State of the Science Symposium: Promoting Successful Community Reintegration After Trauma

Uniformed Services University of the Health Sciences,
Bethesda, Maryland
October 20, 2017
Interagency Care Coordination

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What Challenges Led to the Creation of IC3:

- In late 2012, the Department of Veterans Affairs (VA) and Department of Defense (DoD) Interagency Care Coordination Committee (IC3) was formed as a subcommittee under the Congressionally Mandated VA/DoD Joint Executive Committee (JEC).

- IC3 was formed in response to concerns originating with 2007 Walter Reed Army Medical Center problems, the Warrior Care Coordination Task Force Report and from several Government Accountability Office (GAO) reports on redundancies in care coordination and transition gaps.

The committee was designed to:

- Reduce confusion and frustration for seriously wounded SM/Vs and their families
- Remove the need for the transitioning SM/V to retell their story
- Eliminate redundancy and overlap of services
- Strengthen and standardize care coordination
Accomplishments

VA/DoD Response:

In July 2014, the VA Deputy Secretary and DoD Under Secretary of Defense for Personnel and Readiness (USD P&R) signed the IC3 Memorandum of Understanding (MOU), which spells out key requirements and initiatives designed to reduce confusion for Service members/Veterans (SM/Vs) and their families. These initiatives include:

- **Lead Coordinator (LC) Role:** Serves as the primary point of contact for SM/Vs and their caregivers during recovery and at transition between DoD and VA.

- **Electronic Interagency Comprehensive Plan (ICP):** Serves as a single, interoperable, individualized plan that assists in managing the SM/V’s goals thus reducing the need to retell their story as they transition and relocate.

- IC3 also established the **Community of Practice (CoP)**, which connects over 50 DoD and VA care and benefit programs and fosters increased awareness and synchronization. The CoP also connects the DoD and VA clinical and non-clinical case managers of recovering SM/Vs, enabling collaboration and sharing of best practices.
Full implementation of the Interagency Care Coordination initiatives is critical to each Department’s goal of addressing issues vital to recovering Service Members and Veterans, as well as their families and caregivers.

DoD and VA will continue to work together to assess implementation of this common practices and determine how to best meet the intent of the IC3.

To assess and strengthen these care coordination efforts, VA will be conducting a survey to assess the transition experiences of our severely injured Service members and Veterans.
Interagency Care Coordination

Ms. Lisa Perla
National Polytrauma Coordinator
Polytrauma System of Care
Office of Rehabilitation and Prosthetic Services

Veterans Health Administration
U.S. Department of Veterans Affairs

Version: December 2012
Rehabilitation and Community Reintegration
Past, Present and Future

Polytrauma System of Care
• Drivers Rehabilitation Program
• Smart Technology
• Case Management

“It takes a Village
Community of Practice

“To believe in rehabilitation is to believe in humanity.”
Howard Rusk, MD (1901-1989)
VA Polytrauma/TBI System of Care

- 110 Specialized Rehabilitation Sites
  - 5 Polytrauma Rehabilitation Centers
    - All inpatient, outpatient and telehealth care
  - 23 Polytrauma Network Sites
    - Inpatient and Outpatient TBI and telehealth
    - 87 Polytrauma Support Clinic Teams
    - Outpatient TBI care

- Emerging Consciousness Program
- Polytrauma Transitional Rehabilitation Program
- TBI Screening and Evaluation Program

- Driver Rehabilitation Programs
- Assistive Technology Labs
- Polytrauma Case Management

http://www.polytrauma.va.gov/
VHA Polytrauma/TBI System of Care FY 2013
Driver Rehabilitation Training Sites & Assistive Technology Labs

Legend
- Red: Polytrauma Rehabilitation Center & Assistive Technology Labs
- Blue: Polytrauma Network Site
- Green: Polytrauma Support Clinic Team
- Purple: Polytrauma Point Of Contact
- Yellow: Driver Rehabilitation Training Site

Map Created By: RORC-REAP (ERL, DCR)
Map Information Provided By: Sonya M. Scoriens (R&PS)
Bill Wenninger (R&PS)
Map Creation Date: April 30, 2013
ArcGIS 10.1
Smart Technology

- Customized Wheelchairs
- Amazon Echo – Alexis
- Google Home
- Control4
- Computer Video Tele-rehab
Polytrauma Case Management

- All patients receiving rehabilitation services within the Polytrauma System of Care are assigned a Polytrauma Case Manager.
- All Veterans and SM with TBI receive a case management driven Individualized Rehabilitation Community Reintegration (IRCR) Plan of Care.

Collaboration with VA and DoD case managers to assure continuity within teams and across systems.
Interagency Care Coordination

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Veterans Health Administration
U.S. Department of Veterans Affairs

Version: December 2012
VA Liaison and Transition and Care Management Programs

Jennifer Perez, LICSW
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VA Liaison Program

- VA & DoD partnership began in August 2003
- Now 43 VA Liaisons for Healthcare on-site at 21 DoD Military Treatment Facilities (MTFs)
- Locations based on high concentrations of ill and injured Service members (SMs)
- VA Liaisons are advanced practice, licensed, Masters prepared Social Workers and Registered Nurses
- Care Management begins at the MTF
- Provides critical, early connection to VA for SMs in the transition process
- Provides direct access by coordinating initial health care for transitioning SMs and building a positive relationship with VA
VA Liaisons for Healthcare Across the Country

- Joint Base Lewis McChord (3)
- Fort Carson (2)
- Fort Riley (2)
- Fort Knox (1)
- Fort Campbell (2)
- Fort Drums (2)
- Fort Bragg (2)
- Fort Gordon (2)
- Naval Hospital Camp Pendleton (2)
- Naval Medical Center San Diego (2)
- Fort Bliss (2)
- Fort Hood (3)
- Fort Sam Houston (3)
- Walter Reed National Military Medical Center (3)
- Fort Belvoir & Quantico (2)
- Fort Eustis & Portsmouth Naval Hospital (1)
- Camp Lejeune (1)
- Fort Bragg (2)
- Fort Gordon (2)

- 21 MTFs with VA Liaison(s) on-site
- 2 MTFs with VA Liaison virtual coverage
- ( ) Number of Liaison(s) at site currently assigned

Modified 06/2017
Transition and Care Management Team

Each VA Medical Center has a Transition and Care Management (TCM) team specially trained in coordinating care for transitioning Service members and new Veterans. TCM team members include:

- **TCM Program Manager** (RN or Social Worker): Has overall administrative and clinical responsibility for the team, and coordinates patient care activities to ensure that Service members and Veterans are receiving patient-centered, integrated care and benefits.

- **TCM Case Manager** (RN or Social Worker): Directly coordinates healthcare and community services to meet the needs of the Service member, Veteran and their families, and ensures that all clinicians providing care are doing so in a cohesive and integrated manner.

- **Transition Patient Advocate (TPA)**: Serves as an advocate to help Service members, Veterans, and their families navigate the VA healthcare system.
✓ One Integrated, Interdisciplinary Care Plan
✓ Veteran-Generated Goals and Objectives
✓ Dedicated Case Manager/Lead Coordinator
✓ Continuous care plan review for completion

Transition and Care Management

Lead Coordinator

Mental Health

Primary Care

Traumatic Brain Injury

Transition & Care Management Team

Women’s Health

Polytrauma Rehabilitation

Spinal Cord Injury

Blind Rehabilitation

Post Deployment Integrated Care

Care Review Team
Integrated Partners
Questions?

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Interagency Care Coordination

Mr. Jack Kammerer
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Vocational Rehabilitation and Education

Veterans Benefit Administration
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Nearly 1,000 Master’s degree professional Vocational Rehabilitation Counselors delivering individual case management for Wounded, Ill and Injured Servicemembers and Veterans with Service Connected Disabilities, out of 58 regional offices with a network of nearly 350 office locations

- **Current program participants o/a 131K**
  - As more disability compensation claims are processed, VR&E workload increases (o/a one of every 40 disability claims processed results in a new VR&E participant)
  - Determining eligibility is also workload ... 106K Veterans applied for Chapter 31 Services last year

- **VetSuccess on Campus (VSOC)**
  - Collaborated with 94 schools across the country to provide educational and vocational counseling and other on-site services to support a population of nearly 78,000 student Veterans on campus

- **Integrated Disability Evaluation System (IDES)**
  - Expanded early intervention counseling and other available services for transitioning Wounded, Ill, and Injured Servicemembers at 71 military installations
Entitlement

- 48 months of possible entitlement, with an additional 18 months of employment services in certain situations
  - Must be utilized within 12 years from the date of initial VA disability rating notification
  - Exception for those with a serious employment handicap

Eligibility

- Honorable or other than dishonorable discharge
- VA service-connected disability rating of 10% and serious employment handicap or rating of 20% or more with an employment handicap
- Must apply for Vocational Rehabilitation and Employment services
- Entitlement based on establishment of employment handicap resulting from a service-connected disability
Key Services Provided

- Assist Veterans with service-connected disabilities:
  - Achieve and maintain suitable employment
  - Gain independence in daily living
- Vocational counseling and planning
- Education or vocational training
- Monthly subsistence allowance in addition to disability compensation
- Tools and supplies necessary to achieve program goals (e.g. auto mechanic tools, computers for technology/professional fields)
- Job-seeking skills and assistance in finding employment (not education)
- Independent living:
  - Training in activities of daily living
  - Personal adjustment counseling and support services