

INTEGRATED CASE MANAGEMENT STANDARDS OF PRACTICE

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) revised directive establishes a new policy that introduces integrated case management in the Department of Veterans Affairs (VA). The directive brings an innovative approach to VHA by making case management (CM) services coordinated, collaborative, and Veteran-centric throughout VHA. This VHA directive defines CM services within VHA and sets forth practice framework, standards, competencies, and training requirements for the two largest providers of CM, Nurses and Social Workers.

2. SUMMARY OF MAJOR CHANGES:

a. Revised definitions for care coordination, care management, and case management to align with basic, moderate, and complex Levels of Care Coordination terminology.

b. Addition of practice standards and staff responsibilities related to Care Coordination, Care Management, and Case Management activities.

c. Addition of resources related to caseload sizes, CM Process Flow, and case management certification.

d. Amendment dated May 18, 2020, includes:

(1) Addition of links to guidance on a phased approach to Care Coordination & Integrated Case Management (CC&ICM) model components.

(2) Update of VA Pulse links to VA SharePoint links.

3. RELATED ISSUES: VHA Directive 1010, Transition and Care Management of Ill or Injured Servicemembers and New Veterans, dated November 21, 2016; VHA Directive 1011, Department of Veterans Affairs Liaison for Healthcare Stationed at Military Treatment Facilities, dated January 27, 2017; VHA Directive 1110.02, Social Work Professional Practice, dated July 26, 2019; VHA Directive 1162.05(1), Housing and Urban Development Department of Veterans Affairs Supportive Housing Program, dated June 29, 2017; VHA Handbook 1172.01, Polytrauma System of Care, dated March 20, 2013.

4. RESPONSIBLE OFFICE: The Office of Care Management and Social Work (10P4C) is responsible for the contents of this directive. Questions may be referred to 202-461-6780.

5. RESCISSIONS: VHA Handbook 1110.04, Case Management Standards of Practice, dated May 20, 2013, is rescinded.

September 6, 2019

VHA DIRECTIVE 1110.04(1)

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of September 2024. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

**BY DIRECTION OF THE OFFICE OF
THE UNDER SECRETARY FOR HEALTH:**

/s/ Lucille B. Beck
Deputy Under Secretary for Health
for Policy and Services

NOTE: *All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.*

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INTEGRATED CASE MANAGEMENT STANDARDS OF PRACTICE

1. PURPOSE

This Veterans Health Administration (VHA) directive establishes the policy to ensure Veterans and Service members accessing care through VHA receive high quality, coordinated care that is delivered in a consistent manner, by a well-trained and responsive network of Case Managers. This VHA directive sets forth integrated case management standards and processes, establishes a formal structure for nursing and social work partnership, and describes how case management fits into a care coordination system. This directive also underscores that the Offices of Nursing Services (ONS) and Care Management and Social Work (CMSW) have a dual responsibility for case management (CM) service implementation at all levels of the organization. **AUTHORITY:** Title 38 United States Code (U.S.C.) §1706 and 1710.

2. BACKGROUND

a. VHA provides case management services to assist eligible Service members and Veterans, who have complex chronic care needs and socio-economic vulnerabilities, with system navigation, care coordination, and biopsychosocial rehabilitation. CM services are delivered within specific clinical programs and service areas, and eligibility is determined by population- and condition-based criteria. As a growing number of VHA-enrolled Veterans seek care in the community, it is vital that VHA strengthens and integrates its care coordination services and resources. Care coordination services, including case management, must be synchronized along the health care continuum wherein Veterans needs are stratified, per their complexity, across levels of care. This approach promotes optimal health outcomes and effective utilization of VHA resources.

b. In FY2016, the Offices of Care Management and Social Work and Nursing Services partnered and co-sponsored a CM initiative that aimed to define, transform, and integrate VHA case management. The initiative's work identified and expanded upon internal, program-specific, and private sector CM best practices as well as contextualized CM within a broader Levels of Care Coordination framework. The result of this nation-wide effort is a National Care Coordination & Integrated Case Management model (see paragraph 11, References). The model contains promising and best practices in the areas of care coordination and case management and is designed to keep pace with breakthroughs in these areas that emerge from continual process improvements.

3. DEFINITIONS

a. **Care Coordination.** Care coordination is a system-wide approach to the deliberate organization of all Veteran care activities between two or more participants or systems to facilitate the appropriate delivery of health care services. It can include, but is not limited to, care management and case management. Within the VHA level of care coordination framework, care coordination falls within the basic level.

b. **Care Management.** Care management is a population health approach to longitudinal care coordination focused on primary or secondary prevention of chronic disease and acute condition management. It applies a systems approach to collaboration and the linkage of Veterans, their families, and caregivers to needed services and resources. Care management manages and maintains oversight of a comprehensive plan for a specific cohort of Veterans. Within the VHA level of care coordination framework, care management falls within the moderate level.

c. **Case Management.** Case management (CM) is a proactive and collaborative population health approach to longitudinal care coordination focused on chronic disease and acute condition management. Case management includes systems collaboration and the linking of Veterans, families, and caregivers with needed services and resources, including wellness opportunities. Case management includes responsibility for the oversight and management of a comprehensive plan for Veterans with complex care needs. Within the VHA level of care coordination framework, case management falls within the complex level.

d. **Disease Management.** A system of coordinated health care interventions for defined Veteran patient populations with conditions where evidence-based, standardized self-care efforts can be implemented. Disease management empowers individuals, working with other health care providers, to manage their disease and prevent complications through secondary or tertiary prevention efforts.

e. **Electronic Health Record.** Electronic health record (EHR) is the digital collection of patient health information resulting from clinical patient care, medical testing, and other care-related activities. Authorized VA health care providers may access EHR to facilitate and document medical care. EHR comprises existing and forthcoming VA software including CPRS, VistA, and Cerner platforms. **NOTE:** *The purpose of this definition is to adopt a short, general term (EHR) to use in VHA national policy in place of software-specific terms while VA transitions platforms.*

f. **Integrated Case Management.** A specialized, collaborative practice among multiple interprofessional health care teams. Integrated Case Management (ICM) provides structure and standards to support collaboration throughout the continuum of care and optimal utilization of health care resources. Its focus is on program intersections, care transitions, and provider and patient match. ICM emphasizes the importance of patient stratification by acuity, risk, and intensity into an appropriate level of care coordination. Within the VHA Care Coordination & Integrated Case Management (CC&ICM) framework, ICM services correspond with a complex level of care coordination. Because of this, ICM services are higher in intensity and frequency, and delivered to Veterans with greater complexity, as compared with basic and moderate levels of care coordination. A comprehensive description of the CC&ICM framework is contained within the CC&ICM Portal on VA SharePoint and is beyond the scope of this directive. **NOTE:** *See the Care Coordination and Integrated Case Management Portal on VA SharePoint:*

https://dvagov.sharepoint.com/sites/VHACMSWS/CMI_Taskforce/ICM_Toolkit/Governance

[nceCouncil/Communications](#). This is an internal VA website that is not available to the public. Key components of the CC&ICM model are:

(1) **CC&ICM Co-Champions.** CC&ICM Co-champions are care coordination, care management, or case management leaders (i.e., one Nurse and Social Worker) who are appointed by VA medical facility Executive Leadership and have expertise in coordinated care. CC&ICM Co-Champions serve as the integration liaison(s) between Executive Leadership and CM staff. Their role includes but is not limited to:

- (a) Facilitating CM staff access to CM training and education.
- (b) Tracking performance metric reporting.
- (c) Monitoring quality of documentation and workload productivity.
- (d) Validating accuracy of coding and labor mapping (see paragraph 5.l).

NOTE: For implementation guidance related to CC&ICM Co-Champions, please see https://dvagov.sharepoint.com/sites/VHACMSWS/CMI_Taskforce/ICM_Toolkit/GovernanceCouncil/Communications/SitePages/Start-your-CC&ICM-Journey.aspx. This is an internal VA website that is not available to the public.

(2) **Care Coordination Review Team (CCRT).** CCRT is an interprofessional and inter-departmental team comprised of specialty CM program, primary care, and mental health staff with experience in care coordination that conducts high-level reviews of cases needing special attention. Veterans may be identified through self or provider referral, predictive analytics triggers, or screening/complexity tool. The CCRT assesses Veterans' clinical eligibility and utilizes mutually agreed upon stratification methodologies to determine the most appropriate care coordination level and Lead Coordinator (LC) recommendation. A transition of care or LC assignment is guided by the Veteran's predominant need and their location within the system. This information is applied to match the Veteran's acuity and complexity with the type and intensity of the intervention(s). **NOTE:** For implementation guidance related to Care Coordination Review Team, please see

https://dvagov.sharepoint.com/sites/VHACMSWS/CMI_Taskforce/ICM_Toolkit/GovernanceCouncil/Communications/SitePages/Start-your-CC&ICM-Journey.aspx. This is an internal VA website that is not available to the public.

(3) **Lead Coordinator.** A Lead Coordinator (LC) is a single, readily accessible, and clearly identifiable point of contact for a Service member or Veteran, their family and caregiver, and care team members. The LC has primary responsibility for ensuring the Veteran's care is coordinated across settings, services, and episodes of care, and the care plan is delivered as clinically indicated. While other care team members will provide direct services to the Veteran, having an LC who oversees care coordination and facilitates interprofessional team communication, reduces task and intervention duplication and improves the quality of care plan delivery. The LC role is a critical component of the CC&ICM framework (see paragraph 5.m.). Additionally, the LC role is an expansion of the joint DoD/VA Lead Coordinator Model for transitioning Post 9/11-

era Active Duty Service members to all service era Veterans. **NOTE:** See VHA Directive 1010, *Transition and Care Management of Ill or Injured Service members and New Veterans*, dated November 21, 2016, for further elaboration of the LC role. **NOTE:** For implementation guidance related to Lead Coordinator, please see https://dvagov.sharepoint.com/sites/VHACMSWS/CMI_Taskforce/ICM_Toolkit/GovernanceCouncil/Communications/SitePages/Start-your-CC&ICM-Journey.aspx. This is an internal VA website that is not available to the public.

g. **Self-Management**. Self-management is the ability to manage the mental and medical aspects as well as the functions, roles, and emotions associated with having an acute or chronic condition.

h. **Shared Decision Making**. Shared decision making is defined as a collaborative process that allows patients and their providers to make health care decisions together, taking into account the best scientific evidence available, as well as the Veteran's values and preferences.

i. **Stratification**. Within the health care setting, stratification is the process or result of separating and arranging patient populations into categorical groups (i.e., basic, moderate, complex) per specified criteria (i.e., acuity, risk, intensity). Veteran stratification is based on measures of key prognostic factors (i.e., clinical, psychosocial, timing) obtained by a validated evaluation instrument. Its purpose is to match the right patients to the right level of care coordination and improve health outcomes. **NOTE:** See paragraph 8 for elaboration of VHA's complexity and level of care coordination stratification methodology.

j. **Population Health**. Population health is the health outcomes of a group of individuals, including the distribution of such outcomes within the group. It is an approach to health care that aims to improve the wellness of an entire population.

k. **VHA Case Manager**. VHA Case Managers are specially trained clinical staff with expertise in case management (e.g., complex care coordination). Case Managers are required to follow CM standards of practice (paragraph 6) and CM processes (paragraph 7).

l. **Whole Health**. Whole health is personalized, proactive, integrative, Veteran-centric care that affirms the importance of the relationship and partnership between Veterans and their community of providers. The focus is on self-care strategies, integrative health coaching, appropriate therapeutic approaches, and the components of health and well-being.

4. POLICY

It is VHA policy that all Veterans and Service members accessing care through VHA will receive coordinated care. In addition, Veterans and Service members with complex care coordination needs will have access to CM services that follow evidence-based CM practice standards within an evidence-based CM model.

5. RESPONSIBILITIES

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

(1) CM services are integrated and implemented at every level of VHA in accordance with this directive.

(2) Care coordination is an enterprise-wide, corporate activity supported by all leaders and staff.

b. **Deputy Under Secretary for Health for Operations and Management.** The Deputy Under Secretary for Health for Operations and Management is responsible for:

(1) Communicating the contents of this directive to each Veterans Integrated Service Network (VISN).

(2) Ensuring that each VA medical facility Director has the sufficient resources to fulfill the terms of this directive in all VA medical facilities within their VISN.

(3) Providing oversight to VISNs to ensure compliance with this directive.

c. **Deputy Under Secretary for Health for Policy and Services.** The Deputy Under Secretary for Health for Policy and Services is responsible for ensuring implementation of this directive and quality of case management across VA.

d. **Deputy Under Secretary for Health for Community Care.** The Deputy Under Secretary for Health for Community Care is responsible for ensuring implementation of standards of case management for care provided through community providers.

e. **Deputy Chief Patient Care Services Officer for Care Management and Social Work.** The Deputy Chief Patient Care Services Officer for Care Management and Social Work is responsible for:

(1) Designating a full-time master's prepared social worker or nurse within the Office of Care Management and Social Work to serve as the National Transition and Care Management Program Manager.

(2) Ensuring the implementation of integrated case management practice and process standards is a highly collaborative and coordinated effort with VHA program offices and specialty care management programs including but not limited to: the Office of Nursing Services, Office of Community Care, Office of Primary Care Services, Geriatrics and Extended Care, Office of Mental Health Services, Homeless Program Office, and other specialty case management programs (e.g., Polytrauma, VIST, SCI/D), and other VA Central Office service areas that are impacted by CM integration.

f. **National Transition and Care Management Program Manager.** The Office of Care Management and Social Work, National Transition and Care Management Program Manager is responsible for:

(1) Overseeing the development and implementation of Care Coordination and Integrated Case Management (CC&ICM) in conjunction with the Offices of Nursing and Community Care.

(2) Providing ongoing policy development and guidance as well as responding to internal and external inquiries.

g. **Office of Nursing Services.** The Office of Nursing Services is responsible for ensuring the implementation of the CC&ICM framework is a highly collaborative and coordinated effort with VHA program offices and specialty case management programs including, but not limited to: Office of Care Management and Social Work, Office of Community Care, Office of Primary Care Services, Geriatrics and Extended Care, Office of Mental Health Services, Homeless Program Office and all other specialty case management programs (e.g., Polytrauma, VIST, Spinal Cord Injury/Disorder (SCI/D)), and other VA Central Office service areas that are impacted by CM integration.

h. **Veterans Integrated Service Network Director.** Each VISN Director is responsible for ensuring that all VA medical facilities within the VISN comply with this directive.

i. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Ensuring that the appropriate level of care coordination services is available to all transitioning Service members and Veterans that meet clinical eligibility criteria for that level of coordinated care, according to paragraph 7 of this directive.

(2) Authorizing a VA medical facility executive (e.g., Nursing/Social Work Chief, Assistant Chief, or Executive) to serve as the CC&ICM Sponsor, who in turn authorizes the assignment of a social worker and nurse, with expertise in levels of coordinated care, to co-lead the establishment of an integrated framework and its ongoing operations.

(3) Implementing a level of care coordination stratification methodology to ensure effective use of VA medical facility level care coordination resources, according to paragraph 8 of this directive.

(4) Maintaining adequate staffing levels to safely and appropriately provide the necessary CM services for Veterans with complex level of care coordination needs.

(5) Ensuring health informatics resources are made available to support ongoing data collection and analyses of CM across the Health Care System (HCS), and CM metrics are monitored.

NOTE: For implementation guidance related to CC&ICM responsibilities, please see

https://dvagov.sharepoint.com/sites/VHACMSWS/CMI_Taskforce/ICM_Toolkit/GovernanceCouncil/Communications/SitePages/Start-your-CC&ICM-Journey.aspx. This is an internal VA website that is not available to the public.

j. **VA Associate Director of Patient Care Services.** The Associate Director for Patient Care Service or Nurse Executive in every VA medical facility is responsible for overseeing the professional practice of nursing provided by all nursing staff employed by the VA medical facility.

k. **VA Medical Facility Care Coordination and Integrated Case Management Sponsor.** The VA medical facility Executive Leadership member (e.g., Associate Director for Patient Care Services (ADPCS), Chief of Social Work, or Executive, Chief of Staff) who will serve as the VA medical facility CC&ICM Sponsor is responsible for:

(1) Assigning Nurse and Social Worker CC&ICM Co-Champions to implement CC&ICM framework and serve as ongoing subject matter experts on coordinated care.

(2) Advocating to their service line or department supervisor that CC&ICM Co-Champions have the necessary resources and time allotted to achieve CC&ICM initiative goals.

(3) Ensuring effective communication and collaboration exists among VA medical facility care coordination, care management, and CM service areas and programs (e.g., Patient Aligned Care Team (PACT), Specialty Care), Geriatrics and Extended Care (GEC), Mental Health, and Home Telehealth) through:

(a) Sharing basic CM clinical eligibility criteria across programs and services to ensure Veterans' equal access to, and safe transitions of, care between and from CM service, as defined by this directive.

(b) Ensuring regularly scheduled CCRT are held monthly, at minimum.

(c) Ensuring Lead Coordinator assignment via the CCRT is acknowledged, accepted, and executed by the program/service supervisor.

NOTE: For implementation guidance related to CC&ICM Sponsor, please see https://dvagov.sharepoint.com/sites/VHACMSWS/CMI_Taskforce/ICM_Toolkit/GovernanceCouncil/Communications/SitePages/Start-your-CC&ICM-Journey.aspx. This is an internal VA website that is not available to the public.

l. **VA Medical Facility Care Coordination & Integrated Case Management Co-Champions.** The VA Medical Facility CC&ICM Co-Champions are responsible for:

(1) Serving as consultants and subject matter experts on CM practice, including keeping abreast of VA policies, laws, and regulations that affect CM delivery to Veterans, their families, and caregivers.

(2) Coordinating and collaborating with the VA medical facility level Sponsor(s), care coordination, care management, and CM service area and program leads.

(3) Collaborating with internal stakeholders to assess CM composition, structure, and services to identify promising practices and gaps in CM services and identifying opportunities to enhance communication, collaboration, and coordination across the care continuum.

(4) Facilitating the completion of a Readiness Assessment located at: <https://dvagov.sharepoint.com/:x:/r/sites/VHACMSWS/CMITaskforce/ICMToolkit/GovernanceCouncil/Communications/layouts/15/Doc.aspx?sourcedoc=%7BE42CAD9B-14CC-43EA-A3BD-8836312B3E3D%7D&file=CC&ICM%20Readiness%20Assessment.xlsx=&action=default&mobileredirect=true&DefaultItemOpen=1> for the purpose of identifying VA medical facility strengths and gaps in CM services. The tool is designed to foster communication and information sharing among key stakeholders and reveal opportunities for improvements across the care coordination continuum. **NOTE:** *This is an internal VA website that is not available to the public.*

(5) Ensuring a CCRT is in place to facilitate safe transitions of care from one level of care coordination or setting to another and with the appropriate assignment of staff as LC.

(6) Establishing collaborative relationships with all clinical disciplines and all support staff to foster a culture wherein care coordination is the responsibility of all staff.

(7) Developing procedures and processes to support cost effective, high quality CM across the VA medical facility to eliminate duplication of services where appropriate.

(8) Serving as a VA medical facility consultant regarding quality assurance pertinent to monitoring CM performance measure and meeting CM performance metrics.

(9) Contributing to the community of practice across VHA through use of a data-driven quality improvement approach to CM practice with established goals and outcomes to evaluate and document CM effectiveness.

(10) Identifying and monitoring CM metrics in collaboration with health informatics and preparing program and performance metric reports for VA medical facility leadership on a quarterly basis.

(11) Facilitating and coordinating trainings on nationally recognized CM standards of practice to ensure delivery of professional CM services across the health care continuum in accordance with paragraph 6 in this directive.

(12) Researching community resources (i.e., local, State, and national) available to provide continuity of care and to enhance the quality of life for the Service member or Veteran and disseminating this information annually to Care Coordinators, Care Managers, and Case Managers within the VA medical facility.

(13) Establishing and maintaining contact with other CC&ICM Champions to ensure sharing of best practices and promote standards of practice across VHA.

NOTE: For implementation guidance related to CC&ICM Co-Champions, please see https://dvagov.sharepoint.com/sites/VHACMSWS/CMI_Taskforce/ICM_Toolkit/GovernanceCouncil/Communications/SitePages/Start-your-CC&ICM-Journey.aspx. This is an internal VA website that is not available to the public.

m. **Lead Coordinator.** The LC is a role that can be fulfilled by Care Coordinators, Care Managers, or Case Managers. Case Managers who serve as Lead Coordinators are responsible for:

(1) Providing responsive, integrated care coordination to Service members and Veterans in collaboration and coordination with other care team members who also provide services directly to them. The LC responsibilities include but are not limited to: serving as the primary point of contact and facilitating an exchange of information among care team members, implementing care plans in collaboration with care team members; delivering evidence-based practice interventions, and monitoring Veterans health outcomes and effectiveness of interventions delivered by an interprofessional team. Frequency of monitoring is determined by clinical need and the Veteran's preference.

(2) Communicating with the Service member or Veteran, their family member, or caregiver on an ongoing basis and providing them with contact information for other members of the care team. Documenting all communication utilizing recommended VHA CM templated notes and codes to ensure capture of health factors and Relative Value Units. Veterans' Comprehensive Care Plan functional status is quantified within LC documentation to indicate progress, no change, or decline.

(3) Facilitating the proper phasing of care, benefits, and services to establish, support, and maintain health goals.

(4) Referring or procuring indicated services for the Service member or Veteran, family, or caregiver and ensuring that follow-up communication is documented in the Electronic Health Record. **NOTE:** When assisting VA Community Care with coordinating care for Veterans outside VHA, the Case Manager LC will rely upon the VA Community Care Coordinator to coordinate the technical and business aspects of community care. The LC role is to serve as the upfront point of contact for a Veteran and their family or caregiver who responds to requests for advocacy or information.

(5) Following both VHA CM Practice (paragraph 6) and Process (paragraph 7) standards.

NOTE: For implementation guidance related to Lead Coordinators, please see https://dvagov.sharepoint.com/sites/VHACMSWS/CMI_Taskforce/ICM_Toolkit/GovernanceCouncil/Communications/SitePages/Start-your-CC&ICM-Journey.aspx. This is an internal VA website that is not available to the public.

n. **Federal Recovery Consultant Office Consultants.** Federal Recovery Consultants (FRCs) serve in the role defined for Joint Recovery Consultants in the overarching 2014 VA/DoD Interagency Complex Care Coordination Memorandum of Understanding (MOU). FRCs have agreed to:

(1) Provide enterprise-level consultation and assistance to VA and DoD LC and Care Management Teams (CMTs).

(2) Provide clinical and non-clinical assistance and advice about DoD, VA, other Federal agencies, community, and other resources available to support the Service member or Veteran and the family or caregiver.

6. VHA STANDARDS OF PRACTICE FOR CASE MANAGERS

VHA Case Management standards of practice equip VHA Case Managers with the ability to respond both effectively and consistently to the whole health care needs of Veterans, regardless of discipline, program specialty, or care setting. VHA Case Manager standards are organized around key attributes of responsible practice: advocacy, accountability, professionalism, and facilitation, and each attribute is comprised of and further defined by a specific set of standards. VHA Case Managers are responsible for emulating the attributes and meeting the standards outlined herein as well as the associated CM tasks outlined in the paragraph 7, VHA Case Management Process Standards.

a. **Advocacy.** Case Managers will support and promote the rights, interests, and decisions of Service members and Veterans with individuals, groups, and institutional systems to: protect and advance their dignity, autonomy, wishes, and whole health; remove barriers to care; lend voice to diversity and multicultural concerns and challenges; and seek out new services, resources, and opportunities for growth and well-being.

(1) **Self Determination.** Case Managers will, to the maximum extent possible, support Veterans' autonomy and right to be involved in the shared decision making and determination of their own plan of care to include provision of and education on Living Wills and Advance Directives. **NOTE:** See VHA Handbook 1004.02, *Advanced Care Planning and Management of Advance Directives*, dated December 24, 2013. Case Managers recognize and respect Veterans' lifestyle choices and behaviors that conflict with professional recommendations or Veterans' health and wellness goals. There are circumstances, however, when Case Managers must counsel, strongly advise, and even redirect Veterans when Veteran decisions or actions compromise their own safety or the safety of others.

(2) **Safety.** Case Managers will, to the extent possible, help ensure a Veterans' well-being, rights, and decisions within all domains of living (physical, emotional, environmental, financial, intellectual, occupational, social, and spiritual) are free of influence, exploitation, or coercion by other individuals that may include: health and non-health care professionals, friends, family, or caregivers. Case Managers will obtain

all required safety training, including training related to suicide risk reduction and working safely with high-risk Veterans, in all settings (see paragraph 9, Training and Competency Requirements). Case Managers will adhere to local and national VHA policies and procedures related to management of high-risk safety issues. **NOTE:** See *VHA Directive 1071, Mandatory Suicide Risk and Intervention Training for VHA Employees, dated December 22, 2017*. Case Managers will follow their discipline's and VHA reporting requirements on abuse and neglect to include intimate partner violence. **NOTE:** See *VHA Directive 1199, Reporting Case of Abuse and Neglect, dated November 28, 2017*.

(3) **Multi-Culturalism and Diversity.** Case Managers will work respectfully and inclusively with all Veterans regardless of their demographics or backgrounds, as well as incorporate such multi-various factors and sensitivities into all assessment and care plan interviews and documentation. Case Managers must display and promote tolerance for cultural differences and diversity within all VHA settings.

b. **Professionalism.** Case Managers will carry out all duties expected, per their assigned service or program role and functional statement, with technical proficiency and integrity to instill Veteran confidence, trust, and credibility in both case management and VA. Professionalism aligns competency and practice with the mission of the organization. In VHA, professionalism specifically encompasses:

(1) **Ethical Conduct.** Case Manager practice and behavior will be in accordance with their discipline's specific code of ethics and VHA ideals, codes, and standards. Case Managers should act with beneficence, demonstrate truthfulness and non-maleficence, and maintain appropriate boundaries with both Veterans and colleagues. **NOTE:** To identify a staff member from the Integrated Ethics program who can address health care ethics questions or concerns, please go to the National Center for Ethics in Health Care's website at: <https://vaww.ethics.va.gov>. This is an internal VA website that is not available to the public.

(2) **Education.** VHA Case Managers, and clinical staff functioning as Case Managers, are encouraged to participate in ongoing training and professional development to build and maintain CM competencies, including evidence-based practices that promote positive health outcomes and cost-effective care, including, but not limited to motivational interviewing, cognitive behavioral therapy, and health coaching. **NOTE:** See the CC&ICM Portal on VA SharePoint: (https://dvagov.sharepoint.com/sites/VHACMSWS/CMI_Taskforce/ICM_Toolkit/GovernanceCouncil/Communications) for specifics on VA Social Work and Registered Nurse Case Manager Competencies and Functions. This is an internal VA website that is not available to the public.

c. **Accountability.** Case Managers will demonstrate shared accountability that is intrinsic to collaborative practice and follow through on commitments made to Veterans, their families and caregivers, and interprofessional teams. Case Managers must work within their scope of practice and abide by all applicable Federal, State, and local laws

and regulations, which have full force and effect of law. In VHA, accountability specifically encompasses:

(1) **Privacy and Confidentiality.** Case Managers will safeguard Veteran personal health information by complying with all Federal, State, and local laws and regulations as well as VHA Directive 1067, Confidential Communications, dated November 10, 2015, and VHA Directive 1605.01, Privacy and Release of Information, dated August 31, 2016, and procedures governing patient privacy and confidentiality.

(2) **Documentation and Coding.** Case Managers will document all information in a Veteran's electronic health record (EHR) or any VHA-approved EHR within 48 hours, in accordance with VHA Handbook 1907.01, Health Information Management and Health Records, dated March 19, 2015. Documentation is the key means of communication amongst the health care team, and hence, Case Managers must write clearly, logically, and with proper use of VHA acronyms. The Veteran Health Information Exchange (VHIE) technology is available to VHA staff through EHR and Joint Legacy Viewer (JLV) for viewing community health data on their Veteran patients to support case management (<https://www.va.gov/vler/>). **NOTE:** For further elaboration of CM documentation and coding requirements, see Appendix B.

d. **Facilitation.** Case Managers will establish rapport and build and maintain therapeutic relationships with Veterans to foster trust and engage them in care and empower and equip them in self-care and self-management with the goal of improving positive health and wellness outcomes. Case Managers will utilize facilitation throughout the process of working with the Veteran to organize, streamline, and expedite service delivery. In VHA care, facilitation specifically encompasses:

(1) **Case Management Process.** Case Managers will follow the professionally recognized and VHA-adopted framework for evidence-based case management (CM) practices, with a sequential set of steps and associated tasks that include: identification, screening, assessment, care planning, implementation, monitoring, care transitions, and program and outcome evaluation. Case Managers will document completion of these steps in the Veteran's EHR.

(2) **Communication, Collaboration, Coordination.**

(a) Case Managers will facilitate proactive, patient-centric communication and information sharing between the Veteran or Service member, their family or caregiver, providers, and other care team members, to enhance awareness and clarity, reduce misunderstandings, increase process efficiencies, and improve care plan efficacy.

(b) Case Managers will facilitate collaboration amongst Veterans, their family or caregiver, providers, and other care team members to engage in shared decision making, and develop a safe, integrated and whole health care plan that considers the best scientific evidence available as well as the Veteran's values and preferences.

(c) Case Managers will facilitate the coordination of care by developing integrated, well-sequenced care plans, assisting Veterans with system navigation, and linking them

in a timely manner, to needed health, mental health, health education, self-management and social services, community-based resources, or benefits, as clinically indicated.

(3) **Therapeutic Engagement.** VHA Case Managers will engage, develop, and maintain therapeutic relationships with both the Veteran, families, and caregivers, utilizing resiliency-based, recovery-oriented, Veteran-centered communication and practice techniques (e.g., Health Education, Health Coaching, Shared Decision Making, Motivational Interviewing, Solution Focused Work, Psychosocial Problem Solving, Strength-Based work) to facilitate progress, growth, and positive lifestyle changes.

NOTE: *VHA CM Standards of Practice ensure Veterans' experience of CM is reliable and synchronized within and across health care systems. VHA CM standards are based on the Case Management Society of America 2016 Standards of Practice (<http://solutions.cmsa.org/acton/media/10442/standards-of-practice-for-case-management>), American Case Management Association Standards of Practice and Scope of Services (2013) (https://www.acmaweb.org/forms/Case_Management_SoP_SoS.pdf), and National Association of Social Work Standards for Social Work Case Management Practice (2013) (<https://www.socialworkers.org/LinkClick.aspx?fileticket=acrzqmEfhlo%3D&portalid=0>). These linked documents are outside of VA control and may not be conformant with Section 508 of the Rehabilitation Act of 1973. The aforementioned professional organizations' standards align well with VHA mission, values, and evolving priorities. VHA standards are an amalgamation of those standards most consistent, agreed upon by the three CM professional organizations, and are organized around key attributes of responsible practice: advocacy, accountability, professionalism, and facilitation.*

7. VHA CASE MANAGEMENT PROCESS STANDARDS

a. The CM process represents the steps and tasks associated with the functions of a Case Manager. VHA's framework depicts the overall patient/provider process flow to ensure the delivery of comprehensive, timely, high-quality services is aligned with professional expectations and practice standards. To fulfill the VHA Case Manager functions, a Case Manager must be able to demonstrate competency with associated professional responsibilities and tasks in their clinical documentation, per note content and coding (see Appendix B for further details). Each step in the process builds upon the previous step and benefits the Veteran, their family and caregiver, and employee experience when consistently performed within and without VHA. **NOTE:** *It is for VA medical facility leadership to determine the manner in which standardization occurs per size, complexity, alignment, and resources of their health care system.*

b. The CM process is dependent on patient progress and thus is cyclical and not linear in nature, and previous steps and actions may need to be revisited. The major goal of the CM process is to increase Veteran autonomy and decrease the long-term dependence on the Case Manager. **NOTE:** *VHA's CM process is adapted from the*

Case Management Society of America's (CMSA, 2016) Standards of Practice guidelines.

c. The steps and tasks within VHA's CM Framework are:

(1) **Early Identification.** Veterans are identified for the potential need for case management through self-referral, referral from a family member or caregiver, referral through PACT or other VHA staff such as Transition and Care Management (TCM), referral from VA Liaisons for Health Care, referral through other government (DoD Military Treatment Case Manager/Lead Coordinator, Federal Recovery Consultant), and referrals from community agencies. The goal is to identify Veterans in need of CM services as early as possible and develop a mechanism/procedure that facilitates the process (e.g., electronic health record (EHR) Clinical Reminder or Templated Note triggered consults, VHA Support Service Center, and other health system portals).

(2) **Screening for Clinical Eligibility Criteria.** Veterans are screened for clinical eligibility criteria for CM services. The use of a standardized level of care coordination tool ensures there is consistency amongst providers, patient stratification, and validity of scoring. Veterans found not to require the frequency and intensity of CM services are recommended for either care management or care coordination services through PACT or another clinical area.

(3) **Case Manager Assignment.** Following a thorough screening of needs, qualifying Veterans identified as appropriate for CM will be offered CM services from a Nurse or Social Work Case Manager within a care setting or program (e.g., PACT, Mental Health, Specialty CM Program (e.g., Polytrauma, Housing and Urban Development Department of Veterans Affairs Supportive Housing (HUD-VASH), TCM), Geriatrics & Extended Care, Home Telehealth, VHA Community Care) per the predominate need of Veteran and their location within the system. For Veterans with a complex level of care coordination need, more than one Case Manager may be involved in care planning and service delivery. In these instances, assignment of a Lead Coordinator (LC) is recommended to coordinate CM service delivery, as well as reduce confusion, fragmentation, and unnecessary duplication. **NOTE:** *A close, collaborative relationship between multiple Social Work and Nursing Case Managers provides the most comprehensive approach to CM services.* Such a consultative relationship minimizes unnecessary handoffs to ensure that all the Veteran's bio-psychosocial needs are met with the least interruption.

(4) **Informed Consent.** As a best practice, Case Managers should obtain a Veteran's authorization for CM services as part of the case initiation process. To ensure the Veteran is appropriately informed, the CM must provide a clear definition of CM and its process including: purpose, roles, and responsibilities (of both Veteran and Case Manager), benefits, and risks. If the Veteran, or surrogate, agrees to CM services, it is best practice for the Case Manager to indicate that the CM process is a collaborative one because without collaboration, the ability to provide some services may be challenging.

(5) **Comprehensive Assessment.** A Case Manager completes a comprehensive assessment of the Veteran's needs and goals. The assessment and subsequent reassessments are created in collaboration with the Veteran, their family or caregiver, and interprofessional team, as clinically indicated. Assessments are documented in the EHR and include, but are not limited to, the following elements: military history, social supports, housing, transportation, education and employment, income and finances, and care plan. **NOTE:** See national note template titled, "Social Work Comprehensive Assessment" in EHR. Following the initial comprehensive assessment, reassessment is required at each subsequent contact as part of the monitoring and evaluation process.

(6) **Need Identification.** The key concerns, needs, and preferences of the Veteran and their family or caregiver are identified. This information is used to determine the most appropriate CM intervention(s).

(7) **Problem Solving and Goal(s) Identification.** Problem solving is initiated, and the Veteran and Veteran's family or caregiver's desired or expected goal(s) and outcome(s) are recognized, organized, and prioritized through a brokered process between the Veteran, family or caregiver, and Case Manager. This negotiation ensures goals and objectives are not only agreed upon, but also specific, measurable, action-oriented, realistic, and timebound.

(8) **Resource Assessment.** A resource assessment is completed to identify available assistive options and appropriate services and benefits. **NOTE:** From the strength-based perspective, consideration of previous successes, existing natural supports, and internal skills and coping mechanisms is primary.

(9) **Planning and Implementation.** Planning and implementation are accomplished through coordination, collaboration, and communication with the interprofessional team including: The Veteran, the family or caregivers, and VHA and community providers. The intensity and duration of CM services are dependent on the Veteran's care needs. Available natural and community resources (e.g., decision aids, self-care and self-management support programming) are obtained to ensure the best Veteran, family, caregiver, and organizational outcomes. All elements combine to comprise the Veteran's Care Plan.

(10) **Referrals and Transition.** Access to the appropriate level of care is ensured by coordinating effective and timely referrals, transitioning the Veteran to VHA, DOD, other Federal, State, and local home and community-based services. Timeliness varies and is dependent on what is considered clinically indicated. Case Managers provide referrals to various service resources along a continuum of care to restore or maintain Veterans independent functioning fully possible. Case Managers manage the delivery of an array of labor-intensive services to meet the needs of target populations.

(11) **Monitoring and Evaluation.** Monitoring and evaluation of the care plan is critical to ensure the right care, at the right time, in the right place, at the right cost, is continuous and coordinated each time. Reassessment is necessary to ensure that intervention and CM services are appropriate, effective, timely, efficient, evidence-

based and equitable, promote safety, and are agreed upon by the Veteran or health care decision maker.

(12) **Program and Outcome Evaluation.** Case Managers will use CM best practice processes, procedures, tools, and templates in their work to allow for better tracking, monitoring, and reporting of quality and performance metrics. Program evaluation and reporting allows for continuous performance improvement to ensure a high quality and sustainable CM program. **NOTE:** See Appendix B for more information on performance metrics.

8. VHA LEVELS OF CARE COORDINATION STRATIFICATION

a. **Stratification Methodology.** To ensure patients are consistently receiving the right care, at the right time and in the right place, a validated stratification methodology—wherein a Veteran’s capacity to self-manage (complexity) is evaluated and matched with an associated service—requires the current care facilitation services (i.e., care coordination, care management, and CM) to align along a seamless continuum based on a measurable denominator common to all—the activity of care coordination. **NOTE:** See paragraph 3 for the conceptual definition of stratification.

b. **Levels of Care Coordination.** VHA’s facilitation services of care coordination, care management, and CM will respectively be delineated and defined by the type and intensity of care coordination interventions provided from basic to moderate to complex. **NOTE:** Within complex care coordination, Case Managers will need to further stratify their patients into tiers of case management that clarify the intensity of interventions and the frequency contact. The three VHA levels of care coordination are:

(1) **Basic.** Basic level of care includes system navigation, information, and referral.

(2) **Moderate.** Moderate level of care includes basic care coordination, plus disease management and prevention, health promotion and education, and resource management. Moderate Care Management are typically provided by Care Managers or Specialty Care Coordinators (e.g., Cancer Care Coordinators).

(3) **Complex.** Complex (also known as Chronic) level of care includes moderate care coordination, plus biopsychosocial rehabilitation, which emphasizes coaching/mentoring and counseling/treatment aspects of the patient/clinician relationship. Complex/Chronic is provided by qualified, clinical staff with competencies in case management and who adhere to the case management practice and process standards.

NOTE: For implementation guidance related to Levels of Care Coordination, please see <https://dvagov.sharepoint.com/sites/VHACMSWS/CM/Taskforce/ICM/Toolkit/GovernanceCouncil/Communications/SitePages/Start-your-CC&ICM-Journey.aspx>. This is an internal VA website that is not available to the public.

c. **Tiers of Case Management (CM).**

(1) VHA CM Programs further stratify Veterans receiving complex care coordination into “tiers” or “levels” per the type of CM interventions (e.g., intensive, stabilization, progressive/maintenance, supportive) and corresponding “frequency of contact” (e.g., weekly, monthly, and quarterly) by the Case Manager. The nomenclature and interventions used to describe a tier or level of CM as well as the number of tiers or levels of CM varies across specialty CM Programs. The qualitative determination of CM level is based on a Case Manager’s or LC’s clinical judgment and is applied in conjunction with their respective program’s administrative requirements.

(2) As a Veteran’s level of complexity abates (i.e., biopsychosocial needs stabilize and ability to self-manage improves), it is anticipated that less intensive services and thus fewer contacts with the Case Manager/LC will be required with eventual graduation from CM services. It is also expected, however, that Veterans who have progressed in the continuum may experience significant life events, resulting in a return to a complex level of care coordination (i.e., case management tier). The CM tiers or levels include:

(a) Intensive CM. Intensive CM requires at least weekly Veteran contact and family or caregiver contact, as appropriate, whenever there is transition of care or major change in the Veteran’s clinical, psychosocial, functional status, such as: a new diagnosis, newly identified cognitive and/or behavioral health change, notable change in lifestyle, and/or major access to care concerns. It entails maximum assistance with system navigation and biopsychosocial support from a Case Manager to regain stability.

(b) Stabilization CM. Stabilization CM requires at least two times per month Veteran contact and family or caregiver contact, as appropriate, to support the Veteran’s ability to gain stability following their transition of care or major change in their clinical, psychosocial, functional status. It entails moderate assistance with system navigation and biopsychosocial support from a Case Manager to maintain stability and progress.

(c) Progressive or Maintenance CM. Progressive or maintenance CM requires at least monthly Veteran contact and family or caregiver contact, as appropriate, to ensure a support system and plan of care 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. Moderate changes in functional status or level of natural supports or concerns with access to care could arise. Entails occasional assistance with system navigation and support from a Case Manager to maintain stability and progress.

(d) Supportive CM. Supportive CM requires, at a minimum, quarterly Veteran contact and family or caregiver contact, as appropriate, 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. Minor changes in functional status or level of natural supports and/or minor concerns with access to care may be observed. This entails only minimal assistance with system navigation and support from a Case Manager to maintain stability and progress.

(e) Transitions of Care (Admission/Transfer/Discharge). During transitions of care, Veterans may be discharged from care or transferred to a lower level of care coordination when specific clinical disposition criteria and CM process steps are satisfied. **NOTE:** *There are specific Veteran populations that may progress in treatment, but due to persistent, chronic, or serious mental health or medical issues, require additional clinical consideration prior to any transition to a lower frequency of contact/complexity rating or discharge from long-term CM services.*

(3) **Disposition.** Veteran can be transferred, graduated, or discharged when one of the following criteria is met:

(a) If the Veteran is deceased or becomes incarcerated.

(b) If the Veteran has shown ongoing stability over a cycle greater than 90 days and has accomplished care plan goals. **NOTE:** *Time frame may vary according to specialty CM Program.*

(c) If the Veteran prefers to no longer participate in the collaborative process, as evidenced by:

1. The Veteran's verbal or written request to withdraw from services or

2. The Case Manager's inability to contact the Veteran following outreach efforts and completion of the specialty CM Program's outreach protocol. **NOTE:** *Ensure that Case Managers follow any VISN or local policy on Veterans outreach for inability to contact.*

(4) **Process.** In addition to disposition criteria being met, Case Managers/LC, to fully transfer or discharge Veterans from CM, must complete the following steps and actions:

(a) The Veteran is notified, or attempted to be notified, in advance of plan to discharge or transfer care and again at time of discharge or transfer.

(b) If the Veteran is transferring LC services, the receiving LC is notified and proactively involved in the transition and acknowledges and accepts responsibility for ongoing LC services. **NOTE:** *Disputes regarding the transfer of Veterans must be referred to the VA medical facility's CCRT or in their absence, the VA medical facility's Care Coordination & Integrated Case Management (CC&ICM) Co-Champion(s) and Sponsor for remediation. For implementation guidance related to the LC, CCRT, and CC&ICM Co-Champions and Sponsor, please see https://dvagov.sharepoint.com/sites/VHACMSWS/CMI_Taskforce/ICM_Toolkit/GovernanceCouncil/Communications/SitePages/Start-your-CC&ICM-Journey.aspx. This is an internal VA website that is not available to the public.*

(c) The Veteran's health care team is notified of the plan to discharge or transfer care.

(d) Plans to modify level of care coordination and efforts to discharge are clearly reflected in the Veteran's electronic health record. Discharge from CM/LC services, transition to lower level of coordinated care, or receipt of accepted care by the LC are documented within the Discharge/Transfer Summary Note.

(5) **Readmission to CM Services.** If further health care complexities or acuties or barriers to care arise in the future, Veterans can and should be referred again for CM screening and re-initiation of services.

9. TRAINING AND COMPETENCY REQUIREMENTS

Case Managers will obtain all required safety training related to suicide risk reduction and working safely with high-risk Veterans, in all settings. These include, but are not limited to, Suicide Risk Management Training for Clinicians or S.A.V.E. Training and Refresher Training. Training in evidence-based CM practice is required. Registered Nurse and Social Worker Case Management functions related to standards of practice, core competencies and competency requirements, and training and educational materials are provided on the Care Coordination and Integrated Case Management Portal VA SharePoint. **NOTE:** See paragraph 11, References, and VHA Directive 1071.

10. RECORDS MANAGEMENT

All records regardless of format (e.g., paper, electronic, electronic systems) created in this directive shall be managed per the National Archives and Records Administration (NARA) approved records schedules found in VA Records Control Schedule 10-1. Questions regarding any aspect of records management should be addressed to the appropriate Records Manager or Records Liaison.

11. REFERENCES

- a. VHA Directive 1010, Transition and Care Management of Ill or Injured Servicemembers and New Veterans, dated November 21, 2016.
- b. VHA Directive 1067, Confidential Communication, dated November 10, 2015.
- c. VHA Directive 1110.02, Social Work Professional Practice, dated July 26, 2019.
- d. VHA Directive 1120.02, Health Promotion and Disease Prevention Core Program Requirements, dated February 5, 2018.
- e. VHA Directive 1140.11, Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics, dated October 11, 2016.
- f. VHA Directive 1162.05(1), Housing and Urban Development Department of Veterans Affairs Supportive Housing Program, dated June 29, 2017.
- g. VHA Directive 1172.01, Polytrauma System of Care, dated January 24, 2019.

- h. VHA Directive 1176, Spinal Cord Injury and Disorders System of Care, dated October 1, 2010.
- i. VHA Directive 1199, Reporting Case of Abuse and Neglect, dated November 28, 2017.
- j. VHA Directive 1411, Home-Based Primary Care (HBPC), Special Population Patient Aligned Care Team (PACT) Program, dated June 5, 2017.
- k. VHA Directive 1605.01, Privacy and Release of Information, dated August 31, 2016.
- l. VHA Handbook 1101.10(1) Patient Aligned Care Team Handbook (PACT), dated February 5, 2014.
- m. VHA Handbook 1120.04, Veterans Health Education and Information Program Requirements, dated September 24, 2015.
- n. VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008.
- o. VHA Handbook 1162.01(1), Grant and Per Diem Program, dated June 12, 2013.
- p. VHA Handbook 1162.09, Health Care for Homeless Veterans (HCHV), dated May 8, 2014.
- q. VHA Handbook 1163.06, Intensive Community Mental Health Recovery Services, dated January 7, 2016.
- r. VHA Handbook 1174.03, Visual Impairment Services Team (VIST) Program Procedures, dated November 5, 2009.
- s. VHA Handbook 1907.01, Health Information Management and Health Records, dated March 19, 2015.
- t. American Case Management Association (ACMA) Standards of Practice and Scope of Practice: https://www.acmaweb.org/forms/Case_Management_SoP_SoS.pdf. **NOTE:** *This linked document is outside of VA control and may not be conformant with Section 508 of the Rehabilitation Act of 1973.*
- u. Care Coordination and Integrated Case Management Portal on VA SharePoint (https://dvagov.sharepoint.com/sites/VHACMSWS/CMI_Taskforce/ICM_Toolkit/GovernanceCouncil/Communications). **NOTE:** *This is an internal VA website that is not available to the public.*
- v. Case Management Society of America (CMSA) Standards of Practice: <http://solutions.cmsa.org/acton/media/10442/standards-of-practice-for-case-management>.

w. Congressional Research Service, The Number of Veterans that Use VA Health Care Services Fact Sheet, dated June 3, 2014: <https://fas.org/sgp/crs/misc/R43579.pdf>.

NOTE: This linked document is outside of VA control and may not be conformant with Section 508 of the Rehabilitation Act of 1973.

x. Kathol, Roger G., Andrew, Rachel L., Squire, Michelle, Dehnel, Peter J. (2018). The Integrated Case Management Manual: Assisting Complex Patients Regain Physical and Mental Health. New York: Springer Publishing Company.

y. National Association of Social Work (NASW) Standards for Social Work Case Management Practice:

<https://www.socialworkers.org/LinkClick.aspx?fileticket=acrzqmEfhlo%3D&portalid=0>

NOTE: This linked document is outside of VA control and may not be conformant with Section 508 of the Rehabilitation Act of 1973.

z. National Social Work Program VA Care Management and Social Work CPT Codes for Social Workers, March 2018 and Frequently Asked Questions CPT Codes for Social Workers, March 2017:

<https://dvagov.sharepoint.com/sites/VHACMSWS/SocialWork/Data%20Management/Fo rms/AllItems.aspx?viewid=233127ad%2Dff41%2D43c4%2Da98d%2Dd03e6226bd99&i d=%2Fsites%2FVHACMSWS%2FSocialWork%2FData%20Management%2FKDM%20 Publications>. **NOTE:** This is an internal VA website that is not available to the public.

aa. VHA Homeless Programs Hub: <https://iop.med.va.gov/hub2/hp/>. **NOTE:** This is an internal VA website that is not available to the public.

COLLABORATIVE CASE MANAGEMENT

1. COLLABORATION WITH SOCIAL WORK SERVICE

The National Social Work Program Office serves as the lead authority for the provision of social work practice across Veterans Health Administration (VHA). Social workers are assigned to treatment programs across the continuum of care, including medical, mental health, community-based settings, research, and provide social work services to Veterans, their families, and caregivers. A Social Work Chief or Executive at each Department of Veterans Affairs (VA) medical facility is responsible for the professional social work practice of all social workers employed within the Health Care System (HCS). The Social Work Chief or Executive will support Collaborative Case Management (CCM) through the following:

a. Veterans and transitioning Service members referred to VA social workers will be proactively screened for case management (CM).

b. Referrals to VHA Specialty CM services and social work are bidirectional.

c. Social work representation and participation in the Care Coordination Review Team (CCRT). **NOTE:** For implementation guidance related to the CCRT, please see [https://dvagov.sharepoint.com/sites/VHACMSWS/CMITaskforce/ICM Toolkit/GovernanceCouncil/Communications/SitePages/Start-your-CC&ICM-Journey.aspx](https://dvagov.sharepoint.com/sites/VHACMSWS/CMITaskforce/ICMToolkit/GovernanceCouncil/Communications/SitePages/Start-your-CC&ICM-Journey.aspx). This is an internal VA website that is not available to the public.

2. COLLABORATION WITH OFFICE OF NURSING SERVICE

The Office of Nursing Services (ONS) serves as a leader in clinical practice and education to support patient care and health care delivery across VHA. Nurses are assigned to service lines and programs across the continuum of care to provide clinical nursing services to Veterans, their families, and caregivers. Nurses support health care delivery in both the inpatient and outpatient settings and in the following areas: ambulatory, acute, specialty, mental health, research, geriatrics, and community-based care. An Associate Director for Patient Care Services or Nurse Executive is in every VA medical facility and is responsible for the professional practice of nursing provided by all nursing staff employed by HCS. The Associate Director for Patient Care Services or Nurse Executive will support Collaborative Case Management (CCM) through the following:

a. VHA Nurse Care Managers and Case Managers work collaboratively to promote Veterans' timely access to care to support their continuing care needs. Timeliness is based on what is clinically indicated in the Veteran's electronic health record (EHR).

b. Veterans and transitioning Service members referred to VA nurses are proactively screened for CM.

c. VHA nurses support seamless transitions in care within VA and between VA and community providers.

d. Referrals between VHA Specialty CM services and Nursing services are bidirectional.

e. Professional nurse representation and participation in the Care Coordination Review Team (CCRT). **NOTE:** *For implementation guidance related to the CCRT, please see https://dvagov.sharepoint.com/sites/VHACMSWS/CMI_Taskforce/ICM_Toolkit/GovernanceCouncil/Communications/SitePages/Start-your-CC&ICM-Journey.aspx. This is an internal VA website that is not available to the public.*

3. COLLABORATION WITH PATIENT ALIGNED CARE TEAM

a. Primary Care oversees the Patient Aligned Care Team (PACT) model and promotes team-based, patient-centered care focusing on a personalized, integrated, and coordinated approach to health care. Integrated with PACT, the Health Promotion and Disease Prevention (HPDP) Program offers a variety of health education programs and services that support PACT. For more information, see VHA Directive 1120.02, Health Promotion and Disease Prevention Core Program Requirements, dated February 5, 2018, and VHA Handbook 1120.04, Veterans Health Education and Information Core Program Requirements, dated September 24, 2015.

b. The PACT Registered Nurse (RN) Care Manager and PACT Social Work Case Manager are two interprofessional team members who may screen and refer to specialty CM due to their role in the provision of care coordination services. The following is a description of the intersection of CC&ICM and PACT services when Veterans are referred to specialty CM and assigned a Case Manager or Lead Coordinator (LC). **NOTE:** *For elaboration of the role and responsibilities of the Lead Coordinator, see paragraph 5, Responsibilities.*

(1) Case Managers and LCs collaborate with the PACT RN to harmonize health care services for the Veteran, avoiding duplication of care, preventing miscommunication, providing comprehensive care, and maintaining continuity of care.

(2) Veterans will continue to receive care management services from their PACT RN while receiving specialty CM services. The Case Manager/LC defers to the PACT RN Care Manager's expertise in facilitating care management-related activities (e.g., completion of Primary Care consults). Concurrent, non-primary care-related concerns are addressed directly by the Case Manager/LC (e.g., psychosocial issues). **NOTE:** *Following a warm handoff, PACT Social Work Case Manager discontinues the provision of CM services when Veterans are assigned to a specialty Case Manager/LC, to prevent unnecessary duplication of CM services.*

4. TRANSITIONS AND TRANSFERS

a. When Veterans no longer meet criteria for "specialty" CM, but still require CM services, the specialty Case Manager/LC transfers Veteran to the PACT Social Work Case Manager through a warm handoff for continued CM services. The PACT Social

Work Case Manager becomes the new LC for the Veteran at that time, and their family and/or caregiver.

b. When Veterans no longer meet clinical eligibility for CM services and are ready to be safely maintained with the provision of a lower level of care coordination, the specialty Case Manager/LC transitions the Veteran to the PACT RN for care management services. The PACT RN functions as the LC for Veteran and their family and/or caregiver regarding the Veteran's care.

c. For elaboration of the Care Coordination & Integrated Case Management framework, see the CC&ICM Portal on VA SharePoint. **NOTE:** *For implementation guidance related to CC&ICM, please see https://dvagov.sharepoint.com/sites/VHACMSWS/CMI_Taskforce/ICM_Toolkit/GovernanceCouncil/Communications/SitePages/Start-your-CC&ICM-Journey.aspx. This is an internal VA website that is not available to the public.*

d. For elaboration of the VHA PACT model, see VHA Handbook 1101.10(1), VHA Patient Aligned Care Team (PACT) Handbook, dated February 5, 2014.

5. COLLABORATION WITH SPECIALTY POPULATION PROGRAMS/SERVICES

a. Referral for specialty CM services should be considered to ensure all resources are appropriately utilized. Case Managers may receive the assigned role of Lead Coordinator and would collaborate on the coordination of care and prevent duplication of services with specialty Case Managers through regular assessment and communication, and if necessary, clear deferment to one source of CM by another.

b. Specialty Case Managers can be found in programs such as: Polytrauma; Housing and Urban Development Department of Veterans Affairs Supportive Housing (HUD-VASH); Health Care for Homeless Veterans (HCHV); HUD-VASH; Grant and Per Diem (GPD); Spinal Cord Injury (SCI); Transition and Care Management (TCM); Mental Health Intensive Case Management (MHICM); Visual Impairment Services Team (VIST); Geriatrics and Extended Care (GEC); Home Based Primary Care (HBPC); as well as other VA medical facility and/or community-based programs. **NOTE:** *CM policies for the programs can be found in various VHA directives and handbooks at <https://www.va.gov/vhapublications/>.*

(1) **Collaboration with Homeless Program Office.** VHA's Homeless Programs constitute the largest integrated network of homelessness housing, prevention, and rehabilitation services in the country. These programs are designed to help Veterans live as self-sufficiently and independently as possible. The foundation for these programs is based on the principles of Housing First with supportive services to ensure Veterans are able to end the cycle of homelessness. Homeless and at-risk Veterans are assessed by VHA staff and referred to case management, residential, and other services as their needs indicate.

(2) **Collaboration with Transition and Care Management (TCM) Program.** The TCM program serves as the initial point of contact for newly enrolled Post 9/11-era Veterans. TCM works closely with the National VA Liaison Program and/or DoD Case Managers to ensure the continuity of care and transition into the VA system of care is timely, high quality, and safe. Transitioning Veterans are screened for CM needs and are referred to the appropriate services. VA medical facilities may choose to assign a member of TCM to serve as Lead Coordinator or Case Manager during their own DoD/VA Case Management Review Team meetings. The case management model can be found in VHA Directive 1010, Transition and Care Management of Ill or Injured Servicemembers and New Veterans, dated November 21, 2016.

(3) **Collaboration with Suicide Prevention Program.** As established by department Memorandum, "Mental Health Funding for Suicide Prevention Coordinators," every VA medical facility has at least one suicide prevention coordinator, whose responsibilities include the tracking of Veterans identified as high-risk for suicide through a computerized EHR high-risk flagging system, providing crisis interventions, developing Veteran Safety Plans, and conducting outreach efforts. VHA Case Managers can play a vital role in the agency's multipronged approach to reducing Veteran suicide rate and effectively implementing a public health model of suicide prevention. Case Managers provide:

(a) Increased monitoring, communication, and collaboration with the Veteran, their family, their caregiver, and the interprofessional team through whole health care plan integration.

(b) Augmented one-on-one psychosocial rehabilitative engagement and reinforcement (e.g., coaching, mentoring, and counseling) of the Veteran's clinical treatment plan.

(c) Referrals between VHA CM services and Suicide Prevention Program are bidirectional. Suicide Prevention Coordinators continue to be involved and assist with Veterans' cases; however, it is the Case Manager that will serve as the easily identifiable point of contact responsible for developing, orchestrating, and synchronizing the comprehensive care plan.

(4) **Collaboration with Caregiver Support Program.** Caregivers play a vital role in the health and well-being of Veterans of all eras. VHA's Caregiver Support Program offers training, resources, and extensive tools to help support caregivers of Veterans throughout the caregiving journey. VHA Caregiver Support Coordinators (CSCs) are located at every VA medical facility and are the clinical experts on caregiver issues regarding VA and non-VA resources. CSCs help ensure caregivers are collaborative partners in the care of Veterans.

(a) All Veterans enrolled in the Caregiver Support Program and/or receiving caregiver support services should be screened for CM.

(b) Referrals between VHA specialty CM services and the Caregiver Support Program are bidirectional.

(c) CSCs may continue to be involved with a Veteran's case as it relates to the needs of their caregiver. The Case Manager serves as the point of contact responsible for developing, orchestrating, and synchronizing the comprehensive care plan for the Veteran. Linkage to resources needed by the Veteran is carried out by the Case Manager.

(5) Collaboration with VHA Community Care (VACC) Program. The VHA Office of Community Care (OCC) goal is to provide Veterans with the right care, delivered at the right time, at the right place, and by the appropriate provider. In some cases, Veterans may need to receive care from a local community care provider where efficient care coordination is paramount for seamless transitions of care. Care coordination is a Veteran-centered, team-based activity designed to assess and meet the needs of Veterans, while helping them navigate effectively and efficiently through the continuum of care inside and outside VA medical facilities. VA OCC is committed to collaborating with the community stakeholders to ensure that our partners understand current processes, are informed of future enhancements, and receive excellent customer service. These interactions continue throughout the episode of care to identify risk factors and allow VA staff to engage Veterans across different points of care.

(6) Collaboration with Federal Recovery Consultant Office (FRCO). Federal Recovery Consultants (FRCs) serve in the role defined for Joint Recovery Consultants in the overarching 2014 VA/DoD Interagency Complex Care Coordination Memorandum of Understanding (MOU). FRCs provide enterprise-level consultation and assistance to VA and DoD Lead Coordinators (LC) and Care Management Teams (CMTs), providing clinical and non-clinical assistance and advice about DoD, VA, other Federal agencies, community, and other resources available to support the Service member or Veteran and the family or caregiver. FRCs do not perform direct case management but may engage as early as the time of CMT establishment, as reflected in the Interagency Comprehensive Plan (ICP), at the discretion of the attending physician and upon request of the LC, assigned military headquarters leadership, or senior VA official. Stationed at key military treatment facilities, headquarters for the military's wounded warrior programs, and select VHA polytrauma centers, FRCs oversee a small subset of the population requiring high-intensity management and provide a channel of communication for field level staff to assist Veteran Integrated Service Networks (VISN), VA Central Office leadership, and assigned military headquarters leadership in identifying, validating, and implementing improvements for care and benefits coordination and processes.

CM DOCUMENTATION, WORKLOAD AND PERFORMANCE METRICS

1. CASE MANAGEMENT DOCUMENTATION

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

a. Completing and documenting a comprehensive case management assessment. The documentation in the electronic health record (EHR) must include time spent providing the service, details of the assessment/reassessment with diagnosis, plan of care, and changes in case management intensity when clinically indicated. Documentation must also adhere to The Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), and professional case management organization standards.

b. Ensuring all workload and encounter data utilizes appropriate current procedural terminology, international classification of diseases, and stop codes.

c. Ensuring all documentation occurs in the Veteran's EHR. **NOTE:** *Specialty CM programs, such as Transition and Care Management and Homeless Programs, utilize additional web-based systems for program-specific tracking and reporting.*

2. WORKLOAD, CODING, AND PERFORMANCE MEASURES

Accurate coding describes the scope of services delivered and demonstrates the quality of care. Specialty Program directives, handbooks, and publications provide guidance on productivity and coding (these documents are listed in the last paragraph of this appendix). Decision Support System (DSS) identifiers are composed of a primary stop code and a secondary (i.e., credit) stop code. Two DSS identifiers that are used to collect and evaluate CM data including the number of Veterans who received CM and CM workload are as follows:

a. **DSS Identifier Number 182. Telephone Case Management.** DSS Identifier Number 182 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 EHR. Staff utilizing this code must have documented competencies in CM.

b. **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).** DSS Identifier Number 184 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 Case Manager and must include

elements of Veteran assessment, monitoring, and treatment or care planning. Staff utilizing this code must have documented competencies in case management.

c. **Current Procedural Terminology.** Use of appropriate Current Procedural Terminology (CPT) coding is also vital to accurate workload capture. CPT Code, T1016, is documented in 15 minute increments and applies to direct patient care (face to face visits only with the patient) that is not psychotherapy. Clinical content should include a minimum of one the following: assessment, care planning, referral and related activities, and monitoring and follow-up.

d. **Performance Measures.** Case management program leaders must be data-driven and utilize performance measures and metrics to monitor the quality, effectiveness, and efficiency of their program. The application of national quality improvement principles is needed to ensure program growth aligns with the strategic direction of the organization. CM program-specific metrics may vary, but may be linked by overarching, national CM metrics. The identification of specific quality metrics is beyond the scope of this directive.

NOTE: See VHA Directive 1010, *Transition and Care Management of Ill or Injured Servicemembers and New Veterans*, dated November 21, 2016; VHA Directive 1140.11, *Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics*, dated October 11, 2016; VHA Directive 1162.05(1), *Housing and Urban Development Department of Veterans Affairs Supportive Housing Program*, dated June 29, 2017; VHA Directive 1176.01, *Spinal Cord Injury and Disorders (SCI/D) System of Care*, dated October 1, 2010; VHA Directive 1411, *Home-Based Primary Care (HBPC), Special Population Patient Aligned Care Team (PACT) Program*, dated June 5, 2017; VHA Handbook 1162.01(1), *Grant and Per Diem Program*, dated June 12, 2013; VHA Handbook 1162.09, *Health Care for Homeless Veterans (HCHV)*, dated May 8, 2014; VHA Handbook 1163.06, *Intensive Community Mental Health Recovery Services*, dated January 7, 2016; and VHA Directive 1172.01, *Polytrauma System of Care*, dated January 24, 2019.

CASE MANAGER CASELOAD

1. Review of literature on Case Management (CM) 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.
2. Veterans frequently have complex clinical and psychosocial issues. Determining an appropriate caseload for these patients is dependent on many factors:
 - a. Case severity/complexity (case mix index) and intensity of the care plan requirements.
 - b. Availability of community-based services and network development.
 - c. Communication and coordination between Department of Veterans Affairs (VA), Veterans Benefits Administration (VBA), Department of Defense (DoD), and community resources and partners.
 - d. Case Manager role (including requirements of other duties as assigned, especially if the Case Manager has major responsibilities to another program area).
 - e. Intensity of support needed by the family or caregiver.
 - f. Accessibility to necessary and supportive information.
 - g. Amount of administrative support.
 - h. Benefit provisions.
 - i. Types of CM interaction with beneficiaries (e.g., face-to-face, telephone, V-tel, VA Video Connect).
 - j. Professional experience and knowledge of the patient population.

RESOURCES

1. Commission for Case Manager Certification Case Management Body of Knowledge: <https://www.cmbodyofknowledge.com/content/case-management-knowledge-2>
2. Tahan, H. and Treiger, T. Case Management Society of America Core Curriculum for CM, 3rd edition. 2017. Philadelphia: Wolters Kluwer.
3. Hudson, C. et al. Case Management in Primary Care for Frequent Users of Health Care Services: A Mixed Methods. Study Annals of Family Medicine. May/June 2018; vol. 16. no. 3, 232-239.
4. Kathol, Roger G., Andrew, Rachel L., Squire, Michelle, Dehnel, Peter J. (2018). The Integrated Case Management Manual: Assisting Complex Patients Regain Physical and Mental Health. New York: Springer Publishing Company.
5. Care Coordination Measures Atlas Update. Chapter 2. What is Care Coordination? Content last reviewed 2014. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/atlas2014/chapter2.html>.
6. Mawn, Barbara. Trends in Case Management Acuity Determination. Occupational Medicine and Health Affairs; 2013; Oct; Vol 1, No. 132, 132-144.
7. Tahan, H., Watson, A., Sminkey, P. What Case Managers Should Know About Their Roles and Functions, A National Study from the Commission for Case Manager Certification: Part 1. Professional Case Management, 2015; Vol 20, No. 6, 271 – 296.
8. Hudon, C. et al. Key factors of case management interventions for frequent users of healthcare services: a thematic analysis review. British Medical Journal. 2017; Vol 7.
9. Watson, A. Evaluating and Measuring Quality and Outcomes: A New “Essential Activity” of Case Management Practice. Professional Case Management. January/February 2016; Vol 21. Issue 1, p 51–52.
10. Case Management Model Act. *Revised 2017*. Retrieved from http://solutions.cmsa.org/acton/attachment/10442/f-0464/1/-/-/-/2017%20Model%20Care%20Act_Final%209.27.pdf. **NOTE:** This link is outside of VA control and may not be conformant with Section 508 of the Rehabilitation Act of 1973.
11. Congressional Research Service, “The Number of Veterans That Use VA Health Care Services: A Fact Sheet”, dated June 3, 2014, available from <https://fas.org/sgp/crs/misc/R43579.pdf>. **NOTE:** This linked document is outside of VA control and may not be conformant with Section 508 of the Rehabilitation Act of 1973.
12. Carr, D. Building collaborative partnerships in critical care: The RN Case Manager/Social Work Dyad in Critical Care, Professional Case Management. May-June 2009; Vol 14, No. 3, 121-132.