



Polytrauma System of Care

South Texas Veterans Health Care System

New Model of Care

- “Polytrauma” describes unique, complex patterns of injuries:
 - Complex, multiple injuries occurring as result of same event
 - Unpredictable patterns including: brain injury, amputation, hearing and vision impairments, spinal cord injuries, psychological trauma, and musculoskeletal wounds
- Individuals with polytrauma require extraordinary level of integration and coordination of medical, rehabilitation, and support services
 - Brain injury is primary injury that drives care
 - Unique rehabilitation challenges with blast related injuries
 - Higher level of acuity due to severity of injuries
 - Simultaneous treatment of multiple injuries
 - Sequence and integrate therapies to meet patient need
 - Coordinate interdisciplinary team effort with expanded team of consultants

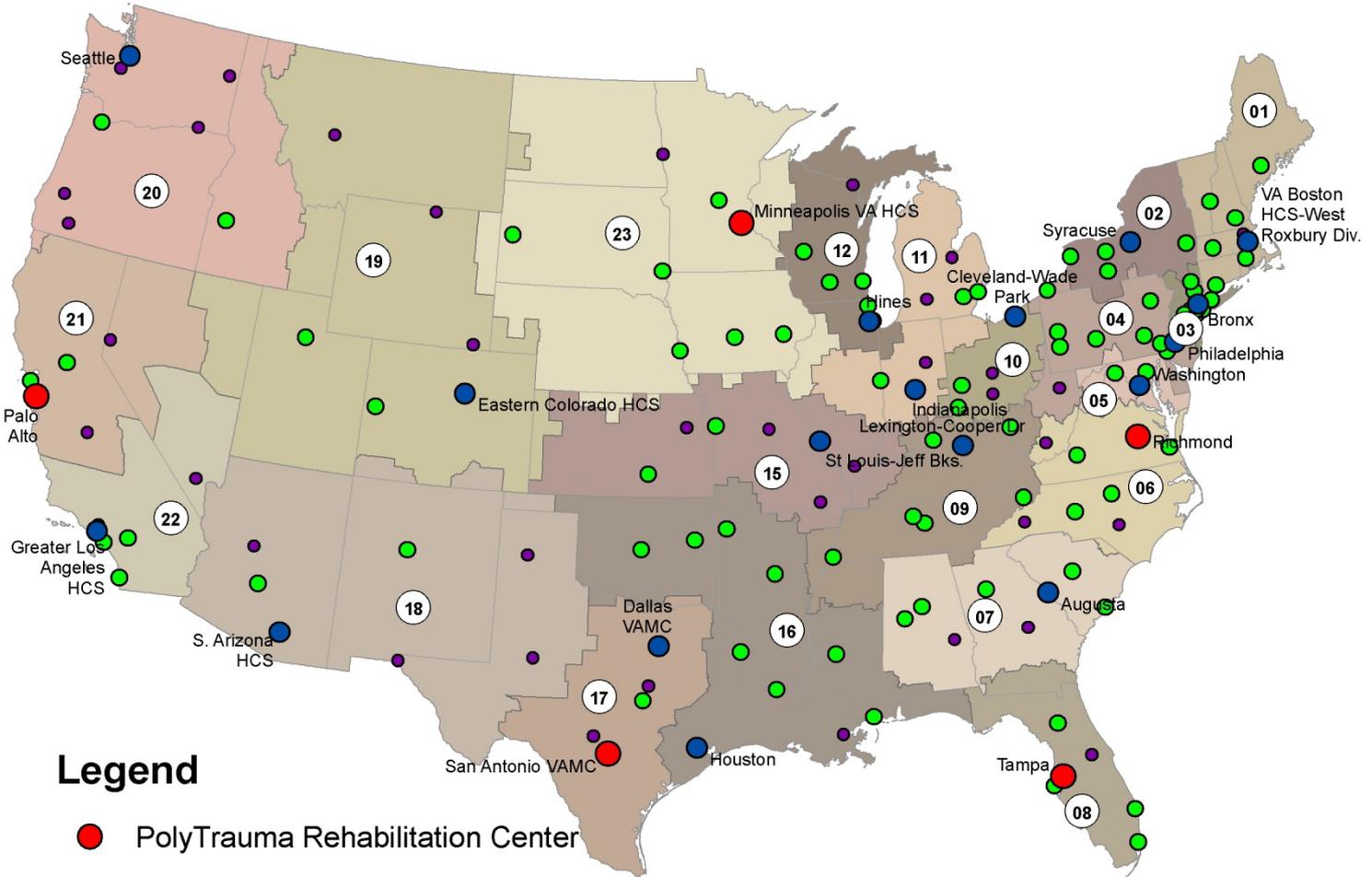
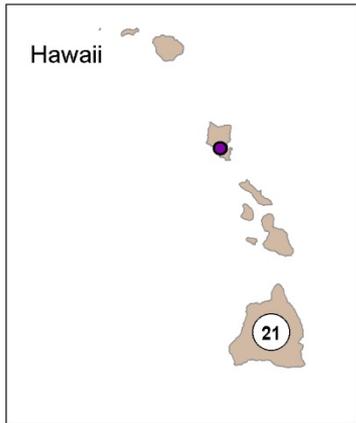
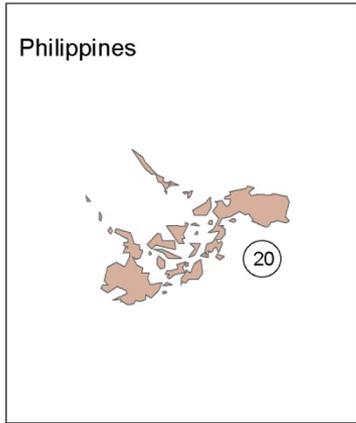
Mission

Provide a comprehensive, patient-centered, integrated system of rehabilitation care for Veterans and Service Members with Polytrauma and Traumatic Brain Injury

VHA Polytrauma / TBI System of Care

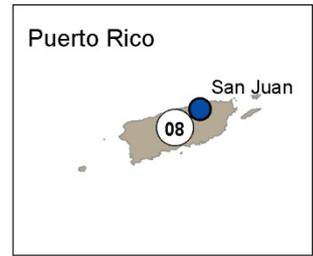
- Level 1: Polytrauma Rehabilitation Centers (5)
 - Regional referral centers for acute, comprehensive rehabilitation
 - Lead clinical care, research, education, program development
 - Tampa, Minneapolis, Richmond, Palo Alto, San Antonio
- Level 2: Polytrauma Network Sites (23)
 - Veteran Integrated Service Network referral sites for post-acute rehabilitation
- Level 3: Polytrauma Support Clinic Teams (87; 2-8 per VISN)
 - Interdisciplinary team follow-up and management of stable TBI/Polytrauma symptoms at local VA facilities
- Level 4: Polytrauma Points of Contact (41 VA medical centers)
 - Care coordination and referral to appropriate services

VHA Polytrauma System of Care FY 2011

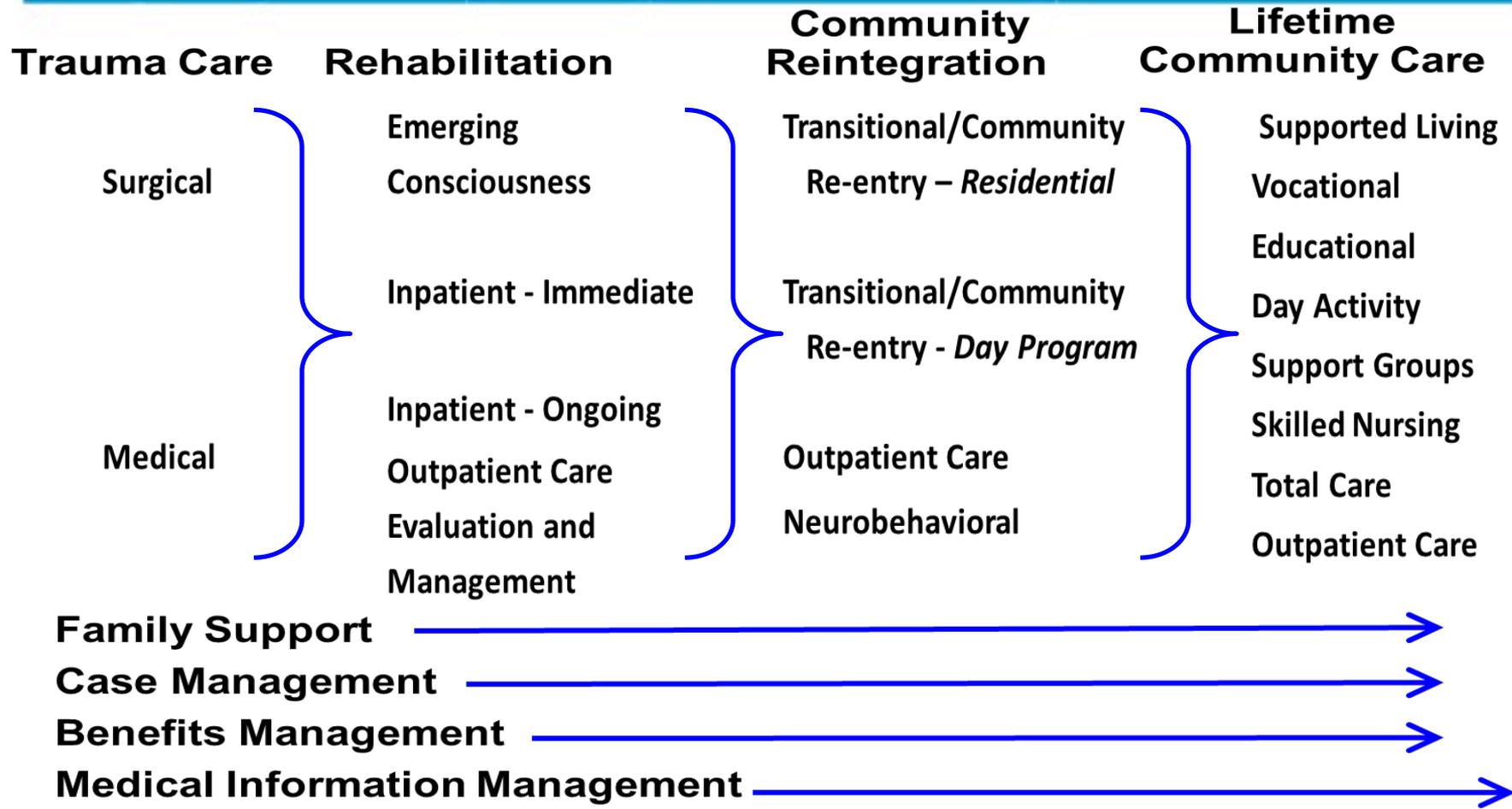


Legend

- PolyTrauma Rehabilitation Center
- Polytrauma Network Site
- Polytrauma Clinic Team
- Polytrauma Point Of Contact



Polytrauma System of Care Transitional Process



VHA Polytrauma Rehabilitation Center (PRC) Sites



Richmond



Minneapolis



Tampa



Palo Alto



San Antonio

PRC Overview

- Five Level 1 medical centers provide the highest echelon of comprehensive medical and rehabilitative services (inpatient and outpatient) for the most complex and severely injured:
 - 12-18 inpatient bed unit providing acute interdisciplinary evaluation, medical management, and rehabilitation
 - 10 inpatient bed residential Transitional Rehabilitation Program
 - Emerging Consciousness Program
 - Assistive Technology Lab
 - Polytrauma Telehealth Network
- National leaders in polytrauma, TBI, and blast-related injuries, providing consultation, medical education, research, & program development for VHA
- Accredited by Commission on Accreditation of Rehabilitation Facilities (CARF) for inpatient TBI and general rehabilitation
- Collaborative partner sites with DVBIC and national TBI Model Systems

PRC Inpatient Care (March 2003 through September 30, 2012)

2,735 inpatients received PRC (inpatient) care

1,532 Active Duty Service members

- *115 new AD patients in FY12 (through Q3)*

1,132 injured in foreign theatre

- *99 new patients in FY12 (through Q3)*

1,203 Veterans

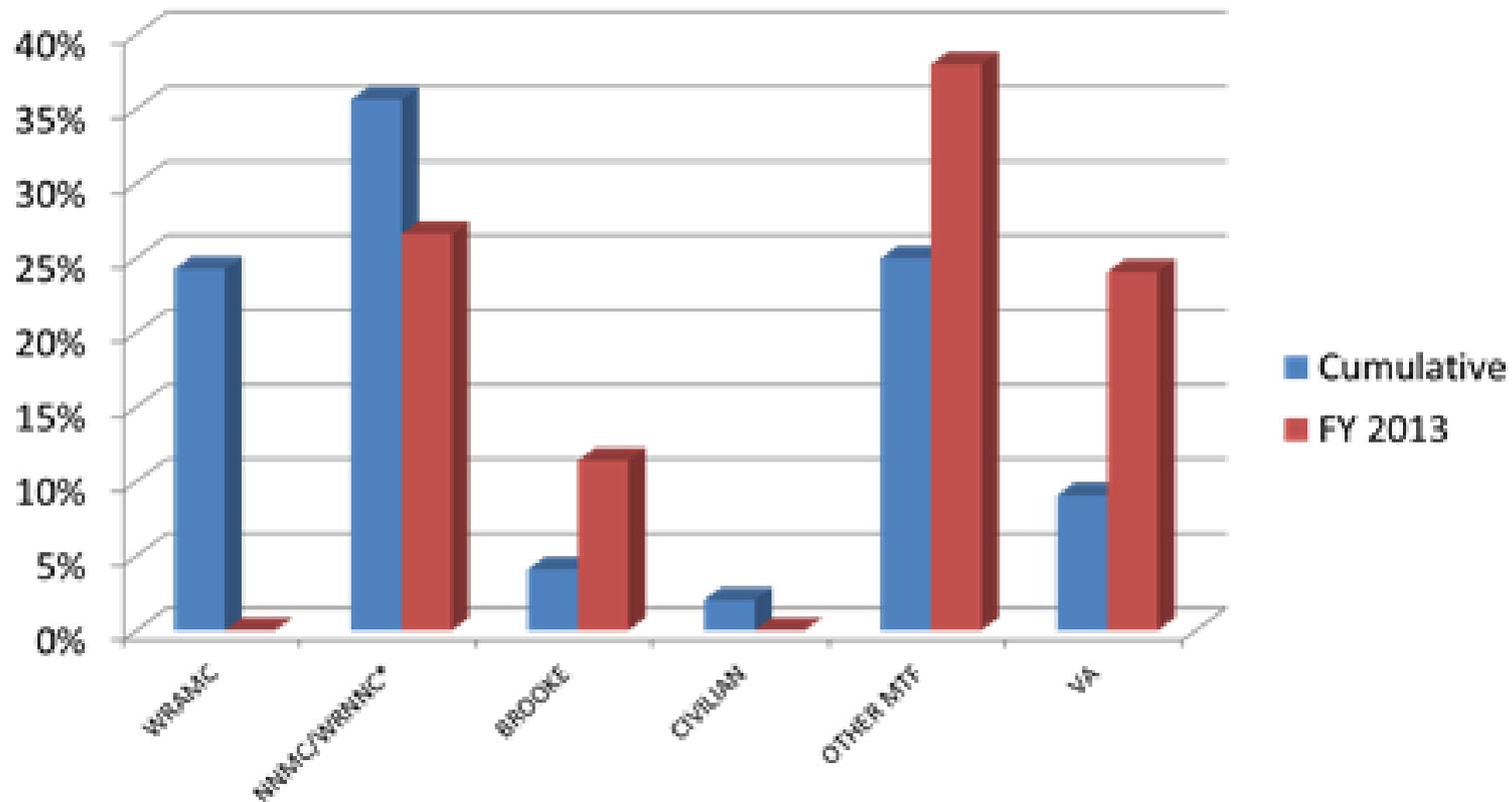
- *125 new patients in FY12 (through Q3)*

166 with Disorder of Consciousness

Current Utilization of the PRCs

- Occupancy rates fluctuate; 85% occupancy rate is preferred maximum
 - June 2012 - Average inpatient occupancy rate = 75% across all PRCs
- Average length of stay (LOS) in PRC: 46 days
 - More severely injured average 83 days LOS
 - Less severely injured average 28 days LOS
- Discharge destinations vary; nearly two-thirds are discharged to home

Patient Referral Sources to PRCs Foreign Theatre



*WRNMC created in Q1 FY12

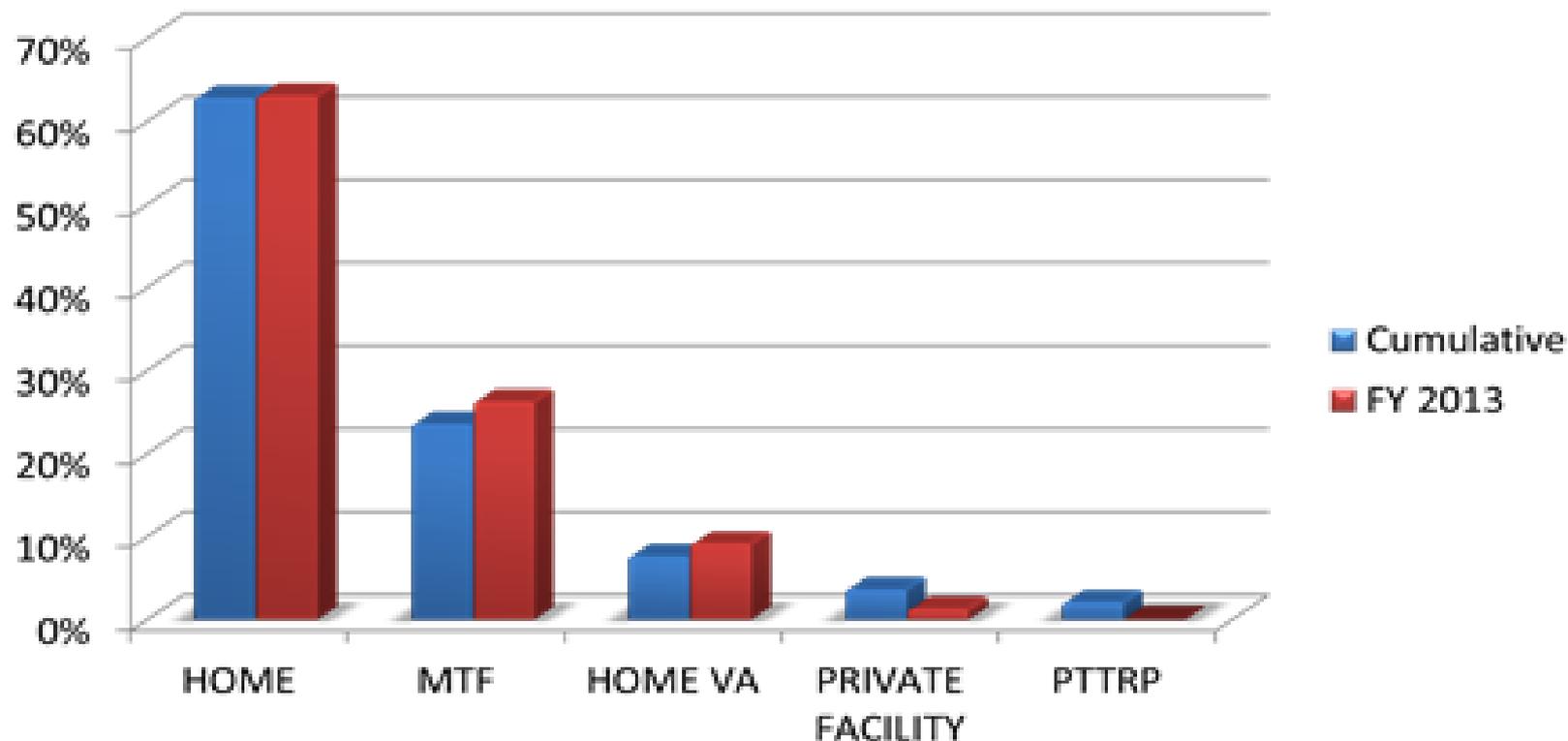
PRC Rehabilitation Team

- Psychiatrist
- Rehabilitation Nursing
- Speech Language Pathologist
- Occupational Therapist
- Physical Therapist
- Blind Rehabilitation Specialist
- Therapeutic Recreation Specialist
- Counseling Psychologist
- Neuropsychologist
- Family Therapist
- Patient/Family Educator
- Nurse Educator
- Social Work / Care Manager
- Driver Trainer
- Prosthetist / Orthotist
- DoD Military Liaison
- Wound Care Team
- Nutritionist
- Pet Therapy
- Assistive Technology Specialist

PRC Specialty Consultants

- Anesthesiology
- Audiology
- Chaplain Services
- Dentistry
- Gastroenterology
- General Surgery
- Infectious Disease
- Internal Medicine
- Neurology
- Neuro-Ophthalmology
- Neurosurgery
- Optometry
- Oral and Maxillofacial Surgery
- Orthopedics
- Otolaryngology
- Pain Clinic
- Plastic Surgery
- Prosthetics
- Pulmonology
- Radiology
- Urology
- VBA Vocational Specialist

Discharge Destination from PRCs Foreign Theatre



****Over 82% of total are Community DC's (Home or military with FIM>90)**

South Texas Veterans Health Care System San Antonio, Texas



PRC – San Antonio

- 5th PRC
- Opening Ceremony October 2011
- \$66 Million Project
- 3 levels - 12 Bed Unit
- Includes inpatient and outpatient programs
- Inpatient Referrals from San Antonio Military Medical Center, Walter Reed National Military Medical Center, community hospitals, Other VAs
- Service veterans and active duty with polytrauma injuries including TBI, Amputations, SCI, burns, limb salvage, multiple fractures, etc.





VETERANS HEALTH ADMINISTRATION

PRC – San Antonio Dec 2010- present

Polytrauma-115
Rehab-146

Active Duty- 75
Veteran- 186

**261 Total
Patients**

Average Age- 45.3

Total average LOS- 26.0 days
Polytrauma LOS- 38.7 days

Polytrauma Transitional Rehabilitation Program (PTRP)

- PTRP - Residential Rehabilitation
 - One at each PRC site
 - 10-20 beds for extended stay rehabilitation (1-6 months)
 - Focus on community reintegration and vocational rehabilitation
 - Linked in with local and regional military treatment facilities
 - Focus of care is on independent living with less family interaction



PTRP Experience FY08-FY12

Average Length of Stay

66.9 days

Average Age

32.8

**415 Unique
Patients**

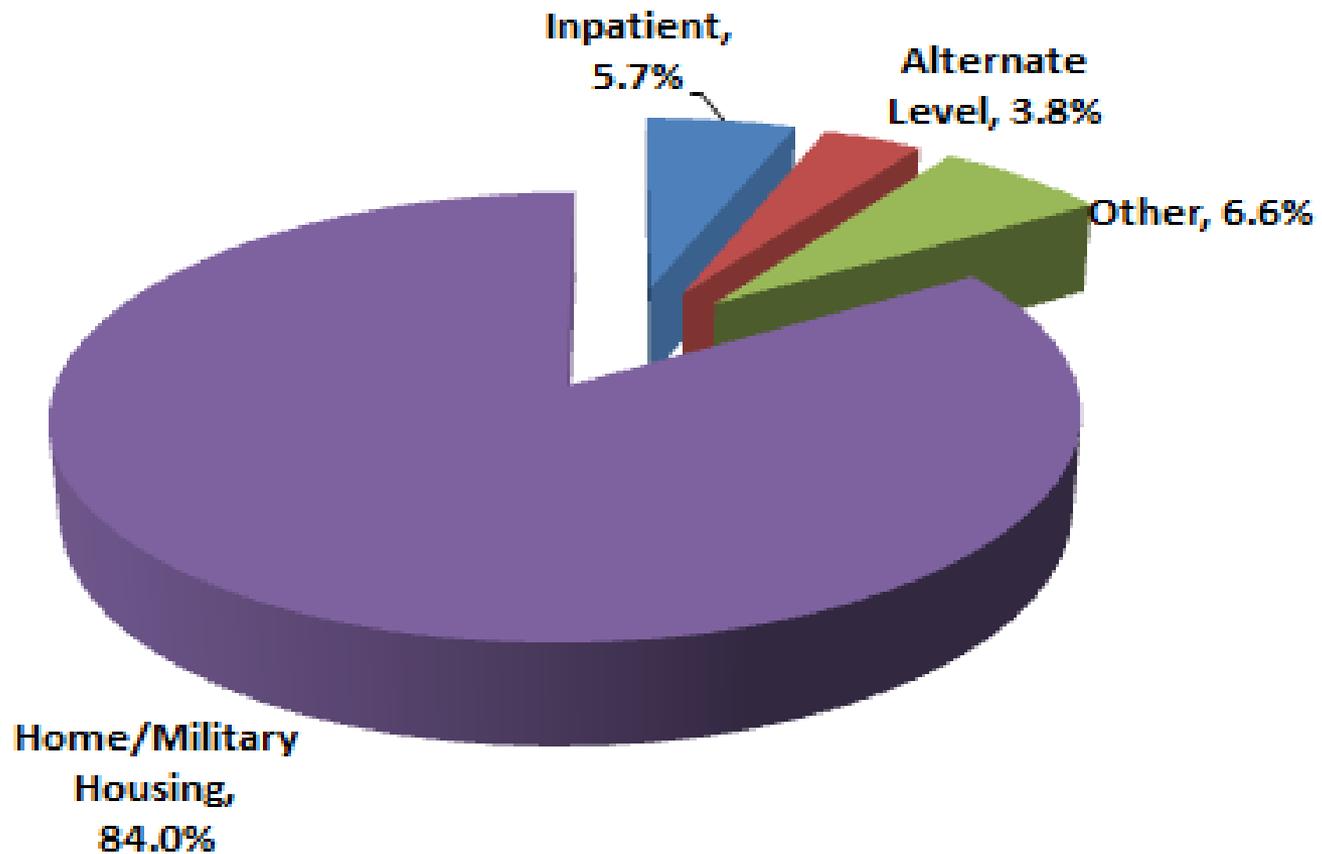
OEF/OIF

23.4%

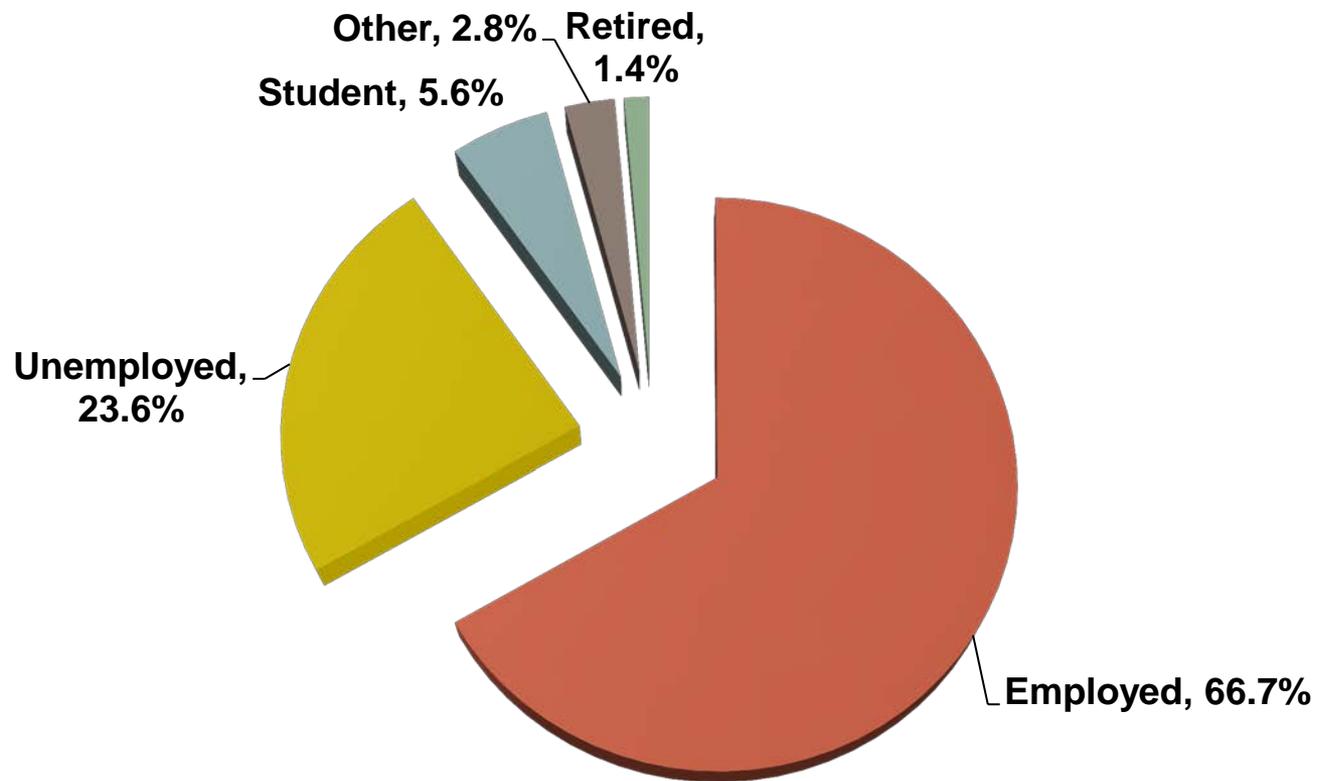
Female

5.1%

Discharge Destination from PTRPs



Transitional Rehabilitation Program Vocational Outcomes



PTRP – San Antonio



PTRP - San Antonio
April 2013- present

Average Length of Stay
62.1 days

Average Age
34.6

**21 Unique
Patients**

Active Duty- 10
Veterans- 11

Polytrauma- 15
Rehab- 6

All PRCs/ PTRPs

October 2012 – September 2013

All Patients

(1N) POLYTRAUMA REHAB
UNIT

(82) PM&R TRANSITIONAL
REHABILITATION

	Unique Patients	Average Daily Census	Average Length of Stay	Unique Patients	Average Daily Census	Average Length of Stay
Richmond, VA	59	7.0	44.1	67	14.9	84.8
Tampa, FL	118	14.8	45.5	35	7.1	79.9
San Antonio, TX	50	5.4	38.7	15	2.1	62.1
Palo Alto, CA	46	6.2	47.4	32	5.0	57.5
Minneapolis, MN	69	7.3	34.7	37	5.1	52.7

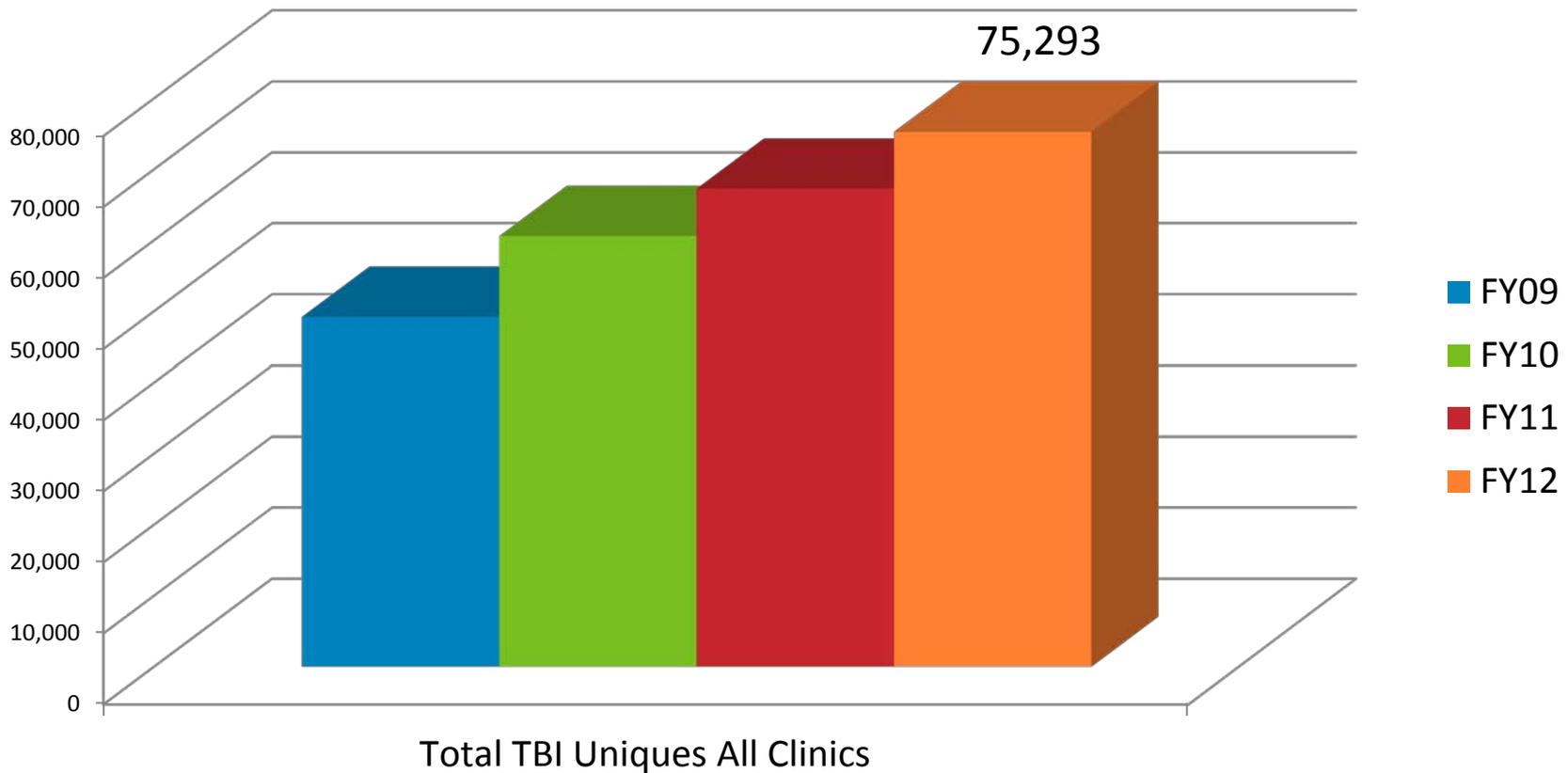
Polytrauma Network Sites (PNS)

- 23 regional (Level 2) medical centers providing full range of comprehensive follow-on medical and rehabilitative services (inpatient and outpatient) for patients recovering from polytrauma and TBI (1 per VISN, and San Juan):
 - Develop and support patient’s rehabilitation plan through comprehensive interdisciplinary, specialized team
 - Serve as resource and coordinate services for TBI and polytrauma across VISN (VHA, DOD, private sector)
- VISN leader for polytrauma/TBI consultation, education, monitoring outcomes, and program development for system
- Accredited by CARF for inpatient general rehabilitation

Screening for Mild Traumatic Brain Injury for OEF/OIF/OND Veterans

- VHA (April 2007 – August 31, 2013)
 - 768,744 have been screened for possible mild TBI
 - 144,787 screened positive and consented to follow-up
 - 108,807 have completed comprehensive evaluation so far
 - 62,545 received confirmed diagnosis of mild TBI

TBI Outpatient Uniques



PNS - San Antonio

- Outpatient Clinic dedicated to TBI (mild to severe) and other polytrauma injuries
- Interdisciplinary Team that includes PM&R physicians, clinic nurse, social work, psychology, neuropsychology, physical therapy, occupational therapy, speech therapy, blind rehab
- Consults received as a result of positive TBI screening
- Currently 3rd nationally in number of uniques
- Treat symptoms related to TBI and other injuries including headaches, dizziness, vision deficits, hearing loss, concentration/ memory deficits, mental health issues (including PTSD), sleep issues
- Goal of community reintegration

PNS - San Antonio

	POLYTRAUMA/TRAUMATIC BRAIN INJURY (TBI)- INDIVIDUAL		POLYTRAUMA/TRAUMATIC BRAIN INJURY (TBI)- GROUP	
	Unique Patients	Encounters	Unique Patients	Encounters
<i>All Facility</i>	50,516	173,131	2,784	12,015
San Antonio, TX	1,073	6,610	80	161

Leaders' Vision

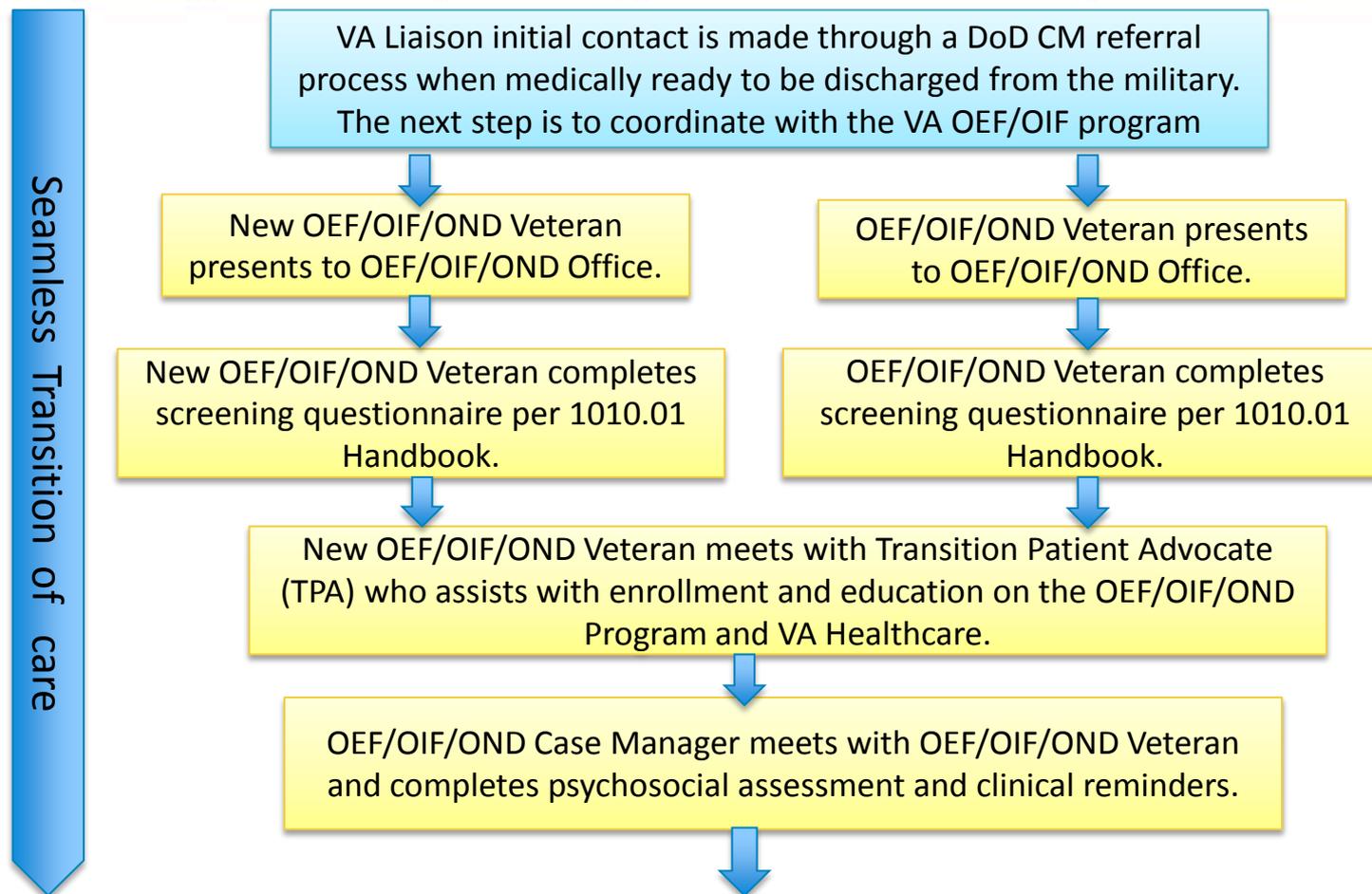
One Mission – One Policy – One Plan

- **Secretary Shinseki and Secretary Panetta met three times to discuss the issue, set the tone, and establish their expectations:**
 - Common, **interagency guidance** driven by an overarching formal **interagency governance structure** in support of the wounded, ill and injured & their families
 - Integrated **interagency community of practice** comprised of professionals that coordinate and manage care, benefits, and services...with shared measures of success to include utilization, quality, and satisfaction
 - **Single comprehensive, interagency plan** developed and shared by both Departments that produces a **common operational picture**, visible to patient, family, and care recovery team...will drive effectiveness/efficiencies for the recovery process in support of both recovering service member and recovery team
 - **Sustainable** model that transcends current conflicts and is scalable to meet both peacetime and wartime support requirements
 - The first step is to **designate a Lead Coordinator** for Service Members and Veterans at each stage of their recovery

Transitioning from DoD to VA

- VA & DoD partnership began in August 2003
- Social Workers and Nurses embedded at Military Treatment Facilities (MTFs)
- Care Management begins at the MTF
- Smooth transition to VA provides the Service member or Veteran and their family a sense of security that VA can meet their needs

Referrals from OEF/OIF/OND Program to Polytrauma System of Care



Referrals from OEF/OIF/OND Program to Polytrauma System of Care (continued)

Seamless Transition of care

If the TBI clinical reminder is positive, OEF/OIF/OND Case Manager submits a consult to Polytrauma for further assessment.

OEF/OIF/OND Veteran contacted by Polytrauma and scheduled.

OEF/OIF/OND Veteran evaluated by Polytrauma and assigned a level of care of one, two, or three. All level three OEF/OIF/OND Veterans are case managed by the outpatient Polytrauma Case Manager.

Outpatient Polytrauma Case Manager and Polytrauma Social Work Supervisor attend the OEF/OIF/OND Care Management Review Team meeting biweekly to complete a warm handoff on OEF/OIF/OND Veterans that will be case managed by Polytrauma.

VA Liaisons for Healthcare

Why VA Liaisons?

Coordinate VA healthcare for Service members (SM) transitioning from DoD to VA

Collaborate and coordinate with MTF treatment team and OEF/OIF/OND Program Manager throughout the referral process

SM has appointments at the VAMC prior to leaving the MTF

SMs who are severely injured are connected with the State Department of Veterans Affairs

Service Members and families/caregivers...

Are educated about VA Healthcare and resources

Discuss individualized VA treatment options and resources with VA Liaisons

Easily access VA Liaisons who are co-located onsite with Military Case Managers

May meet with VA treatment teams via video teleconference at MTF

Lead Coordinator Overview

- The Lead Coordinator (LC) serves as the primary point-of-contact within a DoD or VA Care Management Team (CMT) for a Service member / Veteran (SM/V) and their families/caregivers during their recovery, rehabilitation, and transition
- By assigning a primary point-of-contact on the CMT, it reduces confusion and eliminates complexities for SMs/Vs and their families/caregivers
- Ensures a warm hand-off at the time of transition between DoD/VA facilities, including transfer of documentation and the checklist

Best Practices for Seamless Transfer at South Texas

- Case management hand-offs
 - Lead Coordinator
- V-tel communication with MTF's and other VA's to ensure a comprehensive handoff is completed
- Family meetings with care team
- Family tour of the PSC facilities
- Reintegration plans of care completed prior to discharge and shared for efficient continuation of care
- Liaison involvement from admission to discharge

Best Practices for Transitioning Families at South Texas

PTRP – San Antonio hosts a family conference day with each family on Fridays that include:

- Family conference focusing on plan of care
- Safety and awareness in the community
- Caregiver TBI education group
- Family support & reintegration group
- Meeting with the lead therapist

Rebuilding Injured Lives

