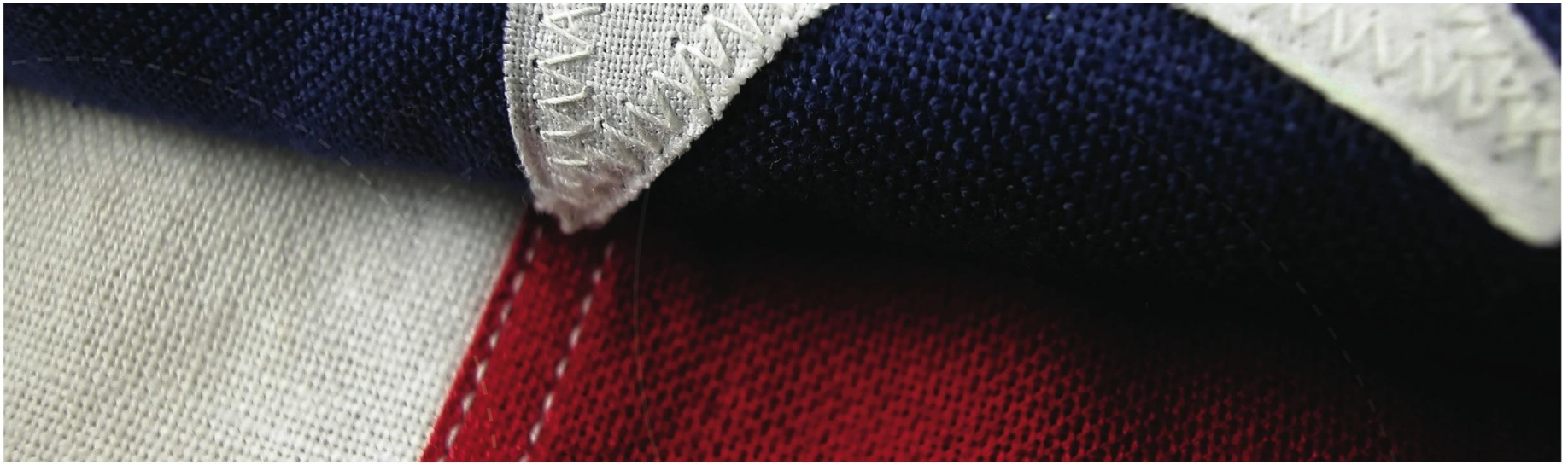

Office of Rehabilitation Services
Polytrauma Case Management

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Polytrauma Case Management

Seamless, comprehensive, high-quality, and interdisciplinary communication

Assure the administration of an individually tailored rehabilitation plan to maximize the Veteran's level of independence and function

Polytrauma/TBI System of Care Tiers

4 Polytrauma Rehabilitation Centers
- Coordinates with the referring facility
- 6:1 ratio per VHA Directive 2006-043
- Central member of the interdisciplinary team

22 Polytrauma Network Sites
- Same as above
- Coordinates with community resources

86 Polytrauma Support Clinic Teams
- Same as above

41 Polytrauma Points of Contact
- Serve as liaison to above

Polytrauma Case Management Intensity Based Model

Intensive, Progressive, Supportive, Lifetime

- The context of the care setting
- The patient's health condition and needs
- The type of care providers needed

Transfer of Veteran case from Polytrauma case management to another case management partner should occur when there are no further physical medicine and rehab goals.

Polytrauma Case Management Intensity Based Model

Intensive

Provided to all patients receiving inpatient rehabilitation and those outpatients who have a high level of intensive care management needs.

Progressive

Usually in the post acute phase of rehabilitation and/or are persons entering the system of care at the polytrauma network site (PNS), polytrauma support clinic team (PSCT), or polytrauma point of contact (PPOC) levels.

Polytrauma Case Management Intensity Based Model

Supportive

Recommend follow-up contact as needed once medical, rehabilitation and psychosocial issues are stable and the patient is well established in the system of care. Typically requiring at a minimum quarterly contact.

Lifetime

Recommend lifetime follow-up and contact as needed for patients with complex medical, rehabilitation, and psychosocial issues.

Services Provided by Polytrauma Case Managers

- Orientation to Veterans Affairs
- Care Coordination/smooth transition
- Identify and address risk factors
- Support families and caregivers
- Link with local resources
- Care Management Tracking and Reporting Application
- Assessment and Satisfaction
- Multi-Service/System collaboration
- Collaboration
- Community Reintegration (Plan of Care)

Collaborations

- Identify goals with rehab team, Veteran and family
- Rehab team's care coordinator
- Consult to needed VA programs
- Link with appropriate resources
- On-going follow up – polytrauma rehab center case manager (PRC CM), polytrauma network site case manager (PNS CM), polytrauma support clinic team case manager (PSCT CM), polytrauma point of contact (PPOC), Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn, federal recovery coordinator (FRC), VA and Military Liaisons, patient aligned care teams (PACT), transitional patient advocate (TPA), spinal cord injury, vision impairment specialty team, mental health, Veterans Benefits Administration, etc.
- Participate in Care Review Team meetings with OEF/OIF/OND Program Manager to determine the Lead Case Manager.

Best Practice

Rehabilitation and Reintegration Plan of Care

VA developed and Polytrauma case managers implemented a national template to ensure that every Veteran receiving ongoing inpatient or outpatient rehabilitation treatment for TBI is provided with an individualized rehabilitation and community reintegration plan, in compliance with section 1702 of Public Law 110-181 (38 U.S.C. § 1710C).

Individualized Rehabilitation and Community Reintegration Care Plan

Example Format

LOCAL TITLE: TBI/Polytrauma Rehabilitation/Reintegration Plan of Care
STANDARD TITLE: TBI TREATMENT PLAN NOTE

Patient's current Military Status: Veteran
Brief History of injuries:
Current problems:
Patient and Family Goals:
Summary of Interdisciplinary Treatment (IDT) evaluations:
Consults requested and/or follow-up on consults:
Interdisciplinary Treatment Goals:
Date of IDT conference with patient and family to review plan:
Written copy provided:
Family education and support needs:
Current location/living arrangements:
Vocational Rehabilitation Plan:
Physician responsible for managing the treatment plan:
Polytrauma/TBI Case Manager responsible for monitoring implementation:
Military Case Manager:
Plan has been communicated to military:
Date care plan will be reviewed:

Challenges

Lifetime Chronic Case Management

- Complexity of injuries and post-acute needs throughout VHA in multiple programs
- Nationally the PMRS Program Office is addressing program needs and collaborating with Geriatric Extended Care, Home Based Primary Care, Mental Health, Caregiver Support Coordinator, Program of Assertive Community Treatment (PACT), and other specialty teams
    - To identify and address evolving needs
    - Enhanced support for chronic needs

Challenges

Education of Resources

- Non-specialty case managers need training/exposure to appropriately respond to the behaviors and needs of Polytrauma/TBI patients and their families.

Sharing of Resources

- Partnering with other layers specifically OEF/OIF/OND, mental health, and PACT teams.
- Continued collaboration with VA and DoD for appropriate referral of Veterans and service members to programs within VA, DoD, and the Private Sector.

Summary

Contact Information

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