Department of Veterans Affairs **VHA DIRECTIVE 1010**
Veterans Health Administration **Transmittal Sheet**
Washington, DC 20420 **November 21, 2016**

TRANSITION AND CARE MANAGEMENT OF ILL OR INJURED SERVICEMEMBERS AND NEW VETERANS

1. **REASON FOR ISSUE:** This Veterans Health Administration (VHA) directive establishes procedures in the transition of care, coordination of services, and case management of ill or injured Servicemembers and new Veterans by VHA Transition and Care Management staff members.

2. **SUMMARY OF MAJOR CHANGES:** Major changes include updating the name of the Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) Care Management Program to the Transition and Care Management Program to more accurately reflect the purpose, target population, and future vision of the program; including Interagency Complex Care Coordination requirements; and removing the Veterans Benefits Administration (VBA) sections from this directive.

3. **RELATED ISSUES:** VHA Directive 1011, VA Directive 0007, and VHA Handbooks 1110.04 and 1101.10.

4. **RESPONSIBLE OFFICE:** The Chief Consultant, Care Management and Social Work Services (10P4C), Office of Patient Care Services, is responsible for the content of this directive. Questions may be referred to the National Transition and Care Management Program Manager, at 202-461-5147.

5. **RESCISSION:** VHA Handbook 1010.01, dated October 9, 2009, is rescinded.

6. **RECERTIFICATION:** This VHA directive is scheduled for recertification on or before the last working day of November 2021. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

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Under Secretary for Health

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TRANSITION AND CARE MANAGEMENT OF ILL OR INJURED SERVICEMEMBERS AND NEW VETERANS

1. PURPOSE

This Veterans Health Administration (VHA) directive establishes procedures in the transition of care, coordination of services, and care and case management of ill or injured Servicemembers and Veterans by VHA Transition and Care Management (TCM) staff. It describes the partnership between the Department of Veterans Affairs (VA) and the Department of Defense (DoD) to transition the health care of injured and ill active duty Servicemembers, mobilized Reservists, mobilized DoD National Guard, and Veterans from DoD to the VA health care system. ***NOTE:*** *The requirement for transition of care applies to active duty Servicemembers directly referred from Military Treatment Facilities (MTFs) and outpatient active duty Servicemembers who present to VA medical facilities seeking health care.* It establishes a standardized care management process and describes the roles and functions of VA staff working with the case management of new Veterans across various program areas within VA.
AUTHORITY: 38 U.S.C. 1706, 1710.

2. BACKGROUND

a. Since 2003, VA has collaborated with DoD and MTFs to transition the health care of injured or ill Servicemembers and Veterans from MTFs to VA medical facilities by assigning VA Liaisons for Healthcare at major MTFs (see Appendix A) to assist with transfers and to provide information to Servicemembers and Veterans and their families and caregivers about VHA health care services. In addition, VHA OEF/OIF/OND Program Managers (presently to be referred to Transition and Care Management (TCM) Program Managers) at each VA medical center have worked closely with the VA Liaisons to arrange outpatient VA appointments and inpatient beds for transitioning Servicemembers. While this initiative was originally established to transition military personnel returning from theaters of combat, as VA transitions from times of war to times of peace, it now includes any active duty military personnel and Veterans who served on or after September 11, 2001, including those who served in support of Operations Enduring Freedom, Iraqi Freedom, and New Dawn, and are ill or injured and transitioning to VA (see Appendix B for guidance on combat Veteran eligibility).

b. In October 2007, VA established Care Management and Social Work Services, Office of Patient Care Services, to address the needs and optimize care management of injured and ill Servicemembers and Veterans transitioning to VA.

c. Many transitioning Servicemembers and Veterans suffer from multiple complex health and mental health problems, including but not limited to Traumatic Brain Injury (TBI), amputations, burns, loss of vision, combat stress and Post-Traumatic Stress Disorder (PTSD). Therefore, it is critical for each VA medical facility to have a process in place to ensure that the care of all transitioning Servicemembers and Veterans is well-coordinated and that those who have a need for care or case management receive care or case management services from a VA case manager.

d. The National Defense Authorization Act (NDAA) 2008, Section 1611 required DoD/VA to develop and implement policy on the care, management, and transition of their wounded, ill and injured Servicemembers and Veterans. In 2012, the Joint Executive Committee approved the establishment of a joint DoD/VA commitment to implement the Warrior Care Coordination Task Force recommendation to develop and implement an interagency overarching policy for a common model of complex care coordination for ill and injured Servicemembers and Veterans. This commitment is in accordance with the DoD and VA Secretaries' objectives to support "One Mission-One Policy-One Plan." The policies and responsibilities set forth in this directive are in furtherance of the overarching Interagency Complex Care Coordination Memorandum of Understanding (MOU).

3. DEFINITIONS

a. **Care Coordination.** Care coordination is the administrative process that facilitates integration of health care services and navigation through complex health care systems. Care coordination involves working across care settings, accessing health care providers, and other services such as community programs, when appropriate.

b. **Care Management.** Care management is a systems approach to the implementation and facilitation of longitudinal care coordination, focusing on linking Veterans and their families or caregivers with needed services, resources, and opportunities for wellness. Care management is the oversight and management of a comprehensive plan for a cohort of patients.

c. **Case Management.** Case management is a specialized and highly-skilled component of care management. Case management emphasizes a collaborative process that assesses, advocates, plans, implements, coordinates, monitors, and evaluates health care options and services in order to meet the needs of an individual patient. Case management services are provided to individuals who require a higher level of care management services. These individuals may include the Veteran, the Veteran's family, and the Veteran's caregiver.

d. **Complex Care Coordination.** Complex care coordination involves assisting the most severely wounded, ill or injured Servicemembers and Veterans, or those Servicemembers and Veterans with complex circumstances. The Servicemembers and Veterans that meet the criteria for complex care coordination, are expected to have a prolonged recovery or rehabilitation process, and may require access to clinical, social, educational, financial, and other services across various organizations and providers.

e. **Care Management Team.** The Care Management Team (CMT) includes individuals who are working together to manage, coordinate, and/or deliver the care, benefits, and services for a Servicemember or Veteran and to support the family or caregiver. The professions and individuals who comprise a specific CMT will vary based on the needs of the individual and their family or caregiver.

f. **Case Management Review Team.** A Case Management Review Team (CMRT) is a high level review team consisting of, at a minimum, experienced medical and mental health nursing and social work clinicians with expertise in case management, who review the optimal management of Veterans needing case management. The CMRT meets on a regularly scheduled basis and collaborates with other disciplines and specialty programs as appropriate.

4. POLICY

It is VHA policy to ensure that the transition and care management of all ill and injured Servicemembers and Veterans treated at VA medical facilities is coordinated, monitored, and tracked, and all Servicemembers and Veterans who served on or after September 11, 2001 are screened for the need for case management services upon entering the VA health care system.

5. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health, or designee, is responsible for ensuring that:

(1) A full-time master's prepared social worker or nurse is funded at each VA medical center and independent outpatient clinic to serve as the TCM Program Manager.

(2) Each VISN is staffed with the appropriate number of Transition Patient Advocates based on the number of ill or injured transitioning Servicemembers and Veterans treated in the VISN.

b. **VISN Director.** The VISN Director is responsible for ensuring that:

(1) A VISN point of contact (POC) is designated within the VISN office to oversee transition and care management services at the VISN facilities and to provide guidance to medical center TCM Program Managers.

(2) A VISN Lead TCM Program Manager is designated from one of the medical center TCM Program Managers to serve as liaison to the VISN POC.

(3) The Transition Patient Advocate (TPA) positions are distributed to VA medical facilities within the VISN based on the number of ill or injured transitioning Servicemembers and Veterans treated by that medical facility.

c. **VA Medical Facility Director.** The VA medical facility Director or designee is responsible for:

(1) Ensuring that health and mental health care services are provided to ill or injured Servicemembers and Veterans when requested and in a timely manner.

(2) Appointing a social worker or nurse to serve as the medical center TCM Program Manager. The position reports directly to the facility Director, or designee.

(3) Hosting discussion groups, at least annually, with post 9/11 Veterans and their family members to identify issues and concerns.

(a) The VA medical facility Director and other senior leaders should attend the discussion group.

(b) Reports regarding the discussion group meeting (including action plans, if any) must be submitted through the VISN Director to Care Management and Social Work Services National TCM Program Manager within 1 week of meeting.

d. **TCM VISN POC.** The TCM VISN POC is responsible for:

(1) Advocating that the TCM Team has the necessary resources to achieve program goals.

(2) Promoting the standardization of the TCM Program and processes across the VISN.

(3) Attending monthly conference calls moderated by Care Management and Social Work Services at VA Central Office.

(4) Collecting, maintaining and forwarding all reports and data prepared by the TCM team and submitted by facility senior management to the appropriate VHA requesting office.

(5) Coordinating with the Lead TCM Program Manager for periodic VISN level face-to-face meetings and conference calls with the TCM team.

(6) Serving as a liaison between the VA Central Office (VACO), the VISN, the VISN Lead, and facility TCM Program Manager and other agencies/organizations.

(7) Providing briefings and presentations to VA staff and non-VA organizations/audiences about TCM services and VHA health care.

(8) Updating Care Management and Social Work Services on changes in medical center TCM Program Managers, Lead Coordinators, and TPAs.

(9) Coordinating and participating in review panels for the selection of new TPAs.

e. **TCM VISN Lead Program Manager.** The TCM VISN Lead Program Manager is responsible for:

(1) Moderating conference calls at least monthly with all medical center TCM Program Managers within the VISN.

(2) Reporting administratively to both their VA medical facility Director and to the VISN Director or designee.

(3) Reporting programmatically to Care Management and Social Work Services which includes attending monthly VISN POC conference calls moderated by the TCM National Program Manager in VA Central Office.

f. **TCM Program Manager.** The primary role of the TCM Program Manager is to ensure that ill and injured Servicemembers and Veterans receive patient-centered, integrated care. The Program Manager has administrative and clinical responsibility for the TCM program. The TCM Program Manager position is funded by VA Central Office. The TCM Program Manager is responsible for:

(1) Leading the TCM team at the VA medical facility which includes the TCM Social Work or Nurse case manager(s) and TPA(s); ensuring TCM policies and procedures are in place; and facilitating communication among the TCM team.

(2) Overseeing all medical facility case management activities provided to transitioning, ill or injured Servicemembers and Veterans.

(3) Ensuring that all transitioning ill or injured Servicemembers and Veterans are screened to determine need for nurse and /or social work case management services and complex care coordination.

(4) Ensuring that all transitioning Servicemembers and new Veterans in need of complex care coordination are assigned a Lead Coordinator (LC).

(5) Leading Care Management Review Team Meetings on a regularly scheduled basis to review new and/or established patients' clinical status and appropriate designation of an LC.

(6) Providing ongoing communication and periodic briefings to senior medical facility leadership regarding the TCM program.

(7) Developing and maintaining effective partnerships throughout the facility and satellite clinics, including Post Deployment Integrated Care Clinic, Primary Care, Veteran Readjustment Centers, Specialty Care Clinics, Facility Patient Advocates, VBA, and the Business Office to ensure access and a unified approach for providing continuity of care.

(8) Attending conference calls moderated by Care Management and Social Work Services at VA Central Office.

(9) Providing direct or indirect supervision for the TCM case manager and TPA if organizationally aligned under the TCM Program Manager.

(10) Acting as a back-up team member in the absence of the TCM case manager or arranging for team member coverage when appropriate.

(11) Serving as the primary POC at the facility for the VA Liaisons for Healthcare at the MTF. Determining, in collaboration with the VA Liaison, if case management, complex care coordination, and TPA services are indicated and assigning a Case Manager or Lead Coordinator as appropriate.

(12) Developing a business plan that outlines the program's mission, strategic goals and objectives, forecasts the yearly budget, and describes all appropriate resources for achieving stated outcomes.

(13) Developing an orientation and continuing education plan for new and existing TCM staff (see the Care Management Orientation Study Guide at the following intranet site http://oefoif.vssc.med.va.gov/Directives%20Policy%20%20Guidance/Pages/OrientationStudyGuide.aspx. ***NOTE:*** *This is an internal VA Web site and is not available to the public*).

(14) Developing an orientation module for all new VA medical facility employees that will be provided at New Employee Orientation.

(15) Tracking and monitoring Servicemembers and Veterans being case managed at the medical facility, performance measures and monitors, and required reports as required for facility senior management. Tracking and monitoring workload and productivity of the TCM team.

(16) Educating the community on VA health care services and benefits, increasing enrollment, and improving patient care coordination. The TCM Program Manager may initiate opportunities to engage in collaborative partnerships with other federal, state and local agencies and departments.

(17) Participating in community outreach activities and events as time allows. The TCM Program Manager ensures that the TCM team's primary responsibility of meeting the case management needs of Servicemembers and Veterans has top priority when scheduling work assignments. Then, if time permits, the TCM team may participate in outreach activities such as: Post Deployment Health Reassessment (PDHRA), career fairs, and stand-downs to help provide information about VA health care and benefits, identify Servicemembers and Veterans in need of case management services, and build relationships and alliances with the community.

(18) Evaluating the facility's TCM program at least annually to determine program effectiveness and identify areas for improvement.

g. **TCM Case Manager.** The primary responsibility of the TCM case manager is to coordinate care and services for ill and injured transitioning Servicemembers and Veterans and others in need of case management services.

(1) Contacting active duty Servicemembers and Veterans prior to transfer for inpatient admission and initial outpatient appointments to answer any questions about upcoming appointments. Assisting to resolve any issues at the local level to include

ensuring appointments are scheduled, authorizations are obtained, family resources are secured, and any psychosocial issues are addressed (temporary lodging, home modifications, community resources, in-home services, etc.).

(2) Completing and documenting a comprehensive case management assessment, updating the assessment as necessary based on clinical judgment, and developing a case management plan of care. Documentation will:

(a) Include information about significant interactions with the patients (whether by telephone or in person).

(b) Occur in the Computerized Patient Record System (CPRS) utilizing appropriate stop codes.

(c) Occur in the Care Management Tracking and Reporting Application (CMTRA) and/or the Interagency Comprehensive Plan (ICP) in the Federal Case Management Tool (FCMT), an electronic database that provides the TCM team with a means to identify and track ill or injured Servicemembers and Veterans receiving case management services.

(3) Continually assessing the need for a change in case management services and adjusting the level of intervention as appropriate based on the medical and psychosocial needs of the Veteran and family.

(4) Supporting and educating the patient and family, referring Veterans to VA program and services, referring Veterans to home and community based services, visiting Veterans in their homes if appropriate, and crisis intervention.

(5) Working closely with the TCM Program Manager to ensure all needs are met. Educating the patient and family to understand who the primary POC/Lead Coordinator is for questions and concerns and providing contact information.

(6) Coordinating any necessary care and services at the VA medical facility that the active duty Servicemember will use while on convalescent leave.

(a) The TCM case manager at that VA medical facility will make contact with the Servicemember as an introduction. If the convalescent leave is planned for 30 days or less and the Servicemember does not plan to use local VA services during that time, the TCM case manager will continue to be available to address issues or concerns.

(b) If the convalescent leave needs to be extended, the TCM case manager will contact the DoD case manager and VA Liaison to obtain necessary authorizations for continued care.

(7) Supporting Veterans and their families during transition. Transitions include, but are not limited to:

(a) Transfer from the MTF to a VA medical facility, skilled nursing facility admission, and transfer of care to a new VA medical facility.

(b) Change in patient's psychosocial status (e.g. caregiver stress, divorce, decline in support system, death of a family member, loss of job, new employment, substance abuse, etc.).

(c) Patient and family relocation.

(d) Significant change in medical status and functional decline.

(e) Newly identified mental health problems (e.g. depression, Post-Traumatic Stress Disorder (PTSD), and behavioral changes.

(f) Referrals to program such as day treatment, partial hospitalization programs, compensated work therapy (CWT), vocational rehabilitation, and community re-entry programs. ***NOTE:*** *CWT and VA Vocational Rehabilitation programs are for Veterans only.*

(8) Serving as the Lead Coordinator when deemed appropriate by the CMT. If functioning as the LC, responsibilities include:

(a) Serving as the primary POC for Servicemembers and Veterans and their families or caregivers for coordination of care, benefits, and services related to the ICP. However, other members of the CMT may communicate with the Servicemember or Veteran. The LC will identify potential conflicts in the ICP, and facilitate resolution within the CMT.

(b) Communicating with the Servicemember or Veteran and family or caregiver on an ongoing basis (in person, when possible), and will provide them with contact information for the LC and other members of the CMT. The contact information will be updated as changes occur.

(c) Updating the CMT during the regularly scheduled CMT meeting and ensuring the ICP is updated on a periodic basis to include at least the following milestones: at the time of transfer from one facility to another or to another geographic area; at the time of discharge from inpatient to outpatient status; upon transfer to an outside or private entity, or upon significant change in the Servicemember's or Veteran's condition.

(d) Identifying the need for and facilitating the proper phasing of care, benefits, and services, to establish and maintain the ICP. The LC will facilitate communication between members of the team about the Servicemember or Veteran and milestone progress, risks, and issues related to their complex care coordination in conjunction with health care providers and the command representative.

(e) Communicating regularly with the Servicemember's command representative and providing periodic status updates no less than monthly. The non-clinical case manager may be the command representative.

(f) When Servicemembers and Veterans transfer from one level of care and/or location to another, the hand-off of accountability for care and information about the course of the recovery to date and details of the ICP will be accomplished with person-to-person communication between the transferring and receiving LCs.

(g) For transfers between DoD and VA, LC identification and communication is facilitated by existing referral processes, including the VA Liaison for Healthcare, TCM Program Manager, and specialty program coordinators.

(h) At the time of transfer from one facility to another or in the event that a change in LC is required, the current LC will provide the next identified LC with a summary of the course of care to date, and a current copy of the ICP and related tools.

(i) The transferring LC will be responsible for providing the Servicemember or Veteran and family or caregiver with information about the receiving LC, inform them of any changes to the ICP, document the hand-off in the Servicemember's or Veteran's health record, and provide contact information to the Servicemember or Veteran and family or caregiver.

(j) The receiving LC should acknowledge and document transfer of responsibility in the Servicemember's or Veteran's health records, review the ICP, and meet with the Servicemember or Veteran and their family or caregiver as soon as clinically indicated (within 24-48 hours if possible) of arrival if the Servicemember or Veteran is inpatient; for outpatients, the LC should contact the Servicemember or Veterans and their family or caregiver within 1 week and arrange a meeting as soon as feasible for the Servicemember or Veteran.

(k) In order to provide consistency for Servicemembers and Veterans, the CMT may choose to retain a TCM CM as the LC even in those circumstances when the Servicemember or Veteran requires the temporary services of a specialty case manager.

h. **TCM Transition Patient Advocate (TPA).** The TPA's primary responsibility is to assist with the short and long-term needs of ill or injured post 9/11 Servicemembers and Veterans and their families as assigned by the TCM Program Manager. The TPA is an employee of the medical facility, and reports to the medical center's TCM Program Manager. Each VISN is staffed with the appropriate number of Transition Patient Advocates based on the number of ill or injured transitioning Servicemembers and Veterans treated in the VISN. The TPA's responsibilities include:

(1) Assisting ill or injured post 9/11 Servicemembers and Veterans, as requested by the VA Liaison for Health Care at the MTF and the TCM Program Manager, at the point when the Servicemember or Veteran is ready to transition from the MTF to a VA medical facility.

(2) Serving as an advocate for the Servicemember, Veteran, and family across episodes and sites of care by helping them access needed services at the facility and in the community.

(3) Providing information and assistance to post 9/11 Servicemembers and Veterans, and family members regarding benefits and health care eligibility.

(4) Recognizing and removing institutional obstacles to providing optimum quality health care and patient satisfaction.

(5) Working closely with the TCM Program Manager and case managers to coordinate services.

(6) Assisting Servicemembers and Veterans with access to care issues.

(7) Documenting significant contacts with Veterans and their families as historical notes in CPRS which allows the TPA to identify issues, concerns, goals, progress, and actions taken on all assigned ill or injured post 9/11 Servicemembers and Veterans.

(8) Traveling, when indicated, to introduce himself/herself to the injured/ill Servicemember and family. At times the incumbent will personally escort a Servicemember or Veteran to a VA medical facility when the patient is transferred.

(9) Assisting ill or injured post 9/11 Servicemembers and Veterans with transitions between VA medical facilities, as assigned by the TCM Program Manager.

(10) Participating in, and assisting in, planning and executing outreach events as assigned by the TCM Program Manager. This may include, but is not limited to, military sponsored events (such as Yellow Ribbon, Post Deployment Health Reassessment (PDHRA), and family day), Veteran and community events and VA sponsored events.

6. DOCUMENTATION

a. Documentation is an important means of communication among interdisciplinary team members. Documentation contributes to the understanding of a patient and family's unique needs and allows for interdisciplinary service delivery to address those needs while reflecting the accountability and involvement of the case manager in patient care.

b. The case manager must complete and document a comprehensive baseline case management assessment. Documentation should include reassessments, the case management plan of care, and information about significant interactions with patients (whether by telephone or in person). Documentation must also occur in the medical record when reassessment indicates a patient's needs for a change in the level of case management intensity.

c. The case manager must document in accordance with The Joint Commission standards, the Commission on Accreditation of Rehabilitation Facilities (CARF) guidelines, accepted professional social work and nursing standards of practice, and local VA medical facility policy.

d. All documentation will occur in CPRS utilizing appropriate stop codes (see paragraph 8.d. for guidance on stop codes).

e. Care management tracking for ill or injured Servicemembers and Veterans receiving case management services will also occur in the electronic database for example in CMTRA or FCMT.

f. For those Veterans requiring complex care coordination, documentation will occur in the electronic Interagency Comprehensive Plan (ICP),

7. CASE MANAGER CASELOAD

a. Review of literature on case management and guidance from professional organizations such as the Case Management Society of America (CMSA) and the National Association of Social Workers (NASW) shows that there is an inconsistent approach to establishing caseloads.

b. Servicemembers and Veterans frequently have complex clinical and psychosocial issues. Determining an appropriate case load for these patients is dependent on many factors:

(1) Case severity/complexity (case mix index), and intensity of the care plan requirements.

(2) Availability of community-based services and network development.

(3) Communication and coordination between VA, VBA, DoD, and community resources/partners.

(4) Case manager's role (including requirements of other duties as assigned, especially if the case manager has major responsibilities to another program area).

(5) Intensity of support needed by the family/caregiver.

(6) Accessibility to necessary and supportive information.

(7) Amount of administrative support.

(8) Benefit provisions.

(9) Types of CM interaction with beneficiaries, e.g., face-to-face, phone, V-tel.

(10) Professional experience and knowledge of the patient population.

8. REPORTING REQUIREMENTS

a. Care Management and Social Work Services created CMTRA and FCMT to track the care and case management of ill or injured Servicemembers and Veterans receiving case management services, performance measure data, Lead Coordinator information,

frequency of expected contact, and special populations. Care Management and Social Work Services monitors these reports at least monthly and uses the data to report to the Secretary of Veterans Affairs.

b. Performance measure data is automatically pulled from the authoritative tracking system (CMTRA or FCMT) on a monthly and quarterly basis for national reporting through the Veterans Support Service Center (VSSC).

c. Ill or injured Servicemembers and Veterans receiving case management must be assigned to the TCM team (non-primary care team) in the Primary Care Management Module (PCMM).

d. The following Decision Support System (DSS) identifiers may be used for patient identification and workload tracking to measure outcomes:

(1) DSS Identifier Number 182: Telephone Care Management. This includes care management for an interdisciplinary care plan via the telephone. All elements of patient assessment, monitoring, and treatment or care planning must be documented in the patient's chart. Staff utilizing this code must have documented competencies in care management.

(2) DSS Identifier Number 184 (This is a secondary stop code and must be used with a primary stop code): Case or Care Management (Office Visit). This records patient care or care management activities in accordance with an interdisciplinary plan of care. The episode of care is a face-to-face clinical office encounter between the patient and the care manager and must include elements of patient assessment, monitoring, and treatment or care planning. Staff utilizing this code must have documented competencies in care management.

MILITARY TREATMENT FACILITIES WITH DEPARTMENT OF VETERANS AFFAIRS (VA) LIAISONS FOR HEALTH CARE STATIONED ON-SITE

18 VA medical facilities	21 MTF LOCATIONS	# OF VA LIAISONS
Augusta, GA VA medical facility	Dwight David Eisenhower Army Medical Center (DDEAMC), Ft. Gordon, GA	2
Alexandria LA VA HCS	Bayne Jones Army Community Hospital, Fort Polk, LA	1
Central Alabama VA HCS	Martin Army Community Hospital (MACH), Ft. Benning, GA	2
Central Texas VA HCS	Carl R. Darnall Army Medical Center (CRDAMC), Ft. Hood, TX	3
Charleston, SC VA medical facility	Winn Army Community Hospital (WACH), Ft. Stewart, GA	2
Eastern Colorado VA HCS	Evans Army Community Hospital (EACH), Ft. Carson, CO	2
Eastern Kansas HCS	Irwin Army Community Hospital (IACH), Ft. Riley, KS	2
El Paso, TX VA HCS	William Beaumont Army Medical Center (WBAMC), Ft. Bliss, TX	1
Fayetteville, NC VA medical facility	Camp Lejeune Naval Medical Hospital, Camp Lejeune, NC	1
	Womack Army Medical Center (WAMC), Ft. Bragg, NC	2
Hampton, VA VA medical facility	McDonald Army Health Center (MCAHC), Ft. Eustis, VA	1
VA Pacific Islands HCS	Tripler Army Medical Center (TAMC), Honolulu, HI	1
Louisville, KY VA medical facility	Ireland Army Community Hospital (IACH), Ft. Knox, KY	2
Puget Sound VA HCS	Madigan Army Medical Center (MAMC) / Joint Base Lewis-McChord (JBLM), Ft. Lewis, WA	3
VA San Diego, HCS medical facility	Naval Hospital Camp Pendleton (NHCP), Camp Pendleton, CA	2
	Naval Medical Center, San Diego (NMCSD), San Diego, CA	2
South Texas VA HCS	San Antonio Military Medical Center (SAMMC)	4
	Center for the Intrepid (CFI), Ft. Sam Houston, TX	

18 VA medical facilities	21 MTF LOCATIONS	# OF VA LIAISONS
Syracuse, NY VA medical facility	US Army Medical Department Activity (USAMEDDAC), Ft. Drum, NY	2
Tennessee Valley VA HCS	Blanchfield Army Community Hospital (BACH), Ft. Campbell, KY	2
Washington, DC VA medical facility	Walter Reed National Military Medical Center (WRNMMC), Bethesda, MD	4
	Ft Belvoir Community Hospital (FBCH), Ft. Belvoir, VA	2

NOTE: *The Transition and Care Management Program Manager at the receiving VA medical facility can be contacted directly for referrals from MTFs where there is no VA Liaison located on-site.*

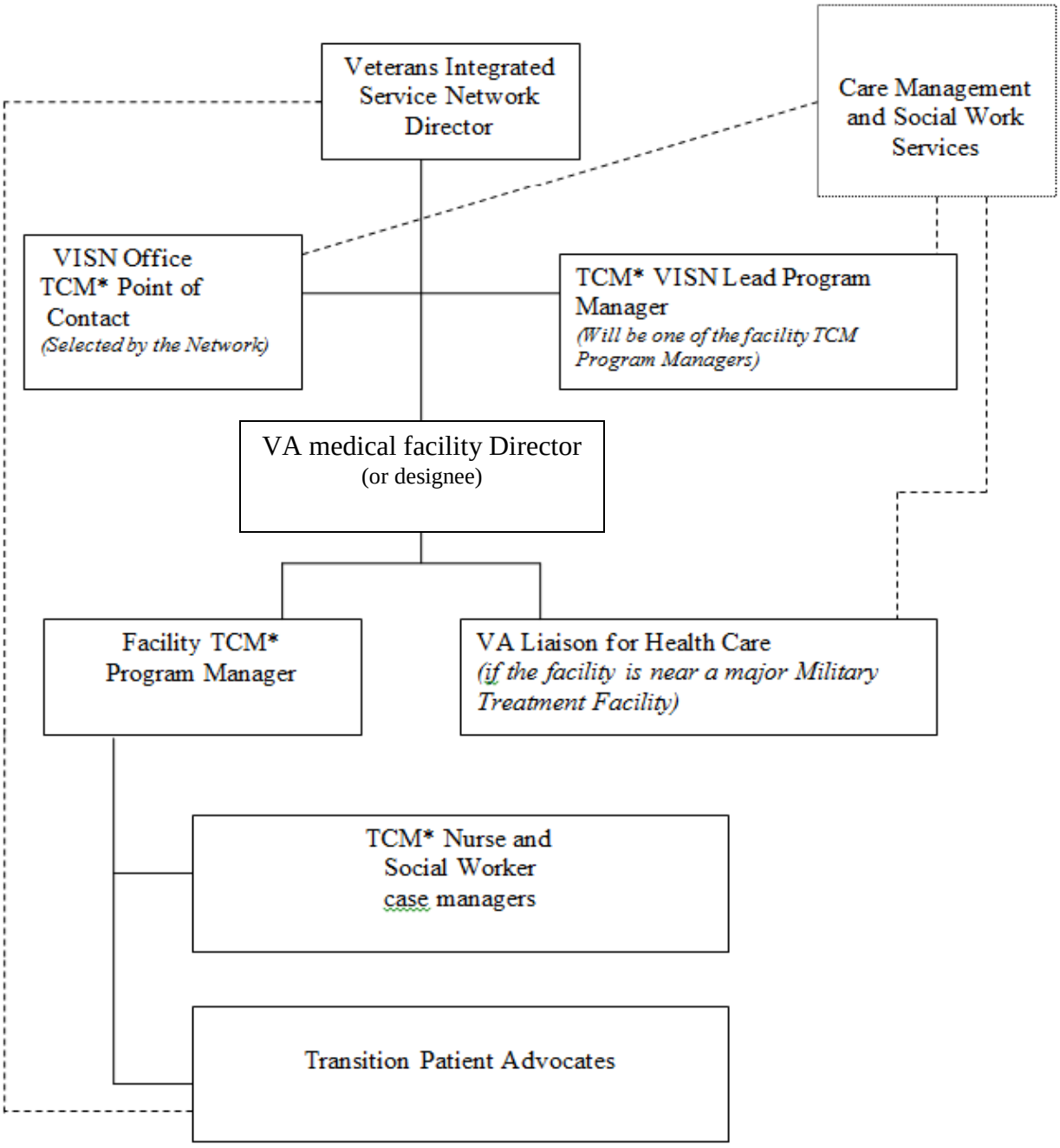
ELIGIBILITY FOR HEALTH CARE SERVICES FOR COMBAT VETERANS

1. Veterans who have served on active duty in a theater of combat operations (as determined by the Secretary of Veterans Affairs in consultation with the Department of Defense (DoD)) during a period of war after the Persian Gulf War, or in combat against a hostile force during periods of hostility after November 11, 1998, are eligible for hospital care and medical service for any illness potentially related to their service in the combat theater for a 5-year period following separation from military service. Under these provisions, they are enrolled in Priority Group 6 unless otherwise eligible for a higher priority group and are not subject to medical care and medication co-payments when their physical or mental condition is determined by their health care provider to be potentially related to their exposure or military experience, regardless of income (known as enhanced combat Veteran benefits). Currently enrolled Veterans and new enrollees who were discharged from active duty on or after January 28, 2003, are eligible for the enhanced benefits for 5 years post discharge. Veterans discharged from active duty before January 28, 2003, who apply for enrollment on or after January 28, 2008, are eligible for the enhanced benefit until January 27, 2011. Those Veterans who did not serve in a combat theater are subject to the same eligibility requirements as all other Veterans. ***NOTE:*** *Please reference VHA Handbook 1601A.03, Enrollment Determinations and VHA Handbook 1601A.02, Eligibility Determination, for further information on eligibility and enrollment determinations.*

2. Members of the Reserve Component (National Guard and Reserve) are eligible for Department of Veterans Affairs (VA) health care if they were called or ordered to active duty by a federal declaration, served the period to which they were called and have separated from active military service under other than dishonorable conditions. National Guard and Reserve members who were mobilized to active duty, served in a combat theater, and separated from active duty receive a DD 214, Certificate of Release or Discharge from Active Duty; they are eligible for VA health care and benefits including the enhanced combat Veteran benefits.

3. Eligibility for VA dental care services differs significantly from eligibility requirements for medical care. In most cases a Veteran must have a VA rated service connected dental condition in order to receive VA dental care. However, recently discharged Veterans, including Combat Veterans, may be authorized dental treatment as reasonably necessary for a one-time period of correction of dental conditions if: (1) they served on active duty and were discharged or released from active duty under other than dishonorable conditions from a period of service not less than 90 days, (2) the certificate of discharge or release does not bear a certification that the Veteran was provided, within the 90-day period immediately before the date of such discharge or release, a complete dental examination (including dental X-rays) and all appropriate dental service and treatment indicated by the examination to be needed and, (3) application for VA dental treatment is made within 180 days of discharge or release. This includes Veterans who reentered active military, naval, or air service within 90 days after the date of a prior discharge and Veterans whose disqualifying discharge or release has been corrected by competent authority.

DIAGRAM OF REPORTING STRUCTURE



NOTE:** TCM refers to Transition and Care Management.* ***Straight lines convey reporting authority. Dotted lines convey collaboration and/or oversight.

CASE MANAGEMENT

1. CASE MANAGEMENT AND TREATMENT OF ACTIVE DUTY SERVICEMEMBERS AND NEW VETERANS

Case management is provided to severely ill or injured Servicemembers and Veterans and other Servicemembers and Veterans as clinically indicated based on assessment or as requested by the Servicemembers and Veterans, family or caregiver.

a. **Care of Active Duty Servicemembers.** VA medical facilities must provide health care services to active duty Servicemembers as follows:

(1) **Urgent or Emergent Care.** VA medical facilities will provide urgent or emergent medical care for active duty Servicemembers presenting at their facility. As soon as possible but without delaying care, the VA medical facility must notify the Military Treatment Facility (MTF), the Service Point of Contact (SPOC), or the regional TRICARE contractor that urgent or emergent care was provided and must seek authorization to provide the care.

(2) **Non-urgent or Non-emergent Care.** If the active duty Servicemember lacks authorization for routine care, VA medical facilities must contact the MTF, the SPOC, or the regional TRICARE contractor prior to providing non-urgent or non-emergent treatment. If the MTF, SPOC or TRICARE Contractor declines authorization, the VA medical facility is not to provide treatment. ***NOTE:*** *Community (non-VA) care is not to be used.*

(3) **Referred.** For active duty patients referred by a VA Liaison for Healthcare stationed at a MTF or by other DoD personnel, the medical facility TCM Program Manager must ensure that arrangements for the requested inpatient or outpatient care are completed. This includes arranging for outpatient treatment for Servicemembers at home on convalescent leave when requested by the MTF.

(4) **Not Referred.** For active duty patients not referred by the MTF, the VA medical facility must request authorization from the MTF, the SPOC, or the regional TRICARE contractor prior to providing services.

b. **Care of New Veterans.** VA medical facilities must provide appropriate health and mental health care services to transitioning Servicemembers and Veterans. Coordination of those services is to be ensured by the TCM Team at each VA medical facility composed of the TCM Program Manager, TCM case manager(s), and Transition Patient Advocate(s). Other major team members include the Lead Coordinator. The team may also include the following representatives: the TCM Veterans Integrated Service Network (VISN) Point of Contact (POC), the Post Deployment Integrated Care Clinic, Specialty Care Providers and case managers, Federal Recovery Coordinator (FRC), and VA Liaison for Health Care.

2. VA CASE MANAGEMENT MODEL

Every Veteran requiring case management services is assigned either a Registered Nurse (RN) or Social Work (SW) case manager. RNs and SW case managers collaborate when both complex medical and psychosocial factors are identified that may adversely impact the Veteran's health. ***NOTE:*** *Although the case management model described in this directive focuses on the roles of Registered Nurses and Social Work case managers, other health care professionals who are trained in another health or human services field that promotes physical, psychosocial, or vocational well- being (e.g. Licensed Professional Mental Health Counselors (LPMHC)) may serve as case managers if they have the appropriate training.* A close, collaborative relationship between RN and SW case managers provides the most comprehensive approach to case management services. Such a relationship minimizes duplication of services and unnecessary handoffs as each discipline brings their unique perspective to ensure that all of a Veteran's bio-psychosocial needs are met.

a. Case managers navigate the health care system with the Veteran and act as a Veteran advocate. Each member of the health care team within a VA medical facility may interact with case managers as they assess, communicate, facilitate care, and advocate within their role. Communication becomes an integral part of this role, including but not limited to: face-to-face and telephonic communication, written communication within the electronic health record, and in other inter- and intra-facility documents as appropriate.

b. Case managers actively and continuously assess the needs of the Veteran, the Veteran's family, and the Veteran's caregiver. Case managers participate in Veteran education, including coaching lifestyle changes. Case managers facilitate communication between the Veteran, the Veteran's family/caregiver, and VA health care providers. Case managers also facilitate communication among a Veteran's various health care providers. Case managers prompt health care interventions based on close or frequent monitoring of a Veteran's health care needs.

c. Case managers are knowledgeable about resource availability. They identify appropriate resources and provide referrals to various service resources along a continuum of care to restore or maintain Veterans independent functioning to the fullest extent possible. Case managers manage the delivery of an array of labor-intensive services to meet the needs of target populations.

d. To the extent possible, case managers support a Veteran's right to determine his or her plan of care.

e. The VA Case Management Model is both a framework and process that serves to support the Veteran, the Veteran's family, and the Veteran's caregiver's health needs across sites and unique episodes of care within the VA health care system in order to ensure the Veteran receives the highest level of quality, satisfaction and cost effective outcomes as possible. A close, collaborative relationship between RN and SW case managers provides the most comprehensive approach to case management services.

Both RN and SW case managers bring their individual discipline's unique perspective to ensure that all of the Veteran's physical and psychosocial needs are met. While these two disciplines work collaboratively, both RN and SW clinicians bring distinct skill sets to case management expertise and each function under different scopes of practice.

f. Levels of Case Management. Within each level of intensity, there are specific case management actions described for RNs and SWs that correlate to accepted case management standards of practice. As the Veterans' recovery continues and their health and psychosocial needs stabilize, it is anticipated that less intensive case management services, and thus fewer contacts with the CM will be required with eventual discharge from case management services. It is also expected that Veterans who have progressed in the continuum may experience significant life events resulting in the need to return to more intensive case management services.

(1) Intensive-Acute Case Management requires daily or weekly patient and family/caregiver contact whenever there is transition of care or significant change in the Veteran's clinical, psychosocial, functional, or mental health status, such as: a new medical diagnosis, newly identified behavioral health changes, or significant change in lifestyle.

(2) Progressive-Chronic Case Management requires at least monthly patient and family/caregiver contact to ensure a support system is in place. The Veteran is clinically stable but still needs ongoing intervention for psychosocial or other clinical issues to ensure continuous coordination of care and access to services.

(3) Supportive-Chronic Case Management requires, at a minimum, quarterly patient and family/caregiver contact to allow for the monitoring of the Veteran's care plan when the Veteran's clinical and psychosocial issues are stable. Quarterly contact also allows the CM to ensure that the Veteran is well established in the system of care.

(4) Lifetime-Chronic Case Management ensures consistent access to, and collaboration for, care delivery at the local VA medical facility, with other providers, or community resources.

3. VA CASE MANAGEMENT PROCESS

The following represents elements of the VA case management process:

a. **Veterans are Identified.** Veterans are identified by self-referral, referral through a family member or caregiver, referral through VA clinicians and non-VA community-based clinicians, or through health informatic portals. The Veteran or surrogate is asked to consent to case management services.

b. **Assessment.** A comprehensive assessment of the Veteran and the Veteran's family/caregiver needs is completed by case management staff. Reassessment is required for Veterans previously referred for case management and for Veterans and families/caregivers after services have been monitored and evaluated.

c. **Problems are Identified.** Veteran and family/caregiver problems are identified.

d. **Problem Solving and Goal(s) Identified.** Problem solving is initiated and the Veteran and the Veterans family/caregiver's desired or expected goal(s) and outcome(s) are identified.

e. **Resource Assessment.** A resource assessment is completed to identify available resources and options for services.

f. **Planning and Implementation.** Planning and implementation are accomplished through coordination, collaboration, and communication with the multi and or interdisciplinary team including VA and non-VA providers. The intensity and duration of case management services are dependent on the Veteran's care needs. Available community resources are obtained to ensure the best Veteran, family, caregiver, and organizational outcomes.

g. **Referrals and Transition.** Timely access to the appropriate level of care is ensured by coordinating comprehensive referrals and transitioning the Veteran to VA, DoD, other federal, state, and local home and community-based services.

h. **Monitoring and Evaluation.** Monitoring and evaluation of the plan of care is critical to ensure the right patient care, at the right time, in the right place, at the right cost, each and every time. Re-assessment is necessary to ensure intervention and case management services are appropriate, effective, timely, efficient, evidence-based, equitable, and promote safety.

i. **Program Evaluation.** Program evaluation and reporting allows for continuous performance improvement to ensure a high quality and sustainable case management program.

4. ADJUNCT TRANSITION AND CARE MANAGEMENT TEAM MEMBERS

a. A VA Liaison for Healthcare serves as a bidirectional bridge between DoD and VA to help ensure a smooth transition for the Servicemember or Veteran between DoD and VA medical facilities. VA Liaisons are VA employees who are stationed at designated MTFs. VA Liaisons facilitate the transfer of Servicemembers and Veterans from the MTF to a VA medical facility closest to their home for the most appropriate specialized services their medical condition requires. VA Liaisons utilize the VA medical facility TCM Program Manager as their primary POC at the facility level. ***NOTE:*** *Although most often between DoD and VA, the VA Liaison role may serve in a capacity to connect Veterans between another external healthcare system and VA.*

b. Federal Recovery Coordinators (FRCs) are VA employees who are located in MTFs or VA medical facilities as part of a joint VA-DoD initiative. The FRC is the primary resource to catastrophically injured and/or ill Servicemembers and Veterans and their families for monitoring the execution of services across the continuum of care

from recovery through rehabilitation to reintegration. The FRC works closely with DoD and VA clinical and administrative teams in concert with patients, family and other care providers, for all episodes of care. The FRC will work closely with the TCM Program Manager to ensure Servicemember and Veteran needs are met and to remove institutional barriers to care.

c. Some VA medical facilities have a Post Deployment Integrated Care Clinic model that provides post-combat evaluations and follow-up for Post 9/11 Veterans, functions as a multidisciplinary clinic and works closely with many specialty services such as Polytrauma rehabilitative services, the Spinal Cord Injury/Disorders Service, Visual Impairment Service Team (VIST), Pain Clinic, Mental Health and PTSD Clinic. This team is an integral partner with the TCM Program.

d. DoD has Wounded Warrior Programs to assist ill and injured Servicemembers and Veterans (e.g., Army Wounded Warrior (AW2) Program, Marine Wounded Warrior Regiment (WWR), Air Force Wounded Warrior (AFWW) Program, Navy Safe Harbor, etc.). TCM team members collaborate with Advocates, Recovery Care Coordinators (RCCs), District Injured Support Coordinators (DISCs), and other staff from the Wounded Warrior Programs to ensure the needs of the Servicemember or Veteran are being met. In addition, the TCM Program Manager will work with the Wounded Warrior Programs to assist with access to space and equipment at a VA medical facility, when needed, to benefit the delivery of Servicemember and Veteran assistance.

e. VBA has many available VA benefits, including disability compensation and ancillary benefits, vocational rehabilitation and employment, insurance education, and home loans. TCM team members collaborate with VBA staff members who can assist in initiating applications for any VA benefits to which a Servicemember or Veteran may be entitled, as well as for compensation benefits for service connected disabilities if appropriate.

COMPLEX CARE COORDINATION

1. INTERAGENCY COMPLEX CARE COORDINATION MODEL

The Interagency Complex Care Coordination model establishes a consistent method for complex care coordination capable of providing clinical and non-clinical information and support for recovery, rehabilitation, and ongoing care of Servicemembers and Veterans and for their families or caregivers wherever care, benefits and services may be delivered.

a. The complex care coordination model is Servicemember- and Veteran-centered, needs-based, and applies to Department of Defense (DoD) and Department of Veterans Affairs (VA) whether care, benefits, and services come from DoD, VA, other government agencies, or the private sector.

b. The complex care coordination model is the foundation for a common set of rules, definitions, tools, and processes shared by all of the professionals supporting and facilitating the care, benefits, and services of Servicemembers and Veterans across the departments.

c. The model addresses and supports requirements for an Interagency Comprehensive Plan (ICP) for Servicemembers and Veterans that support realistic outcomes throughout all stages of recovery through ongoing care. The ICP is a Servicemember- and Veteran-centered recovery plan with identified goals for recovery and rehabilitation developed from a comprehensive needs assessment, which identifies the recovering Servicemember's and Veteran's and family or caregiver's personal and professional needs and goals, and the services and resources needed to achieve them. The ICP addresses clinical as well as non-clinical support (e.g., pay, benefits, family support, vocational rehabilitation, information, and resources, including military, federal, or other governmental and community resources). This model supports a Servicemember's or Veteran's goals (e.g., to recover or complete rehabilitation and return to duty, employment, school, or other meaningful activities).

d. When returning to duty or employment is not possible, the primary objective of the model is to facilitate a plan (ICP) to help the Servicemembers and Veterans reach and maintain the highest achievable level of independent function, life adjustment, and quality of life.

e. This model establishes a requirement to use an ICP that is initiated timely and updated on an ongoing basis to meet the assessed needs of the Servicemembers and Veterans as they change. A Servicemember or Veteran has one ICP at any given time, which is updated as needed.

f. The ICP is tailored to each Servicemember's and Veteran's unique needs and addresses the full spectrum of care, benefits, and services needed for optimal recovery and/or rehabilitation and may include life-long continuity of care, if necessary. If possible, Servicemembers and Veterans, their family member(s) and/or caregiver(s) are

engaged in the establishment and modification of their ICP at all stages of care, recovery and reintegration.

g. This model establishes the role of the Lead Coordinator (LC) which is assigned to a member of the Care Management Team (CMT). The LC serves as the primary point of contact (POC) for the Servicemember or Veteran who requires complex care coordination and their families or caregivers. The LC has primary responsibility for ensuring the establishment and update of the Servicemember's or Veteran's ICP. The LC will be determined based on the predominant specialized clinical care needs of the Servicemember or Veteran and by mutual agreement of the CMT members, including input from the Servicemember's or Veteran's, family or caregiver.

h. The CMT includes individuals who are working together to manage, coordinate, and/or deliver the care, benefits, and services for the Servicemember or Veteran and to support the family or caregiver. The professions and individuals who comprise a specific CMT will vary based on the needs of the Servicemembers and Veterans and their family or caregiver (e.g., health care provider(s), attending physician, nurse case manager, therapist, social worker, vocational rehabilitation specialists, command representative, and all others providing care, benefits, and services, including military or community resources).

2. CRITERIA FOR COMPLEX CARE COORDINATION

The need for complex care coordination is determined by factors including both severity of a wound, illness or injury that is expected to result in prolonged recovery time, or extensive rehabilitation and complexity of care coordination needs involving health care, benefits, and services, including military, federal, or other governmental or community resources. In addition, Servicemembers and Veterans in need of complex care coordination have longitudinal care and case management needs that will require an interdisciplinary team approach to achieve optimal recovery.

a. Such Servicemembers and Veterans might include, but are not limited to, those with multiple, complex, severe conditions such as polytrauma injuries, spinal cord disorders, blindness, amputations, significant burns, complex wounds, traumatic brain injuries, psychological trauma, or other cognitive, psychological, or emotional disorders. Complex care coordination needs may result from either combat or non-combat situations. Further, due to a serious or catastrophic wound, injury or illness, it is unlikely to highly unlikely that the Servicemember will return to duty and may, or will, be medically separated/retired from the military, or it is unlikely to highly unlikely that a Veteran will return to independent living or employment. Other Servicemembers and Veterans who do not meet the above criteria but who may benefit from complex care coordination may be included in this model if needs are identified.

b. The responsibility for assessment of the need for complex care coordination is made by members of the interdisciplinary CMT. The determination for complex care coordination is usually accomplished during the acute/stabilization stage, but may occur at any time during the course of recovery.

c. Complex care coordination is a Servicemember- and Veteran-centered, needs-based system designed to support the recovering Servicemembers and Veterans and their family or caregiver until the criteria for discontinuation have been met. In most cases, enrollment into complex care coordination should occur as early as possible in the course of a hospitalization. This model is continued as a Servicemember or Veteran transitions from an inpatient to outpatient setting, or is applied directly to outpatient Servicemembers and Veterans needing complex care coordination.

d. These Servicemembers and Veterans receive an ICP that has been prepared and updated by members of the CMT. The primary responsibility for maintaining and communicating the ICP to the Servicemember or Veteran is assigned to the LC.

e. Criteria for Discontinuation of Complex Care Coordination. Complex care coordination and use of the ICP continues until the CMT reviews and concurs that one of the following end points is reached:

(1) The Servicemember or Veteran returns to duty or employment with minimal or no limitations,

(2) The Servicemember or Veteran has reached a level of stability making continued formal complex care coordination unnecessary,

(3) The Servicemember or Veteran requests discontinuation of services, or

(4) The Servicemember or Veteran expires or other conditions make complex care coordination unnecessary.