Caring for Our Soldiers—What We Can Learn from VA Models of Care

11:15 am – 12:15 pm
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Presentation Objectives

- Provide one example of a *system of care* by outlining components of VHA’s Polytrauma System of Care
- Illustrate the post acute care provider’s commanding role in establishing a continuum of care
- Demonstrate the care manager’s role in “bringing to life” the concept of patient-centered care and continuity of care

Presentation Objectives

- Describe the role of the Computerized Patient Record System in managing the continuum of care
- Share lessons learned aka “life is a humbling experience.”
Secretary Shinseki’s Guiding Principles

The VA Strategic Plan is crosscutting in nature and intended to reflect combined efforts of all organizational elements to deliver important outcomes to Veterans.

- People Centric
- Results Driven
- Forward Looking

Polytrauma/TBI System of Care (PSC)

- The Polytrauma / TBI System of Care (PSC) provides specialized rehabilitation care for Veterans and Service Members with Polytrauma and TBI.
- The system is designed to balance the need for highly-specialized rehabilitation expertise with the need for accessibility.

Introduction to Polytrauma System of Care

- In January 2005, the Veterans Health Administration realized that individuals serving in Iraq and Afghanistan were sustaining polytraumatic injuries and disabilities.
- Improvised explosive devices, blasts, land mines and fragments accounted for 65 percent of combat injuries.
- Of these injured military personnel, 60-62 percent have some degree of traumatic brain injury (TBI).
- Consequently, the Department of Veterans Affairs (VA) developed the necessary expertise to provide the coordinated interdisciplinary, and specialized care required.
Polytrauma Defined

- Polytrauma is defined as injuries to multiple body parts or organ systems that result in physical, cognitive, psychological, and/or psychosocial impairments and functional disabilities.
- TBI frequently occurs in polytrauma in combination with other disabling conditions (e.g. amputation, burn, pain, fractures, auditory and visual impairments, post-traumatic stress disorder (PTSD), and other mental health conditions.
- When present, injury to the brain is the impairment that guides the course of rehabilitation in patients with polytrauma.

Seamless Transition: From Battlefield to the VA

- Forward Surgical Teams
- Combat Support Hospitals
- Level IV Hospitals (e.g. Landstuhl)
- Military Treatment Facility USA (Walter Reed, National Naval Hospital)
- VA Health Care Facility
VA TBI/Polytrauma System of Care

Component I
4 TBI / Polytrauma Rehabilitation Centers

Component II
22 Polytrauma Network Sites
(1 per VISN)

Component III
82 Polytrauma Support Clinic Teams
(2-4 Teams per VISN)

Component IV
46 Polytrauma Points of Contact

Comprehensive Interdisciplinary Care Beyond Acute Care
- Create a network of care
- Deliver specialized care close to home
- Offer comprehensive interdisciplinary assessment of previously unidentified TBI patients
- Continue to manage existing and emerging sequelae
- Manage "seamless" transitions
- Identify appropriate community resources

TBI Clinical Reminder
- All OEF/OIF veterans are screened for TBI upon initiation of VA care
- Identify any veteran who may have experienced a TBI/current symptoms
- If veteran screens positive for TBI
  - Specific protocol for further evaluation and treatment
- Each facility's performance tracked via national performance measures
Polytrauma/TBI Rehabilitation Centers (PRC)

- Patients with high degree of medical complexity and varied patterns of disabling injuries
- Family Centered Care
- Full range of acute comprehensive medical and rehabilitative services
  - Comprehensive acute interdisciplinary inpatient rehabilitation
    - CARF accredited in CIIRP, BI, SCSC standards
  - Comprehensive interdisciplinary inpatient evaluations
  - Emerging consciousness program
  - Assistive Technology Laboratories – CARF Community Services Standards
  - Residential transitional rehabilitation programs
    - CARF Accredited under the Brain Injury Residential Standards or Community Services Standards

Interdisciplinary Team Approach

Interdisciplinary Rehabilitation Team

- Physiatrist
- Rehabilitation nursing
- Speech language pathology
- Occupational therapy
- Physical therapy
- Therapeutic recreation specialist
- Blind rehabilitation specialist
- Counseling psychology
- Neuropsychology
- Family therapist
- Social work/case manager
- Driver trainer
- Prosthetist/Orthotist
Polytrauma Network Sites (PNS)

- One located in each VISN plus additional one in Puerto Rico
- Specialized post-acute rehabilitative services (in/outpatient)
- CARF accredited CIIRP program
- Manage rehabilitation plan developed at PRC
- Manage polytrauma and TBI Patients
- Extensive interdisciplinary team in place
- Proactive case management and family support
- Regular follow-up care
- Identify VA and non-VA resources for care across VISN
- Coordinate services between VHA, VBA, DoD, civilian

Polytrauma Network Sites

- Boston
- Syracuse
- Bronx
- Philadelphia
- Washington D.C.
- Richmond
- Augusta
- Tampa
- Lexington
- Cleveland
- Indianapolis
- Hines
- St. Louis
- Houston
- Dallas
- Tucson
- Denver
- Seattle
- Palo Alto
- West Los Angeles
- Minneapolis
- Puerto Rico

Polytrauma Support Clinic Teams (PSCT)

- Located at 82 VAMCs across the country
- Lead in OIF/OEF TBI Screen Clinical Reminder
- Primary role
  ~ Proactive follow-up and management of stable effects of polytrauma and TBI
  ~ Response to new emerging problems
  ~ Consult with VISN PNS and/or regional PRC
  ~ Proactive care management and assist with family support services (assigned OIF/OEF case manager)
- Consult with PNS and/or PSCT for follow-up
Polytrauma Point of Contact (PPOC)

- Lead in completion of TBI Screen Clinical Reminder
- Case management
- VA contact close to home
- Coordinate services provided within community
- Consult with PNS and/or PSCT for follow-up
- Providing TBI Second Level Evaluations close to veteran’s home
  - Telehealth linkage with Big Spring, TX

Long Term Follow-up

- Lifelong care management
- Sequelae are lifelong, require special expertise
- Emerging complications
- Changes in developmental stage
- Changes in social situation
- New treatments or technology
- Support and connectivity
- Aging with disability
- Care coordination as needed
  - Care management plan established – weekly, monthly, quarterly, annual

Case Study Example #1

- Severely injured OIF Veteran - 27 y.o.
  - Forward Surgical Team
  - Combat Support Hospital
  - Level IV Hospital - Landstuhl
  - MTF - Walter Reed Army Medical Center
  - Polytrauma Level One Center – Palo Alto, CA
  - Phoenix and Tucson VA Medical Centers
  - Back to Walter Reed Army Medical Center
  - Inpatient/Outpatient Episodes of Care at Tucson VA
  - University of Arizona Freshman
Care Management

- Case Manager involved ongoing
- Stepping in – Pulling away
- Statement made by this veteran to his Federal Recovery Coordinator
  - “… I credit my success to having a team I feel connected to.”

Case Study Example #2

- OIF Veteran, 25 y.o.
  - Injured in 2005, exposure to numerous blasts
    - LOC up to 30 minutes with immediate memory loss, disorientation, confusion up to 7 days, headache, n/v, ringing in ears
  - Additional injury - January 2007 – blast occurred, injured leg

Case Study Continued

- Presented with balance problems, dizziness, headaches, blurred vision/photosensitivity, ringing in ears
- PTSD, anxiety, hypervigilence
  - Interfering with relationships, college, work
  - Difficulty focusing, concentrating, learning
- Depression
Case Study Continued

- Outpatient evaluations/treatment
  - Psychology, speech therapy, physical therapy
  - Ongoing care management/team conference
  - OEF/OIF primary care provider

- Two episodes of care on inpatient mental health unit
- Education provided to fiancée and mother
- Peer Support Group

Post-Acute Care

- Majority of care management occurs within this segment of the continuum
- Care must be provided in the right setting/level of care
  - Essential to ensure efficient utilization of resources – responsible stewardship
- Rules/regulations/mandates/published standards of care provide the framework for systems of care

We Can Do This

- Rehabilitation has always been a team sport
  - Shared mission/goal
    - Patient-centered care
  - Excellent teamwork wins the game
    - Providers feel engaged/sense of purpose
    - Patients’ satisfaction increases when they feel their providers are working together for them
  - Need to pass the ball/baton – timing is key
    - solid, targeted pass/hand-off
Post-Acute Care Team
- Need a strong bench – employ smart strategies when making substitutions
- Everyone plays at the “top of their game”
- The patient is clear regarding “who is in charge”
  - No member of the team “hogs” the ball
- Rules/expectations are established and must be adhered to

Case Manager’s Role
- The Case Manager is the “coach”
- Keeps the patient at the “center”
  - Always involves the patient/family in decisions about care
- Must be clear regarding the scope of practice/strengths/skills of members of the team
- Knowledgeable of regulations related to various levels of care
- Ability to draw members of the team in, when needed

Computerized Patient Record System (CPRS)
- VA’s electronic medical record
- Can access in any clinical setting – inpatient, outpatient, Veteran’s home, etc.
- Access to care provided at any VA facility across the United States
  - DoD connectivity in near future
- Add clinicians on as additional signers
- Alert to new information/communicate
CPRS

- Diagnostics
- Imaging
- Progress Notes/Discharge Summaries
- Submit Referrals for Care
- Operative Reports
- Medications
- Problem List
- Clinical Reminders
- Scanned Reports From Outside Providers

Tools To Facilitate Care Coordination

- Established infrastructure
  - Defined system of care
  - Mandates/Rules/Regulations/Reimbursement Models
  - Support of Leadership / Empowerment
  - Freedom to be creative / take risks
- Computerized Patient Record System
- Telehealth
- Partnering with Community Providers
- My HealtheVet / Technology

Lessons Learned

- Always remain veteran-centered
  - Re-direct each other, when indicated
- Veteran needs to be clear regarding who is in the Lead Case Manager role
- Expect change – constantly learning
- Stay informed of the latest evidence-based practices
- “Let go” when the time is right – do not enable
Thank you.

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Questions