**Department of Veterans Affairs** **VHA HANDBOOK 1110.04**
**Veterans Health Administration** **Transmittal Sheet**
**Washington, DC 20420** **May 20, 2013**

# CASE MANAGEMENT STANDARDS OF PRACTICE

**1. REASON FOR ISSUE.** This Veterans Health Administration (VHA) Handbook establishes procedures and identifies standards of practice for a collaborative Department of Veterans Affairs (VA) patient case management model.

**2. MAJOR CHANGES.** This is a new VHA Handbook that establishes procedures and identifies standards of practice for a collaborative VA patient case management model.

**3. RELATED ISSUES.** VHA Handbook 1110.02, Social Work Professional Practice; VHA Handbook 1010.02, Department of Veterans Affairs Liaison for Healthcare Stationed at Military Treatment Facilities; VHA Handbook 1172.01, Polytrauma System of Care; and VHA Handbook 1172.04, Physical Medicine and Rehabilitation Individualized Rehabilitation and Community Reintegration Care Plan; VHA Directive 2012-008, Social Work Case Management in VA Polytrauma Rehabilitation Centers.

**4. RESPONSIBLE OFFICE.** The Chief Consultant for Care Management and Social Work Service is responsible for the contents of this VHA Handbook. Questions may be addressed at 202-461-6780.

**5. RESCISSIONS.** None.

**6. RECERTIFICATION.** This VHA Handbook is scheduled for recertification on or before the last working day of May 2018.

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# CASE MANAGEMENT STANDARDS OF PRACTICE

## 1. PURPOSE

This Veterans Health Administration (VHA) Handbook establishes procedures for a collaborative Department of Veterans Affairs (VA) patient case management model. This Handbook further identifies standards of practice for VA's patient case management model. ***NOTE:*** *Although the case management model described in this Handbook focuses on the roles of Registered Nurse (RN) and Social Worker (SW) case managers, other health care professionals may provide some aspect of case management within their specialties.*
**AUTHORITY:** Title 38 United States Code (U.S.C.) §§ 1706, 1710.

## 2. BACKGROUND

a. Case management is a critical component of VA's model of Veteran-centric health care delivery.

b. Case management is a specialized and highly-skilled component of patient care management. Case management has an accepted and recognized role in the coordination of care required by patients with chronic, catastrophic, or complex high-risk or high-cost health care issues. Case management also has a recognized role in the coordination of care required by patients with mental health, psychosocial, or environmental issues.

c. 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 encompasses a broad spectrum of care across VA and non-VA continuums. Care Management identifies strategies to provide integrated services, which enhance collaboration with interdisciplinary health care team members and promotes Veteran-centric care. Care management is a set of activities designed to assist Veterans and their support systems in managing medical and mental health conditions and related psychosocial problems more effectively, with the goal of: improving Veterans' functional health status and quality of life; enhancing the coordination of care; eliminating the duplication of services; and, reducing the need for expensive health care services. Activities of care managers typically include: assessing the risks and needs of each Veteran; working with the Veteran, the Veteran's family/caregiver, and the interdisciplinary care team to prepare a care plan; teaching Veterans and their families/caregivers about diseases and medications; coaching Veterans and families/caregivers on healthy living messages and self-management; providing guidance on responding to worsening symptoms in order to avoid emergency department visits and hospital admissions; coordinating appointment scheduling; tracking the Veteran's status over time; and revising care plans as needed.

d. There are many diverse case management roles and practices within the VA. However, there is no standardized approach or system for measuring the impact of case management within the VA. Standardized case management improvement initiatives and effective outcome measurements may decrease unintended or unnecessary variations in VA case management, deliver effective and efficient Veteran-centric care, and result in better role utilization.

e. A variety of approaches may be needed to adequately measure the implementation of case management interventions themselves (process), as well as the actual results or endpoints (outcomes) of that care. Many programs have found it useful to utilize a pre- and post-comparison model, looking at outcomes during a baseline period without case management interventions and comparing them to post-case management intervention periods, in an effort to control some of the complex intervening variables. The Case Management Society of America (CMSA) and its Council for Case Management Accountability (CCMA) have taken a national leadership role to identify standardized performance measurements for case management on performance measures.

## 3. DEFINITIONS

a. **Care Management.** Care management is the oversight and management of a comprehensive health care plan for a cohort of patients. Care management is usually provided by the Patient Aligned Care Team (PACT) RN Care Manager, the Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) Program Manager, or other licensed professionals.

(1) Care management facilitates the delivery of clinically-recommended care, based upon the Veteran's consent, in ways that integrate health care services to avoid duplication, poor timing, or missed care opportunities. Effective care management engages Veterans and their personal support systems in developing strategies for managing the full range of health conditions according to agreed upon goals of care (e.g., improved quality of life, improved functional status, life-sustaining treatments, and palliative care). Care management includes, coordination of care longitudinally and across the continuum of care settings; disease management of an individual Veteran; population management of a cohort of Veterans; and multi-modal communication techniques. Care management facilitates comprehensive, continuous, coordinated, and collaborative delivery of care.

b. **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 so that they meet the needs of the 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.

(1) Individuals who require case management often require intensive support and monitoring due to complex medical, mental health, or psychosocial factors beyond the services offered by the care management team. Case management requires frequent assessment, planning, advocacy, support, coordination of multiple services, and evaluation to meet the Veteran's complex health care needs. Case management may be short-term or long-term and is based on the patient's clinical needs, with interventions occurring at the Veteran, family, or caregiver levels. Case management is intended to maximize resource utilization and promote quality Veteran-centric care while producing cost effective outcomes. Case management requires well-coordinated and collaborative interdisciplinary efforts, which are dependent upon effective communication and cooperation across the health care continuum.

c. **Intensive-Acute Case Management.** Intensive-acute case management is geared towards Veterans with the highest level of need. These Veterans may be hospitalized, or have had recent, extended, or repeat hospitalizations, or recurrent episodes of crisis. Their identified problems interfere with life in a disabling manner and there are multiple service provision needs. Intensive-acute case management includes extensive contact with the Veteran, the Veteran's family/caregiver, and the Veteran's health care providers. The goal is to stabilize the Veteran and eventually transition to less intensive case management.

(1) Intensive-acute case management may be inpatient based on an acute medical, surgical, or mental health or can be outpatient or community-based for the Veteran who is severely physically or mentally disabled. Regardless of the diagnosis, it is critical to involve the Veteran and the Veteran's family/caregiver in evaluating and setting goals for the Veteran's treatment plan.

(2) Case Managers (CM) responsible for intensive-acute case management facilitate the flow of care, expedite appropriate transition to lower and higher levels of care, and seek to prevent hospital readmissions. CMs initiate and participate in early discharge planning to ease the transition to home or the next level of care. Intensive-acute case management is characterized by growing specialization and may involve the implementation of clinical protocols and pathways. Intensive-acute case management requires frequent contacts with providers, the Veteran and the Veteran's family/caregiver as well as intense service delivery.

d. **Chronic Illness Case Management.** Chronic illness case management targets the high-risk Veteran with chronic illness and complex service and support needs, who may be homebound with limited support structures and financial resources.

(1) The goal of case management for chronic illness is to facilitate access to appropriate services for those Veterans with a chronic illness who have complex service and support needs. Veterans identified for chronic illness case management most often have chronic disease states that put them at risk for decline; these chronic disease states include, but are not limited to organ failure or potentially life-threatening or life-limiting illnesses. These Veterans may have psychosocial challenges that interplay among physical, environmental, behavioral, psychological, economic, and social factors.

(2) Chronic illness case management improves coordination and communication of health care needs between the Veteran, the Veteran's family/caregiver, and interdisciplinary team members who care for the Veteran. Veterans in need of chronic illness case management are at risk for more frequent hospitalizations, which result in higher costs and resource utilization, and more importantly a poorer quality of life for the Veteran. Conventional health care alone is often unable to meet these Veterans' health care needs due to fragmentation in care and the Veteran receiving care from multiple providers at multiple settings. This often leads to inadequate communication between health care providers and the Veteran and among providers across settings.

(3) Caseload for chronic illness case management is dependent on many factors: the characteristics of the Veterans served, complexity of the care plan, geographical area covered, and availability of community-based services.

e. **Specialty Populations for Clinical Case Management.** Specialty populations are defined as those Veterans who are considered to be at high risk for clinical decline or increase of resource utilization, have complex care needs, or require significant coordination of care. Case management services are provided to those Veterans determined to be at high psychosocial or health risk.

(1) Typical risk factors include:

(a) Homelessness;

(b) Insufficient income;

(c) Frail elderly;

(d) Serious mental illness;

(e) Inability to care for self;

(f) Frequent hospitalizations or emergency department visits;

(g) Suspected victims of abuse, neglect, or exploitation;

(h) Terminal or life limiting illness;

(i) Catastrophic illness or injury; or

(j) The Veteran is in need of a guardian or fiduciary.

(2) Programs providing case management to specialty populations include, but are not limited to the:

(a) Polytrauma System of Care;

(b) Mental Health and Mental Health Intensive Case Management (MHICM);

(c) OEF, OIF, OND Care Management;

(d) Homeless Programs;

(e) Spinal Cord Injury (SCI);

(f) Traumatic Brain Injury (TBI);

(g) Blind Rehabilitation and Visually Impaired Service Team (VIST);

(h) Geriatric and Extended Care (GEC);

(i) Home Based Primary Care (HBPC);

(j) Telehealth Services;

(k) Dialysis and Transplant; as well as

(l) Other medical center and community-based programs.

f. **Patient Aligned Care Team (PACT).** A model of care known as PACT has transformed the delivery of primary care services in VA.

(1) The PACT delivers comprehensive, collaborative, coordinated, and continuous Veteran-centric team-based health care services. The interdisciplinary PACT, in collaboration with other integrated health care teams, is a key component in identifying Veterans who may benefit from case management services.

(2) The term "teamlet" refers to the provider, RN Care Manager, clinical associate (i.e., Licensed Practical Nurse (LPN), Medical Assistant (MA), or Health Technician) and clerical associate.

g. **Federal Recovery Coordinator Program (FRCP).** The FRCP is a joint VA and Department of Defense (DOD) program. VA serves as the administrative home for the FRCP.

h. **Federal Recovery Coordinator (FRC).** The FRC is a Master's prepared RN or SW who provides assistance to seriously wounded, injured, or ill OEF, OIF, OND Servicemembers or Veterans enrolled in the FRCP. FRC's assist enrolled Servicemembers, Veterans, and their families with recovery, rehabilitation, and reintegration into civilian life. Each wounded, ill, or injured Servicemember or Veteran enrolled in the FRCP has a Federal Individual Recovery Plan created by the assigned FRC. FRCs provide care coordination for these enrolled individuals regardless of where the individual is located or whether the individual is in active duty or Veteran status.

(1) To coordinate each client's particular needs and goals, the FRC works with: military liaisons; members of the Armed Services Wounded Warrior Programs; service recovery care coordinators; TRICARE beneficiary counseling and assistance coordinators; VA vocational and rehabilitation counselors; military and VA facility CMs; VA Liaisons; VA specialty CMs; VHA; Veterans Benefits Administration (VBA); OEF, OIF, and OND Program Managers; VBA benefits counselors; other Federal and state agencies; and the private sector.

(2) Stationed at Military Treatment Facilities (MTF), Wounded Warrior Programs, and VA medical facilities, FRCs serve as the lead point of contact.

(3) Eligibility for the FRCP is not dependent upon the geographic location where the injury or medical diagnosis occurred or was made.

## 4. SCOPE

This Handbook describes the partnership between the Office of Nursing Services and Care Management and Social Work Services on a collaborative, integrated nursing and social work case management model for Veterans. It is recognized that other health professionals may provide some aspect of case management activities within specialty services. This Handbook establishes practice standards, roles, responsibilities, competencies, and training requirements for RNs and SWs who are functioning as CMs. See Appendices A and B.

## 5. CASE MANAGER QUALIFICATIONS

The CMSA recommends CMs maintain competence in their area of practice by having one of the following:

a. A current active and unrestricted license or certification in a health or human services discipline; or

b. Baccalaureate or graduate degree in social work, nursing, or another health or human services field that promotes the physical, psychosocial, and or vocational well-being of the persons being served.

## 6. VA CASE MANAGEMENT MODEL FOR REGISTERED NURSES AND SOCIAL WORKERS

a. Every Veteran requiring case management services is assigned either an RN or SW CM. RNs and SWs collaborate when both complex medical and psychosocial factors are identified that may adversely impact the Veteran's health. A close, collaborative relationship between RN and SW CMs 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 the Veteran's bio-psychosocial needs are met.

(1) Nursing case management addresses the medical, nursing, and/or personal care needs of Veterans to enable their return to an optimal level of functioning. Identification of cost-effective resources while providing quality care is necessary to reach the desired outcome and is an essential component of case management services. RNs conduct a comprehensive assessment of the Veteran and the Veteran's family/caregiver. RNs also support systems that identify actual or potential problems, set health care goals, reassess the Veteran's progress towards those goals, and adjust the Veteran's health care plan as needed in collaboration with the Veteran's multidisciplinary health care team.

(2) Social work case management addresses the individual's bio-psychosocial status, social system, and resources. SWs develop and maintain a therapeutic relationship with the Veteran, which may include linking the Veteran with systems that provide needed services, resources, and opportunities**.** SWs demonstrate their expertise by navigating complex health and social service systems, combined with their unique psychosocial perspective, in helping Veterans and their families/caregivers access resources, to maximize the Veteran's independence, health, and well-being.

b. **RN and SW Case Management Model**

(1) CMs navigate the health care system with the Veteran and act as a Veteran advocate. Each member of the health care team within a facility may interact with CMs 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.

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

(3) CMs 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. CMs manage the delivery of an array of labor-intensive services to meet the needs of target populations.

(4) To the extent possible, CMs support a Veteran's right to determine his or her plan of care.

(5) The RN and SW 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 CMs provides the most comprehensive approach to case management services. Both RN and SW CMs 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.

c. **Framework for Differing Levels of Intensity of Case Management.** Within each level of intensity or event, there are specific CM 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.

d. **Documentation.** Refer to paragraph 13.

## 7. VA CASE MANAGEMENT PROCESS

***NOTE:*** *The VA Case Management Process flow depicts the overall case management process for comprehensive, high-quality case management practice in VA. See Appendix C.*

A CM is required to intervene with specific actions and varying degrees of frequency and intensity along the continuum of care based on the clinical and bio-psychosocial presentation of each individual Veteran. The following represents elements of the 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) Indentified.** 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. See Appendix D.

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.

## 8. THE CASE MANAGER RELATIONSHIP TO HEALTH CARE TEAM MEMBERS

a. **Health Care Team Providers.** The CM shares data and information, seeks clarification, individualizes treatment plans and interventions, and monitors outcomes of the Veteran's treatment and effectiveness of the program in which the Veteran is receiving care. The CM also collaborates with the health care team to ensure acquisition of the appropriate durable medical equipment, medications, disposable supplies, skilled and non-skilled services, and community resources (i.e., structured placement) necessary to meet the unique health and psychosocial needs of the Veteran.

b. **The Patient Care Unit Staff.** The CM may interact with unit staff to identify learning needs specific to the Veteran and discharge planning needs. CMs will share responsibility for identifying educational opportunities for health care staff (nurses and other health care team members), especially those unique or essential to a Veteran's health condition or care situation.

## 9. THE CASE MANAGER RELATIONSHIP TO PATIENT ALIGNED CARE TEAM

a. The CM continuously communicates and coordinates care with the PACT RN Care Manager and with other specialty care team members. The CM shares information with the PACT teamlet or specialty care team members, seeks clarification, helps to individualize treatment plans and interventions, monitors outcomes of the Veteran's treatment, and monitors the effectiveness of the program within which the Veteran is receiving care. The CM collaborates with the PACT or specialty care team members to ensure acquisition of the appropriate durable medical equipment, medications, disposable supplies, skilled and non-skilled services ,and community resources (i.e., structured placement) necessary to meet the unique health and psychosocial needs of the Veteran, family, and caregiver.

b. A PACT typically includes a primary care practitioner (physician, Nurse Practitioner, or Physician Assistant), RN Care Manager, clinical associate, and clerical associate. The PACT establishes Veterans' health care plans, provides primary care services, and provides care management that facilitates comprehensive, continuous, coordinated, and collaborative delivery

of care. These team members are responsible for identifying Veterans under their care that would benefit from assignment to a CM.

(1) The RN Care Manager on the PACT is the primary point of contact for referral of the Veteran to a CM. RN Care Managers continue to provide care management to Veterans who have been referred to CMs. RN Care Managers and CMs collaborate closely to coordinate health care services for the Veteran, thus avoiding duplication of care, preventing miscommunications, providing comprehensive care, and maintaining continuity of care.

(2) CMs are discipline-specific PACT members for the duration of time the CM is involved in the care of the Veteran. RNs and SWs collaborate when both complex clinical and bio-psychosocial factors are identified that may adversely impact the Veteran's health. As a discipline-specific member of the PACT, CMs are expected to:

(a) Consult with the RN Care Manager to determine if case management services are required.

(b) Collaborate and communicate with all PACT members using communication strategies (i.e., formal Computerized Patient Record System (CPRS) consult responses and informal "just-in-time" conversations), and modalities (e.g., CPRS, telephone, VA-approved electronic communication) as agreed upon with the team.

(c) Actively engage in coordination of care for high-risk Veterans, and during transitions of Veterans from Primary Care to another care setting;

(d) As appropriate, participate in PACT operations (e.g., huddles, team meetings, quality improvement activities, systems redesign, and protocol development).

(e) Assume responsibilities and perform activities for discipline-specific PACT members established in VA policy and guidance.

(f) Upon discharge of the Veteran from case management services, the CM transfers full responsibility to the RN Care Manager or other appropriate PACT member for the care of the Veteran.

(3) CMs provide the same comprehensive case management to Veterans assigned to PACT as they do to all other Veterans referred for case management services, including:

(a) Performing a comprehensive assessment of Veteran and his or her family/caregiver needs;

(b) Determining agreed upon goals of care for the Veteran;

(c) Obtaining the Veteran's (or surrogate's) consent for case management services;

(d) Establishing outcomes of care;

(e) Identifying available resources and options for services; and

(f) Referring or procuring indicated services for the Veteran, family, and caregiver.

## 10. THE CASE MANAGER RELATIONSHIP TO SPECIALITY CARE TEAMS

a. The intensity and duration of case management services depends on the care needs of the individual Veteran along the continuum of care. At times, multiple CMs may be involved in a Veteran's care. A lead CM must be identified by the Veteran's interdisciplinary care team as having primary responsibility for the medical, psychological, and psychosocial concerns of the Veteran. The lead CM coordinates health care services with the other CMs involved in the Veterans' care. The lead CM must be the clinician who best understands the needs of the Veteran and is the primary communicator with the Veteran and the Veteran's family/caregiver. CMs must coordinate case management with the principle specialty care provider.

b. **Specialty CMs.** Criteria for admission to a case management program for specialty populations must be developed to ensure that this important Veteran-centric care resource is well utilized. The PACT RN Care Manager and the CM may frequently be in a position to collaborate on the coordination of care with other CMs who are members of specialty care teams such as:

(1) Polytrauma System of Care;

(2) MHICM;

(3) OEF, OIF, OND Care Management;

(4) Health Care for Homeless Veterans (HCHV);

(5) SCI;

(6) TBI;

(7) Blind Rehabilitation and VIST;

(8) GEC;

(9) HBPC;

(10) Home Telehealth (HTS); as well as

(11) Other medical facility and community-based programs.

## 11. THE CASE MANAGER RELATIONSHIP TO THE FEDERAL RECOVERY COORDINATOR

FRC works with Care Managers and CMs within VA and DOD to ensure that Veterans, Servicemembers, and their families receive appropriate benefits and services in a timely manner.

## 12. CASE MANAGEMENT OF SPECIAL POPULATIONS

a. **Case Management Model for OEF, OIF, and OND Program Manager (PM).** The OEF, OIF, and OND PM:

(1) Oversees the transition and case management of OEF, OIF, and OND Servicemembers and Veterans at each VA medical center.

(2) Works closely with the OEF, OIF, and OND CMs to coordinate the care and services provided to ill and injured Servicemembers and Veterans.

(3) Communicates with the VA Liaison before the Servicemember leaves the MTF to establish a direct handoff and coordinate all transition activities and services.

(a) This contact is to provide up-to-date information on the Veteran who will be coming to the local VA medical center.

(b) Veterans are enrolled or registered in the VA system and assigned an OEF, OIF, and OND CM and Transition Patient Advocate.

1. Referrals also come from Post-Deployment Care Clinics and other VA facilities.

2. All Veterans are screened for the need for case management and those identified are assigned to a SW or RN CM.

***NOTE:*** *A care management model can be found in the VHA Handbook 1010.01, located at: http://www1.va.gov/vhapublications/publications.cfm?pub=2*

b. **Case Management Models for SCI, Blind Rehabilitation, Polytrauma, TBI, Mental Health, and Post-traumatic Stress Disorder (PTSD).** Case Management Models for SCI, Blind Rehabilitation, VA Homeless Programs, MHICM, and other programs for specialty populations can be found in various VHA Directives and Handbooks that can be located at: http://www1.va.gov/vhapublications.

## 13. CASE MANAGEMENT DOCUMENTATION

Documentation is a key means of communication among interdisciplinary team members. Documentation contributes to a better understanding of a Veteran and his or her family/caregiver's unique needs and allows for interdisciplinary service delivery to address those needs while reflecting the accountability and involvement of the CM in Veteran care. The CM is responsible for:

a. Completing and documenting a comprehensive baseline case management assessment. This documentation must include periodic reassessments; the case management plan of care; and information about any significant interactions with Veterans (whether by telephone or in person). When reassessment indicates a Veteran's need for a change in the level of case management intensity, that documentation must occur in the electronic health record.

b. Documenting in accordance with The Joint Commission standards, the Commission of Accreditation of Rehabilitation Facilities guidelines, accepted professional case management, social work and nursing standards of practice, and local facility policy.

c. Ensuring all documentation occurs in CPRS.

d. Ensuring all workload capture will utilize appropriate Current Procedural Terminology, International Classification of Diseases and stop codes for those encounters.

e. Documentation for OEF, OIF, and OND ill and injured Veterans must also occur in the Care Management Tracking Record Application (CMTRA). ***NOTE:*** *Other specialty programs, such as Homeless Programs, have specific tracking systems.*

## 14. WORKLOAD AND PRODUCTIVITY

a. Specialty Programs' Directives and publications may indicate program specific Decision Support System (DSS) identifiers. The following DSS identifiers are used for Veteran identification and workload tracking to measure outcomes:

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

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

b. RN and SW CMs may apply national quality improvement processes and reporting structures at the facility level as part of a particular case management tracking application (i.e., CMTRA).

c. Reporting structures related to case management of homeless Veterans must be integrated into the Homeless Operations Management and Evaluation System, the national homeless case management and reporting system.

d. Utilizing data from the performance improvement process, each case management program must communicate program experiences to program staff and others, as appropriate;

identifying opportunities for improvement; and developing action plans to ensure continuous program improvement. Active involvement of Quality Management staff at the facility and Veterans Integrated Service Network level is needed.

## 15. PERFORMANCE MEASURES

The facility Case Management Program must monitor quality and performance for all CMs using aspects designed for:

a. **Utilization.** This includes items such as impact on acute care admissions, unanticipated readmissions, bed days of care, emergency department or urgent care, long term care admissions, and end of life care.

b. **Flow of Care.** This includes items such as access and transitions that include seamless handoffs across the entire health care spectrum.

(1) **Clinical Outcomes.** This includes items such as: those related to the Veteran's achievement of the plan of care goals, adherence to medication or other aspects of the plan of care, functional status, and safety.

(2) **Cost.** Cost-effective analysis tools are available through the VA Health Economic Resource Center at: http://www.herc.research.va.gov/resources/faq.asp.

(3) **Satisfaction.** This includes the Veteran, family, caregiver, and health care team.

## 16. CASE MANAGER CERTIFICATION RESOURCES

The following organizations and their Web sites are recommended for RN and SW CMs who seek certification.

a. The Commission for Case Manager Certification: http://ccmcertification.org/

b. Case Management Society of America: http://www.cmsa.org/

c. National Association of Social Workers: http://www.socialworkers.org

d. Nursing Case Management: http://www.nursecredentialing.org/NurseSpecialties/CaseManagement.aspx

## 17. REFERENCES

a. VHA Handbook 1010.01, Care Management of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans.

b. Case Management Society of America: http://www.cmsa.org.

c. Social Work Service, Practice Guidelines, Number 2: Social Work Case Management" (1995)

d. "Care Management Toolkit" (2001).

e. Case Management Society of America. (August, 2009). *Case Management Model Act*. Retrieved from http://www.cmsa.org/PolicyMaker/tabid/62/Default.aspx

## REGISTERED NURSE AND SOCIAL WORKER CASE MANAGEMENT FUNCTIONS RELATED TO STANDARDS OF PRACTICE

| Function | Both | RN | SW |
|---|---|---|---|
| **Veteran/Client Identification:** | | | |
| Identify cases with high risk potential for complications. | **X** | | |
| Identify cases that would benefit from additional types of services (e.g., disease management, PT, DME, vocational services, testing, counseling and assistive technology). | **X** | | |
| Identify cases that meet criteria for receiving case management services. | **X** | | |
| Identify cases that would benefit from alternate levels of care (e.g., sub-acute, skilled nursing). | | **X** | |
| **Veteran/Client Assessment/Evaluation:** | | | |
| **Assessment:** | | | |
| Perform appropriate assessment of the patient or situation by using established case management processes and standards. | **X** | | |
| Interview the patient to ascertain baseline and ongoing level of physical, emotional, psychological, and spiritual functioning. | **X** | | |
| Assess the patient's social support system and relationships (e.g., family, friends, significant others, community groups). | | | **X** |
| Assess the patient's readiness and willingness for case management services. | **X** | | |
| Assess the patient's relationship with key stakeholders (e.g., providers, payers, and employers). | **X** | | |
| Review information about the patient's social and financial resources (E.G., income, living situation, and insurance). | | | **X** |
| Assess for the presence of multicultural issues and health behaviors that may impact the patient's health status. | **X** | | |
| Assess the need for environmental modifications (including that in the home) to address accessibility barriers. | **X** | | |
| Assess respite needs of the patient and their caregivers. | **X** | | |
| Assess the need for referral to vocational services. | | | **X** |
| Perform resource assessment looking at all the resources available and the need/use for them. | **X** | | |
| **Planning:** | | | |
| Document and communicate case management assessment findings to key stakeholders | **X** | | |
| Verify appropriateness of Level of Care with the health care team. | **X** | | |
| Establish treatment goals that meet the patient's health care and safety needs as well as the referral source's requirement. | **X** | | |
| Establish, in collaboration with key stakeholders (e.g., providers, payers, employers, family, and significant others), comprehensive case management goals, objectives, and expected outcomes including specified times frames. | **X** | | |

| Function | Both | RN | SW |
|---|---|---|---|
| Review requirements for prior approval of services by payer. | X | | |
| Review the health history of the patient to ensure that it is accurate and comprehensive (e.g., interview the patient and health team, conduct a record review). | | X | |
| Complete assessment of adherence to prescribed medication(s) and other prescribed treatments. | | X | |
| Identify regulatory requirements pertinent to the case (e.g., secure and/or verify informed consent from the patient; release of nonpublic personal/financial and/or protected health information). | X | | |
| Evaluate the ability and availability of the designated caregiver to deliver the needed services. | X | | |
| Ascertain the need for referral to evaluate an individual's present level of impairment (e.g., physical, mental and emotional). | X | | |
| Utilize evidenced based practice guidelines in development of the case management | X | | |
| Review the conditions of the patient's insurance policy/policies (e.g., coverage, exclusions, and extra-contractual provisions). | X | | |
| Perform resource research. | X | | |
| Identify the need for specialized services to facilitate achievement of optimal level of wellness/functioning (e.g., work hardening work conditioning, ergonomics, and life care planning. | X | | |
| Determine the ways in which cultural factors might affect service delivery systems. | X | | |
| Review the documentation for competencies and accuracy. | X | | |
| Identify appropriateness/eligibility for community-based services; eligibility for VA/DoD. | X | | |
| Identify eligibility for private-and public sector funding sources for services (e.g., Medicare, Medicaid, community resources, and charitable funds). | | | X |
| Determine the patient's need for assistive technology (e.g., voice enhancer, communication board). | X | | |
| Ascertain that the appropriate payer has the necessary resources to support the patient's re-entry into the labor force and/or return to school. | | | X |
| **Implementation:** | | | |
| Implement the case management plan. | X | | |
| Communicate case management plan to key stakeholders (providers, payers, | X | | |
| Advocate for patients (e.g., negotiate benefits, ensure adequate patient knowledge regarding care choices). | X | | |
| Plan for the patient's transition along the care continuum. | X | | |
| Engage patients to actively participate in the development of their short and long term health goals. | X | | |

| Function | Both | RN | SW |
|---|---|---|---|
| Collect and analyze the necessary data (e.g., cost, health benefits) to determine the feasibility of implementing the case management plan. | X | | |
| Identify formal and informal community resources and support programs. | X | | |
| Arrange for respite needs of patients and their caregivers. | X | | |
| Arrange for vocational assessment and services. | X | | |
| Utilize evidence based practice guidelines in development of the case management | X | | |
| Establish working relationships with referral sources. | X | | |
| Document the implementation of the case management plan. | X | | |
| Initiate referrals to service providers as identified in the case management | X | | |
| Explain services (including limitations) of available resources to patients. | X | | |
| Implement cost effective case management strategies. | X | | |
| Educate and/or facilitate the education of patients about wellness and illness prevention strategies specific to their condition. | X | | |
| Facilitate achievement of optimal wellness/functioning/productivity (e.g., return to work, school, other activities) | X | | |
| Refers patients to formal and informal community resources and support programs. | X | | |
| Facilitate patient access to programs, services, and funding (e.g., SSI, SSDI, Medicare, Medicaid, community resources). | X | | |
| Coordinate the delivery of services funded by multiple payer sources. | X | | |
| Recommend job modifications and accommodations to the employer. | X | | |
| Procure extra-contractual coverage/agreement. | X | | |
| Facilitate the implementation of advanced directives (e.g., health care proxy, consent to DNR order or living will). | X | | |
| Facilitate patient job development and placement. | X | | |
| **Monitoring/Evaluation:** | | | |
| Analyze the case management plan for cost effectiveness including feasibility of | X | | |
| Maintain ongoing communication with key stakeholders (providers, payers, employers, family, and significant others). | X | | |
| Consult with other resources in and outside VA system as needed. | X | | |
| Conduct ongoing interviews and evaluations with patients and other members of the health care team (e.g., providers, RN's, SW's, therapists and other stakeholders including employer and insurers). | X | | |
| Monitor the patient's progress in achieving the goals, objectives and expected outcomes of the case management plan at specified time frames (e.g., direct observation, interviews, record reviews) | X | | |
| Document the patient's progress in achieving the goals, objectives, and expected outcomes of the case management plan. | X | | |
| Organize resources and integrate the delivery of health care services (e.g., arrange home health, necessary DME). | X | | |
| Monitor disease management activities. | X | | |

| Function | Both | RN | SW |
|---|---|---|---|
| Appeal service denials. | X | | |
| Communicate the patient's progress in achieving the goals, objectives, and expected outcomes of the case management plan to key stakeholders (e.g., providers, payers, employers, family, and significant others). | X | | |
| Evaluate the effectiveness of the case management plan as it relates to the identified | X | | |
| Evaluate and document the individual's use of and/or response to therapeutic interventions (e.g., medications, treatment modalities, specialized services, and DME). | X | | |
| Document the patient's response to case management plan. | X | | |
| Review and as needed, modify the delivery of health care services (e.g., arrange home health, DME). | X | | |
| Evaluate the timeliness, availability and access of treatments and services (e.g., variance management). | X | | |
| Bring the case manager – patient relationship to closure. | X | | |
| Determine that case management services are no longer required by the | X | | |
| Communicate the need to terminate case management services to the patient and family. | X | | |
| Evaluate the impact of multicultural issues and health behaviors on the patient's health status and outcomes. | X | | |
| Collect and analyze outcome data (e.g., clinical, financial, variance, quality/quality of life, patient satisfaction) systematically on an ongoing basis. | X | | |
| Prepare and communicate termination of service notification to identified stakeholders (providers and payers). | X | | |
| Prepare reports in compliance with Federal, state, and local regulatory requirements. | X | | |
| Hold a "case closing" conference/meeting with the patient, family, and necessary health care team members. | X | | |
| Examine the effectiveness of case management interventions on the patient's health outcomes. | X | | |
| Evaluate actual patient outcomes in relation to expected outcomes. | X | | |
| Generate a patient summary report for key stakeholders (e.g., provider, payers and employers) | X | | |
| **Outcome Evaluation of Program/Population:** | | | |
| Perform a cost benefit analysis to demonstrate the value (return on investment) of case management services. | X | | |
| Collect and analyze outcomes data (e.g., clinical, financial, variance, quality/quantity of life, patient satisfaction) systematically on an ongoing basis. | X | | |
| Track and trend administrative activities (e.g., report timeliness; quality of service; timeliness of service; workload, quality of service). | X | | |
| Generate and review reports about key outcomes measures (e.g., number of cases opened, number of cases closed). | X | | |
| Review reports about key outcome measures (e.g., number of cases opened, number of cases closed). | X | | |

## REGISTERED NURSE AND SOCIAL WORKER CASE MANAGEMENT CORE COMPETENCIES

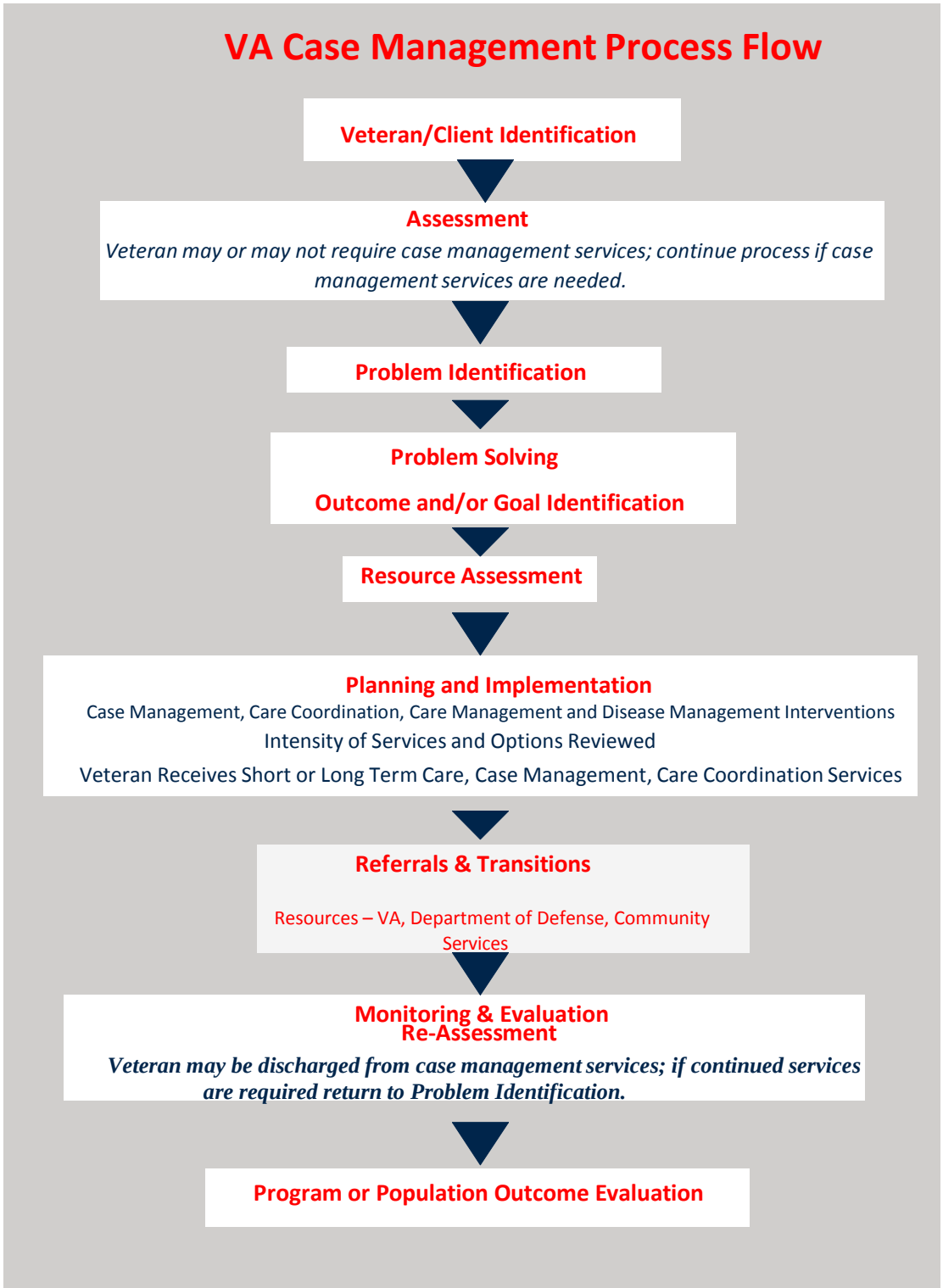
| | RN Lev 2 | RN Lev 3 | Soc. Work |
|---|---|---|---|
| Utilizes population data to identify patients with chronic diseases/conditions and psychosocial needs | x | x | x |
| Receives and processes referral for case management | x | x | x |
| Ability to conduct a comprehensive case management assessment within scope of practice | x | x | x |
| Assesses complexity of care needs and potential/actual Issues | x | x | x |
| Formulates and documents case management plan of care with measurable goals/objectives | x | x | x |
| Identifies VA and/or community resources matched to needs | x | x | x |
| Coordinates care across the continuum, across time, and across systems | x | x | x |
| Secures the most appropriate level, access, and location of care for patient | x | x | x |
| Ensures seamless transitions in care | x | x | x |
| Establishes relationship with patient's caregiver, if any | x | x | x |
| Advocates for patients and caregivers | x | x | x |
| Identifies and intervenes for actual or potential crisis, exacerbations | x | x | x |
| Initiates referrals for other disciplines as needed | x | x | x |
| Identifies the most appropriate level of home telehealth technology needed | x | x | x |
| Ability to identify gaps in services and to develop/utilize resources to fill gaps | x | x | x |
| Teaches patient/caregiver health promotion, prevention, and self management skills | x | x | x |
| Teaches patient/caregiver about psychosocial self-care and available resources | x | x | x |
| Supports the provider/patient relationship and plan of care | x | x | x |
| Utilizes effective approaches for monitoring and managing patient adherence issues | x | x | x |
| Consistently performs medication reconciliation | x | x | x |
| Utilizes evidence-based practice guidelines to guide care | x | x | x |
| Leads interprofessional teams to coordinate care | | x | x |
| Intervenes appropriately for any identified abuse/neglect | x | x | x |
| Utilizes an array of effective communication, coaching, and interviewing methods | x | x | x |
| Utilizes methods such as behavior modification and motivational interviewing | | | |
| Demonstrates skill in conflict resolution | x | x | x |
| Demonstrates knowledge or legal and regulatory information (VA eligibility, guardianship process, insurance rules, abuse/neglect etc.) | x | x | x |
| Interprets dissonance between patient's financial or interpersonal needs and resources | x | x | x |
| Collaborates with other VA or community agents to coordinate care | x | x | x |
| Follows-up on referrals, lab/test results | x | x | x |
| Monitors individual and aggregate indicators of quality | x | x | x |
| Monitors utilization of care and access to care | x | x | x |
| Documents plan of care, progress, outcomes, interventions | x | x | x |
| Works with interprofessional team to address and resolve patterns in aggregate variances in outcome with negative impact on quality/cost/access | x | x | x |
| Leads interprofessional teen, to address and resolve patterns in aggregate variances in outcome with negative impact on quality/cost/access | | x | x |
| Identifies opportunities and systems to improve outcomes of care | | x | x |
| Demonstrates effective interprofessional collaboration | x | x | x |
| Demonstrates proficiency in use of health information systems and technologies | x | x | x |

| | | | |
|---|---|---|---|
| Demonstrates skill in telephone care management | x | x | x |
| Demonstrates skill in deployment, algorithm selection, utilization, troubleshooting, monitoring, data management of home telehealth technologies | x | x | x |
| Demonstrates knowledge of vocational assessment and referral for vocational aspects of chronic illness and disability | | | x |
| Demonstrates knowledge and skills related to barrier-free architectural structures for disability | | | x |
| Demonstrates knowledge and skills related to work adjustment, transition and hardening | | | x |
| Demonstrates knowledge and skills related to job development and placement | | | x |
| Additional competencies specific to patient population served by the case manager | x | x | x |

## SOCIAL WORK CASE MANAGEMENT COMPETENCY REQUIREMENTS

| The competencies required to support the social work model of case management include but are not limited to the following (Additional competencies may be required for special populations): |
|---|
| Ability to conduct a comprehensive biopsychosocial assessment |
| Ability to assess mental status and psychopathology |
| Ability to provide individual, group, marital and family treatment interventions |
| Ability to educate patient and family regarding risk factors for optimal psychosocial functioning: community resources, wellness and health promotion |
| Ability to engage and mobilize patient and family coping strengths and community resources |
| Ability to work with a variety of professionals, agencies, and systems |
| Ability to educate professional staff and community providers regarding psychosocial factors and family dynamics impacting response to treatment |
| Ability to communicate and negotiate with all levels of the organization and community with documented information and recommended solutions |
| Ability to mobilize an array of community resources and services |
| Ability to identify gaps in community services and alternative resources |
| Ability to identify, coordinate, utilize and develop community resources |
| Knowledge of population characteristics to include cultural, ethnic and religious diversity |
| Knowledge of family dynamics |
| Knowledge and application of developmental theory and age specific issues |
| Knowledge about illnesses and medications and their psychosocial sequelae |
| Knowledge of current VA and non-VA entitlements and benefits |
| Skills in communication |
| Skills in advocacy |
| Skills in counseling to facilitate life changes |
| Skills in conflict management and mediation |

**DEPARTMENT OF VETERANS AFFAIRS**
**CASE MANAGEMENT PROCESS FLOW**



1. Each box of the diagram represents a standard of care or action step based on professional standards of practice. A case manager will be required to intervene with specific actions and varying degrees of frequency and intensity along the continuum of care based on the clinical and bio-psychosocial presentation of each individual Veteran. RN's and SWs will collaborate when both complex clinical and bio-psychosocial factors are identified that may place the Veteran at risk for decline. This diagram represents a circular flow of events versus a linear process.

a. Veterans **are identified** by self-referral, caregiver, family member, the PACT RN Care Manager, other VA and non-VA health care team members, VA clinicians and non-VA community-based clinicians, or health informatics portals. The Veteran or surrogate is asked to consent to case management services.

b. A comprehensive **assessment** of the Veteran, caregiver or family needs is documented and communicated in CPRS with the interdisciplinary team in collaboration with the Veteran, and as warranted with the family or family caregivers. ***NOTE:*** *Reassessment is required for patients previously referred for case management and for Veterans family or caregivers after services have been monitored and evaluated).*

c. Veteran, family and caregiver **problems and concerns are identified.**

d. **Problem solving** is initiated and the Veteran, family, and caregiver's desired or expected **goal(s) and outcome(s) are identified.**

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

f. **Planning and implementation** is accomplished through coordination, collaboration and communication with the multidisciplinary team including VA and non-VA providers, the Veteran and as warranted, the family or caregivers. The **intensity and duration of case management services** are dependent on care needs. The case manager ensures the Veteran, family, and caregiver needs are met and interdisciplinary team members are engaged with planning and implementation. The case manager assures available community resources are obtained to ensure the best Veteran, family, caregiver and organizational outcomes.

g. Timely access to the most appropriate level of care is ensured by coordinating comprehensive **referrals** and **transition** between VA, DoD, other Federal, state and local home and community based services.

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

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

## RESOURCES

### 1. WRITTEN MATERIAL

a. Longman, P., (2005) The Best Care Anywhere, Washington Monthly. Jan-Feb, 12.

b. Carr, D. Building collaborative partnerships in critical care: The RN Case Manager/Social Work Dyad in Critical Care, Professional Case Management; Vol 14, No. 3, 121-132 May/June 2009.

c. Case Management Society of America (2008) Core Curriculum for Case Management. Philadelphia, Lippincott.

d. Case Management Society of America and National Association of Social Workers. (October 2008) Case Management Caseload Concept Paper: Proceedings of the Caseload Work Group

e. Howe, R. & Greenburg, L. (2005) Performance measurement for case management: Principles and objectives for developing standard measures. The Case Manager, September-October, 52-56.

f. Vann, J. (2006) Measuring community-based case management performance. Lippincott's Case Management, 11(3), 157-157.

g. Huber, D. and Craig, K. Acuity and Case Management; A Healthy Dose of Outcomes, Part I. Professional Case Management; 2007; Vol 12, No. 3, 132-146.

h. Huber, D. and Craig, K. Acuity and Case Management; A Healthy Dose of Outcomes, Part II. Professional Case Management; 2007; Vol 12, No. .4, 199-210.

i. Huber, D. and Craig, K. Acuity and Case Management; A Healthy Dose of Outcomes, Part III. Professional Case Management; 2007; Vol 12, No. 5, 254-269.

j. Powell, S and Tahan, H. Case Management Society of America Core Curriculum for Case Management, 2nd edition. 2008, Lippincott Williams and Wilkens, Philadelphia.

k. Robbins, C and Birmingham, J. Issues and Interventions. Lippincott's Case Management; May-June 2005; Vol 10, No. 3, 120-127.

l. Tahan, H., Huber, D. and Downey, W. Case Managers' Roles and Functions. Lippincott's Case Management; January-February 2006; Vol 11, No 1, 4 – 21.

m. Courage After Fire: Coping Strategies for Returning Soldiers and Their Families by Keith Armstrong, et al, Ulysses Press, Berkeley, Calif., 2006.

n. Good Practice in Brain Injury Case Management. Parker, Jackie, ed., Jessica Kingsley Publishers, London and Philadelphia, 2006.

o. Hoge, C, et al: "Mental Health Problems After Deployment to Iraq or Afghanistan", Journal of the American Medical Association (JAMA), March 1, 2006, Vol 295, No 9.

p. Suris, A, et al: "Mental Health, Quality of Life, and Health Functioning in Women Veterans– Different Outcomes Associated with Military and Civilian Sexual Assault", Journal of Interpersonal Violence, February 2007, Vol 22, No 2.

q. Case Management Model Act. Retrieved from http://www.cmsa.org/portals/0/pdf/PublicPolicy/CMSA_Model_Act.pdf.

**2. GUIDES**

a. Explosions and Blast Injuries: A Primer for "Clinicians," Centers for Disease Control http://www.bt.cdc.gov/masscasualties/explosions.asp.

b. "Guide to Understanding The National Guard and Reserve Forces," September 2006 developed by the Department of Veterans Affairs (VA) Social Work Staffing and Clinical Practice Committee.

c. 'Military Facts for Non-Military Social Workers," http://www.mhawisconsin.org/Data/Sites/1/media/Veterans/military-facts-for-nonmilitary-social-workers.pdf.

d. "Our Hero Handbook A Guide for Families of Wounded Servicemembers," http://www.militaryhomefront.DOD.mil/portal/page/itc/MHF/MHF_DETAIL_1?section_id=20.40.500.393.0.0.0.0.0&current_id=20.40.500.393.500.180.0.0.0.

e. **TRICARE and VA Training Guide Web Site.**
http://vaww.vistau.med.va.gov/Documents/TRICARE/TRICARETrainingGuide_FC_022707.pdf
***NOTE:*** *This is an internal VA Web site and is not available to the public.*

f. **Veterans Health Initiatives (VHI) Web Sites.** Veterans Health Administration (VHA) Web sites, which include:

(1) Caring for War Wounded,

(2) Endemic Infectious Diseases of Southwest Asia,

(3) Health Effects from Chemical, Biological, and Radiological Weapons,

(4) Hearing Impairment,

(5) Military Sexual Trauma,

(6) Post-Traumatic Stress Disorder,

(7) Spinal Cord Injury,

(8) Traumatic Amputation and Prosthetics, and

(9) Traumatic Brain Injury.

(10) VA-Department of Defense Memorandum of Agreement Regarding Referral of Active Duty Military Personnel Who Sustain Spinal Cord Injury, Traumatic Brain Injury, or Blindness to Veterans Affairs Medical Facilities for Health Care and Rehabilitation Services found at: http://www.heartoftexas.va.gov/HEARTOFTEXAS/Docs/OEFOIF/VA_DOD_MOU.pdf.

## 3. VA KNOWLEDGE NETWORK EDUCATIONAL MATERIALS

Polytrauma Video or DVD (catalog # DXCLN-EES-J678) Seamless Transition Awareness Kit.

## 4. VIDEO

"The Price of Freedom: The Veteran's Experience." ***NOTE:*** *This video tape is located at VHA Central Office and every medical facility library.*

## 5. WEB SITES

a. **Family Assistance, Resources, and Lodging Web Sites.** Family Assistance, Resources, and Lodging Web sites, which include:

(1) http://www.cinchouse.com/ Support for wives in the military.

(2) http://www.fallenpatriotfund.org/qa.html Fallen Patriot Fund.

(3) http://fisherhouse.org/ Fisher House.

(4) http://www.militaryonesource.mil/ Military One Source.

(5) http://www.nmfa.org/site/PageServer?pagename=links#FamilyAssistance- Military Family assistance links.

b. **General Military and DOD Web sites.** General Military and DOD Web sites which include:

(1) http://www.afas.org Air Force Aid Society.

(2) http://www.army.mil/info/institution/ Army.

(3) http://www.defenselink.mil/admin/about.html .

(4) http://deploymenthealthlibrary.fhp.osd.mil/ .

(5) http://www.military.com/ Military (DOD).

(6) http://www.nmfa.org/site/PageServer?pagename=links#FamilyAssistance .

(7) http://www.tricare.org .

c. **Mental Health Web sites.** Mental Health Web sites, which include:

(1) http://www.va.gov/rcs/ Vet Centers.

(2) http://www.ncptsd.va.gov National Center for Post-traumatic Stress Disorder (PTSD).

(3) http://www.mentalhealth.gov

d. **Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) Web sites.** OEF, OIF, and OND Web sites include:

(1) http://www.militaryhomefront.DOD.mil/ Military Home.

(2) http://www.polytrauma.va.gov/downloads/VA_TBI_Toolkit_Brochure.pdf Polytrauma Facilities.

(3) http://www.queri.research.va.gov/ptbri/ Polytrauma and Blast-Related Injuries (PT BRI) QUERI.

(4) http://www.oefoif.va.gov/ Returning Servicemembers (OEF-OIF) internet site.

(5) http://oefoif.vssc.med.va.gov/Pages/home.aspx Returning Servicemembers (OEF-OIF) intranet site. ***NOTE:*** *This is an internal VA Web site and is not available to the public.*

e. **Traumatic Brain Injury (TBI) Education Web sites.** TBI education Web sites, which include:

(1) http://www.biausa.org Brain Injury Association of America.

(2) http://www.tbinrc.com/ National Resource Center for Traumatic Brain Injury

(3) http://www.pdhealth.mil/TBI.asp Deployment Health Clinical Center (TBI).

f. **VA Benefits Web site.** http://www.vba.va.gov/VBA/ .

g. **Vocational Rehabilitation and Independent Living Services Web site.** http://www.vetsuccess.gov/ .

h. **Burns**

(1) http://www.emedicine.com/med/topic3401.htm Emergency Medicine.

(2) http://www.ameriburn.org/ American Burn Association.

(3) http://www.burn-recovery.org Burn Recovery Center .

(4) http://www.burnsurvivor.com Burn Survivor Resource Center.

(5) http://www.burnsurvivorsttw.org/home.html Burn Survivors Throughout the World.

(6) http://www.phoenix-society.org/ Phoenix Society for Burn Survivors.

i. **Spinal Cord Injury (SCI)**

(1) http://www.paralysis.org Christopher and Dana Reeve Paralysis Resource.

(2) http://www.pva.org/ Paralyzed Veterans of America.

(3) http://www.unitedspinal.org/ United Spinal Association.

(4) http://www.spinalcord.uab.edu/ Spinal Cord Injury Information Network.

(5) http://www.spinalcordinjury.org/ Spinal Cord Injury Network International.

j. **Pain Management**

(1) http://www.asahq.org/ American Society of Anesthesiologists.

(2) http://www.aapainmanage.org/ American Academy of Pain Management.

k. **Amputation**

(1) http://www.amputee-coalition.org/ Amputee Coalition of America/National Limb Loss Information Center.

(2) http://www.amputeeresource.org/ Amputee Resource Foundation of America.

(3) http://www.nationalamputation.org/ National Amputation Foundation. Staffed by amputees.

(4) http://www.challengedathletes.org/ Challenged Athletes Foundation.

(5) http://www.oandp.com/organiza/uasa/index.htm United Amputee Service Association, Inc.

(6) http://www.netwellness.org/healthtopics/amputation/more.cfm?categoryid=9-11k Organizations and support group directories.

l. **Blind Resources**

(1) **Organizations**

(a) http://www.acvrep.org/ Academy for Certification of Vision Rehabilitation & Education Professionals.

(b) http://www.acb.org/ American Council of the Blind.

(c) http://www.afb.org/ The American Foundation for the Blind.

(d) http://www.afb.org National Accreditation Council for Agencies Serving People With Blindness or Visual Impairment.

(e) http://www.nfb.org/ National Federation of the Blind.

(f) http://www.blind.msstate.edu/ The Rehabilitation Research and Training Center on Blindness and Low Vision.

(2) **Products and Services for the Blind and Visually Impaired**

(a) http://www.accessiblemail.com/ Accessible Mail.

(b) http://www.aph.org/ American Printing House for the Blind.

(c) http://www.guidedogsofamerica.org/ Guide Dogs of America.

(d) http://www.guidedogs.com/ Guide Dogs for the Blind, Inc.

(e) http://www.guildfortheblind.org/ Guild for the Blind.

(f) http://www.internetspeech.com/ Internet Speech, Inc.

(g) http://blind.state.ia.us/assist/ Department for the Blind's Free Windows Tutorials.

(h) http://www.loc.gov/nls National Library Service (NLS) for the Blind and Physically Handicapped.

(i) http://www.veteranseyecare.com/ Veterans Eye Care.

(j) http://www.visionconnection.org/ Vision Connection.

(k) http://www.va.gov/blindrehab/ VA Blind Réhabilitation Service.

(l) http://www.va.gov/opa/speceven/tee/index.asp National Veterans TEE Tournament.

m. **Women Veteran's Health**

(1) http://www.publichealth.va.gov/womenshealth/ Women Veterans Health Program.

(2) http://www.va.gov/womenvet Center for Women Veterans.

(3) http://dacowits.defense.gov/ Defense Advisory Committee on Women in the Services.

(4) http://www.womenshealth.gov HHS Women's Health Web site.

n. **Toll-free Telephone Numbers**

(1) Veterans Benefits Administration: 1-800-827-1000.

(2) National Polytrauma Call Center: 1-888-827-4824.

(3) National Veterans Crisis Hotline: 1-800-273-8255.

(4) Caregiver Helpline: 1-855-260-3274.

(5) National Call Center for Homeless Veterans: 1-877-4AID VET (1-877-424-3838).