



## OFFICE OF THE UNDER SECRETARY OF DEFENSE

4000 DEFENSE PENTAGON  
WASHINGTON, DC 20301-4000

PERSONNEL AND  
READINESS

The Honorable Carl Levin  
Chairman  
Committee on Armed Services  
United States Senate  
Washington, DC 20510

SEP 7 2011

Dear Mr. Chairman:

This letter is in response to section 716 of the Ike Skelton National Defense Authorization Act for Fiscal Year 2011, which requires the Secretary of Defense to review all policies and procedures of the Department of Defense (DoD) regarding the use of pharmaceuticals in rehabilitation programs for seriously ill or injured members of the Armed Forces. This report is due to the congressional defense committees, with any recommendations for administrative or legislative actions with respect to the review no later than September 20, 2011.

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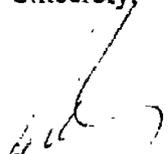
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Thank you for your interest in the health and well-being of our Service members, veterans, and their families.

Sincerely,

A handwritten signature in black ink, appearing to read "Lo Ann Rooney". The signature is written in a cursive style with a long, sweeping underline that extends to the right.

Lo Ann Rooney  
Principal Deputy

Enclosures:  
As stated

cc:  
The Honorable John McCain  
Ranking Member



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The Honorable Jim Webb  
Chairman  
Subcommittee on Personnel  
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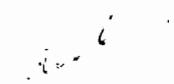
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cc:  
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Ranking Member



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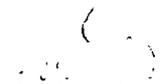
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Enclosures:  
As stated

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The Honorable Susan A. Davis  
Ranking Member



PERSONNEL AND  
READINESS

## OFFICE OF THE UNDER SECRETARY OF DEFENSE

4000 DEFENSE PENTAGON  
WASHINGTON, DC 20301-4000

The Honorable Daniel K. Inouye  
Chairman  
Committee on Appropriations  
United States Senate  
Washington, DC 20510

SEP 7 2011

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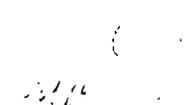
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Enclosures:  
As stated

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PERSONNEL AND  
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OFFICE OF THE UNDER SECRETARY OF DEFENSE  
4000 DEFENSE PENTAGON  
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High Risk Patient Medication Reporting Tools. The Pharmacy Medication Analysis Reporting Tool (P-Mart) and the Controlled Medication Review Analysis Tool (Enclosure 5) were developed by the DoD Pharmacoeconomic Center in San Antonio, Texas. These tools are used to assist providers and pharmacists in performing medication reviews for all high risk patients. Outpatient electronic prescription data from Military Treatment Facility pharmacies, the TRICARE Retail Network pharmacies, and the TRICARE Mail Order Pharmacy program are

consolidated through these tools and provides the reviewers with a comprehensive, up-to-date record of each high risk patient's medication profile.

The Defense Centers of Excellence (DCoE) for Psychological Health (PH) and Traumatic Brain Injury (TBI). DCoE works with a network of military and civilian experts to identify promising practices and quality standards for the treatment of PH and TBI for all Service members, their family members, and veterans. This network includes the Department of Veterans Affairs (VA), civilian agencies, advocacy groups, clinical experts, and academic institutions.

This network provides products to assist providers in multiple areas of care, including the appropriate use of pharmaceuticals (Enclosure 6). The list of organizations involved in the individual products is visible on the product Web sites listed in the table along with the elements of education for each product.

VA/DoD Clinical Practice Guidelines (CPGs), included in the table, are produced to assist providers in pursuing integration of evidence-based treatments with case-based clinical judgment for specific conditions, including reviews of evidence for effectiveness of Complementary and Alternative Medicine Therapies for post traumatic stress disorder (PTSD). The table also includes Clinical Support Tools (CSTs) that further equip providers, patients, family members, and case managers in the pursuit of collaborative care. The CSTs for Substance Use Disorders, PTSD, and bipolar disorders are currently in development and will include tools for providers, patients, and families. These VA/DoD CPGs and CSTs include education about the use of pharmaceuticals and other multi-modal interventions.

The information includes overviews of the fundamentals of safe prescription drug use, as well as the risk and benefits of using the pharmaceuticals in rehabilitation therapies. In addition, the Co-Occurring Conditions Toolkit: Mild TBI and PH (Concussion, Posttraumatic Stress, Depression, Chronic Pain, Headache, and Substance Use Disorder) contains examples demonstrating the use of pharmaceuticals with individuals who have multiple, complex injuries. This toolkit also has links to assist with finding additional resources for basic elements of pain and pharmaceutical management. Additionally, DCoE's Outreach Center has several peer-reviewed and vetted sources of information for prescribing providers. Providers can contact the Outreach Center to obtain information about these sources.

DCoE's Outreach Center serves not only Service members and their families, but also military leaders, support personnel, clinicians, and deployed civilian personnel.

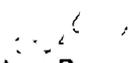
Transition to the Veterans Health Administration (VHA). VHA Handbook 1010.02, dated November 13, 2009 (Enclosure 7). When it has been determined that future care for the Wounded Warrior will be provided by VHA a critical point in the continuum of care for high risk patients is the point of transition of care from DoD to VHA.

In these cases, comprehensive procedures are in place to ensure a seamless transition and to ensure that high risk patients and their families are provided with transition assistance. The VHA Handbook outlines procedures for transitional care and for assigning VA Liaisons for health care at all major military hospitals to assist with transfer to VHA health care system. The VHA Handbook establishes practice standards, roles, responsibilities and training requirements for nurses and social workers. In practice, VA liaisons in military hospitals have developed collaborating relationships with military social workers, case managers, specialty care staff, discharge planners, Warrior Transition Unit staff, military pharmacists, and family members of the transitioning patient.

Completion of this comprehensive review reinforces that the Department's policies and programs address the use of pharmaceuticals in programs for seriously ill or injured members of the Armed Forces and take extraordinary efforts to ensure their safety. Going forward, the Department will work to ensure consistency of policy across all Services, increase our understanding of various patient subsets at highest risk and place appropriate safeguards, improve non-pharmacological modalities for managing pain and sleep, and continue to enhance information technologies. At this time, no additional legislative action is required.

Thank you for your interest in the health and well-being of our Service members, veterans, and their families.

Sincerely,

  
Jo Ann Rooney  
Principal Deputy

Enclosures:  
As stated

cc:  
The Honorable Norman D. Dicks  
Ranking Member



MCCG

REPLY TO  
ATTENTION OF

DEPARTMENT OF THE ARMY  
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND  
2748 WORTH ROAD  
FORT SAM HOUSTON, TX 78234-6000

OTSG/MEDCOM Policy Memo 11-029  
07 APR 2011

Expires 7 April 2013

MEMORANDUM FOR COMMANDERS, MEDCOM REGIONAL MEDICAL  
COMMANDS

SUBJECT: Warriors in Transition High-Risk Medication Review and Sole Provider  
Program

1. References:

- a. Army Medical Action Plan (AMAP), <https://www.us.army.mil/suite/page/400750>.
- b. FRAGO 18 to Operation Order 07-55 (MEDCOM Implementation of the Army Medical Action Plan), 17 Oct 07.
- c. FRAGO 27 to Operation Order 07-55 (MEDCOM Implementation of the Army Medical Action Plan), 16 Feb 08.
- d. FRAGO 30 to Operation Order 07-55 (MEDCOM Implementation of the Army Medical Action Plan), 28 Mar 08.
- e. WTC Policy Memorandum 10-033, Warrior Transition Unit/Community Based Warrior Transition Unit (WTU/CBWTU) Risk Assessment and Mitigation Policy, 16 Jun 10.
- f. OTSG/MEDCOM Policy 10-047, Warrior Transition Unit (WTU) Behavioral Health (BH) Risk Assessment and Comprehensive Assessment Policy, 13 Jul 10.
- g. Final Report of the Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces, Aug 10.

2. Purpose: To provide policy guidance for reviewing high-risk medication use in Warriors in Transition (WTs) and instruction for Sole Provider Programs (SPP).

3. Proponent: The proponent for this policy is the Assistant Chief of Staff for Health Policy and Services.

4. Responsibilities:

- a. The OTSG Pharmacy Consultant will update this policy and share identified best practices as necessary.

\*This policy memo supersedes OTSG/MEDCOM Policy Memo 09-022, 14 Apr 09, subject: Warriors in Transition High Risk Medication Review and Sole Provider Program.

**MCCG**

**SUBJECT: Warriors in Transition High-Risk Medication Review and Sole Provider Program**

b. **Military treatment facility (MTF) Commanders will develop programs for high-risk medication management and education, and implement procedures for enrolling high-risk WTs into an SPP.**

c. **MTF Pharmacy Directors will develop written policies and procedures to establish an SPP.**

**5. Background:**

a. **Recent analysis of suicides and accidental deaths in WTUs suggests that the risk for these events in WTs is higher than in the general military population. WTs represent a significant percentage of high-risk patients cared for by the MTF.**

b. **Assigning WTs to a sole provider may help deter patients from harming themselves through accidental overdose of narcotics and/or other high-risk medications.**

c. **Certain prescription medications, alone or in combination, may cause adverse side effects that may prove lethal. These high-risk medications include, but are not limited to, narcotic analgesics, anxiolytics, and anti-seizure and insomnia medications. Using alcohol and illicit drugs in combination with high-risk medications increases the potential for adverse events and death.**

**6. Policy:**

a. **A baseline medication review and reconciliation must be completed on every assigned or attached WT Soldier within 24 hours of arrival and a deliberate review within 72 hours, to identify potential adverse medication interactions, side effects, or potentially lethal medication combinations. The WT Primary Care Manager (PCM), in collaboration with WTU Nurse Case Managers (NCM), MTF Clinical Pharmacists, and other MTF privileged providers involved in the care of the WT Soldiers, must lead this effort. The reviewing provider must document this encounter in the electronic medical record (AHLTA).**

b. **MTF Directors of Pharmacy will assign Clinical Pharmacist(s) to provide dedicated support to WTUs. They will perform a medication review for all high-risk or sole provider Soldiers at least weekly and as needed when the medical staff identifies new high-risk Soldiers. Commanders should ensure they use pharmacists to provide safe and appropriate medication therapy for WT Soldiers; provide medication therapy management services to prevent, identify, and resolve medication-related problems; and conduct medication reviews of prescription and over-the-counter medications, dietary supplements, and herbal products. To ensure effective communication between the WTU cadre and Clinical Pharmacists, WTU commanders will establish a mechanism for routinely sharing information on the status of all Warriors.**

**MCCG**

**SUBJECT: Warriors in Transition High-Risk Medication Review and Sole Provider Program**

c. All WT Soldiers deemed high-risk after either the 24-hour or 72-hour risk assessment (IAW reference 1.e.) or following any subsequent risk reevaluation will be entered into the SPP. If the PCM or other provider assesses the Soldier as high-risk, the provider will follow local MTF procedures to determine who will become the patient's sole provider. The designated sole provider or designated alternate is the only provider authorized to prescribe or telephonically approve all prescriptions for the high-risk Soldier. The sole provider may be the Soldier's PCM, but could be a specialist, sub-specialist, or other PCM.

d. To improve the appropriate use of medications and minimize risk, WT Soldiers identified as high-risk (and enrolled in an SPP per paragraph 6.c.) will receive no more than a 7-day supply of controlled or non-controlled medications. Providers may include up to three refills for non-controlled prescription medications. WT Soldiers in an SPP are restricted to one pharmacy for prescriptions (e.g., MTF pharmacy or TRICARE retail network pharmacy, if enrolled in a CBWTU). This dispensing restriction applies to all WT Soldiers in an SPP. The MTF Pharmacy and Therapeutics Committee will receive and review summary reports from the SPP monthly.

e. MTF pharmacies will coordinate sole provider restrictions through the Pharmacy Operations Center, Fort Sam Houston, TX. The Pharmacy Operations Center may be reached at 1-866-275-4732, Option 8. For MTF-based WTUs, the WT's sole provider will initiate and complete the provider portion of the form located at [http://pec.ha.osd.mil/pdts/pdts\\_mtf.php](http://pec.ha.osd.mil/pdts/pdts_mtf.php) (Enclosure 1). The provider should forward the form with their completed portion to the Clinical Pharmacist who is supporting the WTU. The pharmacist will coordinate restriction of the Soldier to the sole provider and MTF pharmacy with the Pharmacy Operations Center.

f. CBWTU Commanders should consider returning the high-risk WT Soldiers to the WTU from CBWTU. If not returning to a WTU, the WT Soldier's NCM will initiate and complete the provider portion of the form located at [http://pec.ha.osd.mil/pdts/pdts\\_mtf.php](http://pec.ha.osd.mil/pdts/pdts_mtf.php) (Enclosure 2) restricting the WT Soldier to one retail network pharmacy. The NCM will coordinate restriction of the Soldier to the retail network pharmacy with the Pharmacy Operations Center.

g. Only a Soldier's sole provider or authorized alternate is allowed to modify an existing sole provider arrangement. Providers will coordinate changes to the sole provider arrangement through the pharmacy. Changes to the sole provider arrangement should include (as applicable) removal of restrictions, duty station changes, medical retirements, or change in risk status. The MTF pharmacy will contact the Pharmacy Operations Center to initiate the change.

MCCG

SUBJECT: Warriors in Transition High-Risk Medication Review and Sole Provider Program

h. The MTF prescribing provider and pharmacy will receive real-time warnings when an unapproved provider and/or pharmacy attempt to provide the Soldier medications. The MTF will identify the role of these warnings within existing SPP processes.

i. MTF pharmacists designated to support WTUs will request a Pharmacy Medication Analysis & Reporting Tool (P-MART) report weekly for all high-risk WTU Soldiers. The P-MART tool, which can assist providers performing medication reviews, is available from the Pharmacoeconomic Center at <http://pec.ha.osd.mil/PMART/default.php>. The P-MART contains outpatient prescription data from MTFs, the TRICARE Mail Order Pharmacy, and retail network pharmacies.

j. The Controlled Drug Medication Review Analysis Tool is an automated tool to assist providers in identifying and monitoring controlled substance prescription use and is available from the Pharmacoeconomic Center at <http://pec.ha.osd.mil/CDMART/default.php>.

FOR THE COMMANDER:

2 Encls

  
HERBERT A. COLEY  
Chief of Staff

# MTF Rx Restriction Request Form

Fax this form to the DoD Pharmacy Operations Center (POC) at (210) 295-2567  
To contact the POC dial 1-866-275-4732, option 8

Version 5

## Restricted Beneficiary's Information

Is member assigned to a WTU: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Sponsor's SSN: \_\_\_\_\_

## Sole Provider Information

Reason for Request: \_\_\_\_\_

Member has been notified of restriction  Effective Date: \_\_\_\_\_

**\*Note\*** Medical Management Team should re-evaluate restriction requirement for member six months after effective date. Send update notification to the POC at [ppts.ameddc@amedd.army.mil](mailto:ppts.ameddc@amedd.army.mil)

To Be Completed by Provider

Site / Company: \_\_\_\_\_

Sole Provider Phone Number: \_\_\_\_\_ Sole Provider Email: \_\_\_\_\_

Sole Provider Printed Name / Title: \_\_\_\_\_ Sole Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Nurse Case Manager Printed Name: \_\_\_\_\_ Nurse Case Manager Phone Number: \_\_\_\_\_

Nurse Case Manger Email: \_\_\_\_\_

To Be Completed by Pharmacy

## MTF Pharmacist Information

MTF RPh Phone Number: \_\_\_\_\_ MTF RPh Email: \_\_\_\_\_

MTF RPh Printed Name / Title: \_\_\_\_\_ MTF RPh Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Type of Lock

**Note:** The lock will prevent the member from using their TRICARE benefits at the mail order pharmacy or a retail pharmacy.

Restrict all meds for a beneficiary to a specific pharmacy and/or provider.

Provider Information: \_\_\_\_\_

Provider DEA / NPI #: \_\_\_\_\_

Pharmacy Information: \_\_\_\_\_

Restrict controlled meds for a beneficiary to a specific provider or list of providers. Authorized Prescriber's printed name and DEA / NPI: \_\_\_\_\_

OR

Exclude controlled substances from a beneficiary or specific non-controlled substance(s).  
Select Schedule (all that apply)  II  III  IV  V Other: \_\_\_\_\_

Print Form

ENCLOSURE 1

# Community Based WTU Rx Restriction Request Form

Fax this form to the DoD Pharmacy Operations Center (POC) at (210) 295-2567 or DSN 471-2567  
To contact the POC dial 1-866-275-4732, option 8

Version 3.1

## Restricted Beneficiary's Information

Last Name:	<input type="text"/>	First Name:	<input type="text"/>	M.I.:	<input type="text"/>
Birth Date:	<input type="text"/>	Sponsor's SSN:	<input type="text"/>		

## Sole Provider Information

Reason for Request:

Member has been notified of restriction to physician(s) and/or pharmacy

**\*Note\*** Medical Management Team should re-evaluate restriction requirement for member six months after effective date. Send update notification to the POC at [pdts.ameddcs@amedd.army.mil](mailto:pdts.ameddcs@amedd.army.mil)

**To Be Completed by Provider**

Effective Date:	<input type="text"/>				
Site / Company:	<input type="text"/>				
Sole Provider Phone Number:	<input type="text"/>	Sole Provider Email:	<input type="text"/>		
Sole Provider Printed Name / Title:	<input type="text"/>	Sole Provider Signature:	<input type="text"/>	Date:	<input type="text"/>
Nurse Case Manager Printed Name:	<input type="text"/>	Nurse Case Manager Phone Number:	<input type="text"/>		
Nurse Case Manager Email:	<input type="text"/>				

## MTF Pharmacist Information

**To Be Completed by Pharmacy**

MTF RPh Phone Number:	<input type="text"/>	MTF RPh Email:	<input type="text"/>		
MTF RPh Printed Name / Title:	<input type="text"/>	RPh Signature:	<input type="text"/>	Date:	<input type="text"/>

## Type of Lock

**Note: The lock will limit member to specified retail pharmacy & specific provider(s).**

<input type="radio"/> Restrict all meds for a beneficiary to a specific pharmacy and/or provider.	Provider Information:	<input type="text"/>
	Provider DEA / NPI #:	<input type="text"/>
	Pharmacy Information:	<input type="text"/>
<input type="radio"/> Restrict controlled meds for a beneficiary to a specific provider or list of providers. Authorized Prescriber's printed name and DEA / NPI:	<input type="text"/>	

Print Form

ENCLOSURE 2



DEPARTMENT OF THE ARMY  
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND  
2050 WORTH ROAD  
FORT SAM HOUSTON, TX 78234-6000

REPLY TO  
ATTENTION OF

OTSG/MEDCOM Policy Memo 10-076

MCCS

Expires 9 November 2012

09 NOV 2010

MEMORANDUM FOR Commanders, MEDCOM Regional Medical Commands

SUBJECT: Guidance for Enhancing Patient Safety and Reducing Risk via the Prevention and Management of Polypharmacy Involving Psychotropic Medications and Central Nervous System Depressants

1. References:

a. US Army Center for Health Promotion and Preventive Medicine: "Army Suicide Event Report (ASER) Findings Regarding Psychotropic Medication Use Among Soldiers with Suicidal Behaviors," 2004-2009.

b. US Army Center for Health Promotion and Preventive Medicine: "Analyses of Army Suicides 2003-2009 1<sup>st</sup> quarter," for Subcommittee Hearing, using Army G-1, Armed Forces Health Surveillance Center and The Department of Defense Suicide Event Report (DoDSER) Data.

c. Warrior Transition Unit Prescription Data Review (1 Apr 09-30 Apr 09).

d. Completed Suicide Prescription Data Analysis (1 Jan 02-7 Aug 09), data call and analysis by OTSG Pharmacy Consultant.

e. Active Duty Soldier Prescription Data Analysis (1-30 Apr 09), data call by OTSG Pharmacy Consultant.

f. Mosby's Medical Dictionary, 8<sup>th</sup> edition (2009), Elsevier.

g. Goldsmith SK, Pellmar TC, Kleinman AM, et al (eds): Reducing Suicide: A National Imperative (2002), Washington, DC, Institute of Medicine, National Academies Press.

h. OTSG/MEDCOM Policy 09-022, Warriors in Transition High-Risk Medication Review and Sole Provider Program, 14 Apr 09.

i. OTSG/MEDCOM Policy 09-033, MEDCOM Policy Guidance Informed Consent for Psychoactive Medications, 3 Jun 09.

\*This policy supersedes OTSG/MEDCOM Policy Memo 09-077, 18 Sep 09, subject: MEDCOM Policy Guidance to Direct the Conservative Use of Psychotropic Medications and Polypharmacy.

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**SUBJECT: Guidance for Enhancing Patient Safety and Reducing Risk via the Prevention and Management of Polypharmacy Involving Psychotropic Medications and Central Nervous System Depressants**

- j. The Joint Commission, <http://www.jointcommission.org/standards/>.
  - k. Zarowitz BJ, Stebelsky LA, Muma BK, Romain TM, Peterson EL. Reduction of high-risk polypharmacy drug combinations in patients in a managed care setting. *Pharmacotherapy* 2005; 25:1636-45.
  - l. Technical Report on Psychiatric Polypharmacy, National Association of State Mental Health Program Directors (NASMHPD), 9 October 2001.
  - m. Walsh, T. Declan *Palliative Medicine*. Philadelphia: Saunders, 2008.
  - n. Ferri, Fred F. *Ferri's Clinical Advisor*. Philadelphia: Mosby, 2010.
  - o. ALARACT 160/2010–VCSA Sends on Protected Health Information, 28 May 2010.
  - p. USAMEDCOM OPORD 10-75, eProfile Implementation, 10 Sep 10.
  - q. *Army Health Promotion, Risk Reduction and Suicide Prevention Report*, Army Suicide Prevention Task Force, Jul 10.
- 2. Purpose:** To provide guidance on the prevention and management of polypharmacy with psychotropic medications and central nervous system depressants (CNSDs) to reduce adverse events and optimize clinical outcomes among Soldiers receiving care in the Military Healthcare System (MHS).
- 3. Proponent:** The proponent for this policy is the Assistant Chief of Staff for Health Policy and Services, Behavioral Health Proponency, Office of The Surgeon General.
- 4. Background:** The Army Suicide Prevention Task Force has identified polypharmacy as a contributing factor in suicides, fatal accidents, and other adverse outcomes among Army personnel. As combat operations continue, more Soldiers are presenting with physical injury, psychological injury, or both, which require medication therapy. Consequently, some Soldiers may be treated for multiple conditions with a variety of medications prescribed by several healthcare providers. The resulting polypharmacy can place Soldiers at increased risk for adverse clinical outcomes.
- 5. Definitions:**
- a. **Polypharmacy:** Patients treated for multiple conditions with a variety of medications prescribed by several healthcare providers.

## **MCCS**

**SUBJECT: Guidance for Enhancing Patient Safety and Reducing Risk via the Prevention and Management of Polypharmacy Involving Psychotropic Medications and Central Nervous System Depressants**

b. **CNSDs:** CNSDs include opioid analgesics, anxiolytics, and sedative-hypnotics that, either as a single agent or in combination, can result in suppression of respiratory drive.

c. **Psychotropic medications:** Medications that act on the brain to affect mood, cognition, or perception, and are commonly prescribed to effectively treat psychiatric conditions, such as clinically significant anxiety, depression, sleep disturbance, and psychosis. While some psychotropic medications act as stimulants, many of them can be classified as CNSDs.

### **6. Responsibilities:**

a. **MTF Commander:** Ensure that all aspects of this policy are implemented and followed.

b. **Primary Care Manager (PCM):** Actively coordinate care for the Soldier through communication with the Soldier, pharmacists, other healthcare providers, and Commanders.

c. **Soldier:** Take an active role in his/her care through open communication with PCM, other healthcare providers, pharmacists, and Commanders. Soldier will also work with PCM to set goals for medical care.

d. **Soldier's Commander:** Actively communicate with Soldier's PCM on issues of medical concern and respect limitations placed on Soldiers by their PCM due to medication side effects.

**7. Policy:** The interventions presented in this policy include many practices that facilitate risk reduction and patient safety. This policy mandates changes in the system and practice of clinical care in the military setting; education of both healthcare providers and the Soldiers under their care; and closer communication and collaboration between clinicians, Soldiers, and Commanders.

#### **a. Education and training:**

(1) Any clinician who prescribes psychotropic agents or CNSDs must undergo annual training that addresses principles of evidence-based pharmacotherapy and the risks of polypharmacy and its management. Training can be designed and implemented in collaboration with pharmacy personnel.

#### **b. System and practice changes:**

(1) **Clinical assessment and risk stratification:** Clinical assessment of all patients should consist of a history, physical examination, and laboratory and/or imaging studies,

## **MCCS**

**SUBJECT: Guidance for Enhancing Patient Safety and Reducing Risk via the Prevention and Management of Polypharmacy Involving Psychotropic Medications and Central Nervous System Depressants**

as clinically indicated. Essential elements of the patient's history will include a detailed medical/surgical history; detailed accounts of past medication therapies; a complete and accurate list of current medications, including over-the-counter medications and nutritional/herbal supplements; medication overuse or underuse; current and/or past substance use; and psychiatric history, including a safety risk assessment. Clinicians must include the Soldier in setting goals for his/her medical care. The healthcare provider must also document and recognize the potential obstacles to medication compliance, including memory problems (e.g., cognitive deficits arising from traumatic brain injury), learning disabilities, or language barriers.

(2) Treatment plan: Based on the findings of the clinical assessment, the healthcare provider and the Soldier will formulate a treatment plan. Medication therapy may be one component of an overall treatment plan for medical and psychiatric concerns. Good clinical care must take into account all available modalities of treatment. Healthcare providers will use current clinical practice guidelines (e.g., DoD/VA clinical practice guidelines) specific for the conditions that they address. If patient behaviors give rise to concerns regarding compliance with medications, including the risk of intentional or unintentional overdose, healthcare providers will limit the amount of medication prescribed, coupled with frequent brief clinical visits to closely monitor the patient's condition. Healthcare providers prescribing psychotropic or CNSD medications for a new diagnosis or changing psychotropic or CNSD medications for an existing condition will limit quantities to no more than a 30-day supply to allow them the opportunity to assess effectiveness of, adverse effects from, and compliance with medication therapy. Once the optimum dose has been reached, refills may be provided in 30-day increments with up to 5 refills. Clinical observations and resultant changes in the treatment plan should be clearly documented in the clinical record and discussed with the Soldier. Healthcare providers should consider non-medication therapies to replace or augment medication therapy, as clinically appropriate, to achieve specific treatment goals. Primary care providers should have a low threshold for referring patients to behavioral health resources to augment medication therapy with other modalities of treatment, such as psychotherapy for behavioral health concerns, or to the Army Substance Abuse Program (ASAP) for substance abuse concerns. The PCM is responsible for coordinating care when referring the patient to other healthcare providers. The healthcare provider must communicate the patient's treatment plan to the patient. They must also share the treatment plan with all other healthcare providers involved in the patient's care. This is done most routinely through documentation in the electronic health record. Direct engagement and interdisciplinary collaboration on the management of complex cases, including TRICARE providers, is essential to achieving optimal clinical outcomes.

## **MCCS**

**SUBJECT: Guidance for Enhancing Patient Safety and Reducing Risk via the Prevention and Management of Polypharmacy Involving Psychotropic Medications and Central Nervous System Depressants**

### **(3) Medication reconciliation:**

(a) All healthcare providers have a responsibility to review patient records at each encounter and must screen carefully for specific evidence of CNSD or psychotropic polypharmacy. In addition to transitions from one treatment setting to another, the medication reconciliation process also applies to periods of transition between duty assignments (e.g., Permanent or Temporary Change of Station). The PCM of the losing MTF must print the patient's medication list and instruct the patient to carry the medication list with him or her to the next duty station. The PCM will document this instruction as well as the patient's current medication list in the patient's clinical record.

(b) The automatic drug interaction check imbedded in CHCS assesses for duplicate drugs, duplicate classes of drugs, and potential adverse interactions for prescriptions filled within the MHS or the TRICARE pharmacy network. Nutritional/herbal supplements and over-the-counter medications can also pose a risk for medication interactions. Therefore, the prescribing clinician must obtain an accurate profile of all active medications, including over-the-counter medications and nutritional/herbal supplements, from the patient at the time of assessment and periodically throughout the course of treatment. Healthcare providers must anticipate and monitor for drug interactions when they prescribe additional medications. After identifying potential drug interactions, the prescribing clinician must closely monitor the patient for any adverse effects. Clinical monitoring may include review of potential adverse effects with the patient at each visit, as well as checking blood levels of medications where clinically appropriate.

(4) Pharmacy consultation: When a patient has received four or more medications, which include one or more psychotropic agents and/or one or more CNSD agents within the previous 30 days, the prescribing clinician must refer the patient to a clinical pharmacist for comprehensive review to make recommendations regarding the best medication regimen. Also, no additional medications will be initiated until the pharmacist consultation is completed.

(5) Informed consent for polypharmacy: Knowledge about the associated risks of polypharmacy is the key to improving patient safety. The healthcare provider must review these risks and potential interactions with the patient, educating them regarding potential signs and symptoms of interactions and what to do if they occur. The informed consent process must culminate in a consent form signed by both the patient and the healthcare provider. One copy of the form will become part of the clinical record; another copy will be given to the patient. MEDCOM Policy Memo 09-033, contains further guidance regarding the informed consent process for psychotropic agents.

(6) Sole Provider Program: Soldiers who have displayed behaviors that put them at increased risk of adverse effects or toxic interactions, including obtaining

## **MCCS**

**SUBJECT: Guidance for Enhancing Patient Safety and Reducing Risk via the Prevention and Management of Polypharmacy Involving Psychotropic Medications and Central Nervous System Depressants**

multiple prescriptions of controlled substances from multiple care providers, displaying a pattern of poor compliance with medication regimens or scheduled appointments for medication monitoring, must be enrolled in the local Sole Provider Program. Patients who are enrolled in the Sole Provider Program will be limited to one care provider and one pharmacy for access to specific controlled medications that may be subject to abuse or place the patient at risk.

(7) **Special populations:** For specific populations who are identified to be at risk for polypharmacy, such as Warriors in Transition, healthcare providers are expected to adhere to additional published guidance. OTSG/MEDCOM Policy Memo 09-022 provides guidance to decrease the risk of adverse drug reactions, accidental overdose, and/or suicide in the Warriors in Transition population.

### **c. Collaboration between clinicians and Commanders:**

(1) **Physical profile for polypharmacy:** Soldiers who qualify for a polypharmacy consult IAW this policy are at increased risk of drug interactions that can impose duty limitations due to clouded cognition, reduced alertness, or slowed reaction time as a consequence of medication therapy. Because Soldiers on multiple CNSDs or psychotropics are at increased risk, healthcare providers must advise Commanders accordingly. The prescribing clinician will initiate a profile through the eProfile system and immediately route the completed profile to the Soldier's Commander. The profile will document the prescribed medication's benefits, risks, and potential duty limitations on the Soldier. A copy of the profile will also be available to the Soldier on Army Knowledge Online. The medical profile also alerts the Soldier's Commander to specific safety limitations on duty-related and other activities (e.g., operating motorized vehicles or heavy equipment or handling weapons and ammunition). Use of a hardcopy Physical Profile (DA Form 3349) is authorized until eProfile is implemented IAW USAMEDCOM OPOD 10-75.

### **(2) Communication with Commanders:**

(a) Collaborative communication between Commanders and clinicians is critical to the well-being of our Soldiers. Healthcare providers should communicate directly with the Soldier's Commander via eProfile to notify him/her of potential risks imposed by medication therapy required for treatment of the Soldier's condition(s). eProfile allows Commanders to reply to the healthcare provider any observations or information related to changes in behavior or duty performance that may have bearing on the Soldier's diagnosis or treatment.

(b) The Health Insurance Portability and Accountability Act (Public Law 104-191, 1996) recognizes the unique context of the military mission and allows appropriate disclosure of select protected health information to Commanders to ensure

**MCCS**

**SUBJECT: Guidance for Enhancing Patient Safety and Reducing Risk via the Prevention and Management of Polypharmacy Involving Psychotropic Medications and Central Nervous System Depressants**

the safety and promote the well-being of their Soldiers. Commanders have the same obligation as healthcare providers to safeguard the Soldier's protected health information (see ALARACT 160/2010 – Vice Sends on Protected Health Information for details).

**FOR THE COMMANDER:**

  
**HERBERT A. COLEY**  
Chief of Staff



REPLY TO  
ATTENTION OF

**DEPARTMENT OF THE ARMY**  
HEADQUARTERS, U. S. ARMY MEDICAL COMMAND  
2050 WORTH ROAD  
FORT SAM HOUSTON, TEXAS 78234-6000

MCCS

OTSG/MEDCOM Policy Memo 10-047

Expires 13 July 2012

13 JUL 2010

MEMORANDUM FOR

Commanders, MEDCOM Major Subordinate Commands  
Directors, OTSG/MEDCOM OneStaff

SUBJECT: Warrior Transition Unit (WTU) Behavioral Health (BH) Risk Assessment and Comprehensive Assessment Policy

1. References:

a. Memorandum, WTU Policy Memo 10-033, 16 Jun 10, subject: WTU/CBWTU Risk Assessment and Mitigation Policy.

b. Memorandums, MEDCOM, MCCG, 5 Sep 07, subject: Suicide Risk in WTUs and 18 Oct 07, subject: Suicide Assessment in WTUs.

c. Memorandum, Behavioral Health Division, MCHO-CL-H, 10 Mar 08, subject: Standard Operating Procedure: Behavioral Health Care Management of Service Members Receiving Care at WTUs and CBHCOs.

d. Warrior Transition Program (WTP) Army Knowledge Online (AKO), Comprehensive Transition Plan (CTP) website: <https://www.us.army.mil/suite/page/553880>.

e. WTP Automated CTP User Guide available at <https://www.us.army.mil/suite/doc/22655241>.

2. Purpose: To consolidate and standardize the behavioral health risk and comprehensive assessment of Warriors in Transition (WTs) and reduce the risk of adverse behavioral health events, such as suicide.

3. Proponents: The proponent for this policy is the Warrior Transition Command (WTC) in coordination with the Behavioral Health Proponency and the Behavioral Health Division (BHD), Assistant Chief of Staff for Health Policy and Services .

\*This policy memo supersedes the MEDCOM Memorandums listed in Reference 1.b. and updates policy in 1.a.

## **MCCS**

### **SUBJECT: Warrior Transition Unit (WTU) Behavioral Health (BH) Risk Assessment and Comprehensive Assessment Policy**

#### **4. Policy:**

- a. WTUs will receive a BH risk assessment within 24 hours of attachment/assignment to a WTU.
- b. WTUs will receive a comprehensive BH assessment initiated within 3 duty days of attachment/assignment to a WTU.
- c. Ongoing BH risk assessment and care management will be a standard of WT care.
- d. The WTU Commanders will be notified of the BH risk assessments and comprehensive assessments to ensure informed decisions are made regarding risk mitigation.

#### **5. Responsibilities:**

- a. Preliminary BH needs and risk assessment of WTUs will be conducted by the WTU Clinical Social Worker (CSW) during duty hours and as assigned on-call within 24 hours of attachment/assignment of the WT to the WTU. If the WT arrives after 2000 hours, the assessment will be conducted on the morning of the next day.
- b. At locations where the WT arrives during non-duty hours and/or WTU CSW on-call support is limited, the on-call provider designated to cover BH will meet with the WT to conduct the preliminary BH needs and risk assessment.
- c. The WTU CSW will conduct the comprehensive BH assessment, ongoing BH risk assessment, care management, and support to the Family/Caregivers regarding behavioral healthcare.
- d. Behavioral health providers and primary care managers will continue to conduct BH risk assessments, BH assessments and safety/treatment plans for WTUs under their care and consult with WTU CSWs as appropriate.
- e. The WTU Commanders will utilize the BH risk assessments of the WTU CSW, on-call and BH providers to support risk management/mitigation plans. The WTU Commander is the final decision authority in risk determination and mitigation.

#### **6. Procedures:**

- a. Preliminary BH needs and risk assessment:

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### **SUBJECT: Warrior Transition Unit (WTU) Behavioral Health (BH) Risk Assessment and Comprehensive Assessment Policy**

(1) The WT will complete an interview with an WTU CSW or designated on-call provider and complete the Social Work Risk Assessment-Questionnaire (SWRA-Q/ MEDCOM Form 818-Pilot) within 24 hours of attachment/assignment to a WTU. (See Paragraph 8 for AKO form access.)

(2) The WTU CSW will:

(a) Within 24 hours of attachment/assignment of the WT, meet and welcome the WT; conduct the preliminary BH needs and risk assessment as well as safety plan (as appropriate); schedule an appointment for the WT to meet with the WTU CSW within 3 duty days of the WT's attachment/assignment to the WTU for the initial BH risk assessment and comprehensive assessment; and provide the WT with the Behavioral Health Intake-Psychosocial History and Assessment (BHI-PHA/MEDCOM Form 811-Pilot) to complete prior to the scheduled appointment. (See Paragraph 8 contains AKO form access.)

(b) Complete appropriate referrals/consults, collateral contacts and notifications to address WT needs and mitigate the BH risk.

(c) Enter the WT's responses on the SWRA-Q into the automated BH risk assessment tool (Psychological and Behavioral Health-Tools for Evaluation, Risk and Management/PBH-TERM) to assess the WT's BH risk (severe, high, elevated, guarded, or low). The assessment of risk will consider the eight factor groups in the SWRA including: (1) depression/self-harm (suicide/homicide); (2) mental status; (3) anxiety/post-traumatic stress disorder; (4) anger/domestic violence, (5) substance abuse; (6) early childhood and family relationships; (7) environment/support systems (education, financial, employment, legal, spiritual, cultural and recreation/leisure); and (8) physical health (medications, traumatic brain injury, pain, sleep, and nutrition).

(d) Enter results into AHLTA. In the patient encounter note, enter the risk assessment in the "Objective" section and the safety/treatment plan in the "Plan" section.

(e) Convert the BH risk assessment into the WTU SWRA (MEDCOM Form 816-Pilot) four-point scale (high, moderate, moderate-low, or low) using the automated CTP within AKO. (Paragraph 8 contains, AKO form access.) The CSW will select the appropriate radio buttons within the system and add any additional comments. Following submission, the results of the SWRA will be displayed on the WTU Commander's dashboard for final determination of risk assessment and risk mitigation, as necessary. The paper-based WTU SWRA will be only used and provided to the Commander when the CTP within AKO is down or not available.

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**SUBJECT: Warrior Transition Unit (WTU) Behavioral Health (BH) Risk Assessment and Comprehensive Assessment Policy**

(f) Notify the WTU Commander or designee immediately, by telephone or in person, if the WT is assessed as severe or high BH risk.

(g) Act as a consultant to the Commander to implement a safety and risk mitigation plan for the WT.

(3) At locations where the WT arrives during non-duty hours and/or WTU CSW on-call support is limited, the designated on-call provider will:

(a) Meet with the WT to assess BH immediate needs, provide the WT the SWRA-Q to complete, assess the risk on the SWRA and complete safety/treatment plans as appropriate.

(b) Complete appropriate referrals/consults, collateral contacts and notifications to mitigate risk and ensure provision of appropriate BH care.

(c) Provide the results of the needs assessment and the BH and WTU risk assessment to the WTU Commander or designee via the CTP in AKO or direct notification.

(d) Notify the WTU Commander or designee immediately, by telephone or in person, if the WT is assessed as severe, high or moderate BH risk.

(e) Act as a consultant to the Commander to implement a safety and risk mitigation plan for the WT.

(f) Enter the BH risk assessment (severe, high, moderate, guarded or low) into AHLTA in the patient encounter note in the "Objective" section and the safety/treatment plan in the "Plan" section.

(4) In instances where an on-call provider completed the preliminary BH needs and risk assessment, the WTU CSW will (on the next duty day):

(a) Review the care provided and the SWRA completed by the on-call provider as well as review the BH needs, risk assessment in AHLTA, and safety and risk mitigation plans, if implemented by the WTU Commander.

(b) Obtain the responses to the initial SWRA-Q from the on-call provider and enter them into PBH-TERM.

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**SUBJECT: Warrior Transition Unit (WTU) Behavioral Health (BH) Risk Assessment and Comprehensive Assessment Policy**

(c) Meet and welcome the WT to review the current SWRA and update, if needed; address any additional BH needs; schedule an appointment for the WT to meet with the WTU CSW within 3 duty days of the WT's attachment/assignment to the WTU for the initial BH risk assessment and comprehensive assessment; and provide the WT with the BHI-PHA/MEDCOM Form 811-Pilot to complete prior to the scheduled appointment. (Paragraph 8 contains AKO form access.)

(d) Document the encounter and enter the current BH risk assessment (as assigned by the on-call provider or adjusted by the WTU CSW) in AHLTA; enter the WTU SWRA current risk assessment (as assigned by the on-call provider or adjusted by the WTU CSW) into the automated CTP in AKO. If the CTP in AKO is not available, ensure that the SWRA was provided to the WTU Commander and the Triad.

(5) The WTU Commanders will develop and implement risk management/mitigation plans for WTs as necessary and required.

b. Initial and ongoing BH risk assessment and comprehensive assessment:

(1) The WT will:

(a) Bring the completed BHI-PHA to their scheduled appointment with the WTU CSW. (Paragraph 8 contains AKO form access.)

(b) Complete ongoing BH interviews and risk assessments, as requested/required.

(c) Comply with risk mitigation and BH safety/treatment plans.

(2) The WTU CSW will:

(a) At the first scheduled appointment with the WT:

1) Meet with the WT to re-assess the BH needs of the WT, complete the initial BH risk assessment, initiate the comprehensive behavioral health assessment and complete the safety/treatment plan (as appropriate).

2) Enter and complete the BH risk assessment in PBH-TERM and provide the results of the BH risk assessment (SWRA) to the WTU Commander and/or the Triad. The SWRA results will be entered into the automated CTP available in AKO. *If the WT is assessed as high or severe risk, the CSW will notify the WTU Commander immediately, in person or by telephone, to facilitate a safety and risk mitigation plan for the WT.*

MCCS

SUBJECT: Warrior Transition Unit (WTU) Behavioral Health (BH) Risk Assessment and Comprehensive Assessment Policy

3) Enter the BH risk assessment, the results of the comprehensive behavioral health assessment, and the plan for the WT into AHLTA in the prescribed template for the WTU CSWs entitled SO-BHSW-CM-MEDCOM within 10 duty days. (Paragraph 8 contains AKO template access.) The risk assessment will be entered in the patient encounter note in the "Objective" section and the treatment/safety plan in the "Plan" section.

(b) Conduct ongoing BH risk assessments. WTs assessed at a BH risk of severe or high risk will be re-assessed on a weekly basis; those assessed as moderate or elevated on a monthly basis; those assessed as moderate-low, guarded or low on a quarterly basis. The CSW will document the BH risk assessment and update the WTU Commander and/or Triad regarding current risk assessments.

(c) For special circumstances, conduct BH risk assessment of the WT as soon as possible, but no later than 24 hours (for instance, the break-up of an intimate relationship; release from an inpatient/outpatient program; WT receipt of Uniform Code of Military Justice (pre-and post); the death/suicide of Family member or friend; significant legal difficulties or financial loss; combat injury of a friend; negative events related to domestic violence incidents or alcohol or drug abuse/misuse; acute onset of or chronic, unabated medical illness or pain; release from an inpatient/outpatient program; transfer to a community-based WTU; or impending discharge from the WTU).

(d) For each BH risk assessment, the CSW will enter the responses to the SWRA-Q into the automated BH risk tool (PBH-TERM) at <https://health-terms.army.mil>. The WTU CSW will enter the BH risk assessment into AHLTA in the "Objective section" of the patient encounter note or as an "Add Note" and the SWRA WTU risk assessment into the CTP in AKO.

(e) Coordinate with collateral personnel (for example, Family members, Triad, and other BH providers) to ensure appropriate BH risk estimation, mitigation and care management.

(3) WTU Commanders will adjust risk management/mitigation plans based on assessed risk and the BH comprehensive assessment of WTs as necessary and required.

7. Local Military Treatment may elect to place the SWRA-Q or SWRA into AHLTA in a questionnaire format for use by on-call providers completing the BH assessment for WTs.

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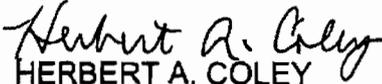
SUBJECT: Warrior Transition Unit (WTU) Behavioral Health (BH) Risk Assessment and Comprehensive Assessment Policy

8. Forms referenced in this policy are available for printing at the Behavioral Health Division AKO page for social workers at <https://www.us.army.mil/suite/page/517> and WTC AKO page at <https://www.us.army.mil/suite/page/544370>.

9. For access to the automated CTP in AKO for the WTs in your WTU/CBWTU, contact your local CTP management analyst.

FOR THE COMMANDER:

2 Encls

  
HERBERT A. COLEY  
Chief of Staff



REPLY TO  
ATTENTION OF

**DEPARTMENT OF THE ARMY  
WARRIOR TRANSITION COMMAND  
2530 CRYSTAL DRIVE, SUITE 3E30  
ARLINGTON, VIRGINIA 22202**

WTC Policy Memo 10-033

JUN 16 2012

MCWT-CG

Expires JUN 16 2012

MEMORANDUM FOR Commander, Regional Medical Commands

SUBJECT: Warrior Transition Unit/Community Based Warrior Transition Unit  
(WTU/CBWTU) Risk Assessment and Mitigation Policy

1. References:

- a. Office of the Vice Chief of Staff Memorandum, DACS, Army Campaign Plan for Health Promotion (ACPHP), Risk Reduction and Suicide Prevention, 16 Apr 09.
- b. AR 600-63, Army Health Promotion Program, 20 Sep 09.
- c. AR 600-85, The Army Substance Abuse Program, 13 Oct 09.
- d. AR 190-11, Physical Security of Arms, Ammunition and Explosives, 15 Nov 06.
- e. DA PAMPHLET 600-24, Health Promotion, Risk Reduction, and Suicide Prevention, 24 Nov 09.
- f. IMCOM Policy Memo, Unaccompanied Personnel Housing (UPH) for Warriors in Transition (WT), 14 Oct 09.
- g. MEDCOM/OTSG Regulation 385-2, U.S. Army Medical Command Safety Program, 18 Mar 08.
- h. OPERATION ORDER 07-55 (MEDCOM Implementation of the Army Medical Action Plan (AMAP)), 05 Jun 07.
  - i. FRAGO 18 to MEDCOM OPORD 07-55 (AMAP), 17 Oct 07.
  - j. FRAGO 27 to MEDCOM OPORD 07-55 (AMAP), 16 Feb 08.
  - k. FRAGO 30 to MEDCOM OPORD 07-55 (AMAP), 28 Mar 08.
- l. MEDCOM Memorandum, MCCG, Suicide Risk in Warrior Transition Units (WTU), 5 Sep 07.
- m. MEDCOM Memorandum, MCCG, Suicide Screening in Warrior Transition Units (WTU), 18 Oct 07.

**SUBJECT: Warrior Transition Unit/Community-Based Warrior Transition Unit (WTU/CBWTU) Risk Assessment and Mitigation Policy**

n. OTSG/MEDCOM Policy Memo 09-022, Warriors in Transition High-Risk Medication Review and the Sole Provider Program, 14 Apr 09.

o. Army Warrior Care and Transition System (AWCTS) Automated Comprehensive Transition Plan (ACTP) user's guide available at <https://www.us.army.mil/suite/doc/21846836>.

2. **Purpose.** The purpose of this policy is (1) to identify actions and processes to reduce high-risk outcomes which may result in harm to Warriors in Transition (WTs) and others, (2) direct risk assessment and reassessments of all WTs and (3) outline mitigating actions for WTs assessed as high risk. This policy consolidates all the directives on risk management and mitigation actions in Fragmentary Orders (FRAGOs) 18, 27 and 30 to U.S. Army Medical Command (MEDCOM) Operation Order (OPORD) 07-55.

3. **Proponent.** The proponent for this policy is the Warrior Transition Command (WTC).

4. **Background.** Risk is defined as the probability of harm or injury. Identification of WT risk level must be done with deliberate scrutiny. WTU commanders will use the expertise of subject matter experts at all levels and available tools and resources to identify and manage high risk Soldiers. The criterion used for determination of risk for WTs is based on input from experts represented by MEDCOM behavioral health staff, U.S. Army Public Health Command, Department of Defense (DoD) Risk Management Task Force and the Walter Reed Army Medical Center, Warrior Transition Brigade staff.

5. **Responsibilities:**

a. WTC will update policy and share feedback and best practices with Regional Medical Centers (RMCs).

b. RMCs will monitor policy execution and track risk levels and appropriate mitigation plans across their commands.

c. Military Treatment Facility (MTF) commanders will:

(1) Implement the risk assessment and mitigation policy.

(2) Develop programs for high-risk medication management and education, and implement procedures for enrolling high risk WTs into a Sole Provider Program (SPP).

(3) Link pharmacy support to each WTU/CBWTU for medication reconciliation and training in WTUs. Training should be focused at both group and individual level and specifically address the dangers associated with polypharmacy, narcotics, and the use of alcohol.

**SUBJECT: Warrior Transition Unit/Community-Based Warrior Transition Unit (WTU/CBWTU) Risk Assessment and Mitigation Policy**

**(4) Execute actions recommended in the Army Campaign Plan for Health Promotion, Risk Reduction, and Suicide Prevention (ACPHP) dated 16 Apr 09.**

**d. WTU/CBWTU commanders will:**

**(1) Ensure compliance with the risk assessment and mitigation policy.**

**(2) Ensure WTs receive a risk assessment and mitigation plan within 24 hours of attachment or assignment to the WTU/CBWTU.**

**(3) Ensure compliance with chain of command safety programs (MTF and MEDCOM).**

**(4) Platoon sergeants (PSGs) and squad leaders (SLs) (and other cadre as directed by the WTU commander) will be trained in Basic Life Saving (BLS) and Automatic External Defibrillation (AED) Training and provided pocket masks and gloves.**

**(5) Units will report all attempted suicides and medication overdoses in accordance with current standard MEDCOM CCIR policy 09-030 and MEDCOM FRAGO 13 to OPOD 07-55.**

**(6) Provide education to cadre, WTs and Families on the roles, responsibilities, programs and services available to support Soldier and family wellness.**

**(7) Develop unit battle drills to provide action steps for personnel to respond quickly and appropriately to potential or actual risk events. Battle drills will include plans for expediting assistance for service members with behavioral difficulties commonly associated with suicide or accidental death. A sample battle drill is at (Enclosure 1).**

**(8) Provide ongoing risk assessment and ensure annual suicide education to Cadre, WTs and their Families. Track and manage mandatory suicide prevention training of individual Soldiers IAW AR 350-1, Army Training and Leader Development.**

**(9) Ensure all WTs who have privately owned weapons (POW) in their possession have these weapons stored under lock and key. Commanders will identify, properly secure and routinely account for all WT POWs as required by AR 190-11, Physical Security of Arms, Ammunition, and Explosives, dated 15 Nov 06. Spouses/family members of WTs should be asked by the SL and Triad about POW availability in the home or accessible to the WT. If there are privately owned weapons in the home, the spouse/family member should be encouraged to remove them, especially if the WT is moderate risk or above.**

**(10) All WTs who have deployed and are assigned or attached to the WTU must have a current Post Deployment Health Assessment (PDHA) (DD Form 2796) on file or must complete one within 72 hours of being assigned or attached (IAW Annex k, para**

**SUBJECT: Warrior Transition Unit/Community-Based Warrior Transition Unit (WTU/CBWTU) Risk Assessment and Mitigation Policy**

3.a. (ii-iii) to OPORD 07-55 dated 05 Jun 07). Additionally, if the deployed WT is assigned or attached to the WTU exceeding the minimum time required to receive a mandatory Post Deployment Health Re-Assessment (PDHRA) (DD Form 2900) (IAW MEDCOM Policy 06-005 dated 07 Mar 06 and Deployment Cycle Support Program), the PDHRA will also be completed and be on file.

(11) Designate the WTU barracks, to include rooms and indoor/outdoor common areas, an alcohol free zone. Ensure WTs are counseled in writing on their understanding of the alcohol free zone policy and that violations of the policy are subject to UCMJ. If it is determined by the Primary Care Manager (PCM) that consumption of alcohol poses an unacceptable risk to the WT, a no alcohol order will be annotated on the physical profile (DA 3349). A review of the no alcohol order will take place during each Triad of Care meeting to evaluate the risk and determine if the continuation of the no alcohol order is appropriate.

(12) Implement written counseling to the WTs requiring (1) disclosure of all prescription medications to include prescription and over-the-counter (OTC) medications, dietary supplements and herbal products and (2) restriction of medications to those prescribed by military authority (MTF and/or TRICARE network providers).

(13) Develop a medication review process which begins with the WT's attachment or assignment to the WTU/CBWTU. Ensure compliance with OTSG/MEDCOM Policy Memo 09-022 and local MTF policy on medication reconciliation and documentation standards regarding the Warriors in Transition High-Risk Medication Review and SPP. Medication review will occur at least weekly and each time there is a change in medication regimen. Pharmacy can be involved in medication reviews and medication turn in programs will occur directly between Soldier and Pharmacy Services. Commanders will ensure Soldiers are escorted to pharmacy to ensure turn in occurs. Restrict the quantity of dispensed narcotics to seven days or less as determined by PCM.

(14) Restrict the refill of all prescribed medications and renewal of schedule II drugs (both MTF and TRICARE retail network) to the MTF pharmacy unless in an emergency situation or if the WTU is not located in an area with a MTF pharmacy. WTU commanders will share a list of WTs with supporting MTF Emergency Departments (ED) to facilitate identification of their WTs and prevent issuance of medications without PCM and Nurse Case Manager (NCM) knowledge. MTF commanders should ask the local civilian EDs that may see WTs to contact a specific POC at the MTF if any military personnel present themselves to their ED to ensure proper coordination of care and treatment. This process will ensure all Health Insurance Portability and Accountability Act (HIPAA) requirements are followed.

(15) Implement a comprehensive discharge plan between multi-disciplinary inpatient staff and the Triad which includes assessment of SM's risk and a plan to

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mitigate and address risk. All WTs will be given a warm hand off between inpatient multi-disciplinary team and WTU Triad.

(16) Ensure WT and their spouse/family member receive education and training to address the dangers associated with poly-pharmacy, narcotics and the mixing of alcohol with any medications.

(17) Ensure WTs are informed of any adverse actions in the morning to permit adequate follow up time by staff to deal with adverse reaction. When possible, adverse actions should not occur on a Friday and never before a long weekend. Inform all members of the Triad, the social worker (SW) and chaplain when any adverse action is initiated on WTs to ensure risk level is reassessed and the mitigation plan updated if necessary. WTs who have had an adverse action initiated will be referred and escorted to either the SW and/or chaplain the day of the adverse action for a clinical reassessment.

(18) Ensure all WTs considered for transfer to WTU/CBWTU have a risk assessment and mitigation plan completed prior to transfer. WTs designated as high risk are not eligible for CBWTU transfer.

**e. Company Commanders will:**

(1) Determine the overall risk designation based on the assessments of the designated WTU staff and identify an appropriate mitigation plan.

(2) The commander designates the WT risk level as Low (Green), Moderate Low (Amber), Moderate (Red), or High (Black). In the event that there are discrepancies in the Triad/or SW risk assessments, select the higher risk level.

(3) Following the overall risk designation, the commander will counsel the WT on the risk mitigation plan and validate the WTs understanding by documenting the counseling in the AWCTS CTP process log.

**f. Platoon Sergeant /Squad Leader:**

(1) Implement an increased risk mitigation plan for a WT based on acute changes in the WT risk indicators as described in paragraph 6.b. (below) and/or upon the request of any member of the Triad and/or WTU SW.

(2) Work with the WTU finance NCO to review WT's pay to determine if there are any indicators of financial stress or issues to corroborate SL, NCM and/or SW risk assessment.

(3) Notify the company commander within one hour of any increase to high risk or an initial assessment of high risk.

**SUBJECT: Warrior Transition Unit/Community-Based Warrior Transition Unit (WTU/CBWTU) Risk Assessment and Mitigation Policy**

**g. The PCM (or credentialed designee after duty hours) will complete a subjective risk assessment within 24 hours of the WT's assignment/attachment based on, but not limited to, the WT's cognitive impairment, behavioral health history, medication regimen, history of substance abuse, compliance with treatment, etc. This risk assessment will be completed within the Army Warrior Care and Transition System Comprehensive Transition Plan (AWCTS CTP) module and will be documented in AHLTA or on the SF 558 if the WT is initially triaged in the ED.**

**h. The NCM will initiate a risk assessment and a medication review within 24 hours of assignment or attachment. The NCM will complete the risk assessment in the AWCTS CTP module and document the corresponding risk level in AHLTA. The NCM will inform the company commander within one hour of any high risk determinations. Additionally, the NCM will include family and social support assessment during in-processing and during weekly NCM contacts in order to determine potential broken relationships. The NCM will annotate this discussion in AHLTA and educate Families regarding risk mitigation measures when developing the plan of care.**

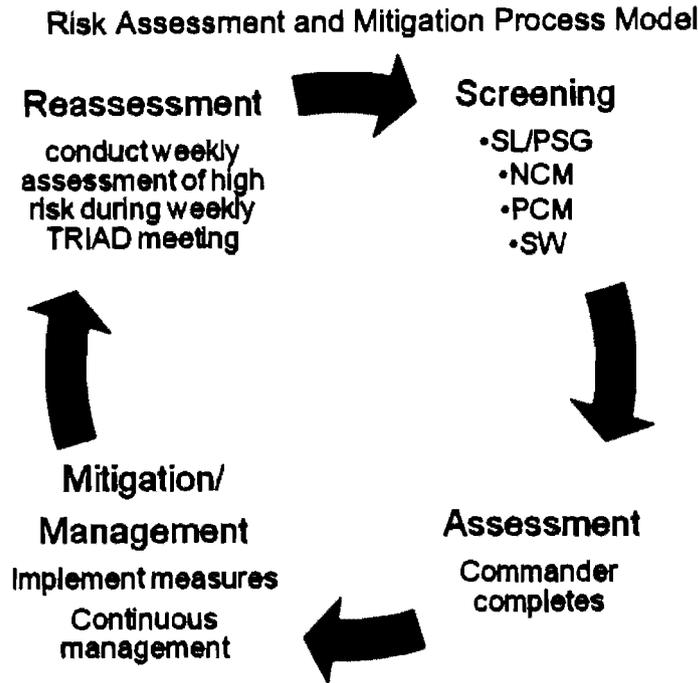
**i. The WTU SW will initiate the initial risk assessment within 24 hours of assignment or attachment and complete the assessment within 72 hours. The SW will complete the risk assessment in the AWCTS CTP module and document the corresponding risk level in AHLTA. The WTU SW will inform the company commander within one hour of any high risk determinations.**

**6. Policy.**

**a. The AWCTS CTP risk assessment and mitigation module will be used as the risk assessment and mitigation program. The AWCTS CTP module can be accessed at <https://www.us.army.mil/suite/page/624712>.**

**b. Identification of risk level and management for WTs is a collaborative process among the commander, Triad of Care and WTU SW and is based on four critical components: screening, assessment, management/mitigation and reassessment as depicted in figure 1.**

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*Figure 1*

c. The SL/PSG, NCM and SW will initiate risk assessments utilizing the AWCTS CTP automated module within 24 hours of the WT's arrival. Screen shots of these tools are at Enclosures 2-5.

d. There is no specific order for the risk assessments to be accomplished and the company commander has the option to determine the WT's risk prior to completion of each risk assessment screening.

e. The overall commander assessment is based on the review of the compiled screening tools. Following this review, the commander completes the commander assessment in the AWCTS CTP risk module (Enclosure 6), makes the final determination of risk level and establishes a mitigation plan if indicated. The AWCTS CTP program automatically emails the WT's Triad the mitigation plan.

**7. Management and Mitigation:**

a. The commander should select risk mitigation actions specific to the level of risk and presence of specific risk factors (see Mitigation Matrix, Enclosure 7). Completed commander assessments are maintained within the AWCTS CTP risk module and viewable to specific cadre members. The AWCTS CTP risk module pre-populates the mitigation plan for all Soldiers evaluated as high risk with the following mitigation actions:

**SUBJECT: Warrior Transition Unit/Community-Based Warrior Transition Unit (WTU/CBWTU) Risk Assessment and Mitigation Policy**

(1) Command and control (C2) contact with WT two times per day, seven days per week.

(2) Medication reconciliation at least weekly and each time there is a change in medication regimen.

(3) Refer to PCM for enrollment in the SPP (IAW MEDCOM policy Memo 09-022) and restrict refill amounts of medications to seven days or less.

(4) Contract for safety.

(5) Issue a no alcohol order.

(6) Roommate/non-medical attendant/family member as WT battle buddy.

(7) Require battle buddy to travel off post (sign in/out with Staff Duty NCO).

(8) Refer to chaplain.

(9) Initiate safety counseling.

(10) Refer to behavioral health for evaluation and follow-up.

b. Additional mitigation actions that the commander deems necessary can be added to the risk mitigation plan.

c. All WTs assessed by any member of the cadre as being at risk for suicidal or homicidal ideations should be escorted 1:1 to the ED.

**8. Reassessment:**

a. WT reassessment by the Triad and WTU SW will occur at the weekly Triad meetings or immediately if WT experiences or exhibits any of the following:

(1) Broken relationship.

(2) Acute or worsening behavioral changes.

(3) High risk behavior such as DUI, positive urinalysis screening or AWOL.

(4) Pending UCMJ action.

(5) Death of a key person in WT's life.

**SUBJECT: Warrior Transition Unit/Community-Based Warrior Transition Unit (WTU/CBWTU) Risk Assessment and Mitigation Policy**

- (6) Greater level of isolative behavior or social withdrawal.
- (7) Change in behavior such as breaking rules, acting out in small ways, etc.
- (8) Receiving upsetting news (financial, children in trouble, etc.).
- (9) Learning of significant combat attack on WT's unit.
- (10) Any other occurrence local command deems appropriate.

b. The WTU/CBWTU commander will institute a battle drill (Enclosure 1), when there is a change in risk indicators. Once the drill is complete, the WTU/CBWTU commander will ensure the new risk level and/or mitigation plan is disseminated to the Triad, SW and chaplain per above policy and timelines.

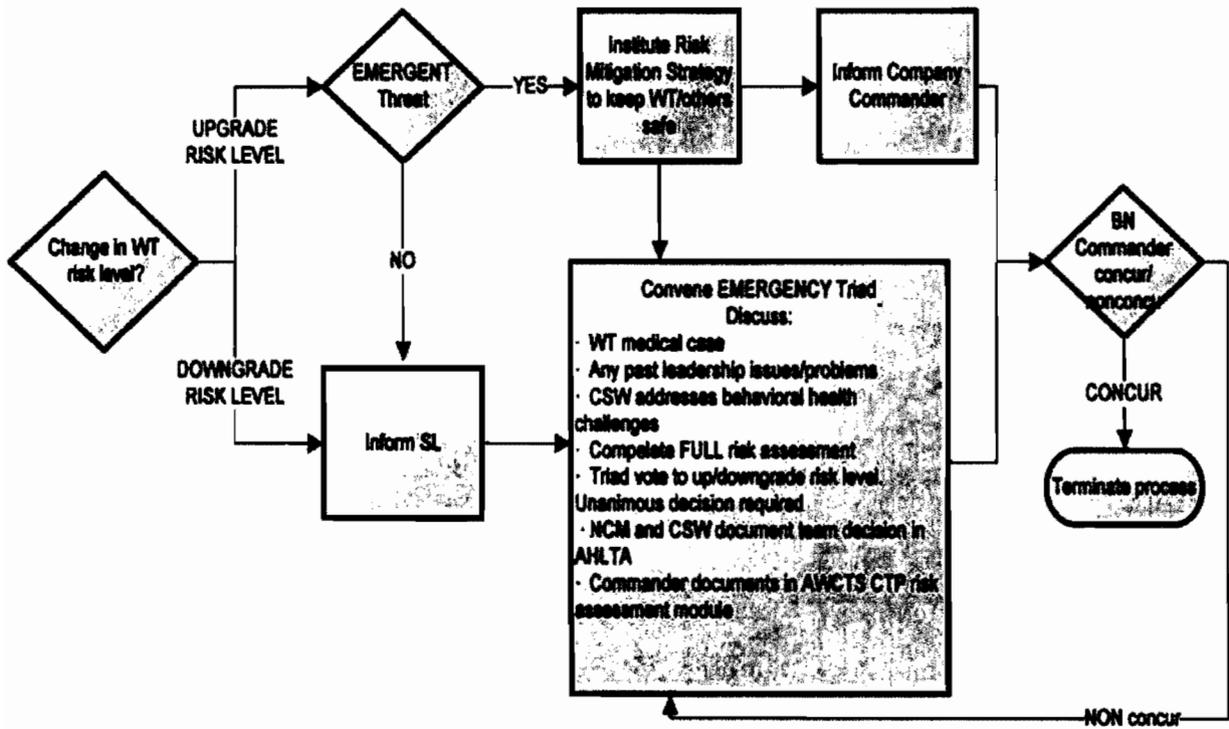
**7 Encls**

1. Sample Battle Drill
2. SW Risk Assessment
3. NCM Risk Assessment
4. SL Risk Assessment
5. PCM Risk Assessment
6. Commander Assessment and Mitigation Plan
7. Mitigation Matrix

  
**GARY H. CHEEK**  
Brigadier General, U.S. Army  
Commanding General

# Example WTU Battle Drill

## Change in Risk Level



**WTU SW Risk Assessment**  
**Screen Capture from AWCTS CTP risk assessment module**

 **SW Risk Assessment -**

Show task info Assigned this task to you on 13 Jan 2019 at 21:38 GMT (0) Attachments and Notes (0)

Please select the appropriate risk level for each Factor (F1 through F8), as well as an overall risk level estimate. Additionally, please indicated the method(s) used to evaluate the WT.

---

**Individual Risk Factors**

**F1 – Behavioral / Mental Health (Self-Harm / Suicide) \***

- Severe
- High
- Elevated
- Guarded
- Low

Includes suicidal or self-harm thoughts or plans, feeling down, depressed or hopeless, loss, emotional pain, previous mental health diagnosis, etc.

**F2 – Mental Status \***

- Severe
- High
- Elevated
- Guarded
- Low

Includes psychosis, racing thoughts, belief in special powers, hearing voices or seeing things, or paranoia, etc.

**F3 – Anxiety and Post-Traumatic Stress Disorder \***

- Severe
- High
- Elevated
- Guarded
- Low

Includes anxiety, panic attacks, exposure to traumatic events, hyper-vigilance, avoidance, re-experiencing, etc.

**WTU SW Risk Assessment**  
**Screen Capture from AWCTS CTP risk assessment module**

<p><b>F4 – Anger / Aggression including Domestic Violence*</b></p> <p><input type="radio"/> Severe  <input type="radio"/> High  <input type="radio"/> Elevated  <input type="radio"/> Guarded  <input type="radio"/> Low</p> <p>Includes harm to others, animals or objects, restraining / protection orders, recent break-up of relationship, weapons possession, etc</p> <p><b>F5 – Substance Use*</b></p> <p><input type="radio"/> Severe  <input type="radio"/> High  <input type="radio"/> Elevated  <input type="radio"/> Guarded  <input type="radio"/> Low</p> <p>Includes use or misuse of controlled or illegal substances (prescription and non-prescription), supplements, or herbal remedies and history of treatment, etc</p> <p><b>F6 – Psychosocial History / Relationships*</b></p> <p><input type="radio"/> Severe  <input type="radio"/> High  <input type="radio"/> Elevated  <input type="radio"/> Guarded  <input type="radio"/> Low</p> <p>Includes psychosocial history, childhood traumas, behavioral / mental health history, family, marriage and relationships, safety at home, issues with children, etc</p> <p><b>F7 – Environment / Support System*</b></p> <p><input type="radio"/> Severe  <input type="radio"/> High  <input type="radio"/> Elevated  <input type="radio"/> Guarded  <input type="radio"/> Low</p> <p>Includes family and friends, education, financial, legal, UCMJ, employment, spiritual, cultural and recreation, etc</p> <p><b>F8 – Health History and Traumatic Brain Injury*</b></p> <p><input type="radio"/> Severe  <input type="radio"/> High  <input type="radio"/> Elevated  <input type="radio"/> Guarded  <input type="radio"/> Low</p> <p>Includes physical health, medications, pain, sleep, and nutrition, etc</p>	
<p><b>Overall Risk Level Estimate</b></p> <p><b>OVERALL ESTIMATED RISK LEVEL:*</b></p> <p><input type="radio"/> Severe  <input type="radio"/> High  <input type="radio"/> Elevated  <input type="radio"/> Guarded  <input type="radio"/> Low</p> <p>Estimate determined by:</p> <p><input type="checkbox"/> Direct Question  <input type="checkbox"/> BNI-PHA  <input type="checkbox"/> BNI-TERM  <input type="checkbox"/> Other  <input type="checkbox"/> Comments</p> <p style="text-align: center;"><input type="button" value="Submit"/></p>	

# WTU NCM Risk Assessment

## Screen Capture from AWCTS CTP risk assessment module

Save Reassign Reject

**NCM Risk Assessment - kara.murray**

Show task info kara murray assigned this task to you on 13 Jan 2018 at 21:36 GMT Attachments and Notes (0)

Please assign a score for each risk factor.

**Failure to progress with medical treatment plan:**

0  
 1

Regularly missing appointments, hard to contact, not complying with provider's directions.

**Family challenges (divorce, adoption, marriage, recent birth, conflict, serious illness or death):**

0  
 1  
 2  
 3

Score based on degree of impact challenges are having on the VT

**History of mental health problems that have warranted an admission or intensive outpatient therapy treatment:**

0  
 1  
 2  
 3

Score should be based on duration, how long ago, and diagnoses

**History of illegal drug use:**

0  
 1  
 2  
 3

Score should be based on type of drug and last usage

**History of ASAP failure:**

0  
 1  
 2  
 3

Score should be based on how long ago individual was in ASAP

**History of drug seeking behavior:**

0  
 1  
 2  
 3

Score should be based on how long ago individual was seeking drugs

**History of domestic violence/neglect:**

0  
 1  
 2  
 3

Score should be based on how long ago the violence/neglect occurred and the degree of both

**Social isolation/withdrawal:**

0  
 1  
 2  
 3  
 4

Score based on degree of isolation

**History of suicidal/homicidal thoughts:**

0  
 1  
 2  
 3  
 4

Any history is bad, the more recent the higher the score should be

**WTU NCM Risk Assessment**  
**Screen Capture from AWCTS CTP risk assessment module**

	<p><b>Family/friend history of suicide/homicide:*</b></p> <p><input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4</p> <p>Any history is bad, the more recent the higher the score.</p> <p><b>History of suicidal/homicidal attempt:*</b></p> <p><input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5</p> <p>Any history is bad, the more recent the higher the score.</p> <p><b>Tragic experience that the WT could answer yes to one or more of the following: Nightmares about event or thought about event when they did not want to; constantly on guard, or startled, numb or detached from others:*</b></p> <p><input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6</p> <p>Score based on how severe the impact of the tragic event is on the WT. The fact that an event occurred should be documented so other TRIAD members are aware.</p> <p><b>Released from in-patient or partial stay psychiatric unit last 2 weeks:*</b></p> <p><input type="radio"/> 0 <input type="radio"/> 17 0 = no / 17 = yes</p> <p><b>Designated High Risk by A&amp;AP:*</b></p> <p><input type="radio"/> 0 <input type="radio"/> 17 0 = no / 17 = yes</p>
	<p><b>History of suicidal/homicidal attempt last 6 months*</b></p> <p><input type="radio"/> 0 <input type="radio"/> 17 0 = no / 17 = yes</p> <p><b>Domestic violence/homicide last 3 months*</b></p> <p><input type="radio"/> 0 <input type="radio"/> 17 0 = no / 17 = yes</p> <p style="text-align: center;"><input type="button" value="Next"/></p>

# WTU SL Risk Assessment

## Screen Capture from AWCTS CTP risk assessment module

SL Risk Assessment - kara.murray

kara.murray assigned this task to you on 13 Jan 2010 at 21:36 GMT

Attachments and Notes (0)

Show task info ▾

Please assign a score for each risk factor.

**Age 25 or under:\***

0

1

2

Age 17-21 = 2 / Age 21-25 = 1 / > 25 = 0

**Multiple combat or imminent danger deployments:\***

0

1

2

Score based on number of deployments and how long the last one was from most recent

**Exposed to combat last 180 days:\***

0

1

2

Score should be based on how much combat WT has seen

**Legal issues (History of ANOL, UCMJ):\***

0

1

2

3

Rating should be based on severity and number of issues

---

**History of non-compliance with Warrior Transition program (fails to meet with SL, CM, PCM, specialty care provider):\***

0

1

2

3

Score should be based on number of no-shows, canceled appointments, etc during the last 30 to 60 days

**Social Isolation/Withdrawal (difficulty making friends, bad influences, friends death):\***

0

1

2

3

Score based on degree of isolation

**Financial Issues:\***

0

1

2

3

4

Score based on severity of issues and how much of an impact they are having on the individual and his family.

**Alcohol or drugs abuse resulting in: missed appt or duty; under influence during duty or appt; referred to community mental health for alcohol or drugs; illegal drug use, alcohol violations:\***

0

1

2

3

4

Score should be based on frequency and type of incident

**Experienced two or more at fault accidents (MVA):\***

0

1

2

3

4

Score should be based on frequency and type of incident

**WTU SL Risk Assessment screen**  
**Screen Capture from AWCTS CTP risk assessment module**

<p><b>Counselled for poor performance within last 90 days:*</b></p> <p><input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4</p> <p>Should be based on how long ago the counseling occurred and type of behavior being demonstrated</p> <p><b>Physical or verbal confrontation 2 or more times in last 90 days:*</b></p> <p><input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7</p> <p>Score based on how long ago confrontation occurred as well as type of confrontation</p> <p><b>Expressed or displayed any acts of self-harm:*</b></p> <p><input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10</p> <p>Score should be based on types of acts coupled with assessment of soldier's intent.</p>	
<p><b>Domestic violence/neglect last 3 months:*</b></p> <p><input type="radio"/> 0 <input type="radio"/> 17 0 = no / 17 = yes</p> <p><b>History of suicidal/homicidal attempt last 6 months:*</b></p> <p><input type="radio"/> 0 <input type="radio"/> 17 0 = no / 17 = yes</p> <p><b>Designated High Risk by ASAP:*</b></p> <p><input type="radio"/> 0 <input type="radio"/> 17 0 = no / 17 = yes</p> <p style="text-align: center;"><input type="button" value="Next"/></p>	

# WTU PCM Risk Assessment screen

## Screen Capture from AWCTS CTP risk assessment module

 **PCM Risk Assessment**

Show task info  assigned this task to you on 13 Jan 2010 at 21:38 GMT.  Attachments and Notes (0)

Please determine the risk decision based on but not limited to cognitive impairment, behavioral health, medications regimen, history of substance abuse, and compliance with treatment.

**WT Risk Level\***

High

Moderate

Moderate-Low

Low

**Comments**

# WTU Commander Risk Assessment and Mitigation Screen Capture from AWCTS CTP risk assessment module

Save Reassign Reject

Commander's Risk Assessment - kara.murray

Attachments and Notes (0)

Show task info kara.murray assigned this task to you on 13 Jan 2010 at 21:36 GMT

Please review the PCM, NCM, SL, and SW assessments to determine the final risk level of the WT and the corresponding management/mitigating actions.

<p><b>NCM Assessment</b></p> <p>Risk Score: 0  <b>Risk Designation: LOW</b>                  Assessment By: stuart.pim                  Assessment Date: 1/14/2010 3:35 PM                  Comments:</p>	<p><b>SL Assessment</b></p> <p>Risk Score: 0  <b>Risk Designation: LOW</b>                  Assessment By: stuart.pim                  Assessment Date: 1/14/2010 9:58 PM                  Comments:</p>
<p><b>PCM Assessment</b></p> <p>Risk Designation: <b>LOW</b>                  Assessment By: stuart.pim                  Assessment Date: 1/14/2010 4:09 PM                  Comments:</p>	<p><b>SW Assessment</b></p> <p>Risk Designation: <b>LOW</b>                  Assessment By: stuart.pim                  Assessment Date: 1/14/2010 4:18 PM                  Comments:</p>

**Commander's Assessment**

Overall Risk Designation

- High
- Moderate
- Moderate-Low
- Low

**Risk Management/Mitigation Plan**

Check all actions to be part of the plan:

- C2 contact to 2 times a day/ 7 days per week
- Medication reconciliation at least weekly and each time there is a change in medication regimen
- Refer to PCM for Safe Provider Program and Restrict refill amounts of medications to 7 days or less
- Contract for safety
- Roommate/NMA/family member:
- Issue No Alcohol Order
- Require Safe Buddy to travel off post (sign intent with SDNCO)
- Refer to Chaplain
- Initiate safety counseling
- Refer to Behavioral Health for evaluation and follow-up
- Refer to ER for Suicidal ideation or Homicidal ideation
- Provide 1:1 escort
- Increase CM Contact
- NMA/family escort
- Refer to Family advocacy/marital counseling
- Move on post/move into Barracks/Return to WTU from CBWTU
- Initiate Multidisciplinary meeting with Soldier
- Include WT's Family/Significant Other in plan
- Refer to PCM for evaluation
- Refer to AGAP

Automatic for HIGH risk WT's

## Risk Mitigation Matrix

Mitigation Action	LOW	Mod Low	Mod	HIGH
Command and control (C2) contact with WT two times per day, seven days per week.				X
Medication reconciliation at least weekly and each time there is a change in medication regimen.				X
Refer to primary Care Manager (PCM) for enrollment in the Army's Sole Provider Program (SPP) and restrict refill amounts of medications to seven days or less.				X
Contract for safety.				X
Roommate/non-medical attendant (NMA)/family member as WT battle buddy per DAIM-ZA Policy Memo dated October 14,2009.				X
Issue a no alcohol order.	When the PCM determines consumption of alcohol poses an unacceptable risk to the Soldier due to a medical condition and/or medication regimen, a no alcohol order will be annotated on the DA 3349. Commanders will ensure the Soldier is counseled in writing acknowledging they are prohibited from consuming alcohol.			X
Require battle buddy to travel off post (sign in/out with SDNCO).				X
Refer to Chaplain.	Refer for any risk when presence of risk factors such as family issues, poor performance, etc.			X
Initiate safety counseling.	X	X	X	X
Refer to behavioral health for evaluation and follow-up.	Refer for sudden, unusual or unexplained change in behavior.			X
Refer to ER for suicidal ideation or homicidal ideation.	Refer WITH 1:1 escort for any suicidal or homicidal ideations.			
Refer to WTU social worker (SW) for weekly f/u Risk Assessments and for appropriate Behavioral Health referral for evaluation and follow-up.	Refer for sudden, unusual or unexplained change in behavior.			
Provide 1:1 escort.	Can be done at ANY risk level if indicated.			
Increase case manager (CM) Contact.	Can be done at ANY risk level if indicated.			
Refer to SW for marital counseling referral.	Can be done at ANY risk level if indicated.			
Refer to Family Advocacy Program.	Can be done at ANY risk level if indicated.			
Evaluate to determine if Soldier requires moving onto post/move into Barracks/Return to WTU from CBWTU to separate from risk stressors or closer monitoring.	Can be done at ANY risk level if indicated.			
Initiate multidisciplinary meeting with Soldier.	X	X	X	X
Include WT's family/significant other in plan (HIPPA Precautions).	X	X	X	X
Refer to PCM for evaluation.	Can be done at ANY risk level if indicated.			
Refer to ASAP.	IAW AR and/or recommendation of commander at any level.			

## Enclosure 5

### High Risk Patient Medication Reporting Tools

The **WTU-Prescription Medication Analysis and Reporting Tool** is a report to assist the medical triad caring for ill and wounded service members. In addition to some of the prepared reports listing what medications the Pharmacy Data Transaction System has recorded for a Service Member, a polypharmacy report is also available which captures information for Service Members who have four or more medications on their profile that includes a controlled substance and a medication labeled as high-risk or a psychotropic drug.

The **Controlled Drug Medication Analysis Reporting Tool (CD-MART)** is another tool developed to assist MTF providers and pharmacists. It identifies patients with possible drug abuse or diversion behavior using controlled substances over a given period of time and provides MTF providers and pharmacists with an automated process to analyze the data. The CD-MART captures prescription utilization from the three points of service and is delivered to the authorized requester in a database that allows the user to individualize the files with pre-set filters and user-identified parameters. The MTF can request the data to be pulled from within the MTF's 40-mile catchment area or all of the DoD pharmacy locations.

Another tool developed to identify and monitor beneficiaries, and includes the high risk population who may exhibit drug-seeking behavior or are at high-risk of harming themselves, is the **Pharmacy Restriction Program**. At the written request of the provider, the Pharmacy Operations Center (POC) uses PDTS to set the restriction. The provider has the option of restricting all medications to a specific pharmacy and/or provider; restricting controlled-substance medications to a specific provider or list of providers; and excluding controlled-substances or specific non-controlled substances to mail-order service or retail pharmacies. The POC coordinates the restriction with the health care provider, the managed care support contractors and the pharmacy contractor. The beneficiary is notified by a letter to choose a pharmacy, provider and medical facility. When the POC is notified of the selections, restrictions are applied in PDTS to their pharmacy benefit. If the beneficiary does not return the letter within 60 days, the beneficiary is locked into 100 percent prepay on all controlled-substance medications. If the beneficiary is a high risk patient, they are restricted to the MTF where they receive care or, if the beneficiary is a Civilian-Based Warrior in Transition, they are restricted to a retail pharmacy of their choice. If the beneficiary fails to comply with the agreement requirements; e.g., attempts to get a prescription filled at a pharmacy other than the pharmacy they are assigned to, the pharmacy claim will not pay at the retail or mail-order pharmacy. The pharmacy and the provider will receive an automated alert in the beneficiary's electronic pharmacy record indicating the high risk patient's specific restrictions and a notice to call the POC for assistance. If required, options to override claim rejections and allow beneficiaries to obtain prescriptions outside of the agreement

requirements are available on a case-by-case basis. If the high risk patient requires disenrollment from the program, the provider calls the POC to coordinate the action.

Enclosure 6  
List of Products to Assist Providers in Multiple Areas of Care – Including Pharmaceuticals

Training Product	Location	Provider	Patient	Patients with Cognitive Disabilities	Nonmedical Case Managers	Military leaders	Family
Co-occurring Disorders Tool-kit	<u>Co-occurring Disorder Toolkit:</u>	√	√	No	No	No	√
Substance Use Disorder	VA/DoD <u>Substance Use Disorder (SUD) Clinical Practice Guideline</u>  (Clinical Support Tool currently developed expected completion in Fall 2011 to include tools for providers, patients, and families)	√	No	No	No	No	No
PTSD	VA/DoD <u>Post Traumatic Stress Disorder (PTSD) Clinical Practice Guideline New</u>  (Clinical Support Tool currently developed expected completion in Fall 2011 to include tools for providers, patients, and families)	√	No	No	No	No	No
Major Depressive Disorder	VA/DoD <u>Major Depressive Disorder (MDD) Clinical Practice Guideline</u>	√	No	No	No	No	No
		√	√	No	√	No	√

Enclosure 6  
List of Products to Assist Providers in Multiple Areas of Care – Including Pharmaceuticals

Training Product	Location	Provider	Patient	Patients with Cognitive Disabilities	Nonmedical Case Managers	Military leaders	Family
	MDD Clinical Support Tool (CST) for MDD is developed for the providers and patients. It can be ordered by the providers at <a href="https://www.qmo.amedd.army.mil/depress/depress.htm">https://www.qmo.amedd.army.mil/depress/depress.htm</a>	√	√	No	√	No	√
Bipolar Disorder	VA/DoD <u>Bipolar Disorder in Adults (BD)</u>  (Clinical Support Tool currently scheduled for development Winter 2011 to include tools for patients, patients, and families)	√	No	No	No	No	No
Behavior Health issues	Deployment Health Clinical Center (DHCC) Respect.mil  <a href="http://www.pdhealth.mil/respect-mil/index1.asp">http://www.pdhealth.mil/respect-mil/index1.asp</a>	√	√	√	√	√	√

This table includes the target audiences for the products in the top row. √ in the target audience columns next to “Training Product” listings signifies that the product contains information for that target population relevant to NDAA 11 Section 716.

Department of Veterans Affairs  
Veterans Health Administration  
Washington, DC 20420

VHA HANDBOOK 1010.02  
Transmittal Sheet  
November 13, 2009

**DEPARTMENT OF VETERANS AFFAIRS LIAISON FOR HEALTHCARE  
STATIONED AT MILITARY TREATMENT FACILITIES**

- 1. REASON FOR ISSUE.** This Veterans Health Administration (VHA) Handbook establishes procedures in the transition of health care of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) active duty service members (ADSM), non-OEF and OIF ADSM, mobilized Reservists, mobilized National Guard and Veterans.
- 2. SUMMARY OF CONTENTS.** This Handbook describes the role of the Department of Veterans Affairs (VA) Liaison for Healthcare. VA Liaisons are masters prepared social workers (MSWs) and Registered Nurses (RNs) stationed at designated Military Treatment Facilities (MTFs) who are transitioning the health care of OEF and OIF ADSM, non-OEF and OIF ADSM, mobilized Reservists, mobilized National Guard, and Veterans into the VA health care system. The intent of the Handbook is to establish practice standards, roles, responsibilities, and training requirements for RNs and MSWs who are functioning as VA Liaisons for Healthcare.
- 3. RELATED ISSUES.** VHA Handbook 1010.01.
- 4. FOLLOW-UP RESPONSIBILITY.** The Chief Consultant, Care Management and Social Work Service (11CMSW), Office of Patient Care Services, is responsible for the contents of this Handbook. Questions are to be referred to VA Liaison National Program Manager at (202) 461-6065.
- 5. RESCISSION.** None.
- 6. RECERTIFICATION.** This VHA Handbook is scheduled for recertification on or before the last day of November 2014.

Gerald M. Cross, MD, FAAFP  
Acting Under Secretary for Health

DISTRIBUTION: E-mailed to the VHA Publications Distribution List 11/17/2009

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STATIONED AT MILITARY TREATMENT FACILITIES**

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## DEPARTMENT OF VETERANS AFFAIRS LIAISON FOR HEALTHCARE STATIONED AT MILITARY TREATMENT FACILITIES

### 1. PURPOSE

This Veterans Health Administration (VHA) Handbook establishes procedures in the transition of health care of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) active duty service members (ADSM), non-OEF and OIF ADSM, mobilized Reservists, mobilized National Guard, and Veterans referred directly from Military Treatment Facilities (MTFs) to the Department of Veterans Affairs (VA) health care system.

### 2. BACKGROUND

Since 2003, VA has collaborated with the Department of Defense (DOD) to seamlessly transition the health care of injured or ill combat Veterans and active duty service members from MTFs to VHA facilities by assigning VA Liaisons for Healthcare at major MTFs (see App. A). VA Liaisons assist with transfers to VHA facilities and provide information to service members, Veterans, and families about VHA health care services. While the VA Liaison program pertains primarily to military personnel returning from Iraq and Afghanistan who served in OEF and OIF, it may include other active duty military personnel and Veterans who are injured or ill and transitioning to VA.

### 3. SCOPE

a. This Handbook describes the role of the VA Liaison for Healthcare stationed at designated MTFs who are transitioning the health care of OEF and OIF ADSM, non-OEF and OIF ADSM, mobilized Reservists, mobilized National Guard, and Veterans into the VA health care system. This may also include other military personnel who were injured while in support of OEF and OIF and military personnel injured in training accidents while on active duty. When transitioning health care for Veterans, unless the Veteran was discharged from the military after 2003, the VA Liaisons' role may be minimal and will mainly consist of connecting DOD case managers, or the Veteran, to an appropriate contact at a receiving VA health care facility in order to coordinate the transition of health care. **NOTE:** *OEF and OIF ADSM will be used to refer to active duty component, Reserve component and National Guardsman who are currently on active duty orders as established by DOD, and who recently served in a theater of combat operations or in combat against a hostile force during a period of hostilities. See Title 38 United States Code section 1710(e) for VA's authority to treat combat Veterans. For additional information about eligibility, refer to VHA policy regarding Combat Veteran Healthcare Benefits and Co-pay Exemption Post-Discharge from Military Service.*

b. The intent of the Handbook is to establish practice standards, roles, responsibilities, and training requirements for registered nurses (RNs) and masters prepared social workers (MSWs) who function as VA Liaisons for Healthcare (see App. B and App. C for VA Liaison functional statements).

#### 4. RESPONSIBILITY OF THE UNDER SECRETARY FOR HEALTH

In collaboration with DOD, the Under Secretary for Health, or designee, is responsible for ensuring that full-time MSWs and RNs are appointed as VA Liaisons for Healthcare (see App. B and App. C for required functions) for major MTFs to:

- a. Assist with the transition of care to a VA health care facility.
- b. Educate active duty OEF and OIF service members and their families about health care services.
- c. Document all pertinent transition information in the Computerized Patient Record System (CPRS).

***NOTE:** Although the VA Liaisons report administratively to the VA health care facility closest to the MTF, they report programmatically to Care Management and Social Work Service (11CMSW), Office of Patient Care Services, VA Central Office. The assignment of a VA Liaison to additional MTFs will be determined collaboratively between DOD and 11CMSW and the Deputy Under Secretary for Health for Operations and Management (DUSHOM) (10N). The number of VA Liaison positions at each MTF will be based on workload.*

#### 5. RESPONSIBILITY OF THE VA LIAISON NATIONAL PROGRAM MANAGER

The VA Liaison National Program Manager is assigned to 11CMSW and is accountable for ensuring that the VA Liaison Program is standardized nationally with consistent policies and procedures across the program. The VA Liaison National Program Manager is responsible for:

- a. Standardizing the process and procedures for the VA Liaisons nationally.
- b. Providing salient direction and guidance to the VA Liaisons on a regular basis.
- c. Providing orientation and training to new VA Liaisons.
- d. Providing ongoing education and training on updated policies and procedures to VA Liaisons.
- e. Collaborating with DOD to ensure effective incorporation of VA Liaisons at identified MTFs.
- f. Collaborating with the Office of the DUSHOM when placing VA Liaisons at MTFs.
- g. Moderating regular national conference calls for all VA Liaisons.
- h. Advocating for the VA Liaison with DOD as well as senior and local VA leadership to ensure the VA Liaison has the support and resources needed to fulfill the role.

i. Standardizing the documentation in CPRS via a national template available on the Health Information Management website at <http://vaww.vhaco.va.gov/him/natldoctypeemplates.html>.  
*NOTE: This is an internal VA web site, not available to the public.*

## **6. RESPONSIBILITY OF THE VETERANS INTEGRATED SERVICE NETWORK (VISN) DIRECTOR**

The VISN Director is responsible for:

- a. Ensuring RNs or MSWs are assigned to serve as VA Liaisons for Healthcare at designated MTFs, as directed by 11CMSW, Office of Patient Care Services, VHA, VA Central Office.
- b. Ensuring that appropriate care transitions and health care services are provided to OEF and OIF ADSMs and Veterans when requested by the DOD treatment team in a timely manner and coordinated with VA Liaisons.

## **7. RESPONSIBILITY OF THE FACILITY DIRECTOR**

The Facility Director is responsible for:

- a. Assigning RNs or MSWs to serve as VA Liaisons for Healthcare at designated MTFs, as directed by 11CMSW. *NOTE: The VA Liaison reports directly to the Facility Director, or designee.*
- b. Monitoring the workload of the VA Liaison for Healthcare and if necessary, assigning additional VA Liaisons based on workload. *NOTE: Requests for additional VA Liaisons need to be directed to the VA Liaison National Program Manager in coordination with 10N and the VISN.*
- c. Providing health care services to authorized OEF and OIF ADSMs and eligible Veterans when requested and in a timely manner.
- d. Providing VA Liaisons with the resources and support necessary to fulfill the duties of the VA Liaison position.
- e. Ensuring the national VA Liaison note template is loaded into the CPRS at the local VA health care facility.
- f. Performing all personnel actions for the VA Liaisons including hiring actions and professional competencies.

## **8. RESPONSIBILITY OF THE VA LIAISON FOR HEALTHCARE**

The primary role of the VA Liaison for Healthcare is to facilitate the transfer of health care, both inpatient and outpatient, from MTFs to the appropriate VA health care facility. The responsibilities of the VA Liaison include:

a. Working closely with the MTF treatment team to provide ongoing consultation regarding complex discharge planning issues, VHA health care benefits and resources, and identifying the VHA facility where care will be transferred.

b. Developing relationships and collaborating with the MTF social workers, case managers, specialty care staff, managed care staff, discharge planners, and Warrior Transition Unit and Brigade or Medical Holding Company staff, where applicable, to identify patients ready for discharge to VHA, and obtain clear referral information and authorization for VHA to treat those still on active duty. The referral needs to:

(1) Clearly identify the patient's diagnoses, health care and psychosocial needs, and requests for VHA health care services.

(2) Include the VA Form 10-0454 Referral (see App. D) and pertinent MTF medical records, such as the admission sheet, history and physical and daily clinical notes for inpatients, or recent outpatient clinical notes.

(3) If patient is still Active Duty, include clinical orders from an MTF clinician specifying which services are authorized for VHA to provide. In addition, the referral must include verification that TRICARE or other appropriate authorization, i.e., Military Medical Support Office (MMSO), TRICARE Managed Care Support Contractor (MCSC), or VA and DOD Sharing Agreement has been requested. *NOTE: If the patient will be discharged from Active Duty prior to the time of the first appointment at the VA health care facility, no TRICARE authorization will be needed.*

c. Include a meeting with the ADSM and family to provide education and an overview of VHA health benefits and resources to address current medical issues identified as part of the service member's treatment plan. The VA Liaison will provide contact information for the OEF and OIF Program Manager and Case Manager at the receiving VA health care facility. In collaboration with the MTF treatment team, the VA Liaison must consider the patient and family's psychosocial situation, their ability to comprehend and comply with VA treatment plan, and any special needs of the patient and family that may impact reaching optimal psychosocial functioning. *NOTE: Regular onsite collaboration and coordination is crucial to provide effective consultative services and the referral, linkage, education, and assessment functions. The provision of direct services may be necessary to enhance the communication and relationship with service members and their families.*

d. Ensure, through direct coordination with the Eligibility, Business Office, and Enrollment Coordinator, or designated point of contact, that all referrals and authorizations are entered into CPRS at the Liaison's home facility. It is expected for the ADSM and Veteran to be enrolled and registered in the Liaison's home facility CPRS within 72 hours after the receipt of the referral. The VA Liaison needs to coordinate with their Eligibility, Business Office, and Enrollment Coordinator or designated point of contact to establish a means of securely transferring this information to the receiving VA health care facility Veterans Health Information Systems and Technology Architecture (Vista) and CPRS. *NOTE: Patient Data Exchange (PDX) is one means of information transfer.*

e. Identifying and communicating with the facility OEF and OIF Program Manager, and if indicated, a specialty program admissions coordinator, i.e., Polytrauma Rehabilitation Center (PRC), Spinal Cord Injury Rehabilitation Center, etc., at the receiving VA health care facility via telephone and email to initiate the requested health care.

(1) The Liaison must transmit the referral form and pertinent health records to the OEF and OIF Program Manager and admissions coordinator via fax or encrypted electronic mail attachment.

(2) Outpatient appointments need to be given to the ADSM prior to leaving the MTF, however, it must be for a date after their expected discharge or release from the military or appropriate authorization is required.

(a) Appointments that will occur after an ADSM is discharged from active duty and is a Veteran need to be made in advance while a service member is still on active duty.

(b) If the appointments are not available at the time the ADSM is leaving the MTF, the VA Liaison must make arrangements for the ADSM to be notified. The VA Liaison or OEF and OIF Program Manager may contact the ADSM with the appointment information. *NOTE: A primary care appointment will be established within 30 days of the ADSM's desired appointment date, generally within 30 days of the military discharge date. If specialty appointments are also needed within 30 days to continue the ADSM's treatment plan, the VA Liaison will coordinate with the OEF and OIF Program Manager to schedule those appointments.*

(3) If the patient will still be on active duty at the time of any appointments, TRICARE authorization will be required and the Liaison needs to assist in obtaining clinical orders from an MTF clinician to obtain TRICARE authorization for the appointment(s). There must be a designated person at the receiving VA health care facility to then acquire the required authorization number from the MTF initiating the referral or the MCSC.

(4) The VA Liaison will collaborate with the OEF and OIF Program Manager regarding the patient's need for services from a Transition Patient Advocate (TPA). In cases where the patient is receiving care at a VA health care facility which is not his or her preferred VA health care facility, the Liaison will collaborate with the preferred VA health care facility OEF and OIF Program Manager to determine the need for a TPA.

f. The Liaison will ensure the receiving VHA facility OEF and OIF Program Manager or specialty program admissions coordinator has contact information for pertinent DOD points of contact, i.e., military case manager, WTU case manager, etc., needed for ongoing communication and collaboration about an ADSM's health care.

g. The Liaison will address any barriers to health care and communicate those barriers to the OEF and OIF Program Manager or specialty program admissions coordinator to reduce or eliminate these barriers as appropriate.

h. Documenting all VA Liaison activity as follows:

(1) Every referral will be documented in CPRS using the appropriate national template available on the Health Information Management website at <http://vaww.vhaco.va.gov/him/natldoctypeemplates.html>.

(2) Every referral will be registered in the Veterans Tracking Application (VTA). **NOTE:** *Severely Ill and Injured or Non-severely Ill and Injured must be indicated within VTA. The designation of Severely Ill and Injured will trigger a performance measure for the receiving VA health care facility.*

(3) Each week, the VA Liaison will document workload in the web-based workload report, which is monitored by VA Central office.

i. Maintaining a relationship and collaborating where applicable with Federal Recovery Coordinators (FRCs) on-site at the MTF.

j. Maintaining a relationship where applicable with the Veterans Benefits Administration (VBA) staff on-site at the MTF.

k. Representing VHA at the MTF on a global, non-patient specific basis at briefings, participating in educational opportunities, meeting with the MTF Command, etc.

l. Reporting programmatically to the VA Liaison National Program Manager, Care Management and Social Work Service, in VA Central Office. This includes, but is not limited to:

(1) Implementing the national standardized procedures of the VA Liaison Program.

(2) Reporting programmatic issues directly to the VA Liaison National Program Manager in a timely fashion.

(3) Responding to regular direction and requests from the VA Liaison National Program Manager.

(4) Participating in regular national conference calls for VA Liaisons.

(5) Participating in special projects as assigned by the VA Liaison National Program.

(6) Informing the VA Liaison National Program Manager of any high profile or high priority issues that may be of interest to VA Central Office leadership.

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

1. Walter Reed Army Medical Center (Washington, DC).
2. National Naval Medical Center (Bethesda, MD).
3. Brooke Army Medical Center, Fort Sam Houston (San Antonio, TX).  
Center for the Intrepid
4. Darnall Army Community Hospital (Ft. Hood, TX).
5. Madigan Army Medical Center, Fort Lewis (Tacoma, WA).
6. Eisenhower Army Medical Center, Fort Gordon (Augusta, GA).
7. Evans Army Community Hospital (Ft. Carson, CO).
8. Naval Medical Center (San Diego, CA).
9. Naval Hospital, Camp Pendleton (Oceanside, CA).
10. Womack Army Medical Center (Ft. Bragg, NC).
11. Martin Army Community Hospital (Ft. Benning, GA).
12. Winn Army Community Hospital (Ft. Stewart, GA).
13. Ireland Army Community Hospital (Ft. Knox, KY).
14. Irwin Army Community Hospital (Ft. Riley, KS).
15. William Beaumont Army Medical Center (Ft. Bliss, TX).
16. McDonald Army Health Center (Ft. Eustis, VA).
17. U.S. Army Medical Department Activity (Ft. Drum, NY).
18. Blanchfield Army Community Hospital (Ft. Campbell, KY).

**NOTE:** *The OEF and OIF Program Manager at the receiving VA health care facility can be contacted directly for referrals from the remaining MTFs.*

**FUNCTIONAL STATEMENT FOR DEPARTMENT OF VETERANS AFFAIRS (VA)  
LIAISON FOR HEALTHCARE (REGISTERED NURSE) ASSIGNED TO MILITARY  
TREATMENT FACILITIES (MTFS)  
(NURSE III)**

**A. Qualifications**

The Department of Veterans Affairs (VA) Liaison is a graduate from a program accredited by the National League for Nursing Accrediting Commission (NLNAC), or the Commission on Collegiate Nursing Education (CCNE), and has met registered nurse (RN) licensure requirements for practice in accordance with VHA Handbook 5005, Part II, Appendix G. The VA Liaisons are stationed at major Military Treatment Facilities (MTFs) nationwide.

**B. Education and Experience Requirements**

- a. Masters degree in nursing or related field with a Bachelor of Science degree in nursing (BSN) or bachelors degree in a related field (if Master of Science degree in nursing is obtained in a bridge program, no BSN is required) or doctoral degree in nursing or a related field.
- b. Three to five years of clinical nursing experience, preferably in care of patients with polytrauma injuries, as well as returning service members with both severe and non-severe combat injuries.
- c. Knowledge of discharge planning.
- d. Demonstration of clinical competencies specified for the Veterans Health Administration (VHA) liaison role.

**C. Scope of Practice**

a. The VA Liaison is seen as the VHA representative to the military installation, as designated by the Under Secretary for Health, and must represent VA in all aspects of the patient care, patient transfer, and patient outreach. The primary role of the VA Liaison is to ensure the smooth transition of patients and families, both inpatient and outpatient, from the MTF to the appropriate VA health care facility. The VA Liaisons must work on site at the MTF with clinical and administrative staff, service member(s), families, and Veterans to ensure priority access to needed health care services and education regarding VHA benefits is met. The service members or Veterans are primarily returning from Iraq and Afghanistan and may have severe and complex injuries, minor injuries, and mental health needs. Although the liaisons must report administratively to the VA health care facility closest to the MTF, they must report programmatically to the Care Management and Social Work Service, Office of Patient Care Services (11CMSW).

b. Additionally, the VA Liaison develops a high level of clinical practice, leadership, and skills to improve and coordinate patient care. The practice of each VA Liaison is based on

knowledge, experience, and research, and is expected to impact patient outcomes and improve care coordination and continuity for patients with both severe and non-severe combat injuries. The VA Liaison executes position responsibilities that demonstrate leadership, experience, and creative approaches in the management of complex care of severely injured patients.

**D. Responsibilities**

a. The VA Liaison is responsible to the VA health care facility clinical executive team (Chief of Staff and Chief Nurse Executive) with matrix responsibility to the Nurse Executive at the MTF. Programmatic oversight of activities of all VA Liaisons is provided by the VA Liaison National Program Manager in VA Central Office, Care Management and Social Work Service, Office of Patient Care Services (11CMSW). The VA Liaison possesses the knowledge and skills to effectively apply all aspects of the nursing process and care management principles within a collaborative, interdisciplinary practice setting. The VA Liaison will demonstrate knowledge and skills necessary to provide a smooth transition for the patient with both severe and non-severe combat injuries and the patient's family and significant other to VHA. This includes understanding specific age-related competencies that pertain to the principles of growth and development relevant to the adult and young adult population.

b. The responsibilities of the VA Liaison include:

- (a) As an independent clinical practitioner, working closely with the MTF treatment team using advanced practice skills and expertise to provide ongoing consultation regarding complex discharge planning issues, VHA health care benefits, resources, and facilities. This will require an intimate knowledge of VHA programs and services nationwide, and the ability to match Veterans' needs with appropriate resources.
- (b) Developing relationships and collaborations with the VA and MTF social workers (SW), nurses, RN and SW case managers, managed care staff, and discharge planners to identify patients ready for discharge to a VA health care facility, and to obtain clear referral information and authorization for VHA to treat those still on active duty. This referral needs to:
  1. Include appropriate sections and documentation from the MTF Medical Records; VA Referral Form (entitled *Military Treatment Facility Referral Form To VA Liaison*); Admission Sheet; Clinical and Consult Orders; or other authorization for VHA to provide services and bill TRICARE or other appropriate entity through a VA-Department of Defense (DOD) Sharing Agreement.
  2. Clearly identifying the patient's health care and psychosocial needs, and requests for VHA health care services to ensure Clinical and Consult Orders or authorizations, specifying which VHA services are authorized and are completed prior to transfer of any patient(s) to their preferred facility.

- (c) Meeting with the service member and family to provide education and an overview of VA health benefits and resources, and to address current medical and psychosocial issues identified as part of the service member's treatment plan. In collaboration with the MTF treatment team and military case manager, the VA Liaison must use advanced clinical skills to assess the patient and family's psychosocial situation, their ability to comprehend and comply with VA's treatment plan determined by the MTF staff, and any special needs of the patient and family that may impact reaching optimal physical and mental functional status.

*NOTE: Regular onsite collaboration and coordination is crucial to provide effective consultative services with the referral, linkage, education, and assessment functions. The provision of direct services may be necessary to enhance the communication and relationship with service members and their families.*

- (d) Coordinating with the Liaison's home facility Enrollment Coordinator and case manager to initially register active duty Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) service members, or enroll OEF and OIF Veterans at their facility utilizing the referral information.
- (e) Collaborating with MTF social workers, nurses, and case managers in identifying the VA health care facility where care will be transferred to an accepting physician at that facility. To ensure ease of registration or enrollment procedures, information must be transmitted using Patient Data Exchange (PDX) or Network Health Exchange (NHE) from the liaison's facility to the identified receiving VA health care facility.
- (f) Identifying and communicating with the OEF and OIF Program Manager and RN or SW Case Managers at the receiving VHA facility to initiate and process referrals and linkages for transfer of care.
- (g) Documenting all liaison activity in the Computerized Patient Record System (CPRS) nationally standardized template that is available on the Health Information Management website at <http://vaww.vhaco.va.gov/him/natldoctemplates.html>, as well as in the Veterans Tracking Application (VTA) or its equivalent.
- (h) To facilitate the seamless transition of care, communicating the transfer plans to the patient and family while determining any unique patient or family needs requiring attention.
- (i) Communicating ongoing needs of the patient and family to the receiving VA medical center OEF and OIF Program Manager to further facilitate the seamless transition of care.

- (j) Maintaining contact with the facility OEF and OIF Program Manager at the accepting VA health care facility and with MTF staff, and coordinating the transfer of care upon discharge from the MTF. Assists in identifying and obtaining additional information needed from the MTF staff to optimize the transfer of care to the case manager at the designated VA health care facility.
- (k) Providing patient level referral and outcome information on all transfers of care from the MTF to the VA Liaison National Program Manager, Care Management and Social Work Service, Office of Patient Care Services (11CMSW), on a monthly basis through the use of a spreadsheet, inputting summary information into an automated intranet workload report on a weekly basis, and attending regularly scheduled conference calls.
- (l) Collaborating programmatically and communicating pertinent patient referral information with Veterans Benefit Administration (VBA) staff also located at the MTF.
- (m) Collaborating and communicating with various agencies and departments at the national, state and local level in ensuring the seamless transition of health care.
- (n) Preparing reports, briefs, and presentations for VA staff at all levels, DOD staff, Congressional Staff, community organizations, etc., regarding the seamless transition process and specific mechanics of their program.
- (o) Managing the day-to-day operations of the liaison initiative and providing accountability to program effectiveness and modifications of service patterns to enhance customer service. Identifying gaps in the transition system and collaborating with MTF and DOD staff and other departments to enhance the seamless transition process.
- (p) Protecting printed and electronic files containing protected health information and sensitive data in accordance with the Privacy Act of 1974 and other applicable laws, Federal regulations, and VA statutes and policies. Protecting the data from unauthorized release or from loss, alteration, or unauthorized deletion. Following applicable regulations, the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security procedures and instructions regarding access to computerized files, releases of access codes, etc.
- (q) Using word processing software to execute office automation functions such as storing and retrieving electronic documents and files, activating printer, inserting and deleting text, formatting letters, reports and memoranda, and transmitting and receiving email. Competent in Microsoft Office programs to include, but not limited to, Word, Excel, and Power Point. Must be competent using the intranet and internet to access resources and utilize web based tracking systems. Uses the Veterans health Information and Technology Architecture (VistA) and CPRS to document VA Liaison activities appropriately.

**E. Professional Nursing Practice**

The VA Liaison meets all mandatory requirements for assigned area and performs activities that reflect the educational, experiential and competency requirements outlined in the following four dimensions of Professional Nursing Practice:

**Nursing Practice. The effective use of the nursing process to make practice decisions in an ethical manner. Practice encompasses factors related to safety, effectiveness, and cost in planning and delivering care.**

**1. Practice. Provides programmatic leadership in the application of the nursing process to client care, organizational processes and systems, improving outcomes at the program or service level.**

a. Using discharge planning concepts, provides holistic assessments of patients and family relating to the transition of care. Integrates bio-psychosocial concepts, cognitive skills, and cultural and age-specific patient characteristics to coordinate improved holistic outcome-based health care services.

b. Demonstrates advanced knowledge and skills necessary to provide customer service appropriate to the age of the patient population, including the ability to obtain and interpret information to identify patient and family concerns to resolve issues to the patient and family's satisfaction when at all possible.

c. Uses sound clinical judgment in assessing, planning, implementing, documenting and evaluation patient and family concerns at the program and service level.

d. Collaborates and consults with patient and multidisciplinary staff at DOD and VHA to effect plan of care.

e. Articulates differences in responses to illness and therapies considering individual's cultural, ethnic, socioeconomic, linguistic, religious, and lifestyle preferences.

f. Utilizes a repertoire of strategies to coordinate advance care planning and address responses to care planning decisions in order to effect the smooth transition of care. Ensures continuity during the transition of care.

**2. Ethics. Provides leadership in identifying and addressing ethical issues that impact client and staff, including initiating and participating in ethics consultations. Supports and enhances client self-determination.**

a. Demonstrates sensitivity to the cultural values and belief of patients and staff, identifies ethical issues and advocates for patient and family rights related to all facets of care.

b. Supports the American Nurses' Association Code of Ethics.

- c. Safeguards patient privacy and maintains confidentiality of patient information.
- d. Promotes VHA and DOD mission, vision and values.

**3. Resource Utilization. Manages program resources (financial, human, material, or informational) to facilitate safe, effective, and efficient care.**

- a. Integrates care provided by all health care providers at DOD and VHA facilities to facilitate discharge or transfer appropriate to the needs of polytrauma patients.
- b. Promotes practices that both reduce transfer and discharge delays and enhance cost effective use of resources.
- c. Explores alternative solutions to problems and selects the most appropriate, efficient and effective approach to problem solving.
- d. Initiates and maintains compatible working relationships with VA and DOD staff in order to obtain cooperative sharing of resources.

**Professional Development. Demonstrated by active pursuit of learning opportunities for self and others, as well as evaluation of his or her own practice and the performance for others.**

**1. Education and Career Development. Implements an educational plan to meet changing program or service needs for self and others. Maintains knowledge of current techniques, trends and professional issues.**

- a. Applies nursing standards and guidelines to clinical practice and care of polytrauma patients.
- b. Keeps self and staff equipped with current knowledge and skills to meet changing program and service needs. Recommends valuable programs to colleagues and staff.
- c. Develops and provides ongoing in-service to staff to facilitate and increase sensitivity and understanding about patient perceptions and satisfaction.
- d. Contributes to the achievement of applicable performance measures.

**2. Performance. Uses professional standards of care and practice to evaluate programs and service activities.**

- a. Assumes responsibility and accountability for processes and systems for the coordination of care at the program level.

b. Initiates and leads interdisciplinary team meetings to mediate or resolve identified patient and family issues.

c. Works effectively with patient, families, significant others, as well as with professionals and support personnel.

**Collaboration. Creates an atmosphere in which nurses build professional relationships with peers and colleagues in the interdisciplinary team. Provides opportunities for nurses to share knowledge through coaching and mentoring.**

**1. Collegiality. Serves as a preceptor and mentor. Coaches colleagues in team building. Makes sustained contributions to health care by sharing expertise within the medical center, or external to it.**

a. Serves as a resource to both VA and DOD.

b. Facilitates team efforts to achieve positive patient outcomes of program and service goals.

c. Shares clinical expertise with other professionals within or outside the facility.

**2. Collaboration. Uses group process to identify, analyze, and resolve care problems.**

a. Interacts with patients, family, significant others, and members of VA and DOD interdisciplinary teams, consistently demonstrating skilled communication techniques.

b. Works collaboratively with all members of the health care team at both VA and DOD settings to review and discuss any practices which appear to infringe on patient rights, or may cause unnecessary discomfort or embarrassment to patient(s) and families.

c. Initiates and conducts interdisciplinary team conferences to mediate and resolve identified patient and family issues and improve their quality of care.

d. Serves as a mentor and preceptor to nurses in VA and DOD facilities.

**Scientific Inquiry. Established by the extent to which the RN systematically evaluates and improves the quality and effectiveness of nursing practice and health care delivery based on research.**

**1. Quality of Care. Initiates interdisciplinary projects to improve organizational performance and outcomes.**

a. Assesses nursing implications and accountabilities to promote patient safety throughout the transition process. Ensures that all required health care information and data is documented, complete, and included in the patient care record prior to transfer.

- b. Collaborates with the interdisciplinary teams, patients, and families to establish satisfactory outcomes and goals for patient and family concerns.
- c. Continually evaluates the achievement of the VA Liaison program goals and objectives.
- e. Demonstrates ability to work effectively with polytrauma patients, and professional and supportive personnel in both VA and DOD.

**2. Research. Collaborates with others in research activities to improve care. Uses a body of research to validate and change work group practice.**

- a. Conducts and participates in studies, surveys, and activities to improve patient outcomes and satisfaction with health care.
- b. Applies current concepts and accepted findings from research studies to practice and when making recommendations for change.
- c. Uses evidence as a foundation for practice and changes in practice.

**FUNCTIONAL STATEMENT FOR DEPARTMENT OF VETERANS AFFAIRS (VA)  
LIAISON FOR HEALTHCARE (SOCIAL WORKER) ASSIGNED TO MILITARY  
TREATMENT FACILITY (MTF)  
GS-12**

**1. GENERAL DESCRIPTION**

There is a nationally recognized initiative to seamlessly transition the health care of injured and ill service members and Veterans from the Department of Defense (DOD) to the Department of Veterans Affairs (VA) health care system. The initiative is led by the VA Central Office, Care Management and Social Work Service, Office of Patient Care Services (11CMSW). The VA Liaison for Healthcare (hereinafter referred to as VA Liaison) is seen as the Veterans Health Administration (VHA) representative to the military installation and must represent the VA in all aspects of patient care, transfer and outreach. The primary role of the VA Liaison is to ensure the transfer of health care, both inpatient and outpatient, from the Military Treatment Facility (MTF) to the appropriate VA health care facility. The VA Liaisons must work on-site at the MTF with staff, service member(s), families, and Veterans to ensure priority access to needed health care services and education regarding VHA benefits. Service members and Veterans returning from Iraq and Afghanistan may have severe and complex injuries, minor injuries, and mental health needs. Although the VA Liaisons must report administratively to the VA health care facility closest to the MTF, they must report programmatically to the VHA Care Management and Social Work Service, Office of Patient Care Services (11CMSW).

The practice of each VA Liaison is based on knowledge, experience, and research, and is expected to impact patient outcomes and improve care coordination and continuity for polytrauma patients, as well as for returning service members with both severe and non-severe combat injuries.

The VA Liaison is accountable for clinical program effectiveness and modification of service patterns. They are also assigned in a setting where they have no access to social work supervision, and are assigned to work with special patient populations with highly complex health or mental health problems.

**2. FUNCTIONS OF POSITION**

The responsibilities of the VA Liaison for Healthcare include:

(1) Working closely with the MTF treatment team as an independent practitioner; using advanced practice skills and expertise to provide ongoing consultation regarding complex discharge planning issues; and VA health care benefits, resources and facilities. This requires an intimate knowledge of VHA programs and services nationwide, and the ability to match Veterans' needs with appropriate resources.

(2) Developing relationships and collaborating with the MTF social workers, nurses, case managers, managed care staff, and discharge planners to identify patients ready for discharge to a

VA health care facility and to obtain clear referral information and authorization for VHA to treat those still on active duty. This referral needs to:

(a) Include the MTF Medical Records; VA Referral Form (*entitled Military Treatment Facility Referral Form to VA Liaison*); Admission Sheet; Clinical and Consult Orders; or other authorization for VHA to provide services and bill TRICARE or other appropriate entity through a VA-DOD Sharing Agreement.

(b) Clearly identify the patient's health care and psychosocial needs, and include requests for VHA health care services to ensure Clinical and Consult Orders or authorizations, specifying which VHA services are authorized and are completed prior to the transfer of any patient(s) to a VA health care facility.

(3) Include a meeting with the service member and family to provide education and an overview of VA health benefits and resources, and to address current medical and psychosocial issues identified as part of the service member's treatment plan. In collaboration with the MTF treatment team, the liaison must use advanced clinical skills to assess the patient and family's psychosocial situation, their ability to comprehend and comply with VA's treatment plan determined by the MTF staff, and any special needs of the patient and family that may impact reaching optimal psychosocial functioning.

***NOTE:** Regular onsite collaboration and coordination is critical to provide effective consultative services with the referral, linkage, education, and assessment functions. The provision of direct services may be necessary to enhance the communication and relationship with service members and their families.*

(4) Coordinating with the liaison's home VA health care facility Enrollment Coordinator, to initially register active duty service members or enroll Veterans at their facility utilizing the referral information. Registering active duty service members in the VA computer system eases transfer of care to the VA health care facility.

(5) Collaborating with MTF social workers, nurses and case managers to identify the VA health care facility where care will be transferred to an accepting physician at that facility. To ensure ease of registration or enrollment procedures, information is transmitted using Patient Data Exchange (PDX) or Network Health Exchange (NHE) from the liaison's facility to the identified receiving VA health care facility.

(6) Identifying and communicating with the OEF and OIF Program Manager at the receiving VA health care facility to initiate and process referrals and linkages for transfers of care.

(7) Documenting all liaison activity in the Computerized Patient Record System (CPRS) nationally standardized templates that are available on the Health Information Management website at <http://vaww.vhaco.va.gov/him/natldoctemplates.html>, as well as documenting in the Veterans Tracking Application (VTA) or its equivalent.

(8) Communicating the transfer plans to the patient and family while determining any unique patient or family needs requiring attention. Communicating ongoing needs of the patient and family to the receiving VA health care facility OEF and OIF Program Manager to further facilitate the seamless transition of care.

(9) Maintaining contact with the OEF and OIF Program Manager and with MTF staff, coordinating the transfer of care upon discharge from the MTF, and assisting in identifying and obtaining additional information needed from the MTF staff to optimize the transfer of care.

(10) Providing patient level referral and outcome information on all transfers of care from the MTF to the VA Liaison National Program Manager, Care Management and Social Work Service, Office of Patient Care Services (11CMSW), on a monthly basis through the use of a spreadsheet, inputting summary information into an automated intranet workload report on a weekly basis, and attending regularly scheduled conference calls.

(11) Collaborating and communicating pertinent patient referral information with Veterans Benefit Administration (VBA) staff also located at the MTF.

(12) Collaborating and communicating with various agencies and departments at the national, state and local level in ensuring the seamless transition of health care.

(13) Preparing reports, briefs, and presentations for VA staff at all levels, DOD staff, Congressional Staff, Community Organizations, etc., regarding the Seamless Transition process and specific mechanics of their program.

(14) Managing the day-to-day operations of the VA Liaison initiative, and providing accountability to program effectiveness and modifications of service patterns to enhance customer service. Identifying gaps in the transition system and collaborating with MTF and DOD Staff and other departments to enhance the seamless transition process.

(15) Demonstrating knowledge and skills necessary to provide a smooth transition for patients with severe and non-severe injuries and the patient's family and significant other to VHA.

(16) Interpreting guidelines consisting of VHA general administrative and clinical management policies, Directives, Handbooks, nationwide patient care initiatives, VA and VBA policies and procedures, Public Law, Federal Regulations, the Joint Commission (JC) and Commission on Accreditation of Rehabilitation Facilities (CARF) standards, and other program-specific guidelines.

(17) Utilizing the above guidelines, the incumbent exercises considerable judgment in designing, writing, developing, coordinating, and implementing plans, data collection, reporting requirements, and evaluation of seamless transition services provided by VHA staff. The incumbent is recognized as an expert in the development and interpretation of guidance for seamless transition.

(18) Collaborating with many VA, VHA, and VBA offices, including field staff, VISN offices, VHA facilities, VA Central Office programs, DOD, Veterans Service Organizations, and other Federal agencies. Collaborating also with professional organizations, accrediting bodies, the general public, and VA offices external to VHA, including General Counsel, Office of Human Resources Management, Office of Acquisition and Materiel Management, and Congressional Affairs. The work assignments require an interdisciplinary, integrated approach and collaboration with other agencies and departments. The issues are interrelated, as the work involves planning and policies affecting the VA national health care system as well as the administration and application of organizational policies and procedures related to other VA Central Office program offices. The work may also require partnerships, collaborations and reporting to the following VA and DOD groups: Joint Executive Committee, the Health Executive Committee, and the Benefits Executive committee.

(19) Utilizing the above contacts to coordinate patient care referrals, ensure compliance with policies and objectives, and serve as the VA representative while at the MTF, exchanging relevant and functional information regarding policies and data. Contacts may also involve members of various work groups and task forces which the incumbent may lead. In these situations, the purpose of the contacts is to build consensus for ideas and recommendations, to persuade others to adopt particular points of view, and to produce final reports.

(20) Developing, gathering, and applying new data as needed in order to successfully plan for and implement program goals and projections. Changes in policies and procedures, program resources and functions, and new legislation add to the complex coordination and implementation of seamless transition activities. Also, changes in mission, objectives, and proposed initiatives (from DOD, Office of Management and Budget (OMB), etc.) must be considered in reviewing and analyzing reports and studies for the Seamless Transition Liaison Program Manager.

(21) Assisting in developing and implementing seamless transition policies and programs that are of vital significance and interest to the top management of VHA, VA, DOD, Veterans Service Organizations, and Congress. Incumbent provides administrative, technical, professional and managerial support to VA Central Office, Veterans Integrated Service Network (VISN) offices, and VA health care facility regarding interpretation and implementation of policies, directives and national program monitoring and review.

(22) Assessing and improving the quality of services provided by VHA staff assigned to seamless transition activities. Work affects many clinical programs and all sites of health care delivery in VHA, as well as national assessment of the quality of care provided.

### **3. SUPERVISORY CONTROLS**

The VA Liaison will report administratively to a designated supervisor at the VA health care facility closest to the incumbent's designated MTF and will report programmatically to the VA Liaison Program Manager in the Care Management and Social Work Service (11CMSW), VA Central Office. The VA Liaison is responsible to the Medical Center Director at the VA medical center closest to the incumbent's designated MTF, with matrix responsibility to Care

Management and Social Work Service, Office of Patient Care Services (11CMSW) in VA Central Office. The incumbent works with substantial independence and on own initiative, and is expected to identify additional necessary functions and employ well developed problem solving approaches. The program management responsibilities of this position are such that the incumbent must exercise individual initiative in planning and implementing program policies and procedures. Work is evaluated on the basis of results achieved and overall quality of reports and analysis.

The VA Liaisons are stationed at major MTFs nationwide. Other sites may be added as needs warrant and are identified by the Care Management and Social Work Service, Office of Patient Care Services (11CMSW) in VA Central Office.

#### **4. QUALIFICATIONS REQUIREMENT**

Meets the qualification standard for the GS 12 Senior Social Worker as defined in VA Handbook 5005, Part II Appendix G, Social Worker Qualification Standard GS-185 Veterans Health Administration.

A master's degree in social work from a school fully accredited by the Council on Social Work Education is required. VA Liaisons must be licensed or certified by a state at the advanced practice level which included an Association of Social Work Boards advanced generalist or clinical examination, unless they are grandfathered by the state in which they are licensed to practice at the advance practice level (except for licenses issued in California, which administers it's own clinical examination for advanced practice). VA Liaisons may have certification or other post masters training from a nationally recognized professional organization or university that includes a defined curriculum and course of study and internship or equivalent supervised professional experience in a specialty. Clinical and administrative experience is also required.

The incumbent is an experienced social worker, recognized to be an independent practitioner who can demonstrate the ability to manage and evaluate programs and policies. Knowledgeable about the principles and theories in Social Work Practice. Possesses professional judgment, including knowledge of normal and abnormal behavior, which is an inherent competency applied in daily interactions with service members and Veterans. Highly developed professional, clinical, and advanced practice skills are routinely used in the transition process of service members and Veterans with complex problems, brought about by combat related psychiatric and medical disabilities.

The incumbent possesses detailed knowledge of mission, goals, objectives, organization, and programs of VHA health care service and delivery systems and an awareness of VBA benefits delivery systems. Comprehensive knowledge of management techniques and practices, especially related to patient care activities and how they relate to the complex and evolving health care environment.

Projects are of a specialized nature and therefore require a person with knowledge, experience and expertise in VA health care facility operations and clinical management. Requires

comprehensive knowledge of VA and VHA policies, issues, clinical and political complexities essential to the management of a complex system-wide health care delivery system.

The incumbent must possess excellent communication skills, both oral and written, in order to transmit information regarding seamless transition services to professional and other staff both within and outside VA. The incumbent must be able to interact effectively with a wide variety of health care professionals and VBA professionals.

A VA Liaison has experience that demonstrates possession of advanced practice skills and judgment. The VA Liaison has the ability to expand clinical knowledge in the profession, provide consultation and guidance to colleagues, role model effective social work practice skills, teach or provide orientation to less experienced social workers, develop innovations in practice interventions, and provide clinical supervision for social work licensure or certification. The incumbent has comprehensive professional expertise in policy development, performance standards and strategic planning initiatives.

A high level of physical energy is required as the incumbent is expected to meet with many people in many different locations in the course of a work day. There may be some field travel involved with this position. Work is normally performed in an office environment with adequate lighting, heating, and ventilation.

#### **5. CUSTOMER SERVICE REQUIREMENTS**

Incumbent meets the needs of customers while supporting VA missions. Consistently communicates and treats customers (Veterans, their representatives, visitors, and all VA staff) in a courteous, tactful, and respectful manner. Incumbent provides the customer with consistent information according to established policies and procedures. Handles conflict and problems while dealing with the consumer constructively and appropriately.

#### **6. AGE, DEVELOPMENT, AND CULTURAL NEEDS OF PATIENTS REQUIREMENTS**

The incumbent provides age-specific care that is appropriate to the cognitive, emotional, cultural and chronological maturation needs of the patient. Demonstrates knowledge of changes associated with aging and principles of growth and development relevant to the young adult through geriatric age groups; ability to assess and interpret data about the patient's status; and ability to identify age-specific needs and provide the appropriate care based upon the age related factors.

Take into consideration the age-related difference of the various Veterans populations served:

(a) Young Adulthood (20-40). Persons in general have normal physical functions and lifestyles. Persons establish relationships with significant others, are competent to relate to others, may begin to expand their family with children. This population is the most frequently served by the incumbent; however, injuries may have impaired or altered the "normal physical functioning" and "competency," which will affect their psychosocial needs.

(b) Middle Age (40-65). Persons may have physical problems and may have changes in lifestyle because of children leaving the home or occupational goals. Persons may have been injured and now face employment and lifestyle changes that affect the family and all aspects of life. Persons may be family relatives of a patient that is directly impacted by injury to relative.

(c) Older Adulthood (65-75). Persons may be adapting to retirement and changes in physical abilities. Chronic illness may also develop.

(d) Middle Old (75-80). Persons may be adapting to decline in physical functioning to include movement, reaction time and sensory abilities. May also have an increase in dependency on others.

(e) Old (85 and over). Increasing physical problems may develop and increased dependency on others.

## **7. COMPUTER SECURITY REQUIREMENTS**

Incumbent protects printed and electronic files containing sensitive data or protected health information in accordance with the provisions of the Privacy Act of 1974 and other applicable laws, Federal regulations, VA statutes and policy, and VHA policy. Incumbent protects the data from unauthorized release or from loss, alteration, or unauthorized deletion. Incumbent follows applicable regulations, Health Information Portability and Accountability Act (HIPAA) Privacy and Security procedures, and instructions regarding access to computerized files, release of access codes, etc.

Incumbent uses word processing software to execute several office automation functions such as storing and retrieving electronic documents and files; activating printers; inserting and deleting text, formatting letters, reports, and memoranda; and transmitting and receiving e-mail. Incumbent uses the Veterans Health Information and Technology Architecture (VistA and CPRS) to access information in the medical center computer system and to document Liaison activities appropriately. Incumbent is competent in Microsoft Office programs to include, but not limited to: Word, Excel, and Power Point, as well as the intranet and internet to access resources and utilize web based tracking systems.

## **8. SAFETY**

- a. Appropriately uses equipment and supplies.
- b. Maintains safe, orderly work areas.
- c. Reports any accident involving self or patient(s) and complete appropriate form(s).
- d. Environment of Care: Follows Life Safety Management (fire protection) procedures. Reports safety hazards, accidents and injuries. Reviews hazardous materials, Material Safety Data Sheets (MSDS), and waste management. Follows the Emergency

Preparedness plan. Follows security policies and procedures. Complies with Federal, state and local environmental and other requirements preventing pollution, minimizing waste, and conserving cultural and natural resources.

- e. Infection Control: Demonstrates infection control practices for disease prevention, i.e., hand washing, universal precautions, and isolation procedures, including tuberculosis (TB) requirement and precautions.
- f. Health and Safety: Fosters a high profile of VA's Occupational Safety and Health Program by ensuring employee awareness of potential safety hazards, promptly reporting all injuries, and effecting corrective actions necessary to eliminate safety and health hazards in the work area.

\_\_\_\_\_  
Supervisor Signature

\_\_\_\_\_  
Date

**Department of Veterans Affairs (VA) Form 10-0454, Military Treatment Facility Referral  
To VA**

Department of Veterans Affairs (VA) Form 10-0454, Military Treatment Facility Referral To VA, will be available on the VA forms intranet web site <http://vaww.va.gov/vaforms> and internet forms web site <http://www.va.gov/vaforms> within 48 hours of the issuance of this Handbook.



10-0454-fill.pdf