



Department of Veterans Affairs

Post-Deployment Integrated Care Initiative-Next Steps:

Implementing, Nurturing, Disseminating and Sustaining

Presentation February 2009; Gordon Schectman MD Acting Chief Consultant
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Presentation Objectives

- The Case for Integrated Post Combat Care
- Review the Post-Deployment Integrated Care Initiative
- Vision for Implementing, Nurturing and Sustaining the Initiative



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Who are the OEF/OIF patients?

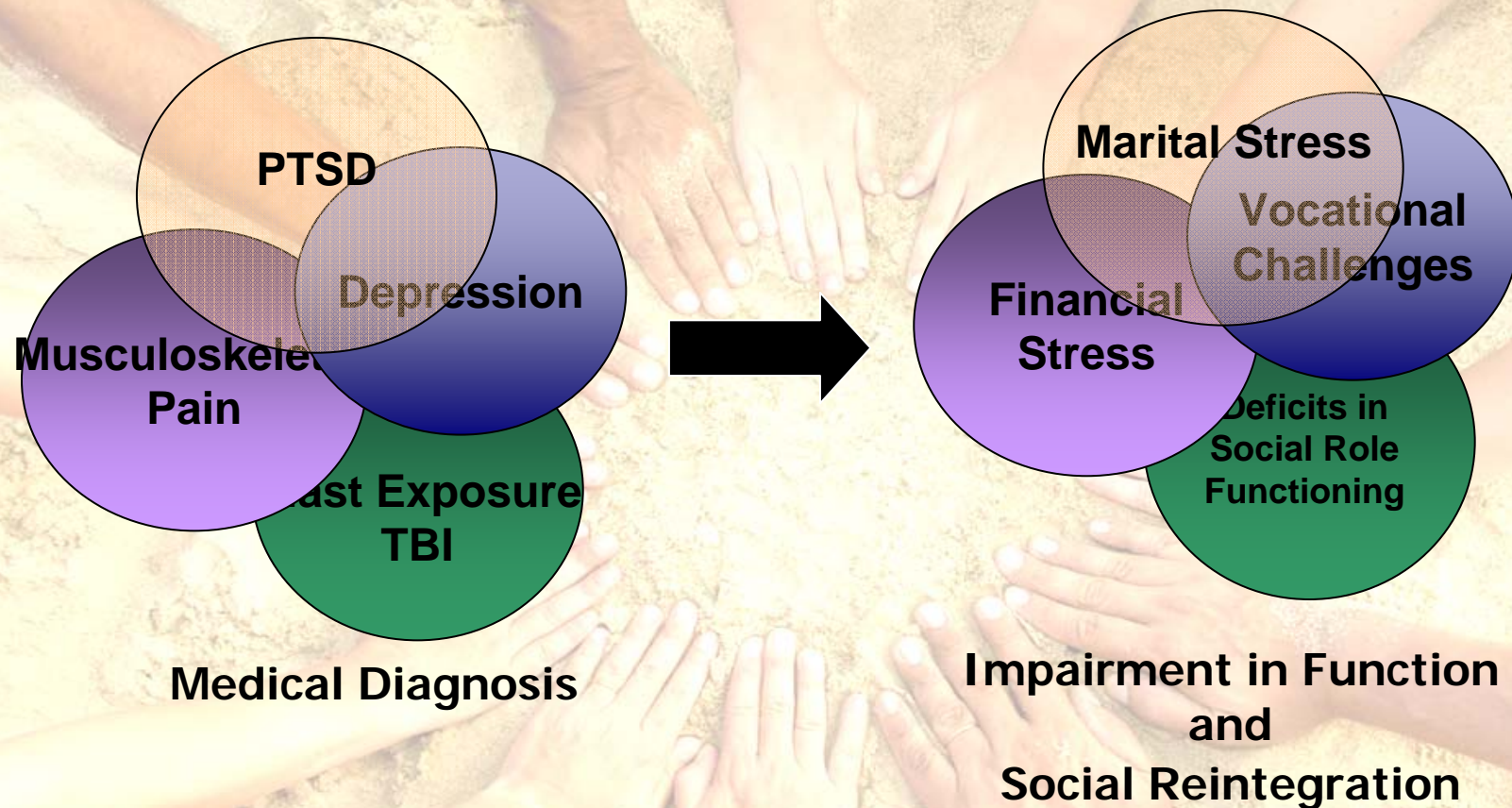
“The war changed me...
people say I am a different person...
my whole life seems off track...”



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Who are the OEF/OIF patients?



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Who are the OEF/OIF patients?

OEF/OIF Post Deployment Complaints

- Musculoskeletal 47.6%
- Mental disorders 42.5%
- Symptoms/signs 39.7%
- Nervous system (hearing) 34.9%
- GI (dental) 31.8%
- Respiratory 20.4%
- Endocrine/Nutrition 21.8%
- Injury/Poisoning 21.2%

**VHA Office of Public Health and Environmental Hazards
August 2008, Seen at VA by 3-31-08, N=347,750**



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Who are the OEF/OIF patients?

Health
Concerns of
Combat
Veterans
Returning
from Iraq
and
Afghanistan

• Medical Care	49
• Assistance with C&P claim	21
• Financial	19
• Employment	19
• Dental	16
• Someone who understands	15
• Sleep	13
• Education	13
• Mental Health	13
• Counseling	12
• Marital	9
• Help with family/friends	8
• Housing	6
• Sexual functioning	6
• Legal	4
• ETOH treatment	2



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What Can We Do as a Treatment Community to Best Help Those Who Are Experiencing Health Affects of War?



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Post-Deployment Integrated Care

Premises

- The health care risks and health care needs of combat veterans differ from those of non-combat veterans.
- The health care needs of combat veterans are best served by clinicians familiar with the unique health risks of combat.
- The health care needs of combat veterans are best served in a setting utilizing multidisciplinary resources and integrated care.



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Post-Combat Care

Using an Integrated Care Model:
Potential advantages of a post-combat
evaluation and treatment clinic:

- Normalizes the post-combat reintegration experience
- Utilizes a rehabilitative orientation
- De-stigmatizes the mental health aspects of care
- Appreciates the common as well as the unique aspects of military service as an occupation and combat as an environment
- Acknowledges the veteran's service



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Post-Deployment Integrated Care

Philosophy of Post-Combat Care

Using the five years of post-combat priority eligibility proactively as a period for assessment, monitoring and utilization of appropriate resources directed towards optimal recovery, rehabilitation and reintegration into post-combat, non-military life by the end of the five year period.



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Post-Deployment Integrated Care

Post-Combat Health Concerns

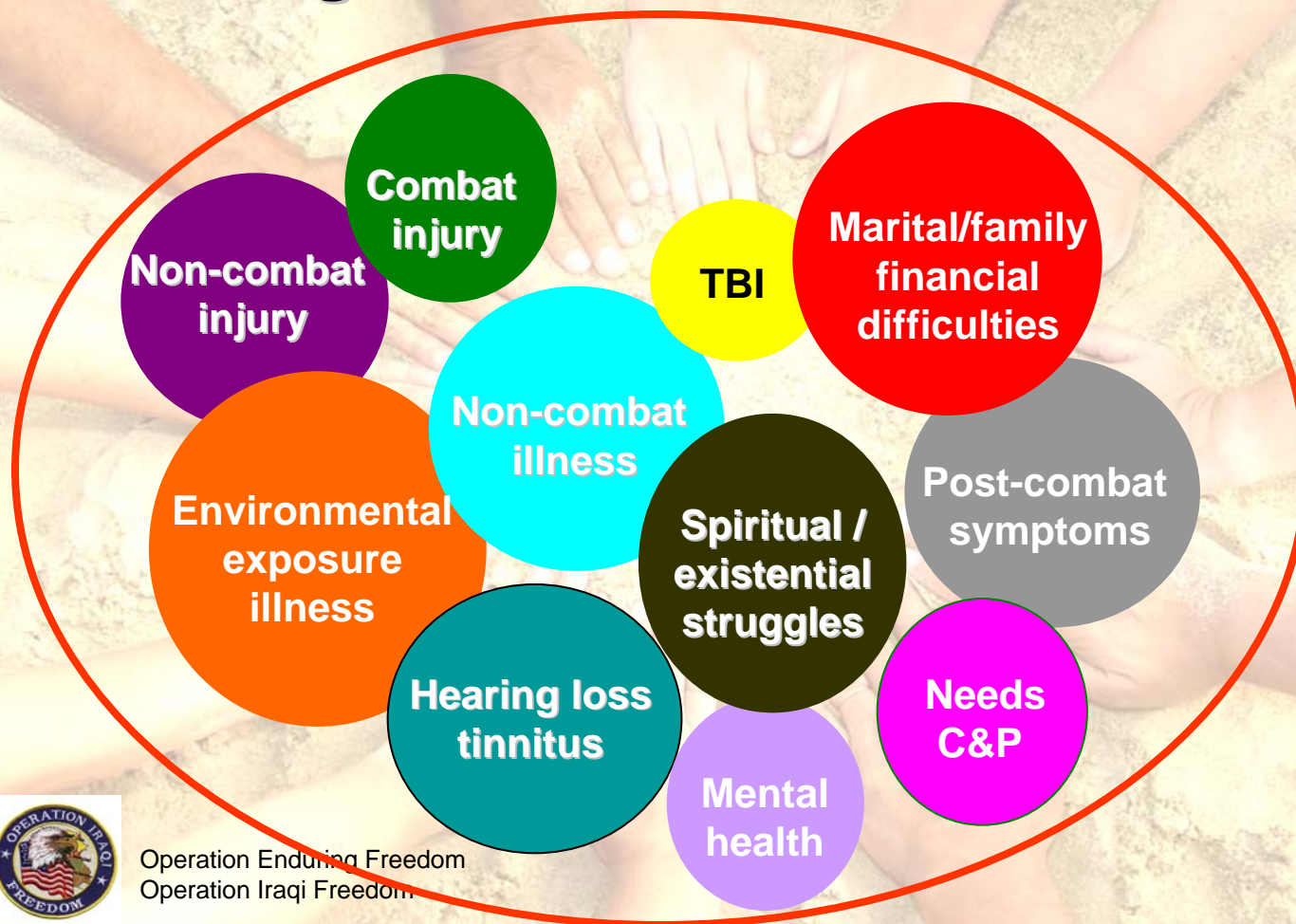


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Post-Deployment Integrated Care

Integrated Post-Combat Care



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Post-Deployment Integrated Care

What do we say to combat veterans returning home from a combat deployment?

We would recommend a post-combat evaluation:

1. Physical exam, mental health evaluation and social work assessment with attention to pertinent combat related exposures, experiences and psychosocial impacts
2. Ongoing care to provide necessary treatment and monitoring for any emerging combat related conditions
3. Education regarding available benefits/sources of support for the veteran and his/her family



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Post-Deployment Integrated Care

The Vision

- Every returning combat veteran to be cared for by an integrated team of health care professionals that are
 - knowledgeable in post-combat medical, behavioral and psychosocial problems
 - sensitive and responsive to the personal, family, and employment concerns of post-combat veterans.
- Integrated care is provided by a core team comprised of a mental health provider, a social worker and a primary care medical provider who work as a team to provide, in a purposeful, timely, and thoughtful manner, comprehensive care that is tailored to the specific post-combat health care needs of the individual veteran.

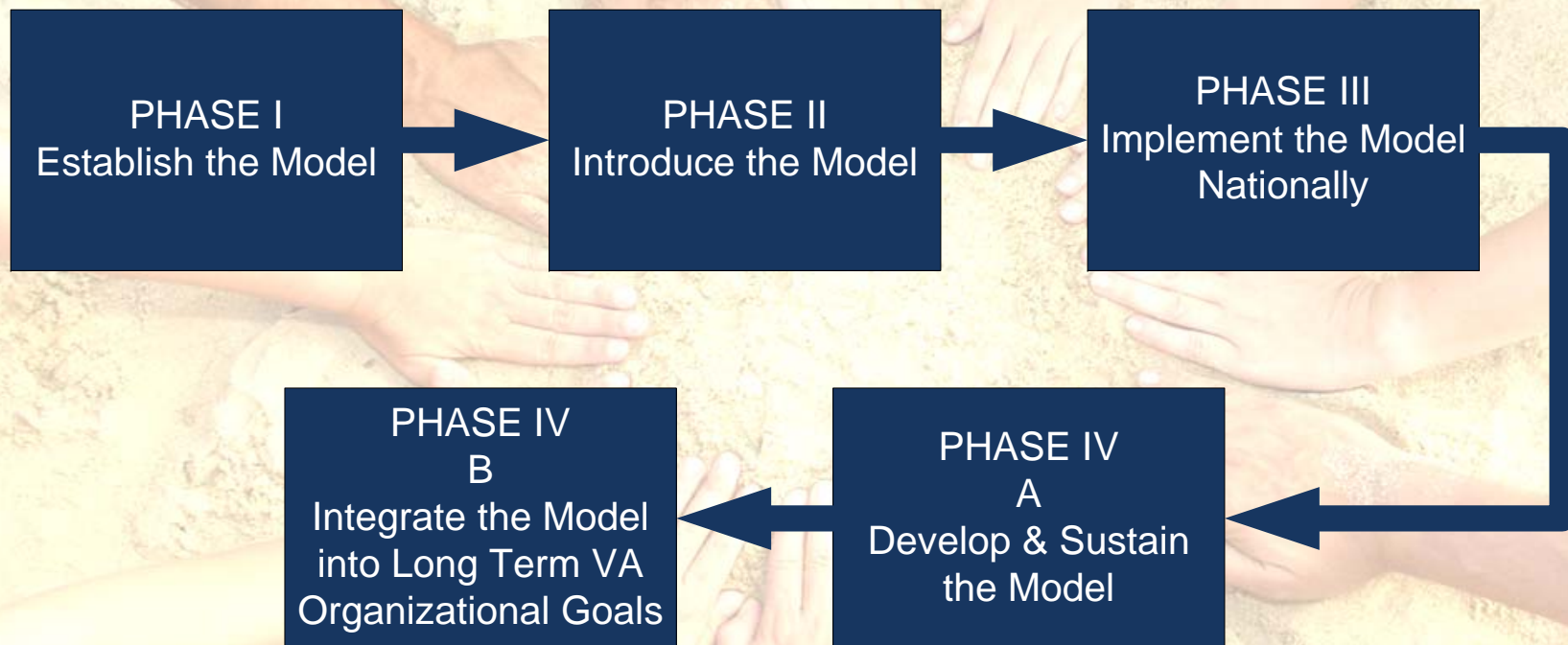


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Post-Deployment Integrated Care Initiative

Phased Process



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Post-Deployment Integrated Care Initiative

Phase I: Establish the model – FY08

- Develop Model for Post-Deployment Care- Gulf War Veterans Clinic and DoD Post-Deployment Health Clinical Center
- Identify “Best Practices” – VA Puget Sound – Summer 2006
- Establish Technical Assistance Team (TAT) to provide national interdisciplinary leadership and guidance – Winter 2008
- Survey the field & interact with leaders- Spring 2008



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Essential Elements of Integrated, Coordinated Care

- Comprehensive psychosocial and medical intake performed on all recent combat veterans
- Full integration of all post deployment services including close links to allied clinics and programs (Polytrauma, Pain, Substance abuse, etc)
- Meetings (at least bi-weekly; provider attendance essential) of the entire integrated team to discuss patient care and systems issues.



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Models for Integrated Post-Combat Care

Post Deployment Clinic Model

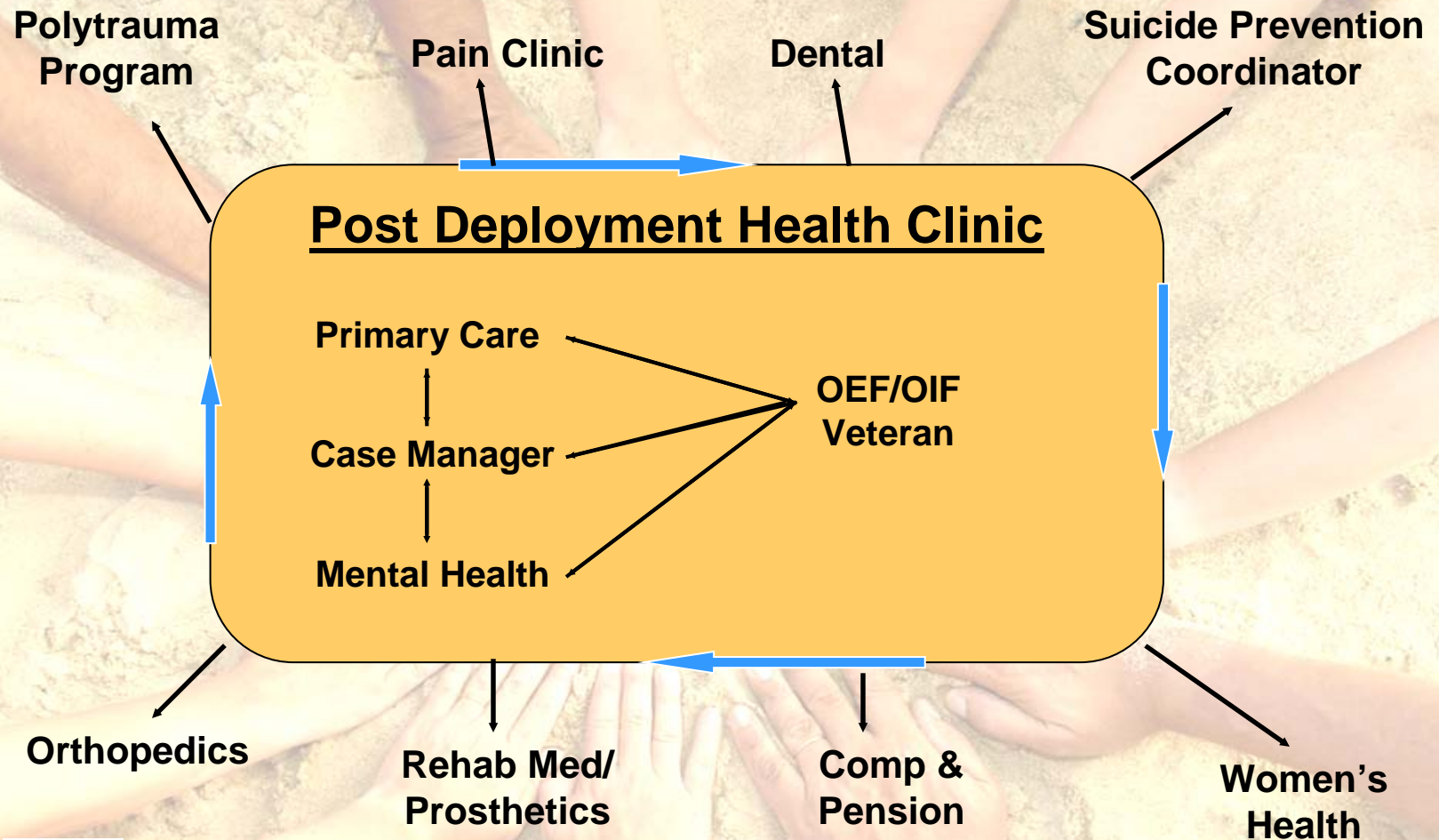
- Dedicated space
- Dedicated staff
 - Small group of dedicated, experienced primary care providers
 - Primarily see recent combat veterans
- Close partnership with
 - Social Work
 - Mental Health
- Consultation to specialty services



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Models for Integrated Post-Combat Care

Cohort Model

- Selected primary care providers are identified to develop skills and expertise
- Most OEF/OIF patients are assigned to these providers
- Representatives from other disciplines similarly identified



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Models for Integrated Post-Combat Care

Consultative Model

- OEF/OIF veterans are assigned to all primary care providers
- Most providers care for few combat veterans
- Medical, Mental Health and Social Work resources with specialized knowledge and skills are identified to assist in a consultative role



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Phase II: Introduce Initiative - FY08

- Introduce the initiative to central/clinical leadership
 - CMO Launch (June 2008)
 - Provide resources to support implementation
 - National conference (August 12-14 2008)
 - Train the trainer
 - Prepare for VISN implementation
- Introduce the initiative to clinicians in the field
 - VISN conferences: train the champion (September 2008-December 2008)
 - (PCP, MH provider, SW, administrators from each site)
 - Action plans for centers and for VISN
 - Coordination with VISN Polytrauma, Mental Health, SW programs
 - Monthly calls initiated for ongoing training, support, monitoring



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Phase III: Implement Initiative Nationally - FY09

VISN conferences

- **Develop VISN-wide Implementation plan**
 - Apply post-deployment care vision to all facilities, CBOCs, and rural health areas
 - Utilize Telehealth and Telemedicine resources
 - Integrate Post-Deployment Care resources at VISN level
- **VISN Conference Structure**
 - Planned by VISN leadership and clinical champions who attended the August Seattle National Conference
 - Pain, Mental Health, Substance abuse, TBI, Social Work modules
 - Enthusiasm and commitment to PDC concept
 - 1-2 days
 - Multidisciplinary teams from each facility and CBOC in attendance



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Phase IV: A. Nurture and Sustain Initiative

- Monthly VISN-wide and national teleconference calls for integrated care teams
- Develop an active community of practice
 - Promote successes in medical centers and CBOCs in each VISN
 - Identify and develop clinical leaders among all post-combat care disciplines in each medical center, CBOC and VISN
- Engage and utilize primary care leadership infrastructure
- E-mail and telephone access to national champions
- Ongoing guidance from the VACO Interdisciplinary Technical Advisory Team
- Ongoing training and re-design/improvement



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Phase IV: B. Integrate model into long term VA organizational goals

- Develop VISN infrastructure to disseminate PDICI concepts/principles and provide ongoing training
- Collaborate with other integrated care programs within the VA
 - Women's Health
 - PC/MH Integration Clinics
 - GRECC/SCI



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Recognition

**Special Thanks: Steve Hunt MD!!
National Director for Post-
Deployment Care
For his untiring efforts
and priceless contributions:
1990 - Present**



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Q&A

Questions?



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Post Combat Primary Care

Essential Elements that Social Work provides in the Post Combat Primary Care Clinic

- Sees all OEF/OIF veterans entering Primary Care
- Completes Psycho-Social Assessment on each OEF/OIF veteran coming in for Primary Care
- Provides educational materials regarding resources and coping strategies and sources of support
- Determines the need for seriously ill or injured care management
- Generates consult or referral to OEF/OIF Program Manager if intense Case Management needed
- If not severely injured and not needing close case management follow-up, Primary Care social worker follows, completes clinical screens as appropriate
- Ensures veterans have contact information for the OEF/OIF team for future reference



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Role of the OEF/OIF Program Manager

- The RN or MSW OEF/OIF Program Manager at each VA facility oversees all services provided to OEF/OIF service members and veterans.
- Ensures collaboration of OEF/OIF Team with other specialty and primary care needs to ensure coordinated care
- Ensures that all OEF/OIF veterans are screened to determine the need for case management
- Assigns Transition Patient Advocate to assist with non-clinical needs of OEF/OIF severely injured veterans
- Oversees the tracking and monitoring of OEF/OIF veterans including the performance measures



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