, healthcare advice and self-care

365 days a year. TMA is developing criteria to follow the progress and measure the results of this innovation.

CONCLUSION

Collaboration among the numerous components of the MHS to more effectively integrate nurse advice and healthcare information services has resulted in both a more prudent fiscal design for delivering these services, as well as one that adequately measures and meets the best interests of our providers and the 9.1 million beneficiaries they serve. Based upon a very detailed analysis prior to the delivery of the new contracts and other retrospective assessments during and after the transition, the Department is confident of the decision to eliminate the HCIL from the national suite of healthcare contracts, and further, that the design implemented effectively incorporates nurse advice and health information activities, streamlines front-end demand management for care, more effectively routes patient concerns to the appropriate level of care, and more effectively influences higher use of TRICARE resources including existing web-based information services, call center functionalities, and other complementary military treatment facility services.

We trust that the foregoing analysis of the Department's management of the contract transition, with respect to nurse advice and healthcare information services, depicts the careful deliberations by the OASD(HA), TRICARE Management Activity, and the Services, to reach an informed decision on the most appropriate placement of these services within the context of cost avoidance, beneficiary satisfaction, clinical outcomes, and leveraging best practices for managing demand locally—in our military treatment facilities and identified multi-Service health markets. As highlighted by our MTF data call, beneficiary surveys, and other indicators, the Department has achieved an economical,

beneficiary-centered outcome, per the investment of resources, and has remained committed to the objective of optimizing the military healthcare benefit with consideration towards access, quality and cost.

Our research and analysis reaffirms that, in the aftermath of the transition, the majority of MTFs across the military Services have utilized the intended design of the local support model to supplement established policy guidance with structured contractual arrangements and/or partnership agreements in the interest of appropriately triaging patients and providing access to healthcare information sources twenty four hours a day, seven days a week. Evidence of our experience in forging a more effective patient-provider relationship within this economy of scale is further validated by the data extracted from our MTF commanders in each of the TRICARE regions.

SUMMARY

The OASD(HA) will continue to assess potential process and business practice improvements, and evaluate possible future-state models, such as those offered by the TRICARE Area Office in Europe and the Navy. Nonetheless, the Department is pleased with the improvements recognized under the current design since the transition, and remains confident that this is the most prudent and appropriate approach for achieving economies of scale, strengthening beneficiary access to care, providing better continuity of care and leveraging local innovations while lowering the cost for these important healthcare services.