CASE MANAGEMENT OF TRANSITIONING SERVICE MEMBERS AND POST-9/11 ERA VETERANS

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive specifies policy for the transition into VA care and provision of case management for transitioning Service members and Post-9/11 era Veterans by VHA Post-9/11 Military2VA Case Management staff members.

2. SUMMARY OF MAJOR CHANGES: Major changes include:

a. Updating the name of Transition and Care Management Program to Post-9/11 Military2VA Case Management Program to reflect the program's target population and scope of services,

b. Aligning definitions with current VHA case management policy,

c. Adding new Post-9/11 Transition and Case Management National Director position and responsibilities.

3. RELATED ISSUES: VHA Directive 1011, Department of Veterans Affairs Liaison for Health Care Stationed at Military Treatment Facilities, dated January 27, 2017; VA Directive 0007, Interagency Coordination of Complex Care, Benefits and Services, dated December 22, 2014; VHA Directive 1110.04(1), Integrated Case Management Standards of Practice, dated September 6, 2019; and VHA Handbook 1101.10(1), Patient Aligned Care Team (PACT) Handbook, dated February 5, 2014.

4. RESPONSIBLE OFFICE: The Executive Director, Care Management and Social Work (12CMSW), Office of Patient Care Services (12), is responsible for the content of this directive. Questions may be referred to the Post-9/11 Military2VA Case Management National Program Manager, VHA12CMSWCareMgmtTCMSSection@va.gov.

5. RECISSIONS: VHA Directive 1010, Transition and Care Management of Ill or Injured Servicemembers and New Veterans, dated November 21, 2016, is rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of February 2027. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.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/ Beth Ann Taylor, DHA, RN, FAAN, NEA-BC
Assistant Under Secretary for Health
for Patient Care Services/CNO

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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1. PURPOSE

This Veterans Health Administration (VHA) directive specifies policy for the transition of care and provision of case management for transitioning Service members and post-9/11 era Veterans by VHA Post-9/11 Military2VA (M2VA) Case Management program staff. This policy ensures Post-9/11 M2VA Case Management program's case management practice is aligned with standards of professional practice endorsed by the Department of Veterans Affairs (VA) and professional case management organizations, such as Case Management Society of America, American Case Management Association and Commission for Case Management Certification. It also establishes the requirements pertaining to the transition of Service members' and Veterans' care into VA and describes the responsibilities of VA staff working on the case management of post-9/11 era Veterans across various program areas within VA. ***NOTE:*** *The requirement for transition of care applies to active duty Service members directly referred from Military Treatment Facilities (MTFs), outpatient active duty Service members who present to VA medical facilities seeking health care, and post-9/11 era Veterans and active duty Service members referred through public-private partnerships*. **AUTHORITY**: 38 U.S.C. § 7301(b); Public Law (P.L.) 110-181 § 1611.

2. BACKGROUND

a. Since 2003, VA has collaborated with the Department of Defense (DoD) to transition injured and ill Service members and Veterans from MTFs to VA medical facilities. VA established the VA Liaison Program and assigned VA Liaisons for Healthcare to support major MTFs. In accordance with VHA Directive 1011, Department of Veterans Affairs Liaison for Healthcare Stationed at Military Treatment Facilities, dated January 27, 2017, VA Liaisons for Healthcare facilitate transitions of care and provide information to Service members, Veterans, their families, and caregivers about VA healthcare services. A comprehensive list of locations with VA Liaisons for Healthcare can be found at http://tcm.vssc.med.va.gov/POCList/_layouts/15/WopiFrame.aspx?sourcedoc=%7b76577155-F66F-4B23-93C2-1A41D3A28570%7d&file=LOCATIONS%20WITH%20VA%20LIAISONS%20FOR%20HEALTHCARE.docx&action=default. ***NOTE:*** *This is an internal VA website not available to the public.*

b. The National Defense Authorization Act (NDAA) of 2008 (P. L. 110-181), Section 1611 required DoD and VA to develop and implement policy on the care, management, and transition of their wounded, ill and injured Service members and Veterans. Many transitioning Service members and Veterans suffer from multiple complex physical and mental health problems, including but not limited to traumatic brain injury (TBI), amputations, burns, loss of vision, combat stress, posttraumatic stress disorder (PTSD) and serious mental illness. In addition to health complexities, the transition from active duty to civilian life can also contribute to social complexities. Therefore, it is critical for

each VA medical facility to utilize the VHA standardized process that ensures care and services for all transitioning Service members and Post-9/11 era Veterans are well-coordinated and case management services are provided to those who need them.

c. In 2012, the Joint Executive Committee approved a joint DoD and VA commitment to develop and implement policy for a common model of complex care coordination for ill and injured Service members and Veterans. This commitment is in accordance with the DoD and VA Secretaries' objectives to support "One Mission-One Policy-One Plan." The responsibilities set forth in this directive are intended to implement this common model.

d. Executive Order (EO) 13822, Supporting Our Veterans During Their Transition from Uniformed Service to Civilian Life, dated January 9, 2018, was issued to ensure transitioning Service members and Veterans have access to high-quality mental health care and suicide prevention resources in the first year after their separation from service. The EO 13822 directed VA, DoD and DHS to develop a Joint Action Plan that addressed the complex challenges faced by our transitioning Service members and Veterans and ensured knowledge of and access to mental health care and suicide prevention resources. ***NOTE:*** *For more information, on the EO 13822, a Fact Sheet is available here: https://www.mentalhealth.va.gov/transitioning-service/docs/FINAL_EO_Fact_Sheet_508.pdf*.

e. The Joint Action Plan collaborative goals include:

(1) Improve actions to ensure all transitioning Service members are aware of and have access to mental health services.

(2) Improve actions to ensure the needs of at-risk Veterans are identified and met.

(3) Improve mental health and suicide prevention services for individuals that have been identified in need of care.

3. DEFINITIONS

a. **Care Coordination.** Care coordination is a system-wide (VHA) 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 is 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. **Care Coordination Review Team.** Care Coordination Review Team (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).

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. **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 coordination and planning. The LC role is a critical component of the Care Coordination & Integrated Case Management (CC&ICM) framework (see VHA Directive 1110.04(1), Integrated Case Management Standards of Practice, dated September 6, 2019). Additionally, the LC role is an expansion of the joint DoD/VA Lead Coordinator Model for transitioning Service members.

4. POLICY

It is VHA policy to ensure that the military to VA transition and case management of ill and injured Service members and Post 9/11 era Veterans treated at VA medical facilities is coordinated, monitored, and tracked. ***NOTE****: All transitioning Service*

members and Veterans who served on or after September 11, 2001 who are new to the VA Health Care System are screened for the need for case management services to ensure early identification of risk factors.

5. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring overall VHA compliance with this directive.

b. **Assistant Under Secretary for Health for Patient Care Services.**

(1) Supporting the Post-9/11 TCM Office with implementation and oversight of this directive.

(2) Identifying the offices and programs responsible for supporting transitioning Service members and Post-9/11 era Veterans and ensuring their collaboration with the Post-9/11 TCM Office.

c. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations is responsible for:

(1) Communicating the contents of this directive to each of the Veterans Integrated Services Networks (VISN).

(2) Ensuring that each VISN Director has the sufficient resources to implement this directive in all VA medical facilities within that VISN.

(3) Assisting VISN Directors to resolve implementation and compliance challenges.

(4) Providing oversight of VISNs to assure compliance with this directive and its effectiveness.

d. **National Director, National Post-9/11 Transition and Case Management**. The National Director, National Post-9/11 Transition and Case Management (TCM), Care Management and Social Work is responsible for:

(1) Ensuring that VA medical facilities are in compliance with the standards defined in this directive.

(2) Providing consultation to Post-9/11 M2VA Case Management VISN point of contact (POC) and Program Managers and VA medical facility leadership to support the program in accomplishing its mission.

(3) Educating internal and external stakeholders on public-private partnerships that support transitioning Service members and post-9/11 era Veterans.

(4) Providing oversight of the Post-9/11 Transition and Case Management Leadership Council that reports directly to National Director.

(5) Establishing and overseeing national performance metrics and measures based on available data. ***NOTE:*** *Post-9/11 M2VA Program metrics and measures are located on the Post-9/11 TCM Hub site:* https://r03cleapp06.r03.med.va.gov/hub2/tcms/. *This is an internal VA website that is not available to the public.*

e. **National Program Manager, Post-9/11 Military2VA Case Management.** The National Program Manager of the Post-9/11 Military2VA Case Management Program is responsible for:

(1) Overseeing the Post-9/11 Military2VA (M2VA) Case Management Programs embedded within VA medical facilities and serving as the program's national POC. Providing consultation and guidance to Post-9/11 M2VA Case Management Program members on public-private partnerships, complex transitions of care and case management practice issues.

(2) Identifying knowledge gaps and organizing national and VISN level education and training on topics within the program's scope.

(3) Advocating for program development and resource allocation to support Post-9/11 M2VA Case Management Programs across all VISNs in accomplishing their objectives.

(4) Monitoring VA medical facility Post-9/11 M2VA Case Management Program adherence to performance metrics and measures. Submitting requests for supplemental VA medical facility Post-9/11 M2VA Case Management Program information through the Post-9/11 M2VA Case Management VISN POCs as needed.

(5) Promoting continuous quality improvements with respect to the provision of services and development of the Post-9/11 M2VA Case Management Program.

f. **Post-9/11 Transition and Case Management Leadership Council.** The Post-9/11 TCM Leadership Council is responsible for:

(1) Consulting with the National Post-9/11 TCM Office once a month, at minimum.

(2) Providing oversight to the Post-9/11 TCM National Committees.

g. **Veterans Integrated Service Network Director.** The VISN Director is responsible for:

(1) Ensuring that all facilities within the VISN comply with this directive and informing leadership when barriers to compliance are identified.

(2) Designating a Post-9/11 M2VA Case Management VISN POC to oversee Post-9/11 M2VA Case Management Program services and provide guidance to Post-9/11 M2VA Case Management Program Managers at the VA medical facilities within the VISN.

(3) Designating a Post-9/11 M2VA Case Management VISN Program Manager Lead from one of the VA medical center Post-9/11 M2VA Case Management Program Managers to serve as liaison to the VISN POC.

(4) Distributing Transition Patient Advocates (TPA) to VA medical facilities within the VISN based on various factors including the number of ill or injured transitioning service members and Post-9/11 era Veterans enrolled in each health care system.

h. **Post-9/11 Military2VA Case Management Veterans Integrated Services Network POC.** The Post-9/11 M2VA Case Management VISN POC is responsible for:

(1) Serving as a primary POC at the VISN for Post-9/11 M2VA Case Management Program Managers and VA medical facility leadership within the VISN, as well as public-private partnerships signed by VISN leadership.

(2) Overseeing and monitoring VA medical facility Post-9/11 M2VA Case Management Program compliance with this directive within the VISN. Providing support and guidance to Post-9/11 M2VA Case Management Programs if non-compliance is identified.

(3) Assembling, maintaining and forwarding information provided by the Post-9/11 M2VA Case Management teams and submitted by facility senior management to the appropriate VHA requesting office.

(4) Communicating VA medical facility Post-9/11 M2VA Case Management Program staffing changes to the Post-9/11 Transition and Case Management Program Office.

(5) Monitoring Post-9/11 M2VA Case Management Program and partnership performance metrics and measures within the VISN. Supporting Post-9/11 M2VA Case Management Program Managers when there are barriers to assisting transitioning service members and Veterans with accessing health care. Elevating barriers or challenges to the national program office when a resolution at the VISN level is not possible.

(6) Assisting with resolving issues that arise within the VISN regarding variances across sites that affect Post-9/11 M2VA Case Management teams' ability to effectively transition Service members into VA health care.

(7) Ensuring monthly communication with the Post-9/11 M2VA Case Management Program Managers within the VISN in collaboration with the Post-9/11 M2VA Case Management VISN Program Manager Lead.

i. **Post-9/11 Military2VA Case Management VISN Program Manager Clinical Lead.** The Post-9/11 M2VA Case Management VISN Program Manager Clinical Lead is responsible for:

(1) Serving as a liaison between the Post-9/11 M2VA Case Management VISN POC, and VA medical facility Post-9/11 M2VA Case Management Program Managers within the VISN and other agencies or organizations.

(2) Collaborating with Post-9/11 M2VA Case Management VISN POC on oversight and monitoring of VA medical facility Post-9/11 M2VA Case Management Program compliance with this directive within the VISN. Providing support and guidance to Post-9/11 M2VA Case Management Programs if non-compliance is identified.

(3) Serving as Post-9/11 M2VA Case Management Program subject matter expert and consultant to the VISN and VA medical facilities within the VISN to address program-related issues that arise. Providing Post-9/11 M2VA Case Management Program briefings to stakeholders within the VISN as needed.

(4) Collaborating with Post-9/11 M2VA Case Management VISN POC with updating Post-9/11 TCM Office on medical center Post-9/11 M2VA Case Management staffing changes.

(5) Ensuring monthly communication with Post-9/11 M2VA Case Management Program Managers within the VISN in collaboration with the Post-9/11 M2VA Case Management VISN POC.

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

(1) Ensuring that eligible transitioning Service members and Veterans are able to access medical and mental health care services as clinically indicated.

(2) Appointing a social worker or registered nurse to serve as the VA medical facility Post-9/11 M2VA Case Management Program Manager. The position reports directly to the facility Director, or designee. In the event a Post-9/11 M2VA Case Management Program Manager leaves the position or is temporarily assigned to other duties, ensuring an Acting Program Manager is identified and assigned within 30 days and recruitment for the position begins within 90 days.

(3) Ensuring VA medical facility and Post-9/11 Military2VA Case Management Program compliance with this directive and that appropriate corrective action is taken if non-compliance is identified.

k. **VA Medical Facility Post-9/11 Military2VA Case Management, Program Manager.** The primary role of the Post-9/11 M2VA Case Management Program Manager is to ensure that transitioning Service members and Post-9/11 era Veterans receive patient-centered, integrated Whole Health care. The Post-9/11 M2VA Case Management Program Manager has administrative and clinical responsibility for the Post-9/11 M2VA Case Management Program. The Post-9/11 M2VA Case Management Program Manager position is funded by Veterans Health Administration Central Office (VHACO). The Post-9/11 M2VA Case Management Program Manager is responsible for:

(1) Leading the Post-9/11 M2VA Case Management team at the VA medical facility which includes the Post-9/11 M2VA Case Management Program case management professionals and TPAs.

(2) Serving as the primary POC at the VA medical facility for the VA Liaisons for Healthcare to receive and coordinate referrals from MTFs and public-private partners.

(3) Establishing relationships to strengthen collaboration among internal partners (e.g., VA medical facility Enrollment Coordinators, Schedulers, Suicide Prevention Coordinators) to improve efficiency and effectiveness of safe transitions of care.

(4) Ensuring that all transitioning Service members and Post-9/11 era Veterans who are new to the VA health care system are screened to determine the need for case management services. Assigning a Lead Coordinator (LC) or facilitating the assignment of an LC in collaboration with other case management programs for transitioning Service members and Post-9/11 era Veterans as clinically indicated.

(5) Monitoring Service members and Post-9/11 era Veterans receiving case management through the Care Management Tracking and Reporting Application (CMTRA), monitoring performance measures and metrics, as well as meeting VA medical facility, VISN and VACO level reporting requirements. The Post-9/11 M2VA Case Management Program Manager must also monitor Post-9/11 M2VA Case Management team workload and productivity.

(6) Ensuring Post-9/11 M2VA Case Management Program adherence to VHA case management practice and process standards. ***NOTE****: For more information about case management standard, see VHA Directive 1110.04, Integrated Case Management Standards of Practice, dated September 6, 2019*.

(7) Prioritizing Post-9/11 era Veterans served by the Post-9/11 M2VA Case Management Program based on level of risk, acuity and complexity.

(8) Providing subject matter expertise on transitioning Service member and Post-911 era Veteran transition and reintegration. Educating the community on VA services and benefits as well as resources pertinent to this population.

(9) Leading huddles, case reviews and team meetings to maintain effective communication, collaboration and coordination between team members and promote a high reliability culture.

(10) Identifying operational goals and objectives that align with their VA health care system’s operational plan.

(11) Establishing VA medical facility Post-9/11 M2VA Case Management Program standard operating procedures and processes.

(12) Providing ongoing performance metric and measure and periodic briefings to senior VA medical facility leadership regarding the Post-9/11 M2VA Case Management

Program. ***NOTE****: Post-9/11 M2VA Program metrics and measures are located on the Post-9/11 TCM Hub site:* https://r03cleapp06.r03.med.va.gov/hub2/tcms/*. This is an internal VA website that is not available to the public.*

(13) Providing direct or indirect supervision to the Post-9/11 M2VA Case Management Program Case Manager(s) and Transition Patient Advocate(s) who are organizationally aligned under them.

(14) Providing or arranging coverage for Post-9/11 M2VA Case Management Program team member during their absence.

(15) Ensuring the Post-9/11 M2VA Program Orientation Guide is made available to Post-9/11 M2VA Case Management Program staff. To access the Post-9/11 M2VA Case Management Program Orientation Guide, visit the Post-9/11 TCM Hub site: https://r03cleapp06.r03.med.va.gov/hub2/tcms/. ***NOTE****: This is an internal VA website and is not available to the public.*

(16) Ensuring Post-9/11 M2VA program representation or participation in outreach activities and events serving transitioning Service member and Post-9/11 era Veteran population.

(17) Engaging with federal, state, and local agencies and departments as well as community partners, as needed, to enhance level of collaboration and coordination in supporting transitioning Service members and Post-9/11 era Veterans.

(18) Evaluating the VA medical facility's Post-9/11 M2VA Case Management program at least annually to determine program effectiveness based on program metrics and measures and identify areas for improvement.

(19) Limiting collateral duty participation to no more than 15% of their time to ensure VA medical facility Post-9/11 M2VA CM Program Manager is able to meet the responsibilities of the position and fulfill the program's mission and objectives.

l. **VA Medical Facility Post-9/11 M2VA Case Management Program, Case Manager.** The primary responsibility of the Post-9/11 M2VA Case Management Program Case Manager is to coordinate care and services for transitioning Service members and post-9/11 era Veterans with health and/or social complexity. The Post-9/11 M2VA Case Management Program Case Manager is also responsible for:

(1) Adhering to VHA case management practice and process standards. ***NOTE:*** *For more information about these case management standards, see VHA Directive 1110.04, Integrated Case Management Standards of Practice, dated September 6, 2019*.

(2) Contacting transitioning Service members and Veterans prior to transfer to VA to facilitate their registration, enrollment, initial VA appointment scheduling or inpatient admission and provide education on VA care, services and benefits.

(a) Collaborating with VA medical facility Enrollment and Eligibility staff to initiate verification of Service member and Veteran eligibility and completion of eligibility procedures. ***NOTE:*** *For more information about Enrollment and Eligibility Staff, see VHA Directive 1601A.02(2), Eligibility Determination, dated July 6, 2020. For more information about registration and eligibility, see VHA Directive 1601A.01, Registration and Enrollment, dated July 7, 2020.*

(b) Collaborating with VA medical facility Scheduler(s) to facilitate Service members' and Veterans' VA health care appointment scheduling. ***NOTE:*** *For more information about scheduling, see VHA Directive 1230(5), Outpatient Scheduling Processes and Procedures, dated July 15, 2016.*

(a) Assisting Service members in minimizing barriers to and delays in care through obtaining necessary authorizations when necessary.

(2) Screening and assessing for case management needs and risk factors, including suicide and homelessness.

(3) Coordinating any necessary appointments and services at the VA medical facility under TRICARE that the Service member will use while still on active duty including terminal leave and convalescent leave. This may require communicating regularly with the Service member's command representative and providing periodic status updates no less than monthly while the Service member remains on active duty. ***NOTE:*** *The non-clinical case manager may be the command representative*.

(4) Entering case management documentation into EHR (see paragraph 7, Documentation for additional information).

(5) Continually reassessing Veteran's acuity and complexity of biopsychosocial need(s) and adjusting level of case management intensity as clinically indicated.

(6) Providing case management during transitions of care for service members and Post-9/11 era Veterans. Transitions include, but are not limited to:

(a) Transfer from a DoD military treatment facility or other VA medical facility.

(b) Transfer from Warrior Care Network academic medical center or Marcus Institute for Brain Health.

(c) Veteran relocation from one VA medical facility to another VA medical facility.

(d) Change in Veteran's psychosocial status (e.g., perception and level of social support, significant relationship stressors (e.g., abuse, separation), death of a family member, change in employment status, substance use).

(e) Significant change in health or functional status and level of care coordination need (e.g., newly diagnosed acute or chronic health condition).

(7) Applying clinical interventions uniquely tailored to the Service member or Veteran, their family, and caregiver, and communicating with them on the contents of the agreed upon plan of care, including case management contact frequency.

(8) Serving as the Lead Coordinator (LC) when deemed appropriate.

m. **VA Medical Facility Lead Coordinator**. The VA medical facility Lead Coordinator (LC) is responsible for:

(1) Serving as the primary POC for Service members and Veterans, and their families or caregivers, for coordination of care and services, identifying gaps or barriers to adherence to the care plan. This information is communicated to members of the care team and facilitating resolution in collaboration with members of the care team. ***NOTE:*** *Although the Lead Coordinator is the main POC, other members of the care team will communicate with the Service member and Veteran.*

(2) If a transition plan is provided, ensuring pertinent information from the transition plan is updated on a periodic basis and communicated to other members of the care team at the time of transfer from one facility to another, or to another geographic area; at the time of discharge from inpatient to outpatient status; or upon a change in the Service member's or Veteran's level of care need.

(3) Ensuring the hand-off with oral and written communication between the transferring and receiving LCs when there is a change to a Service member's and Veteran's LC assignment.

(4) For a transferring LC, providing the Service member, Veteran, and their family or caregiver, with information about and contact information for the receiving LC and documenting the transfer in the Service member's or Veteran's EHR.

(5) For a receiving LC, acknowledging and documenting reception of the LC assignment in the Service member's or Veteran's EHR, and contacting the Service member or Veteran as soon as clinically indicated. ***NOTE:*** *The LC must contact the Service member or Veteran within 72 hours of arrival, if inpatient, and within* seven *days, if outpatient.*

n. **VA Medical Facility Post-9/11 Military2VA Case Management Program, Transition Patient Advocate.** The Transition Patient Advocate's (TPA's) primary responsibility is to assist with the short and long-term needs of transitioning Service members and post-9/11 era Veterans and their families as assigned by the Post-9/11 M2VA Case Management Program Manager. ***NOTE:*** *The TPA reports to the medical center's Post-9/11 M2VA Case Management Program Manager. The Post-9/11 M2VA Case Management Program, TPA position is partially funded by VACO*. The TPA is responsible for:

(1) Assisting with Post-9/11 case management screenings for transitioning Service members and post-9/11 era Veterans as directed by the VA medical facility Post-9/11 M2VA Case Management Program Manager.

(2) Serving as an advocate for transitioning Service members, Post-9/11 era Veterans, their families and caregivers to minimize barriers to VA and community care, services, benefits and resources. Ensuring Service members and Veterans are informed about eligibility, health care system navigation, benefits and pertinent resources.

(3) Documenting significant, non-clinical encounters with Service members, Veterans, their family or caregiver in the EHR to support communication, collaboration and coordination among Service members' and Veterans' care team members.

(4) Collaborating with DoD, VA and community partners to plan, execute, and participate in outreach events as assigned by the Post-9/11 M2VA Case Management Program Manager. This may include but is not limited to events sponsored by the Armed Services (e.g., Yellow Ribbon, Post Deployment Health Reassessment (PDHRA)), and Transition Assistance Program), community, and VA-sponsored events.

(5) Tracking and reporting Service member and Post-9/11 era Veteran new enrollee and outreach data to the Post-9/11 M2VA Case Management Program Manager.

(6) Contacting transitioning Service members and Veterans prior to transfer to VA to facilitate their registration, enrollment, initial VA appointment scheduling and provide education on VA, care, services and benefits.

(a) Collaborating with VA medical facility Enrollment and Eligibility staff to initiate verification of Service member and Veteran eligibility and completion of eligibility procedures. ***NOTE:*** *For more information about Enrollment and Eligibility Staff, see VHA Directive 1601A.02(2), Eligibility Determination, dated July 6, 2020. For more information about registration and eligibility, see VHA Directive 1601A.01, Registration and Enrollment, dated July 7, 2020.*

(b) Collaborating with VA medical facility Scheduler(s) to facilitate Service members' and Veterans' VA health care appointment scheduling. ***NOTE:*** *For more information about outpatient scheduling, see VHA Directive 1230(5), Outpatient Scheduling Processes and Procedures, dated July 15, 2016.*

6. POST-9/11 TRANSITION AND CASE MANAGEMENT LEADERSHIP COUNCIL

a. The VA Central Office Post-9/11 Transition and Case Management (TCM) Leadership Council serves in a consultative capacity to the Post-9/11 TCM Office, CMSW, and provides oversight to the Post-9/11 TCM National Committees

b. Membership consists of Chair, Chair Elect, Secretary, National Committee Chairs and three appointees. Oversight to the Post-9/11 TCM National Committees and membership on the national committees are multidisciplinary and, to the extent possible, diverse.

7. DOCUMENTATION

a. Documentation is an important means of communication among interdisciplinary team members across a large integrated health care system. Documentation contributes to an integrated care approach to service delivery that addresses the service member's and Veteran's holistic needs.

b. The Post-9/11 M2VA Case Management Program Case Manager must document a case management screening using the Post-9/11 Case Management Screening note template or reminder. When clinically indicated, a comprehensive case management assessment must also be documented. Additionally, when ongoing case management services are delivered, case management documentation must also include a holistic and Veteran-centered care plan, case management progress note(s) and discharge/graduation summary. Documentation will:

(1) Include case management engagement and interventions delivered either by telephone, in person, telehealth or other virtual care options (e.g., VA Video Connect), ensuring documentation is complete and consistent with policy.

(2) Occur in the Electronic Health Record (EHR) utilizing appropriate coding.

(3) Occur in the Care Management Tracking and Reporting Application (CMTRA) or the Interagency Comprehensive Plan (ICP) in the Federal Case Management Tool (FCMT), an electronic database that provides the Post-9/11 M2VA Case Management team with a means to identify and track ill or injured service members and Veterans receiving case management services.

8. REPORTING REQUIREMENTS

a. Care Management and Social Work created CMTRA and FCMT to track the care and case management of ill or injured Service members and Veterans receiving case management services, performance measure data, Lead Coordinator information, frequency of expected contact, and special populations. Care Management and Social Work monitors these reports at least monthly and uses the data to report to the Secretary of Veterans Affairs.

b. Performance measure data is automatically pulled from the authoritative tracking system (CMTRA, FCMT, Post 9/11 Case Management Screening Report) on a monthly and quarterly basis for national reporting through the Veterans Support Service Center (VSSC) and Corporate Data Warehouse (CDW).

c. Post 9/11 Case management screening data is available real-time via the web-based Post 9/11 Case Management Screening Report.

9. TRAINING

a. There are no specific training requirements associated with this directive.

b. The Post-9/11 M2VA Case Management Orientation Guide is highly recommended for oriented new employees to the program and may also utilized as a just in time training tool for existing employees. See the link to guide in the Post-9/11 TCM Hub: https://r03cleapp06.r03.med.va.gov/hub2/tcms/. ***NOTE****: This is an internal VA Web site not available to the public.*

10. RECORDS MANAGEMENT

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

11. REFERENCES

a. 38 U.S.C. § 1706, 1710.

b. E.O. 13822 Supporting Our Veterans During Their Transition from Uniformed Service to Civilian Life, dated January 9, 2018.

c. E.O. 13625 Improving Access to Mental Health Services for Veterans, Service Members, and Military Families, https://www.gpo.gov/fdsys/pkg/FR-2012-09-05/pdf/2012-22062.pdf, dated August 31, 2012.

d. VHA Directive 1110.04(1), Integrated Case Management Standards of Practice, dated September 6, 2019.

e. VHA Directive 1011, Department of Veterans Affairs Liaison for Healthcare Stationed at Military Treatment Facilities, dated January 27, 2017.

f. VHA Directive 1601A.02(2), Eligibility Determination, dated July 6, 2020.

g. VHA Directive 1601A.01, Registration and Enrollment, dated July 7, 2020.

h. VHA Directive 1230(5), Outpatient Scheduling Processes and Procedures, dated July 15, 2016

i. VHA Post-9/11 TCM Hub: https://r03cleapp06.r03.med.va.gov/hub2/tcms/. ***NOTE****: This is an internal VA Web site not available to the public.*

COLLABORATION WITH PROGRAMS SERVING TRANSITIONING SERVICE MEMBERS AND POST-9/11 ERA VETERANS

a. **VA Liaisons for Healthcare.** VA Liaisons for Healthcare provide direct access and coordinate individualized VA health care for Service members transitioning from DoD and Veterans transitioning from specialized programs through public-private partnerships to bridge the vulnerable time of transition when there is a higher risk for suicide and other factors such as homelessness. VA Liaisons are VA social workers and registered nurses who are either stationed onsite at MTFs or at public-private partnership Academic Medical Centers, or virtually support designated regions of MTFs. VA Liaisons coordinate the transfer of Service members and Veterans from the MTF to a VA medical facility closest to their home for the most appropriate specialized services their medical condition requires. VA Liaisons partner with the VA medical facility Post-9/11 M2VA Case Management Program Manager as their primary POC to ensure transitioning Service members and Veterans are registered or enrolled in their home VA medical facility, obtain initial VA appointments as appropriate, and are connected with the Post-9/11 M2VA Case Management team for screening and ongoing case management if indicated, and whole health peer groups (e.g., Introduction to Whole Health and Taking Charge of My Life and My Heath) per Executive Order 13822 to support health and well-being plans during transition.

b. **Federal Recovery Consultant.** Federal Recovery Consultants (FRCs) provide enterprise-level consultation and assistance to VA and DoD Lead Coordinators (LCs), 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/Veteran (SM/V), 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 Network (VISN), VHA Central Office leadership and assigned military headquarters leadership in identifying, validating and implementing improvements for care and benefits coordination and processes

c. **DoD Wounded Warrior Programs** assist ill and injured Service members and Veterans (e.g., Army Recovery Care Coordination Directorate (ARCCD), Marine Wounded Warrior Regiment (WWR), Air Force Wounded Warrior (AFWW) Program, Navy Wounded Warrior, etc.). Post-9/11 M2VA Case Management team members collaborate with Advocates, Recovery Care Coordinators (RCCs), District Injured Support Coordinators (DISCs), and other staff from the Wounded Warrior Programs to ensure the needs of the Service member or Veteran are being met. In addition, the Post-9/11 M2VA Case Management Program Manager will work with the Wounded

Warrior Programs to assist with access to space and equipment at a VA medical facility, when needed, to benefit the delivery of Service member and Veteran assistance.

d. **VA Solid Start** is a service of the Veterans Benefits Administration. It helps Veterans connect with many available VA benefits, including disability compensation and ancillary benefits, vocational rehabilitation and employment, insurance education, and home loans. Post-9/11 M2VA Case Management team members collaborate with VBA staff members who can assist in initiating applications for any VA benefits to which a Service member or Veteran may be entitled, as well as for compensation benefits for any service-connected disabilities.

e. **inTransition** is the DoD's policy-mandated program that provides individualized coaching support to Service members and Veterans when transitioning between mental health care providers and health care systems. These transitions often occur when a Service member is separating or retiring from the military and wishes to continue their care at a VA health care facility. inTransition continues to assist separating Service members transitioning their care to other settings, such as the military health care system, Vet Centers and community providers. inTransition also provides resources on a variety of topics targeted to the individual Service member to help ease transitional stressors and reduce barriers to care. inTransition services are available 365 days a year, 24 hours a day and are available to all Service members and Veterans, regardless of discharge characterization. As the program has grown, inTransition has expanded to proactively reach out to separating Service members who have received mental health care within the year prior to separation, as well as provided support for those seeking care for sexual assault or trauma in a military setting and those Service members transition from the military with a moderate to severe traumatic brain injury. inTransition works in concert with the VA Post-9/11 Military2VA Case Management Program and VA Liaison program to assist Service members and recently separated Veterans with access to the VA health care system.