Department of Veterans Affairs

Office of Inspector General

Follow-Up Healthcare Inspection

VA's Role in Ensuring Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation

Report No. 08-01023-119 **May 1, 2008**

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

In a July 2006 report, the VA Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) described the health status of and services provided for a group of service members and veterans who had received inpatient rehabilitative care in VA facilities for traumatic brain injury (TBI) sustained during or after tours of duty in Iraq or Afghanistan. At the request of the Chairman of the Senate Committee on Veterans' Affairs, the OIG conducted a follow-up assessment to determine the extent to which the Veterans Health Administration (VHA) maintains involvement with these same individuals to ensure that their health care needs are met.

OHI inspectors extracted data on VA health care utilization from electronic medical records. Interviews with patients and/or family members were conducted by telephone or in person, and all participants were given explicit permission to decline participation. Interviewers inquired about changes since the initial interview in 2005. Specifically, questions pertained to education or training received, current employment or student status, military status, marital status, living situation, driving status, sources of health care, role of VA in health care, and presence of behavioral problems. OHI physician, nursing, and social work staff reviewed each case to establish whether patients had significant unmet needs.

Three years after completion of initial inpatient rehabilitation for TBI, many of these patients continue to have significant disabilities. VHA and Veterans Benefits Administration support for TBI patients is extensive. While case management has improved, long-term case management is not uniformly provided for these patients, and significant needs remain unmet. OIG will continue to monitor VHA's progress toward achieving consistent delivery of case management services for this select group of injured veterans.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Under Secretary for Health

SUBJECT: Follow-Up Healthcare Inspection – VA's Role in Ensuring Service for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation

Purpose

In a July 2006 report,[1] the VA Office of Inspector General (OIG), Office of Healthcare Inspections (OHI) described the health status of and services provided for a group of service members and veterans who had received inpatient rehabilitative care in VA facilities for traumatic brain injury (TBI) sustained during or after tours of duty in Iraq or Afghanistan. At the request of the Chairman of the Senate Committee on Veterans' Affairs, the OIG conducted a follow-up assessment to determine the extent to which the Veterans Health Administration (VHA) maintains involvement with these same individuals to ensure that their health care needs are met.

Background

In 1992, VHA designated four VA medical centers to provide dedicated beds and staff for specialized TBI rehabilitation.[2] Beginning in January 2002, these centers began receiving patients from military hospitals for rehabilitation following injuries sustained in combat operations in Afghanistan and Iraq. In 2005, OHI identified 74 patients who had been discharged during a 7-month period in 2004 after inpatient TBI rehabilitation at one of the four TBI lead centers.[3] OHI inspectors completed detailed direct assessments for 52 of these patients and found that they had very similar functional outcomes when

[1] *Healthcare Inspection – Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation* (Report No. 05-01818-165, July 12, 2006). Report available at http://www.va.gov/oig/54/reports/VAOIG-05-01818-165.pdf.
[2] Sigford BJ. "To care for him who shall have borne the battle and for his widow and his orphan" (Abraham Lincoln): The Department of Veterans Affairs Polytrauma System of Care. *Arch Phys Rehabil.* 2008;89:160–2.
[3] These facilities, now referred to as Polytrauma Rehabilitation Centers, are part of the VA medical centers located in Tampa, FL; Richmond, VA; Minneapolis, MN; and Palo Alto, CA.

compared with a matched group of TBI patients from the private sector. However, long-term case management was felt to require improvement.

Specific attention to the long-term needs of those living with TBI is warranted in part because cognitive and emotional impairments compromise patients' capacity to seek help on their own.[4] Unlike other types of injury, brain injury often causes long lasting emotional difficulties and behavioral problems. Further, in contrast to amputations and other disabilities, these problems are often not apparent to casual observers even though they exact a huge toll on patients and families.

In response to our recommendations in the 2006 report, the Under Secretary for Health stated, "…case managers will provide long-term case management services and coordination of care for polytrauma patients and will serve as liaisons to their families." This report describes VHA's ongoing involvement in the care of the individuals described in the 2006 report and outlines certain aspects of these patients' health, health care, and benefits.

Scope and Methodology

A. Patients

We focused on the 52 patients described in detail in our 2006 report. Each of these patients had been discharged March 1 through September 30, 2004, from one of the four VA TBI lead centers after a first admission for TBI rehabilitation. TBI rehabilitation was specified by International Classification of Diseases (ICD)-9 codes.[5] We included only patients who were on active duty at the time of their TBI and who were designated as having served in Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF).[6]

B. Health Care Utilization

OHI inspectors extracted data on VA health care utilization from electronic medical records. The presence of any one of the following during the period

[4] Lew HL, et al. Persistent problems after traumatic brain injury: the need for long-term follow-up and coordinated care. *J Rehabil Res Dev.* 2006;43:vii-x.

[5] Utilizing VHA's Patient Treatment File (PTF), we identified patients discharged with ICD-9 code V57.x (care involving use of rehabilitation procedures) and at least one of the following ICD-9 codes:

310.2: Post-traumatic encephalopathy, post-concussion.
800.xx-804xx: Skull fracture.
851.xx: Cerebral laceration and contusion.
852.xx: Subarachnoid, subdural, and extradural hemorrhage.
853.xx: Other and unspecified intracranial hemorrhage following injury.
854.xx: Intracranial injury of other and non-specified injury.

[6] While all patients were designated as having served in the Persian Gulf, one was a veteran of a prior Persian Gulf conflict (Desert Storm) who was injured while working as a civilian contractor in Iraq, and two were subsequently found to have never been in Iraq or Afghanistan.

February 1, 2007–January 31, 2008, was considered evidence of VA health care involvement:

- Primary care visit at a VHA facility.
- Hospitalization, acute or long term.
- Social work or case management progress note.

C. Patient Interviews

Patient contact information as of December 2007 was obtained from electronic medical records as well as from VA's corporate database (Austin Automation Center) and OIG's investigations resources. For patients who could not be contacted and for whom we had no recent VA health care information, Department of Defense (DoD)/TRICARE[7] health care utilization data were extracted from the LC database.[8] Interviews with patients and/or family members were conducted by telephone or in person, and all participants were given explicit permission to decline participation.

Interviewers inquired about changes since the initial interview in 2005. Specifically, questions pertained to education or training received, current employment or student status, military status, marital status, living situation, driving status, sources of health care, role of VA in health care, and presence of behavioral problems. OHI physician, nursing, and social work staff reviewed each case to establish whether patients had significant unmet needs.

D. VA Benefits

To obtain information about VA benefits for these patients, we queried two Veterans Benefits Administration (VBA) files, (1) the December 2007 Compensation and Pension File for fiscal year 2007 and (2) the Target Payment History File for the 1st quarter of fiscal year 2008. Compensation is paid based on service-connected disability regardless of other income. The Target Payment System includes data about educational benefits.

This review was conducted in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

[7] TRICARE is DoD's health care program for members of the uniformed services, their families and survivors, as well as for retired service members.
[8] *Informational Report – Quantitative Assessment of Care Transition: The Population-Based LC Database* (Report No. 07-00380-202, September 13, 2007). Report available at http://www.va.gov/oig/54/reports/VAOIG-07-00380-202.pdf.

Inspection Results

Issue 1: Utilization of VA Health Care Services

At the time of this review, more than 3 years had passed since the 52 patients described in the 2006 report were discharged from the VA hospital after initial TBI rehabilitation (median time from discharge, 44 months; range, 38–46 months). Evidence of recent VA health care utilization was found for 41 of the 49 patients who were no longer on active duty. Most of these patients had primary care visits and/or interactions with social workers. (See Figure.) Only 6 of the 52 patients received recent care at the rehabilitation center from which they were discharged in 2004.

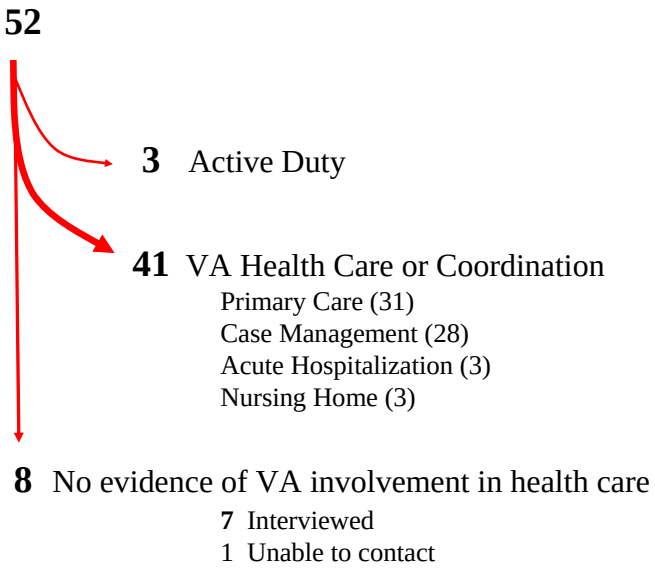

Figure: VA health care utilization February 2007–January 2008 by 52 OEF/OIF veterans 38–46 months following initial rehabilitation for TBI.

Of the eight non-active duty patients with no evidence of recent VA health care involvement, seven patients and/or their families participated in interviews. One patient could not be contacted. When evaluated in 2005, five of these eight patients had been considered to have relatively mild functional impairment (FIM™ scores > 120).[9] One of the remaining three patients, a patient with severe chronic disability, is not currently eligible for VA care. (See Table 1.)

[9] FIM,™ originally an acronym for Functional Independence Measure, is the most widely accepted functional assessment tool in rehabilitation. Scores range from 18 to 126. A score of 18 indicates the lowest level of independence, and a score of 126 is indicative of the very highest level of independence. See http://tbims.org/combi/FIM/index.html (The Center for Outcome Measurement in Brain Injury). Note that the FIM™ is relatively insensitive to mild cognitive impairment.

Patient	Service-Connected Rating (percent)	Disability in 2005	Source of Health Care	Status
1	0	Mild	Private insurance	Interviewed
2	50	Mild	TRICARE	Needs vocational rehabilitation[10]
3	0	Mild	TRICARE	Interviewed
4	0	Severe	Medicaid (VA ineligible)	Interviewed
5	0	Mild	Unknown (active duty as of Feb. 2006)	Unable to contact
6	90	Moderate	TRICARE	Interviewed
7	0	Mild	Private insurance	Interviewed
8	100	Moderate	TRICARE	Needs VA assistance

Table 1. Characteristics of eight TBI patients with no evidence of VA health care involvement February 1, 2007–January 31, 2008. Disability categorizations refer to FIM™ scores for these specific patients (mild, > 120; moderate, 116–117; severe, 27). See footnote 9.

Issue 2: Patient/Family Interviews

Forty-one patients and/or their families were available for interview and agreed to participate. Three declined to be interviewed, and eight were not able to be contacted. Of the 11 patients who were not interviewed, 10 had evidence of recent VA health care or were on active duty. The single patient who was not known to be on active duty and for whom there was neither interview nor health care utilization information had been noted to have a mild disability when interviewed in 2005 and was on active duty as of February 2006.

As in 2005, these TBI patients varied considerably with respect to their functional independence. Most patients were living independently in the community, including nine who were living alone. Three patients were living in nursing homes. Table 2 outlines characteristics of the patients interviewed. For 12 patients, information was provided by or with the assistance of family members.

[10] VBA's Vocational Rehabilitation and Employment Program assists veterans who have service-connected disabilities to achieve and maintain suitable employment or independence in daily living.

Patient Characteristic	Number (Percent)
Have received additional education/training	21 (51)
Working or attending school full time	17 (41)
Active duty National Guard/Reserves (not active)	1 (2.5) 2 (5)
Newly married Newly separated/divorced	2 (5) 4 (10)
Living with others Living alone Institutionalized	28 (69) 10 (24) 3 (7)
Driving	22 (54)
Someone from VA coordinates care	21 (51)
Utilizing non-VA providers	22 (54)
Anger is a problem	18 (44)
Violence is a problem	1 (2)
Receiving needed support Financial Physical Behavioral/emotional	 30 (73) 26 (63) 21 (51)

Table 2. Characteristics of 41 TBI patients interviewed approximately 3 years after inpatient TBI rehabilitation.

Twenty-two patients (or family members) reported receiving non-VA health care, and most of this care was funded by TRICARE. (See Table 3.) Eleven of these patients indicated having more than one source of health care funding.

Payment Mechanism	Number
TRICARE/DoD	16
Medicare	8
Private insurance	4
VA fee basis	2
Medicaid	1
Indian Health Service	1

Table 3. Reimbursement mechanisms for non-VA health care.

Interviews revealed that 10 patients and/or their families had significant unmet needs. Some of these needs pertained to difficulties obtaining necessary primary or specialty medical care. Lack of awareness about or assistance with applying for vocational

rehabilitation was also a prominent unmet need. In addition, two families clearly needed supportive counseling or assistance negotiating VA processes. Notably, 7 of these 10 patients are not employed or in school. (See Tables 4 and 5.) Only 2 of these 10 patients had evidence of VA case management.

Unmet Need	Number
Medical care, primary and specialty	4
Vocational rehabilitation/education	3
Financial support	2
Family support (Supportive counseling and assistance with VA services)	2
Adaptive housing	2

Table 4. Unmet needs in 10 of 41 TBI patients and/or families interviewed.

Patient	Current Age, Marital Status	Service-Connected Rating (percent)	Employed or in School	Living Alone	Unmet Needs
1	29, Divorced	60	Yes	Yes	Needs primary care and appointment with Ophthalmology.
2	23, Single	60	No	No	Needs medical care closer to home and vocational rehabilitation.
3	25, Single	80	Yes	Yes	Needs primary care.
4	26, Single	100	No	No	Family needs help coordinating care. Patient needs vocational rehabilitation and adaptive housing.
5	28, Single	100	No	No	Mother needs help coordinating care.
6	37, Divorced	0	No	No	Has medical, emotional, and financial needs.
7	48, Married	50	No	No	Needs educational support.
8	25, Single	0	No	Yes	Needs help to get compensation and pension exam.
9	24, Single	100	Yes	No	Mother needs supportive counseling.
10	26, Married	70	No	No	Still waiting for adaptive housing.

Table 5. TBI patients with unmet needs. Most patients had no evidence of recent VA case management, but patients 9 and 10 did have case management. Marital status "single" denotes single, never married.

Issue 3: Benefits

At the time of this review, 40 of the 52 patients were receiving monthly compensation payments for service-connected disabilities. (See Table 6.) Twenty-five patients had 100 percent service-connected disability ratings, and 8 of these had been found to be impaired enough to require "aid and attendance" or "housebound" support.[11] Seven patients were considered incompetent, with payments being received by others.

Five patients were awarded compensation benefits prior to discharge from inpatient rehabilitation. For the remaining 37 patients, the median time from discharge after inpatient rehabilitation to an initial decision to award compensation benefits[12] was 53 weeks (range 10–132).

Service-Connected Rating (percent)	Number	Annual Compensation median (range)
0	10	$0
10–20	4	$702 ($0–1,404)
30–50	4	$7,440 ($4,272–10,200)
60–90	9	$17,280 ($11,052–32,028)
100	25	$35,952 ($30,324–88,788)

Table 6. VA compensation received by 52 TBI patients as of December 2007. For one patient, data pertain to February 2008. Two patients with 10–20 percent ratings received no payments while collecting military severance pay.

Conclusions

Three years after completion of initial inpatient rehabilitation for TBI, many patients continue to have significant disabilities. VHA & VBA support for TBI patients is extensive. Case management has improved, but long-term case management is not uniformly provided for TBI patients. In some cases, significant needs remain unmet.

[11] Aid and Attendance and Housebound benefits are paid in addition to monthly a pension. See http://www.vba.va.gov/bln/21/pension/vetpen.htm, No. 7.
[12] Original award effective date. Two patients with 10–20 percent ratings were receiving no payments.

Comments

The Under Secretary for Health agreed with the findings and conclusions (See Appendix A, pages 10–11 for the complete text of the Under Secretary's comments.) and stated that "we now have systems in place to ensure that all veterans with TBI are being followed as their clinical needs require." However, our recent survey revealed that 8 of 49 veterans we contacted had significant unmet needs and no evidence of VA case management in the previous year.

Also in the Under Secretary's comments was the statement that VA had plans to contact "all of our OEF/OIF veterans by telephone." Then, in an April 24, 2008 news release,[13] the Department of Veterans Affairs announced that on May 1, VA would begin contacting nearly 570,000 recent combat veterans to ensure they know about VA's medical services and other benefits. A contractor-operated "Combat Veteran Call Center" will telephone two distinct populations of veterans from Iraq and Afghanistan. The first phase of calls will go to an estimated 17,000 veterans who were sick or injured while serving in Iraq or Afghanistan; VA will then offer to appoint a care manager to work with them if they do not have one already. The second phase will target 550,000 OEF/OIF veterans who have been discharged from active duty but have not contacted VA for services.

VHA's statement that systems are in place to ensure that all veterans with TBI are being followed and the Secretary's plan to contact 570,000 recent combat veterans are positive steps. Nevertheless, we continue to be concerned that all OEF/OIF veterans discharged after inpatient rehabilitation for TBI receive case management, unless this has been explicitly declined by the patient or assumed by another healthcare organization. Our concerns pertain to veterans injured throughout the course of the war and those injured after return from service in Afghanistan and Iraq. OIG will continue to monitor VHA's progress toward achieving its goal "to ensure that all veterans with TBI are being followed as their clinical needs require."

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

[13] News Release at http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=1493.

Appendix A

Under Secretary for Health Comments

Department of Veterans Affairs **Memorandum**

Date: April 11, 2008

From: Under Secretary for Health (10)

Subject: OIG Draft Report, *Follow-up Healthcare Inspection: VA's Role in Ensuring Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation*, Project No.: 2008-01023-HI-0069, (WebCIMS 401551)

To: Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed and concur with this draft report. It is gratifying to know that the Veterans Health Administration (VHA) and the Veterans Benefits Administrations' support for patients with traumatic brain injury (TBI) is extensive and that case management has improved. VA continues to identify measures to increase and improve care coordination for TBI patients.

2. VHA is aware of and agrees with the need to provide long-term case management for TBI patients. The draft report underscores the need for a robust TBI care management system. VHA has continued to improve care management processes, and although not all staff and processes were in place when the 52 patients included in your review were discharged from the military in 2004, we believe that you would find, upon a review of patients discharged more recently, a much more comprehensive program to include long-term care management. We believe we now have systems in place to ensure that all veterans with TBI are being followed as their clinical needs require. In 2004, VHA implemented a Polytrauma system of case management, which provides long-term case management to all Polytrauma patients. Additionally, in June 2007, VHA established an Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) Care Management Program at each VA medical center for the purpose of providing long-term care management to all OEF/OIF veterans who need it. All OEF/OIF veterans with any level of TBI are screened for care management. This program currently serves 6,800 OEF/OIF veterans,

many of whom have TBI. Starting next month, VA will be contacting all of our OEF/OIF veterans by telephone. This will further assist us in ensuring that we are meeting the current needs of this deserving population. For those not being care managed who indicate that they would like to discuss this program, they will receive a second phone call from local VA care management staff to discuss their needs.

3. You do not provide a clear definition of the ideal state of long-term case management. I understand the challenge of providing such a definition since an "ideal state" of long-term case management has yet to be found in any organization. I believe VA is arguably the leader in establishing this ideal, and we will continue in the development of the best model of care management for VA facilities. VHA has developed a charge for a workgroup that will convene during the third week in April 2008. The group will consist of our "best" care managers from Polytrauma, mental health, spinal cord injury and illness, and OEF/OIF, as well as a transition patient advocate and a new federal recovery coordinator (FRC). (A FRC is the ultimate, constant, across the "life-long" care continuum point of contact and advocate for the Federal Individualized Recovery Plan for each seriously injured service member/veteran.) We look forward to developing this model of care and providing this guidance to our facilities.

4. Thank you for the opportunity to review the draft report. If you have any questions, please contact Margaret M. Seleski, Director, Management Review Service (10B5), at (202) 565-7638.

(original signed by:)
Michael J. Kussman, MD, MS, MACP

Attachment

Appendix B

OIG Contact and Staff Acknowledgments

OIG Contact	Nelson Miranda, Director Washington, DC, Office of Healthcare Inspections (202) 461-5668
Acknowledgments	Gail Bozzelli Verena Briley-Hudson Judy Brown Shirley Carlile Paula Chapman Linda DeLong Marnette Dhooghe Donna Giroux Wachita Haywood Jerome E. Herbers, Jr., M.D. Karen Moore Roxanna Osegueda Jennifer Reed Wilma Reyes Randall Snow Marilyn Walls

Appendix C

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