

National Social Work Program VA Care Management and Social Work Services

Overview of VA Programs Where Social Workers Serve

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VA Care Management and Social Work Services
Care and Compassion across the Continuum

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INTRODUCTION

The members of the National Social Work Public Relations Committee are pleased to present Overview of VA Programs Where Social Workers Serve. The VA currently employs over 10,000 social workers and has over 900 social work interns who hold a range of positions from clinical to administrative. This document serves as a reference for current VA employees, potential VA employees and others who may be interested in what type of positions social workers hold in the VA. This product gives a brief explanation of the various VA programs and the roles of the social worker within that program. It is a comprehensive, but not exhaustive, list as there may be additional VA programming where social work is involved. Each program area listed has links to VA publications such as; directives, handbooks and program websites for additional information about the program. To access the links, hold down the “control” key and left click on the link. For additional publications, please go to <http://vaww1.va.gov/vhapublications/>.

If you know of a program in the VA where a social work serves and it is not listed, please contact the Chair of the Public Relations Committee and ask to have that information added to next revision of this document. The current members of the Public Relations Committee are credited by name at the end of this document .

In our mission to provide the foremost leadership in the psychosocial care of Veteran, their families and Caregivers this document supports the National Social Work strategic plan to provide personalized, proactive and patient-driven healthcare, as well as, align resources to deliver sustained value to Veterans.

ADULT DAY HEALTH CARE (ADHC)

Adult Day Health Care (ADHC) programs enable elderly and disabled Veterans to reside in supportive home environments rather than in nursing homes, and improve the Veteran's quality of life by supporting their caregivers and maintaining the Veteran's highest level of functioning possible. Some VA's have ADHC programs on site; others provide this service through contracts with community ADHC programs (CADHC). ADHC centers, on site or contracted, are therapeutically oriented ambulatory day programs that provide health maintenance and supervision to patients with a need for personal assistance with activities of daily living, medication management, or with significant cognitive impairments. ADHC services provided at a VA involve an interdisciplinary team of staff, which includes a social worker. The CADHC social worker provides direct services and advocacy to Veterans and their families and provides oversight of the care provided at CADHC facilities by means of annual inspections, medical record reviews, and regular visits with the Veteran at the CADHC center every 30 days, or with a VA nurse.

VHA Handbook 1141.03, Adult Day Health Care (ADHC):

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2086

VHA Directive 2008-076, Copayments for Extended Care Services Provided to Veterans by Department of Veterans Affairs (VA):

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1800

BLIND REHABILITATION/LOW VISION

The VA provides extensive blind rehabilitation and support services to visually impaired Veterans. This includes Visual Impairment Service Team (VIST) Coordinators, Blind Rehabilitation Outpatient Specialists (BROS), Low Vision Clinics, case management, and Blind Rehabilitation Centers. There are currently 13 inpatient Blind Rehabilitation Centers. These centers provide intensive rehabilitation services including optometry, medical support, low vision specialists, orientation and mobility, manual skills, computer access training and living skills. Instructors and blind rehab teams focus on individualized goals and incorporate the Veteran's support network into the learning process through the Family Education Program. Blind Rehabilitation Centers also utilize low vision devices and technology to support the Veteran's independence. A key component of one's blind rehabilitation may include adjustment to loss, coping skills, stress management, and community support and resources. The Blind Rehabilitation Center social worker is a key member of the interdisciplinary team. They conduct psychosocial assessments, coordinate both inpatient and outpatient services, make referrals as necessary, facilitate various psycho-educational groups, contribute to quality management operations, educate the Veteran's support network, provide outreach to stakeholders and other health professionals, communicate with the Veteran's local blind rehabilitation support services, and work with master's level graduate interns.

Blind Rehab Center Locations:

- Hines, IL: Established 1948
- Palo Alto, CA: Established 1967
- West Haven, CT: Established 1969
- American Lake, WA: Established 1971
- Waco, TX: Established 1974
- Birmingham, AL: Established 1982
- San Juan, Puerto Rico: Established 1986
- Tucson, AZ: Established 1994
- Augusta, GA: Established 1996
- West Palm Beach, FL: Established 2000
- Cleveland, OH: Established 2010
- Biloxi, MS: Established 2011
- Long Beach, CA: Established 2011

VHA Handbook 1174.01, Blind Rehabilitation Outpatient Specialist (BROS) Program Procedures:

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1763

VHA Handbook 1174.04, Blind Rehabilitation Center Program Procedures:

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2126

Website for Department of Veterans Administration Blind Rehabilitation Services:

<http://www.va.gov/blindrehab/>

CAREGIVER SUPPORT PROGRAM

The role of the caregiver support program is to assess the strain and burden on the caregiver, explore various programs available in order to provide help and support to the caregiver, and describe educational and training resources that are available to the caregiver. The caregiver support program provides assistance to those who are the primary caregivers for Veterans with severe medical illness such as dementia, Alzheimer's, Spinal Cord Injury, Multiple Sclerosis, Amyotrophic Lateral Sclerosis (also known as Lou Gehrig's disease), and HIV/AIDS.

Social workers are often assigned as the Caregiver Support Coordinator (CSC) and provide not only individual and group counseling in mental health care, but also provide resource support and advocacy to Veterans with many other illnesses and their caregivers. Some of the most common support provided by VA social workers include assisting with finances or housing, help accessing community resources, guidance in applying for benefits such as Social Security or Medicare, education on Advance Directives, and providing referrals for multiple resources such as respite care, Meals on Wheels, long-term care services, and community counseling.

National VA Caregiver Program SharePoint site:

<http://vaww.infoshare.va.gov/sites/cmsws/CGPOC/default.aspx>

Website for Department of Veterans Administration, Caregiver Support Program:

<http://www.caregiver.va.gov/>

COMMUNITY BASED OUTPATIENT CLINIC (CBOC)

Community Based Outpatient Clinic (CBOC) social workers play a critical role in the Veteran's health care and must be knowledgeable about the varied aspects of the Veteran's needs, as well as appropriate services and resources within VA and their local community. The CBOC social worker provides case management, psychosocial assessment, high-risk screening, individual, family, and group therapy, crisis intervention, advocacy, family education, service coordination, and referrals for home health services, skilled nursing care, respite care, and vocational rehabilitation. They also provide services to assist with marital, family, and legal problems, as well as employment, financial, and housing problems. CBOC social workers also address issues such as abuse and neglect, Advance Directives, end of life planning, discharge assessment and planning, linkage with family members, linkage with and referrals to VA and community resources, and supportive guidance. Social workers in this setting often teach patient education classes on a variety of subjects, and complete HIV Consults and consultation for HIV counseling/education.

VHA Handbook 1006.1, Planning and Activating Community-Based Outpatient Clinics:

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=410

COMMUNITY LIVING CENTER (CLC)

Each VA Community Living Center (CLC) provides compassionate, person-centered care in a safe and home-like environment to eligible Veterans who require assistance with daily care needs. The goals of care are to restore function, reduce decline, maximize independence, and provide comfort when dying. Veterans can achieve their goals in an environment where they are respected, treated with dignity, and invited to be an active participant in their care. The CLC team emphasizes enhancing and supporting the Veteran's quality of life. CLC programs vary from one VA to another but can include skilled nursing, restorative care, rehabilitation, maintenance for those awaiting alternative placement, psychiatric care, dementia care, Geriatric Evaluation and Management, Spinal Cord Injury, hospice/palliative care, and respite care.

The role of the CLC unit social worker is largely dependent upon the programs offered at the particular CLC, but includes psychosocial assessments, case management, discharge planning, advance directives, and attending monthly Resident Council Meetings. Additionally, the social worker is responsible for portions of the Minimum Data Sheet (MDS) assessments and patient centered care plans. Since Veterans on the CLC are usually there for an extended period, the social worker often works very closely with the Veteran and their families to assist with coping related to aging and end of life care. Social workers are an integral member of the multidisciplinary team meetings and family meetings.

VHA Handbook 1142.01, Criteria and Standards For VA Community Living Centers (CLC):

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1736

COMMUNITY NURSING HOME – CONTRACT (CNH)

The VA Contract Community Nursing Home (CNH) Program is designed to assist eligible Veterans and their families in making the transition from an episode of hospital or domiciliary care to the community, or to provide indefinite nursing home placement for Veterans who require 24-hour medical care and/or supervision. The primary goals of the CNH Program are to meet the Veteran's health care needs, provide rehabilitation services with a goal of returning home, and promote the maximum well being of the Veteran. A Veteran is placed in a CNH when his/her medical, physical or mental condition is so impaired that he/she are unable to care for himself/herself and he/she requires 24-hour care. CNH oversight is provided by an interdisciplinary team, which includes a social worker. The CNH social worker provides direct care and advocacy to Veterans and their families, administrative oversight of the CNH facility, conducts annual reviews of contracted facilities with a team of VA providers (including a dietician, safety specialist, nurse, social worker), reviews medical records, and visits with the Veteran at the CNH every 30 days (or with the VA nurse). The CNH social worker also serves as a liaison between the contracted CNHs and the local VAMC. CNH programs vary widely between VAMCs, with some providing short-term contracts and others that use CNHs only for long-term care.

VHA Handbook 1143.2, VHA Community Nursing Home Oversight Procedures:

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1098

COMMUNITY RESIDENTIAL CARE PROGRAM (CRC)

The Community Residential Care (CRC) Program, available at some medical centers, provides health care supervision using community-based residential settings for eligible, self-pay Veterans who are not in need of hospital or nursing home care, but are unable to live independently. Additionally, eligibility requirements require that the Veteran has no suitable family or significant others to provide the necessary supervision and supportive care. All homes and facilities in the CRC Program are licensed and VA approved. Veterans are responsible for the cost of care, which includes room and board, medication supervision, 24-hour supervision, and limited assistance with activities of daily living (ADL). Veterans enrolled in this program receive at least alternating monthly visits from a VA nurse and social worker. The program coordinator, often a social worker, acts as a liaison between the VA and facilities and meets with the patients, families, fiduciaries, and others at the homes as necessary regarding the needs and concerns of the patients and the organization. The social worker participates in annual home and facility inspections and notifies the program director when a Community Residential Care facility does not meet the standards required by VA. The team's goal is to provide a wide range of health services to patients, such as bio-psychosocial assessments, linkage to community resources, crisis intervention, financial counseling, supportive counseling, and psychotherapy, and to coordinate discharge and transitional planning. Social workers also monitor potential cases of abuse and neglect to try to ensure Veteran safety.

VHA Handbook 1140.01, Community Residential Care Program:

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1551

COMPENSATED WORK THERAPY (CWT)

Compensated Work Therapy (CWT) is a vocational rehabilitation and work therapy program that works with Veterans on employment readiness and assisting them with the tools needed to engage in gainful work opportunities that enhance their strengths, needs, abilities, and desired outcomes. The goal is to increase their chance for successful re-adjustment back into the competitive workplace. While each CWT program has its own individual structure and format, these goals are accomplished through Vocational Intake, Assessment, Referral Services, Case Management, Treatment Planning, Transitional Work Experience (TWE), Incentive Therapy (IT), and/or Supported Employment (SE) programs. The Transitional Residences (CWT/TR) Program provides a time-limited community living/residential experience based on a psychosocial rehabilitation model of treatment for Veterans enrolled in the CWT Program. Social workers are often a part of the multidisciplinary team providing referrals to community resources, assistance with family issues, financial concerns, emotional support, and general case management.

Website for Department of Veterans Administration, Comprehensive Work Therapy (CWT):
<http://www.cwt.va.gov/>

VHA Directive 2007-005, Compensated Work Therapy Supported Employment Services Implementation Plan:
http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1531

VHA Handbook 1163.02, Therapeutic and Supportive Employment Services Program:
http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2427

COMPENSATION & PENSION (C&P)

The Compensation and Pension (C&P) Program identifies clinical need and financial needs in wartime Veterans and awards compensation based on that need, as appropriate. The C&P program is primarily coordinated and run by the Veterans Benefits Administration (VBA). The Veterans Health Administration (VA) assists the VBA by conducting the clinical evaluations to determine the Veterans need. A social worker can serve as an ancillary member of the VA C&P team, by conducting thorough psychosocial assessments as part of the evaluation process. The psychosocial assessment often includes military history, past/current living situation, past/current social situation, educational/work history, income level, and past/current ability to function on a daily basis. A social worker's role in completing a (C&P) evaluation is not to provide treatment or resources, only a detailed assessment.

VHA Handbook 1601E.01, Compensation and Pension (C&P) Examinations:
http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2094

Website for Department of Veterans Administration Compensation & Pension:
<http://www.vba.va.gov/bln/21/>

DAY TREATMENT PROGRAM

The Day Treatment Program is an outpatient program, often under the auspices of Mental/Behavioral Health. It provides a structure in the Veteran's environment to promote growth and development. The mission of the program is to assist Veterans in living as independently as possible in their communities, with an emphasis on developing the skills necessary for independent community living. Support, challenge, involvement, structure, and feedback are essential ingredients in the program. Treatment goals include reduction in re-hospitalization, improved quality of life, and returning the Veteran to effective community living. The social worker meets with each Veteran and completes a social work assessment and treatment plan, often using the Recovery Model. The social worker also assists the Veteran in community resource linkage, family issues, financial concerns, emotional support, and general case management.

DIALYSIS

For Veterans with renal failure, the VA can provide dialysis and skilled nursing care in a Hemodialysis unit (HDU). The HDU uses a multidisciplinary approach to meet the complex needs of Veterans with renal failure and provides a wide range of services including chronic and acute hemodialysis, continuous renal replacement therapy, peritoneal dialysis, contract dialysis, and patient education. Dialysis social workers work with Veterans and their families as part of a multidisciplinary team providing support and counseling, information about and assistance with advance directives, referrals to community resources, and community nursing home placement.

Website for Department of Veterans Administration VA Kidney Diseases Program:
<http://vaww.medicalsurgical.va.gov/kidney/>

DOMICILIARY (DOM)

Domiciliary Residential Rehabilitation and Treatment Programs (DOM) provide coordinated, integrated rehabilitative and restorative clinical care in a bed-based unit. The goal is to help eligible Veterans achieve and maintain the highest level of functioning and independence possible. Veterans must be capable of daily self-care and not require any assistance in performing activities of daily living. Veterans may suffer from a wide range of problems, illnesses, or areas of dysfunction, which can be medical, psychiatric, vocational, educational, or social. The peer community provides a conscious, purposeful way to facilitate social, psychological, and behavioral change. Multiple therapeutic and rehabilitative activities are used, designed to produce therapeutic and educational changes, and all participants, Veterans and staff, are considered mediators of these changes. Social workers are an integral member of the interdisciplinary clinical teams who develop, integrate, and coordinate comprehensive and individualized treatment plans. The social worker may also perform outreach duties, and provide post-discharge follow-up, screenings, and referral community resources.

Website for Department of Veterans Administration Domiciliary Care:

<http://vbrs.vba.va.gov/vbrs/doBreadcrumb.do?path=Federal%20Benefits%20to%20Veterans%20and%20Dependents.Veterans%20Health%20Administration.Health%20Care.Domiciliary%20Care&index=3>

EMERGENCY DEPARTMENT (ED)

The level of care provided at the Veterans Health Administration (VA) Emergency Department (ED) varies between medical centers. There are always multiple complex medical and psychiatric emergent situations on a given day. The hours of service also vary and many social workers provide extended care in the evenings and weekends. Some sites have a separate psychiatric emergency department, which is often staffed by social workers and other disciplines. Social workers are often the front line of contact for the Veteran in the emergency department to assist with resources, referrals, and discharge planning on many levels. Resources may include shelters and transitional housing, referrals for substance detoxification, family or pet care after admission, food, transportation, linkage to primary care, and supportive counseling.

VHA Directive 2006-051, Standards for Nomenclature and Operations in VA Emergency Departments:

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1485

EMPLOYEE ASSISTANCE PROGRAM (EAP)

The EAP Program consists of a network of health care professionals and concerned representatives of management and labor who provide assessment, crisis intervention, emotional support, and referral services to any Veterans Health Administration (VA) employee. They assist employees with a wide variety of problems including alcohol and drug abuse, work and family pressures, legal issues, financial referrals, job stress and other concerns that can affect work performance and personal health. Social workers can serve as program coordinators and/or EAP counselors.

ENVIRONMENTAL HAZARDS COORDINATOR

The Environmental Hazards Coordinator is responsible for administrative management of the local facility registry program. This includes completing registry worksheets, scheduling appointments (each Veteran needs a Gulf War Registry (GWR) examination within 30 days of the request date), monitoring timeframe compliance, reviewing records for accuracy and completeness, providing Veterans with an explanation of the purposes of the registry exam, examination process, and disseminating information. A health registry examination is a personalized and comprehensive examination which includes blood work, urinalysis, and, where medically indicated, a chest x-ray and EKG for Veterans who served in locations where they may have been exposed to environmental hazards. This exam is available to all eligible Veterans with no co-payment requirement. The demographic information, exposures, reported

symptoms and diagnoses are all included in a computerized index located at the Austin Automation Center in Austin, TX.

Veterans Health Administration (VA) has the following registries:

- Agent Orange for Vietnam Veterans and others exposed to Agent Orange and other herbicides used in Vietnam and other military locations
- Gulf War/Operation Iraqi Freedom (OIF) for Veterans of the 1991 Gulf War or who served in OIF
- Depleted Uranium (DU) for Veterans possibly exposed to DU
- Ionizing Radiation for Veterans who participated in a “radiation-risk activity”

VHA Handbook 1302.01, Agent Orange Health Registry Program Procedures:

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1474

VHA Handbook 1303.2, Gulf War (including OIF) Registry (GWR) Program (formerly Persian Gulf War Registry Program):

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1574

VHA Handbook 1303.1, Evaluation Protocol for Gulf War and Iraqi Freedom Veterans With Potential Exposure to Depleted Uranium (DU):

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1158

VHA Handbook 1303.4, Evaluation Protocol for Non-Gulf War Veterans With Potential Exposure to Depleted Uranium (DU):

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1254

VHA Handbook 1301.01, Ionizing Radiation Registry Program Procedures:

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1374

FEDERAL RECOVERY COORDINATION PROGRAM (FRCP)

The Federal Recovery Coordination Program (FRCP) provides support for the recovery, rehabilitation and reintegration of severely injured, ill or wounded service members and Veterans.

An assigned Federal Recovery Coordinator will develop a Federal Individualized Recovery Plan with input from the multidisciplinary health care team, the service member or Veteran, and their family or caregiver. They track the care, management and transition of a recovering service member or Veteran through recovery, rehabilitation and reintegration.

FISHER HOUSE

Fisher Houses are large homes, typically built on the grounds of VA or military medical centers, which provide free, temporary, short- or long-term housing for families of severely wounded service members where care is being provided for their loved ones. The homes have 20 bedroom suites with private baths; common areas such as kitchen, dining rooms,

living rooms, family rooms, and libraries; laundry facilities and an elevator. This home-like environment offers families a great opportunity to meet other families who may provide the needed moral and psychological support during a stressful time. Veterans who are receiving extended outpatient medical care (e.g., chemotherapy, radiation therapy, organ transplant) may stay if their family members/caregivers accompany them. Veterans must be self-sufficient. Social workers conduct screenings of a patient's family before making a referral to the Fisher House manager. The Fisher House manager informs the social worker of room availability and contacts the family to arrange the specific dates of their stay. At some facilities, the Fisher House manager may also be a social worker. Their role is to oversee and manage the overall operations of the Fisher House, including supervising clerical staff. As of April 2013 there were 23 VA Fisher Houses spread across the country, with two more currently under construction. There are also 22 Fisher Houses connected to the Department of Defense on military installations.

VA Fisher House Locations:

- Albany (Stratton), NY
- Augusta, GA
- Bay Pines, FL
- Cincinnati, OH
- Denver, CO
- District of Columbia
- Gainesville, FL (under construction)
- Greater LA, CA
- Hines, IL
- Houston, TX
- Miami, FL
- Minneapolis, MN (2 sites)
- Murfreesboro, TN (under construction)
- North Texas (Dallas), TX
- Palo Alto, CA
- Pittsburg, PA
- Richmond, VA
- St. Louis, MO
- Salt Lake City, UT
- Seattle, WA
- South Texas (San Antonio), TX
- Tampa, FL
- West Palm Beach, FL
- West Roxbury (Boston), MA

VHA Handbook 1110.1, VHA Fisher House Program:

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1242

Department of Veterans Affairs Website, Fisher House Program:

<http://www.socialwork.va.gov/fisher.asp>

GERIATRIC, RESEARCH, EDUCATION, CLINICAL CENTER (GRECC)

Geriatric Research, Education, and Clinical Centers (GRECCs) offer outpatient medical care to elderly Veterans. An interdisciplinary team works together to improve the various aspects in the quality of life and care for the older Veteran, utilizing the most up-to-date and leading edge research and education in the area of Geriatrics. GRECC staff conducts research in the area of aging with the goal to promote education, training, and clinical care for the elderly Veteran. Such research results have influenced different medical and psychological therapies for diseases affecting older Veterans and their families/caregivers. A major component of GRECC is to disseminate information and teach interdisciplinary staff, Veterans, family members and community members about the clinical advancements in geriatrics to improve

their daily lives. Social workers in a GRECC conduct psychosocial screenings and assessments that address a Veteran's physical limitations, psychological needs and age associated illnesses and conditions. In collaboration with the interdisciplinary team, Veteran, and family/caregiver, the social worker develops goals and treatment plans designed to promote health, daily functioning and adjustments to the aging process. Social workers make referrals to Veterans Health Administration (VA) and community agencies, collaborate with service providers, provide supportive counseling through individual, couple, and family therapy, provide crisis intervention, and advocate within VA and/or community agencies. Social workers also provide education to promote health, wellness, and advanced planning for the elderly Veteran. There are 20 GRECCs throughout the VA system.

GRECC Locations:

- Ann Arbor
- Baltimore
- Birmingham/Atlanta
- Bronx/New York Harbor
- Cleveland
- Durham
- Gainesville
- Greater Los Angeles
- Little Rock
- Madison
- Miami
- *Minneapolis*
- *New England (Bedford & Boston Divisions)*
- *Palo Alto*
- *Pittsburgh*
- *Puget Sound (Seattle & American Lake Divisions)*
- *Salt Lake City*
- *San Antonio*
- *St. Louis*
- *Tennessee Valley*

VHA Handbook 1140.08, Geriatric Research, Education and Clinical Centers (GRECC's):
http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2037

VHA Department of Veterans Affairs Website, Geriatric Research Education and Clinical Centers:
<http://www1.va.gov/grecc/>

GRANT AND PER DIEM (GPD)

The VA's Homeless Providers Grant and Per Diem Program (GPD) is offered annually (as funding permits) to fund community agencies providing services to homeless Veterans. The purpose is to promote the development and provision of transitional housing and supportive services with the goal of helping homeless Veterans achieve residential stability, increase their skill levels and/or income, and obtain greater self-determination. Only programs with supportive housing (up to 24 months) or service centers (offering services such as case management, education, crisis intervention, counseling) are eligible for these funds. The program has two types of funding: Capital Grants – set amount for all services provided, not dependent on length of stay and Per Diem - fees paid for services/residence per day. The social workers in GPD are most often program coordinators or liaisons, serving a vital link between the community service provider and the VA, and providing oversight for clinical services and fiscal arrangements. The social workers may provide case management,

advocacy, resource and referral linkages, crisis counseling, and consultation. They often coordinate the yearly inspections and are responsible for communicating needs and challenges to VA leadership.

VHA Handbook 1162.01, Grant and Per Diem Program:

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1589

VHA Handbook 1162, Mental Health Homeless and Residential Rehabilitation Treatment Programs:

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1866

HEALTH CARE FOR HOMELESS VETERANS (HCHV)

Approximately 15 percent of all homeless adults in the United States are Veterans. VA's efforts have contributed to a significant reduction in the numbers of homeless Veterans. [Veteran Homelessness: A Supplemental Report to the 2009 Annual Homeless Assessment Report \(AHAR\) to Congress](#) estimates that on any given night 75,609 Veterans were homeless. An estimated 149,635 Veterans spent at least one night in an emergency shelter or transitional housing program over the course of the year. Many other Veterans are considered at risk because of poverty, lack of support from family and friends and precarious living conditions in overcrowded or substandard housing.

Health Care for Homeless Veterans (HCHV) Program operates at 135 sites, where extensive outreach, physical and psychiatric health exams, treatment, referrals and ongoing case management are provided to homeless Veterans with mental health problems, including substance abuse. This program makes assessments and referrals for more than 40,000 Veterans annually. In FY 2010, HCHV teams conducted 42,371 initial clinical assessments of Veterans nationally. This represents an increase in initial clinical assessments of approximately 5 percent from FY 2009 (40,216) and FY 2008 (40,422). At the end of the second quarter of FY 2011, HCHV teams had conducted 21,404 initial clinical assessments of Veterans nationally.

VHA Directive 1162, Mental Health Homeless and Residential Rehabilitation Treatment Programs:

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1866

HEALTH CARE FOR REENTRY VETERANS (HCRV)

Health Care for Re-Entry Veterans' (HCRV) goals are to prevent homelessness, reduce the impact of medical, psychiatric, and substance abuse problems upon community re-adjustment, and decrease the likelihood of re-incarceration for those leaving prison. HCRV services by a social worker include outreach and pre-release assessments services, referrals and linkages to medical, psychiatric, and social services, including employment services, and short term case management assistance. A critical part of HCRV is providing information to Veterans while they are incarcerated so they may plan for their own community re-entry and maintain the highest level of independence possible.

HEALTH PROMOTION DISEASE PREVENTION (HPDP)

The National Health Promotion and Disease Prevention Program (NCP) addresses the provision, evaluation, and improvement of preventive health services through activities focused on training clinical providers in preventive medicine; preparing and disseminating preventive health education materials for patients; developing clinical programs, tools, and other resources to assist providers in improving delivery of preventive services; and supporting clinical efforts to achieve high levels of prevention-related performance measures through the sharing of best practices. This is done locally through a multidisciplinary teach approach, program planning, VA & community health promotion, staff training, program evaluation, employee wellness and reporting the status of the program and special initiatives to NCP.

Social workers can be employed as the HPDP Health Behavior Coordinator (HBC) which can serve several roles. The HBC trains, mentors and guides primary care and other staff members to support patient self management of health-related behaviors via effective health behavior coaching and the use of motivational interviewing and other empirically-based communication and health behavior management approaches. The HBC has a significant role as a consultant for clinical staff members who promote patient self-management of health behavior. The HBC has clinical responsibilities related health promotion interventions such as group and individual smoking cessation and weight management counseling. Finally, the HBC will carry out discipline-specific health behavior assessments and interventions as appropriate.

Social workers can also be employed as the HPDP Program Manager (PM) which coordinates the overall HPDP Program in medical facilities and affiliated Community Based Outpatient Clinics (CBOCs). The PM is responsible for strategic planning, program development, implementation, and monitoring and evaluation of the overall HPDP Program. The PM serves as a communication liaison between the VISN HPDP Program Leaders, the VA National Center for Health Promotion and Disease Prevention and the facility HPDP Program Committee. The PM also serves as a subject matter expert related to evidence based health promotion and disease prevention.

The National Health Promotion and Disease Prevention Website for National Center for Health Promotion and Disease Prevention: www.prevention.va.gov

VHA Directive 1120, Responsibilities of the National Center for Health Promotion and Disease Prevention (NCP): http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2051

HOME BASED PRIMARY CARE (HBPC)

Home Based Primary Care (HBPC) is a VA program that delivers primary health care in the home using a hospital based interdisciplinary team to homebound, and often bedridden, eligible Veterans. This program provides Veterans with individual medical, nursing, social,

dietetic, pharmacy, and rehabilitation services within the milieu of the Veteran's home and family. HBPC is a direct care outpatient program providing health care to individuals who require continuing care and for whom follow-up in an outpatient clinic is not feasible. The HBPC social worker provides Veterans in HBPC with high quality case management, clinical treatment, advocacy, and coordinates linkages with appropriate VA and community service providers/agencies as needed by the Veteran. This is facilitated by maintaining home visits, and is accomplished in collaboration with other members of the HBPC Team, or other interdisciplinary treatment teams as appropriate, i.e. specialty clinics, primary care, mental health.

VHA Handbook 1141.01, Home-Based Primary Care Program:
http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1534

HOME TELEHEALTH (HT)

Home TeleHealth (HT) uses health informatics, disease management, and TeleHealth technologies to target care and provide case management thereby facilitating access to care and improving the health of Veterans. Home TeleHealth changes the location where health care services are routinely provided and supports Veterans' preferences to live in the least restrictive settings possible. In HT programs, social workers assist with supportive counseling and monitor health informatics responses, following up on depression and caregiver stress.

VHA Handbook 1173.17, Home TeleHealth Equipment Management Procedures:
http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1657

Website for Department of Veterans Administration, Home TeleHealth:
<http://www.telehealth.va.gov/ccht/index.asp>

HOPTEL OR HOMETEL

Hoptel or Hometel is a VA program designed to provide on-campus, temporary, overnight lodging for Veterans who live a significant distance from the VA health care facility. Some Veterans stay for an extended period receiving chemotherapy, radiation therapy, or organ transplant. Others may stay for a night to ensure their timely arrival for outpatient appointments (e.g., Compensation and Pension) and examinations, outpatient tests, or procedures (e.g., GI endoscopies, cardiac catheterizations, MRI's, etc.), or a scheduled surgery the next day. Adult family members or caregivers may stay, if beds are available. Veterans must be medically stable and able to provide for their daily needs. The social worker's role is to manage the daily operation of the program, develop policies and procedures for program operation, and prepare occupancy reports and statistics for the facility. Additionally, the social worker may provide administrative oversight of clerical staff who typically schedules the reservations.

VHA Directive 2003-009, Temporary Lodging and Hoptel Programs:
http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=232

HOSPICE AND PALLIATIVE CARE (HPC)

The Hospice and Palliative Care Program (HPC) provides holistic care to Veterans threatened with a life-limiting illness. Focus is often on symptom management and comfort for the Veteran. Along with managing physical symptoms, the team approach also helps to manage psychosocial issues and spiritual comfort to the Veteran and their support system (family, friends, primary caregiver, etc) in relation to end-of-life care. The program can serve Veterans in outpatient and inpatient settings depending on the facility. Roles for social workers in HPC can range from serving on both inpatient and outpatient hospice teams, supporting palliative care consultation teams, coordinating bereavement support and arranging for onsite memorial services. Social workers often complete psychosocial assessments, coordinate referrals, provide bereavement support, end of life education, and help with the overall communication process.

VHA Directive 2008-041, Hospice and Palliative Care Workload Capture:
http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1740

VHA Directive 2008-006, Palliative Care Consult Teams (PCCT):
http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1784

HOUSING AND URBAN DEVELOPMENT – VETERANS ADMINISTRATION SUPPORTIVE HOUSING PROGRAM (HUD-VASH)

HUD-VASH is a collaborative effort, supported through HUD Section 8 “Housing Choice” rental assistance vouchers and VA’s provision of intensive case management services. The HUD-VASH program is designed to support the national goal of ending chronic homelessness for the hardest-to-serve individuals who are often living with a disability, mental illness, or addiction. The primary components of the program are rental assistance (Section 8 vouchers) managed by the local Public Housing Authorities and VA case management services designed to improve the Veteran’s physical and mental health, and enhance his/her ability to remain stable, housed, and community-integrated.

Veteran participants in the HUD-VASH Program must be eligible for VA health care, must be homeless, and must have an identified need for case management services. Veterans with acute medical, substance use disorders, and/or mental health needs may be admitted to the program for case management; however, these needs must be met prior to placement in Section 8 housing. Admission to the HUD-VASH Program emphasizes those Veterans who are chronically homeless.

VHA Handbook 1162.05, Housing and Urban Development (HUD) Department of Veterans Affairs Supported Housing (VASH) Program:
http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2446

INTERN / GRADUATE PROGRAM

The VA operates the largest and most comprehensive clinical training program for social workers. The VA is affiliated with over 100 graduate schools of social work and trains approximately 900 MSW interns a year. Overall the VA's impact on social work education effects the current health care curriculum, standards for clinical practice and in expanding the roles and functions of clinical social workers. The Social Work Intern Program Coordinator is the primary liaison for schools of social work who place master's-candidate and/or bachelor of social work-candidate interns with social work field instructors (supervisors) in the VAMCs and community clinics. Typically, the coordinator links with schools of social work, identifies appropriate field placements and field instructors, assists in selection through interviewing and applications, and assists in facilitating required paperwork. She/he may also provide group supervision and orientation for the interns. His/her duties may be a collateral duty or part of an administrative position.

VHA Handbook 1400.04, Supervision of Associated Health Trainees
http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1754

[National Social Work SharePoint Site – Student Program](#)

MEDICAL FOSTER HOME (MFH)

Medical Foster Homes (MFH) provide an alternative to institutionalization, and are intended to improve the Veteran's quality of life and to provide health care in a home setting. The VA defines a Medical Foster Home as an adult foster home that is combined with a VA interdisciplinary home care team, such as Home Based Primary Care, to provide non-institutional long-term care for Veterans who are unable to live independently and prefer a family setting. The program coordinator is typically a social worker. MFH's include homes that are either rented or owned by a live-in caregiver who provides 24-hour supervision and needed personal care for no more than three residents, including Veterans and non-Veterans, and the Veteran(s) in the home is enrolled in the Home Based Primary Care Program.

The MFH target population includes eligible Veterans who meet nursing home level of care, are unable to live independently due to functional, cognitive, or psychosocial impairment, prefer a non-institutional setting for long-term care, and have the financial resources, or eligibility for VA benefits, to pay for care on an ongoing basis. Duties of the program coordinator include: (1) Maintaining appropriate working relationships with all levels of VA staff including the Veteran's VA care manager and interdisciplinary home care team; (2) Recruiting, and recommending approval of new homes that could provide care to Veterans in need of MFH care; (3) Assessing potential MFH environments for needed structural alterations; facilitating Home Improvement Structural Alterations (HISA) grant, if needed; (4) Ensuring initial and annual home inspections are done by the interdisciplinary VA inspection team; and (5) Ensuring a safe, suitable, and therapeutic environment for Veterans residing in MFH.

VHA Handbook 1141.02, Medical Foster Home Procedures:
http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2111

MEDICAL-INPATIENT

Medical-inpatient usually admits Veterans who are not assigned to a specialty care team (surgery, cardiology, neurology, etc.). Often these patients have chronic diseases, such as end stage renal diseases, diabetes, COPD, CHF and vascular disease, and/or an acute illness, such as gastrointestinal (nausea, vomiting, diarrhea) or pneumonia. A Veteran could also be admitted for alcohol abuse/intoxication and need to be medically stable before admittance to a treatment program.

A medical-inpatient social worker usually completes a psychosocial assessment to determine discharge and coping needs. Discharge needs could include acute rehab placement, skilled nursing placement and/or in-home care (homemaker chore, home based primary care, home health). Social workers often are in charge of coordinating the discharge to make sure that all discharge services are in place and discharge transportation has been arranged. Social workers also provide support to Veterans and/or families for coping related to diagnosis and may lead family meetings. Veterans are usually seen on an inpatient basis while they are admitted to the hospital.

MENTAL HEALTH - INPATIENT

Inpatient psychiatric units provide a psychiatric milieu for Veterans with acute mental health needs; specific programmatic offerings vary between medical centers. Social workers play an integral role in the overall coordination of aftercare and discharge planning, and are a valued member of the interdisciplinary clinical team. Social workers perform initial comprehensive assessments and may be responsible for facilitating family meetings and other communication with outside agencies. Social workers facilitate inpatient psycho-educational groups on inpatient units that relate to improved coping skills, interpersonal skills, and stress reduction. Social workers ensure that Veterans have follow-up appointments with mental health and medical providers if needed. They may also assist in housing, food, and benefit needs. In addition, social workers may perform post-discharge calls to evaluate the transition from inpatient to home or another natural environment.

MENTAL HEALTH – OUTPATIENT

Social workers in outpatient mental health settings provide mental health assessment, treatment, and social services to patients by appointment, walk-in, and telephone. Social workers provide brief or ongoing services for mental health crisis and chronic disorders on an individual, family, or group basis. Veterans seen in these settings have a broad range of needs, ranging from those experiencing situational stress to those with chronic and severe mental illness. Outpatient mental health social workers provide triage and assessment of Veterans who are self-referred for outpatient mental health treatment, or are referred by outpatient clinics, hospitals, and emergency care units. The services of the social worker is providing Veterans with accurate and timely assessment of mental health needs, establishing appropriate follow-up and intervention, educating Veterans regarding mental health services

available within VA and the local area, providing referrals to VA and community resources, and facilitating efficient use of mental health resources by accurate initial assessment and referral of Veterans.

VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics:
http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1762

MENTAL ILLNESS RESEARCH, EDUCATION AND CLINICAL CENTERS (MIRECC)

Congress established the Mental Illness Research, Education, and Clinical Centers (MIRECC) with the goal of researching the causes and treatments of mental disorders in Veterans and using education to put new knowledge into routine clinical practice in the VA. The mission of MIRECC is to generate new knowledge about the causes and treatments of mental disorders, apply new findings to model clinical programs, and widely disseminate new findings through education to improve the quality of Veterans' lives and their daily functioning in their recovering from mental illness. The MIRECCs conduct research and produce clinical educational programs and products but generally provide direct clinical treatment to Veterans only in the context of research protocols. There are presently at 10 MIRECCs nationwide and each has a particular area(s) of emphasis. MIRECC social workers are often most heavily involved in the clinical care component of the program. The social worker's role involves case management, completing assessments, consulting with family members and other healthcare professionals, education, and working with an interdisciplinary team of staff.

MIRECC VISN Locations and Emphases:

- VISN 1 Dual Diagnosis
- VISN 3 Serious Mental Illnesses
- VISN 4 Mental Health and Substance Abuse
- VISN 5 Severe and Persistent Mental Illnesses
- VISN 6 Post-Deployment Mental Illness
- VISN 16 Serving Rural and Other Underserved Populations
- VISN 19 Suicide Prevention
- VISN 20 Schizophrenia, PTSD and Dementia
- VISN 21 PTSD and Dementia
- VISN 22 Psychotic Disorders, Stress, Mental Health
- The National Center for PTSD

Website for Department of Veterans Administration, MIRECC:
<http://www.mirecc.va.gov/MIRECC/index.asp>

MENTAL HEALTH INTENSIVE CASE MANAGEMENT (MHICM)

MHICM has two distinct branches, Intensive Psychiatric Community Care (IPCC) and Satellite Day Treatment Centers (SDTC), with the overall mission to optimize the health, quality of life,

and community functioning of Veterans with serious mental illnesses who are high users of VA mental health inpatients services. IPCC interventions may include the following ensuring continuity of care during the discharge process, community visits to provide counseling, education to Veterans and their families, friends, and caregivers, accompanying Veterans to appointments, medication and money management, support, education, group and individual therapy, assisting with transportation and housing issues, crisis response services, and ongoing monitoring of client safety issues.

The social workers role is to plan, develop, and conduct a program of casework and group work services, integrated with a bio-psychosocial program, which contributes to the overall aims of the medical center. The social worker provides services to patients and their families who are experiencing emotional, social, or economic problems of a serious or complex nature. These services are primarily provided in the community, often within the Veteran's own home. The social worker is a valuable member of an interdisciplinary team and participates in activities designed to gain a total understanding of the patient's needs and problems, such as daily briefings, treatment planning conferences,. Seriously Mentally Ill (SMI) Veterans are seen for management of mental health care due to de-compensation of their mental status, psychosis, suicidal ideation, homicidal ideation, noncompliance with medication/treatment plan, and medication side effects.

RANGE (Rural Access Network Growth Enhancement) is another MHICM program that provides intensive case management for seriously mentally ill Veterans receiving VA services. The RANGE team is usually comprised of one nurse and one social worker.

MILITARY SEXUAL TRAUMA (MST)

Every VA hospital/medical center has a designated Military Sexual Trauma (MST) Coordinator who serves as a contact person for MST-related issues. The MST Coordinator serves as an advocate and can help find and access VA services and programs, state and federal benefits, and community resources for victims of MST. The VA provides free, confidential counseling and treatment for mental and physical health conditions related to experiences of MST.

VHA Directive 2010-033, Military Sexual Trauma (MST) Programming:
http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2272

MOVE! WEIGHT MANAGEMENT PROGRAM FOR VETERANS (MOVE!)

MOVE! is an evidence-based patient-centered weight management program for medically overweight or obese Veterans. The comprehensive program focuses efforts on behavior, nutrition, and physical activity to help Veterans lose weight, keep it off, and improve their health. As part of this program, social workers serve as support group facilitators and counselors.

VHA Handbook 1120.01, MOVE! Weight Management Program for Veterans (MOVE!):
http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2403

MULTIPLE SCLEROSIS (MS)

The Multiple Sclerosis Centers of Excellence (MSCoE) established by the Veterans Health Administration in 2003, is committed to serving the health care needs of approximately 28,000 Veterans with MS. The Centers of Excellence are located in Seattle and Portland (MSCoE, West) and Baltimore (MSCoE, East). These cooperative centers are organized around four functional cores: Clinical Care, Education and Training, Research and Development, Informatics and Telemedicine. The Centers of Excellence are dedicated to further the understanding of the disease, its impact on Veterans, and effective treatments to help manage MS symptoms. By collaborating with Veterans, caregivers, and health care providers the Centers hope to minimize disease impairment and increase the quality of life for Veterans with MS. Veterans with MS are also seen locally in outpatient clinics for day-to-day management of MS needs and/or concerns.

Social workers in the MS program assist with advance directives information, education, and referrals for VA and/or community resources. Social workers provide supportive counseling to the Veteran and family to assist with coping related to diagnosis. Social workers also teach Veterans how to advocate for themselves, provide crisis intervention, case management, and coordination of discharge planning. They work with multidisciplinary teams including physicians, nursing, occupational therapy, physical therapy and pharmacy.

VHA Handbook 1011.06, Multiple Sclerosis System of Care Procedures:
http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2129

Website for the Multiple Sclerosis Center of Excellence:
<http://www.va.gov/ms>

NEUROLOGY

Neurology is a field of medical practice that deals with disorders of the nervous systems. Specifically, it deals with the diagnosis and treatment of all categories of disease involving the central (brain and spinal cord), peripheral, and autonomic nervous systems. The corresponding surgical specialty is neurosurgery. Neurological episodes include, but are not limited to, migraine headaches, strokes, traumatic brain injury, spinal cord trauma, cerebral palsy, epilepsy, Alzheimer's disease, and Parkinson's disease.

A neurology and/or neurosurgery social worker usually completes a psychosocial assessment to determine discharge and coping needs. Discharge needs could include acute rehabilitation placement, skilled nursing placement, and/or in-home care (homemaker chore, home based primary care, home health). Social workers are often in charge of coordinating the discharge to make sure that all needed durable medical equipment has been provided, discharge services are in place, and discharge transportation has been arranged. Social workers also

provide support to Veterans and/or families for coping related to diagnosis and possible lifestyle changes after a neurological episode and/or neurosurgery. Veterans are usually seen on an inpatient basis either before/after surgery or in the clinic during follow-up appointments.

ONCOLOGY

Oncology is the area of medicine that deals with the study and treatment of cancer. Social work services provided in the inpatient oncology unit and outpatient clinics include assisting with Veteran/family care issues, patient education, supportive counseling, case management, and discharge planning. Social workers ensure efficient and professional services for oncology patients and their families designed to promote and enhance their physical and psychosocial functioning, with attention to the social and emotional impact of the illness and disability. As a member of a multi-disciplinary team, the social worker is responsible for assessing and providing support and intervention for the social and emotional needs of Veterans and their families to promote continuity of care.

OPERATION ENDURING FREEDOM/ OPERATION IRAQI FREEDOM / OPERATION NEW DAWN (OEF/OIF/OND) PROGRAM

Every VA Medical Center has an OEF/OIF/OND Care Management Team ready to welcome recently returning Veterans and Active Duty Servicemen to help coordinate their care. Each team consists of a Program Manager and Clinical Case Manager(s). Social workers serve as program managers or case managers to organize patient care activities and help Veterans navigate their way through the VA system. Case managers work closely with Military Treatment Facilities (MTF) and the Department of Defense (DOD) to ensure that Veterans make a seamless transition from active duty to Veteran status.

The OEF/OIF/OND Care Management Team is responsible for documenting and tracking Veterans receiving case management services in the national Care Management Tracking and Reporting Application (CMTRA). The members of the Care Management Team attend National Guard and Reserve outreach events, such as Pre-mobilizations, Demobilizations, Yellow Ribbon Reintegration's (YRRP), and Post-Deployment Health Re-Assessments (PDHRA), to enroll and educate the Veterans on their health care benefits and VA services. Additionally, the OEF/OIF/OND Care Management Team holds an annual Welcome Home Event for all the OEF/OIF/OND Veterans and their families.

Website for Department of Veterans Affairs, Returning Service Members (OEF/OIF/OND):
<http://www.oefoif.va.gov/>

ORGAN DONATION PROGRAM

The Organ Donation Coordinator works diligently with executive leadership, hospital staff, and Organ Procurement Agencies (OPO) in an effort to provide education regarding organ

donation. The social worker reports the possibility of organ and/or tissue recovery to Donor Services, and resolves issues that may arise during procurement. He/she tracks data related to procurements and reporting deaths on a monthly basis to calculate and report a conversion rate to OPO. The social worker develops, coordinates, tracks, and completes reports and audits, serves as a liaison between recovery agencies and each medical center, coordinates education for staff, case manages and assists with discharge planning as needed, and assists with reviewing charts for the conversion rate.

VHA Handbook 1101.03, Organ, Tissue and Eye Donation Process:
http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2020

PATIENT ADVOCACY

The Patient Advocacy Program was established to ensure that all veterans and their families, who are served in VA facilities and clinics, have their complaints addressed in a convenient and timely manner. The program operates under the broader philosophy of Service Recovery, whereby patient complaints are identified, resolved, classified, and utilized to improve overall service to veterans. The Patient Advocacy Program is an important aspect of patient satisfaction and contributes proactively to VA initiatives to provide world-class customer service. Social workers often serve as Patient Advocates who are responsible to listen to Veteran complaints, facilitate resolutions, and to analyze and trend data. The Patient Advocate is also responsible for improving Veteran satisfaction by taking a pro-active role in increasing staff awareness of patient perceptions and Veteran services through supporting medical center efforts to reduce the number of complaints, and by supporting proactive Veteran service initiatives.

VHA Handbook 1003.4, VA Patient Advocacy Program:
http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1303

PATIENT ALIGNED CARE TEAMS (PACT) - PRIMARY CARE

The Office of Patient Care Services, Primary Care Program Office, has undertaken a new initiative to implement a patient-centered medical home (PCMH) model at all VA Primary Care sites which is referred to as Patient Aligned Care Teams (PACT). This initiative supports VA's Universal Health Care Services Plan to redesign VA healthcare delivery through increasing access, coordination, communication, and continuity of care. PACT provides accessible, coordinated, comprehensive, patient-centered care, and is managed by primary care providers with the active involvement of other clinical and non-clinical staff. PACT allows patients to have a more active role in their health care and is associated with increased quality improvement, patient satisfaction, and a decrease in hospital costs due to fewer hospital visits and readmissions. PACT social workers work in the medical clinic areas where primary medical providers see Veterans; these clinics are referred to by a variety of names, such as Medical Practice. PACT social workers provide case management that includes providing information about financial resources and options, referring to collateral agencies, and ensuring coordination of services and continuity of care. Social workers provide complex and

varied services including education to assist in understanding the information given by the primary care teams, information about resources in the VA system and the community, supportive counseling for related medical issues and long-term illnesses and to problem-solve resources, identifying Veteran strengths and support systems available within the family and community, advocating for Veterans needs, explaining VA benefits and services, providing education and assistance in completing advanced directives, and reporting suspected cases of abuse and/or neglect.

VHA Directive 2012-11, Primary Care Standards:

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2504

VHA Handbook 1101.02, Primary Care Management Module (PCMM):

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2017

Website for Department of Veterans Affairs, Primary Care:

<http://www.va.gov/PrimaryCare/pcmh/>

POLYTRAUMA

VA offers specialized expertise in the care of patients with multiple traumas at VA Polytrauma Rehabilitation Centers (PRC) located at the. PRCs provide coordinated health and rehabilitation services to active duty service members and Veterans who have experienced severe injuries resulting in multiple traumas, including spinal cord injuries, traumatic brain injuries (TBI), visual impairment, amputations, combat stress, and post traumatic stress disorder (PTSD). Twenty-one Polytrauma Network Sites were designated in 2006 to provide continuity of care in the outpatient setting in Veterans' home areas to enhance therapy and service needs of the patients. These are interdisciplinary outpatient teams comprised of nurses, social workers, psychologists, and rehabilitation therapy staff.

Polytrauma clinical case management and care coordination is provided to polytrauma patients across the continuum amongst various systems of care. This involves acting as the primary case manager for emerging medical, psychosocial, or rehabilitation problems, managing the continuum of care, care coordination, acting as patient and family advocate, and assessing clinical outcomes and satisfaction.

A close, collaborative relationship between RN and SW Case Managers (CM) provides the most comprehensive approach to case management services. Each brings their discipline's unique perspective to ensure that all of the patient's physical and psychosocial needs are met. While these two disciplines work collaboratively, both RN and SW clinicians bring distinct skills sets to case management expertise and function under different scopes of practice. The role of the social worker in the Polytrauma System of Care coordinates services that include intake, assessment, evaluation and long-term case management of both inpatient and outpatient referrals for rehabilitative services. The case manager coordinates care with internal and external referral sites regarding physical transfer of patients to VAMC Polytrauma/TBI

program. The social worker provides the comprehensive range of social work activity for all patients and families identified, regardless of the complexity of the problems.

The polytrauma social work case manager also acts as a consultant and resource for community agencies, military points of contact, other VAMCs and the Department of Defense. The social work case manager serves a point of contact for referrals to the VAMC Polytrauma/TBI program.

Polytrauma Rehabilitation Centers Locations:

- Minneapolis , MN
- Palo Alto, CA
- Richmond, VA
- San Antonio, TX
- Tampa, FL

VHA Directive 2006-043, Social Work Case Management in VHA Polytrauma Centers:

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2490

VHA Handbook 1172.1, Polytrauma Rehabilitation Procedures:

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2875

Website for Department of Veterans Affairs, Polytrauma / TBI System of Care:

<http://www.polytrauma.va.gov/>

POST TRAUMATIC STRESS DISORDER (PTSD)

Post Traumatic Stress Disorder (PTSD) program social workers in the VA specialize in PTSD and provide many types of therapeutic services to Veterans who have, or are suspected to have, PTSD. These services include initial and diagnostic assessments; referrals to services and information about resources; education to Veterans and families; therapy and psycho-educational groups, including Cognitive Processing Therapy (CPT) groups; and individual intensive therapy.

VHA Handbook 1160.03, Programs for Veterans With Post-Traumatic Stress Disorder (PTSD):

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2174

Website for Department of Veterans Affairs , National Center for PTSD:

<http://www.ptsd.va.gov/>

PRISONER OF WAR PROGRAM (POW)

All VA's maintain a Prisoner of War (POW) Program and though the size and complexity of the program varies, it often consists of a Program Coordinator and a Medical Coordinator, who provide specialized assistance to former POW's. The POW program coordinator, typically a

social worker, is often responsible for administration of the program. Social work duties may include maintaining an up-to-date database of former POWs served by the facility, maintaining current knowledge regarding VA benefits to serve as an informational resource and advocate, serving as a point of contact to assist in referral, problem resolution, and case management issues, and planning and executing an annual National POW/MIA Recognition Day program.

VHA Directive 2011-018, Certification of Special Care and Benefits Teams (CBTs) Evaluating or Treating Former Prisoners of War (FPOW):

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2402

PSYCHOSOCIAL RECOVERY AND REHABILITATION CENTER (PRRC)

The Psychosocial Rehabilitation and Recovery Center (PRRC) goal is to help Veterans with chronic severe mental illness, such as Schizophrenia, Major Depression, Bipolar Disorder, and PTSD, lead more fulfilling lives and develop their full potential. Veterans participate in classes aimed at promoting community integration through effective symptom management, communication, and coping, as well as expressive arts skills. Interdisciplinary staff, including social workers serve as program managers, counselors, and teachers, support Veterans to address a variety of issues, such as stigma and recovery, and utilize peer support as a foundation.

VHA Handbook 1163.03, Psychosocial Recovery and Rehabilitation Center (PRRC):

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2428

RECOVERY COORDINATOR

The Recovery Coordinator serves as a recovery ombudsman to other VA directors, program managers, and staff on recovery and implementation of recovery-oriented services. The coordinator develops a facility recovery education plan for providers, Veterans, and their families and serves as a consultant to mental health programs and recovering Veterans in development of peer support groups, consumer counseling, and consumer-operated services, depending on local needs and resources. The focus is to train staff in how to put the Recovery Model into action by focusing on a system of care that supports recovery and building the resilience of people with mental health problems; not just on managing their symptoms.

REHABILITATION - MEDICAL

Social workers are assigned to both inpatient and outpatient rehabilitation programs within VA, and provide community resource referrals for supportive living services and coordinate outpatient needs and services such as prosthetic equipment, home adaptation benefits, VA disability and social security disability benefits, and automobile adaptations. They provide discharge-planning services from acute and sub-acute rehabilitation programs that may involve nursing home referrals, transitional housing programs, medical foster care, or residential care.

Social work services may also include individual and family counseling to help patients/families adjust to physical limitations and coping strategies in managing the changes in functional level of the Veteran. Social workers also work closely with the Caregiver Support program within VA to assist caregivers in managing patient care needs.

VHA Directive 2011-017, Physical Medicine and Rehabilitation Outcomes for Acute Stroke, Traumatic Brain Injury, and Lower-Extremity Amputation Patients:

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2401

VHA Handbook 1170.01, Accreditation of VA Rehabilitation Programs:

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1757

RESPIRE PROGRAM

The Respite Program is designed to give caregivers of Veterans a break from day-to-day care giving responsibilities. Inpatient Respite programs offer 24 hour care in VA Community Living Centers (CLC) or community nursing home to family and other unpaid caregivers of disabled or ill Veterans who are cared for in their homes. Outpatient respite programs provide care for Veterans in an outpatient setting, which can include Adult Day Health Care or paying for attendants in the Veteran's home, so the caregiver can safely attend to other duties or respite outside of the home. The goal is to improve the quality of life for both the Veteran and caregiver, by providing relief and support to caregiver who are at risk for caregiver burnout. Social workers serve as program coordinators, long-term care planners, supportive counselors, and educators to Veterans/caregivers/community members and VA staff.

VHA Handbook 1140.02, Respite Care:

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1802

SMOKING CESSATION

The smoking cessation program is offered to help Veterans and VA staff stop tobacco use. Psycho-educational treatment is offered in group settings, individually, and over the phone depending on individuals needs. For Veterans, referral to the program is initiated by the Veterans primary care provider or by the Veterans themselves. For VA staff the referral is self initiated. It is tied to several performance improvement measures for smoking cessation. Social workers can serve as the program coordinators or counselors.

VHA Directive 2008-081, National Smoking and Tobacco Use Cessation Program:

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1809

SOCIAL WORK ADMINISTRATION

Social workers are responsible for leadership at all levels of the organization. At VA Social Work and Case Management Service, the VA Central Office (VACO) staff provides oversight

and direction to all social workers in the VA. On a local VAMC level, a designated Social Work Executive is responsible for aspects of the social work profession, (see VA Directive). The Social Work Executive may often be the Chief, Associate or Assistant Chief of a designated Social Work Service or a Director of a Care Line Service or a social worker in a Care line or program, depending on the structure of the institution.

In addition, many social workers are program coordinators who coordinate and oversee a complex array of programs and responsibilities including services, budgets, and clinical and program planning. Program coordinator positions that are primarily administrative include Education, Field Instruction and Quality Management. Social Work Supervisors provide individual supervision and/or program coordination to social workers and/or other staff in many VA programs.

VHA Handbook 1110.02, Social Work Professional Practice:

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1585

SOCIAL WORK VETERANS INTEGRATED SERVICE NETWORK (VISN) LEAD

The Social Work VISN Lead acts as the contact person for social work issues within the VISN. VISN leadership needs approve the Social Work VISN Lead and each VISN has a set procedure on rotation of the lead position. The lead is responsible for attending a monthly national VISN Lead conference call and sharing information from this call with the other VISN social work chiefs/executives. Other responsibilities include leading a monthly VISN social work conference call for chiefs/executives, holding face-to-face meetings periodically, discussing relevant social work issues from CO, VISN, and facility level, fielding social work questions that arise within the VISN, and supporting other social work chiefs/executives within the VISN. The lead is highly experienced in social work practice and has served as a social work chief or executive for a period, understands the VA system, and has developed a social work service or program.

SPINAL CORD INJURY/DISORDERS (SCI/D) SYSTEM OF CARE

VA has the largest single network of SCI care in the nation. VA services are delivered through a “hub and spoke” system of care, extending from 24 regional SCI/D Centers offering primary care and specialty care by multidisciplinary teams (hubs) to the 134 SCI/D Primary Care teams (spokes) at local VA medical centers. Social workers play a key role in the mission of the VA SCI/D Services, which is to support and maintain the health, independence, quality of life, and productivity of individuals with spinal cord injury and disorders throughout their lives. This mission is accomplished through rehabilitation, sustaining medical and surgical care, patient and family education, psychological and vocational care, education, and professional training.

Social workers in the SCI system of care provide supportive counseling to Veterans and their families, advocacy, crisis intervention, case management, and coordination of care planning. Social workers in the SCI Centers and those in the spokes are critical members of

the SCI multidisciplinary team. They work with multidisciplinary teams that include physician(s), nurses, occupational therapists, physical therapists, dietitians, recreation therapists, psychologists, other social workers, prosthetics and pharmacists, among others. The social worker in the SCI Center also assists with many aspects of care, such as patient education, preparing and implementing the discharge plan, arranging meetings with the Veteran and their family, arranging and providing family training days and working closely with other team members to identify and achieve the goals of the Veteran. The social workers in the “spoke” sites serve as the SCI Coordinator and work with their locally assigned SCI physician and nurse and their designated SCI Center, to improve access to SCI primary care services, provide ongoing patient and family education, and to track the care of the Veteran to ensure appropriate referrals are made within the hub and spoke system of care. In addition, they provide needed assistance for transportation of Veterans and also assist with any additional care needs and benefits through VA and/or community resources. Veterans with SCI/D have complex problems and social workers working with this population require specialized knowledge. Close collaboration with the SCI Center helps to ensure healthier Veterans with SCI/D, through consultative care and comprehensive annual evaluations.

Website for Department of Veterans Affairs , Spinal Cord Injury and Disorders Services:

<http://vaww.sci.va.gov/>

VHA Handbook 1176.01, Spinal Cord Injury And Disorders (SCI/D) System of Care:

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2365

VHA Directive 1176, Spinal Cord Injury and Disorders System of Care:

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2299

SUBSTANCE ABUSE/ADDICTIONS TREATMENT PROGRAM (ATP)

Substance abuse programs across VA Medical Centers vary widely and range from supportive psychotherapy drop-in groups to residential programs. VA Medical Centers also may have opioid treatment programs where Methadone and Suboxone is available. Social workers perform comprehensive assessments, provide various types of evidence-based therapies, and coordinate the Veterans' medical and psychiatric needs. In addition, they facilitate support groups and perform alcohol breathalyzer tests to ensure that Veterans' needs are addressed.

Substance abuse treatment groups that may be offered:

- Intensive Outpatient Program or Day program: Time limited intensive structured program ranging from four days to two weeks
- Drug and Alcohol Treatment Program: Combination of assessment, group treatment, and/or individual treatment following a prescribed Phase program or similar, implementing individualized treatment plans for Veterans
- Specialty Treatment Programs: These specialty programs provide specific interventions for particular populations or needs such as Substance Use, PTSD and Dual Diagnosis

- Upload Treatment or Opioid Replacement Program: Comprehensive program where Veterans are dispensed either Methadone or Suboxone, then are placed on a comprehensive protocol and monitored by a multi-disciplinary team
- Types of Groups: Sobriety Support Drop-In , After –Care, Anger Management, Gambling, Process, Mood Management, Relapse Prevention, Resentment, Recovery, SATP Orientation , Self Reflection and Women's

SUICIDE PREVENTION

VA mental health officials estimate there are 1,000 suicides per year among Veterans receiving care within VA and as many as 5,000 per year among all living Veterans. In response, the VA has created a National Suicide Prevention Plan. The Suicide Prevention Coordinator (SPC) manages the national suicide prevention plan at the facility level. SPCs have multiple responsibilities to Veterans and their families, VA staff, community members, and the national database. SPC responsibilities include assessing the risk of suicide in individual Veterans in conjunction with treating clinicians, and ensuring patients identified as being at high risk for suicide receive follow-up and that follow-up is documented in the electronic medical record. They work with clinicians who refer potential high risk patients for flagging to determine the advisability of the flag, review the provider-completed Suicide Behavior Reports, maintain communications with the facility-designated advisory group or committee, maintain a list of Veterans who are currently flagged and establish a system of reviewing the flags at least every 90 days, documents the nature of the follow-up and plans for continuing treatment, and identifies training needs relating to the prevention and management of suicide.

In July of 2007, the VA opened a Veterans Crisis Hotline staffed with mental health professionals, including SPCs 1-800-273-TALK (8255). The Hotline is available 24 hours a day 7 days a week.

VHA Directive 2008-051, Mandatory Suicide Risk and Intervention Training for VHA Health Care Providers:

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1750

SURGICAL SERVICES

Surgical services social workers assist Veterans who are discharging and transitioning from the hospital back to their communities. She/he completes a psychosocial assessment to determine discharge needs and may need to make referrals for VA/community resources, which may include transportation and in-home services, and/or assist with nursing home placement for short-term skilled rehab. Often, surgery patients need arrangements made for home intravenous (IV) antibiotics and/or home wound care. Social workers also provide support to Veterans and/or families for coping related to diagnosis and possible lifestyle changes after surgery. Veterans are usually seen on an inpatient basis either before and/or after surgery and may be seen by social workers in the clinic during follow-up appointments.

- Cardiothoracic Surgery (CT surgery) is a field of medical practice that involves surgical treatments for diseases that affect the organs inside the thorax (the chest). Usually these surgeries involve treatment for conditions of the heart and lungs such as; coronary artery bypass graft surgery(CABG), aortic valve replacement, lung biopsies, bronchoscopy and wedge resections, to name a few. Since cardiothoracic surgeons are very specialized not every VA Medical Center has a CT surgery team.
- General Surgery is a field of medical practice that involves surgical treatments that often focus on the abdominal organs: intestines, stomach, colon, liver, gallbladders, bile ducts, thyroid glands and hernias. Typical general surgeries can include cholecystectomy, appendectomy, hemicolectomy and hernia repair.
- Orthopedic Surgery (Ortho) is a field of medical practice that involves conditions of the musculoskeletal system. Orthopedic surgeons use both surgical and non-surgical interventions to treat musculoskeletal trauma, sports injuries, and degenerative diseases. Typical orthopedic surgeries include knee and shoulder arthroscopy, knee & hip replacement and ankle fractures.
- Vascular Surgery is a field of medical practice that uses medical therapy, minimally invasive procedures, and surgical reconstruction for disease of the vascular system (arteries and veins). Common surgeries include abdominal aortic aneurysm repair, carotid endarterectomy, angioplasty, with or without stent, and amputations.

TRANSPLANT PROGRAM

The Transplant social worker assists Veterans and their families with non-medical issues that may arise before, during, or after organ or tissue transplantation. The social worker completes a comprehensive evaluation on potential recipients and donors and can initiate/coordinate the referral process. He/she assists Veterans and their families manage the complex emotional, personal, social, and psychological issues of transplantation throughout the transplant process.

VHA Directive 2012-018, Solid Organ and Bone Marrow Transplantation:
http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2765

TRAUMATIC BRIAN INJURY (TBI)

Each VA Medical Center has a TBI Coordinator, who assists Veterans diagnosed with mild and moderate to severe traumatic brain injury. Services include assisting with appointments and managing the Veterans overall care. The TBI coordinator is often a social worker and is responsible for referring Veterans to community and VA resources and can facilitate locating resources for Veterans with financial problems, transportation issues, housing/homelessness, and VBA benefits and claims. The TBI coordinator tracks Veterans listed in the National TBI Registry Database and is responsible for data collection and action plans related to TBI Performance Measures.

VHA Handbook 1172., Polytrauma System of Care:
http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2032

VA LIAISONS FOR HEALTHCARE

VA has a robust system in place to transition severely ill and injured service members from DoD to the VA system of care. A key component of transitioning these injured and ill Service members and Veterans are the VA Liaisons for Healthcare, either social workers or nurses, strategically placed in Military Treatment Facilities (MTFs) with concentrations of recovering Service members returning from Iraq and Afghanistan. Having started in 2003 with one VA Liaison at two MTFs, VA now has 33 VA Liaisons for Healthcare stationed at eighteen MTFs. The VA Liaisons facilitate the transfer of Service members and Veterans from the MTF to a VA health care facility closest to their home or most appropriate for the specialized services their medical condition requires.

VA Liaisons are co-located with DoD case managers at MTFs and provide onsite consultation and collaboration regarding VA resources and treatment options. VA Liaisons educate service members and their families about the VA system of care, coordinate the service member's initial registration with the VA, and secure outpatient appointments or inpatient transfer to a VA health care facility as appropriate. VA Liaisons make early connections with service members and families to begin building a positive relationship with the VA.

VHA Handbook 0320.04, Department of Veterans Affairs and Department of Defense Contingency Plan:

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1629

VETERANS JUSTICE OUTREACH (VJO)

The Veterans Justice Outreach (VJO) initiative is designed to provide outreach to Veterans in contact with the justice system through encounters with police, jails, and courts. The goal of the VJO program is to provide timely access to VA services for eligible justice-involved Veterans to avoid unnecessary criminalization and incarceration of Veteran offenders with mental illness. VJO services provided by a social worker involve direct outreach, assessment, and case management for justice-involved Veterans in local courts and jails, and act as a liaison with local justice system partners. The difference between VJO and HCRV program is that the HCRV targets Veterans who are already incarcerated and are planning re-entry back to community. The VJO program makes contact prior to incarceration as prevention.

Department of Veteran Affairs website:

<http://www.va.gov/HOMELESS/VJO.asp>

VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics:

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1762

VISION IMPAIRED SERVICE TEAM (VIST)

The Vision Impaired Service Team (VIST) Coordinator is responsible for overseeing and coordinating vision rehabilitation services for eligible Veterans and is the VA Medical Center's primary contact for matters related to blind or vision impaired rehabilitation. This includes

assessing referred Veterans for VIST eligibility, tracking VIST eligible Veterans in the VA Blind Rehabilitation Services (BRS) database, completing annual reviews with each VIST Veteran to determine further plan of care, and educating Veterans about VA and non-VA benefits and community resources for Veterans with blindness or vision impairment. The VIST coordinator handles all of the referrals to VA Blind Rehabilitation Centers, where Veterans can receive the most comprehensive level of blind rehabilitation services and training. The VIST coordinator may lead a support group and serves as the public relations contact and intra-service contact for matters related to vision rehabilitation. He/she is responsible for providing in-service trainings to VA and non-VA staff throughout the year. There is some variance nationwide regarding the type of blind or vision impaired rehabilitation services that can be provided locally. Some VA Medical Center's have a part-time VIST coordinator or it may be a collateral duty.

VHA Handbook 1174.03, Visual Impairment Services Team Program Procedures:
http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2110

VOCATIONAL REHABILITATION

Vocational Rehabilitation assists unemployed and underemployed Veterans in finding and maintaining employment. The services provided may be linked to the Compensated Work Therapy (CWT) program and Supported Employment or it may be a separate program (see CWT section). Social workers and/or vocational rehabilitation specialists provide case management. Staff in this role assists Veterans in acquiring the skills, knowledge, and resources to find and obtain employment through resumes, interviewing, presentation, and personal hygiene, and referrals to retraining. Additionally, they assist the Veteran in maintaining and keeping their job through conflict resolution skills training, case management, recovery, and goal setting.

WOMEN VETERANS PROGRAM

The Women Veterans Program offers services designed to meet the needs of female Veterans including primary care, pap smears, breast screening, mammography, birth control, menopause treatment, sexual trauma counseling, and fee basis maternity care. Eligible Veterans may be provided with substance abuse treatment, surgical, mental health, HIV counseling, referrals that range in complexity from HIV Counseling to a referral for Military Sexual Trauma. Social workers may serve as the Women Veterans Program Manager (WVPM), which combines clinical and administrative program management. The WVPM is responsible for outreach to women Veterans, education within the VA, coordinating services, improving services, coordinating designated performance measures, and the overall functioning of the women Veterans' health program.

VHA Handbook 1330.1, VA Services for Women Veterans:
http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2246

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