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Information Brief

DCoE Summit

Continuum of Care and Care Transitions in the MHS
Interagency Complex Care Coordination

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Disclosures

• Dr. Jack Smith has no financial or nonfinancial interest to disclose.

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Learning Objectives

• At the conclusion of this activity, the participant will be able to:
  – Describe the circumstances that led to creation of the Interagency Care Coordination Committee
  – Explain the intent behind the phrase “One Mission, One Policy, One Plan”
  – List key features of the VA/DoD model for interagency complex care coordination
What is the Interagency Care Coordination Committee?

(And why do we need it?)
Brief History of IC3

• More than a decade of combat operations created tremendous demands on SM/Vs and their families, “...particularly our wounded, ill and injured.”

• Advances in trauma care and our ability to provide critical care in flight have led to unprecedented survival rates from what previously would have been mortal injuries. DoD and VA significantly expanded staffing and programs in response. In addition, states, communities, other government agencies and NGOs have responded with a plethora of benefits and services for wounded, ill and injured SM/Vs. Subsequently, reports from GAO, IG and focus groups identified problems with care coordination. They pointed out that although excellent services were being provided, they were often asynchronous. The primary complaint from SM/Vs and families was CONFUSION
Brief History of IC3 Continued

• To assess and improve Warrior care and coordination, in May 2012 VA Secretary Eric Shinseki and DoD Secretary Leon Panetta established a joint VA/DoD Warrior Care and Coordination Task Force

• The TF established several work groups to assess the problem and make recommendations for improvement. This work resulted in a Secretaries’ Letter of Intent in November 2012 and a commitment to “One Mission—One Policy—One Plan”

• Key Features
  – Common interagency guidance driven by formal interagency governance structure
  – Establishment of an interagency community of practice for care, benefits & services
  – Establishment of a single, comprehensive interagency plan managed by a Lead Coordinator to create a common operational picture visible to patient, family and care recovery team
Establishment of IC3

• The Interagency Care Coordination Committee (IC3) was chartered under the Joint Executive Committee (JEC) in January 2013.
  – IC3 is co-chaired by the DoD Principal Deputy Assistant Secretary of Defense for Health Affairs (PDASD) and the VA Assistant Secretary, Office of Policy and Planning.
IC3 Organizational Chart

- DoD/VA Joint Executive Committee (JEC)
  - DoD/VA Health Executive Committee (HEC)
  - DoD/VA Benefits Executive Committee (BEC)

DoD/VA Interagency Care Coordination Committee (IC3)

IC3 Governance

- Policy and Oversight
- Community of Practice
- Technology, Tools, & Change

IC3
ONE MISSION

• One Mission: Integrated interagency community of practice comprised of professionals that coordinate and manage care, benefits, and services

Community of Practice Members

DoD
- Air Force Clinical Case Management
- Air Force Warrior and Survivor Care
- United States Army Reserve Recovery Care Coordination
- Army Wounded Warrior (AW2) Program
- Behavioral Health System of Care
- Community Counseling and Prevention
- Defense Health Agency, Clinical Support Division - Health Promotion and Disease Prevention
- Defense and Veterans Brain Injury Center (DVBIG)
- Families Overcoming Under Stress (FOCUS)
- Headquarters Marine Corps (Health Services)
- iTransition
- MEDCOM Ombudsman Program / Wounded Soldier & Family Hotline
- National Intrepid Center of Excellence (NICOe)
- Navy Clinical Case Management
- Navy Wounded Warrior Safe Harbor
- NECC Recovery Care Management
- Project C.A.R.E. (Comprehensive Advanced Restorative Effort)
- Recovery Care Coordination Program (RCP)
- Reintegrate, Educate, and Advance Combatants in Health Care (REACH)
- Soldier for Life (Office, Chief Staff of the Army)
- Soldier for Life Transition Assistance Program (formerly ACAP)
- TRICARE
- US Marines Corps and Navy Reserves Psychological Health Outreach Program (PHOP)
- US Special Operations Command Care Coalition (USOCOM)
- USMC Wounded Warrior Regiment
- Yellow Ribbon Reintegration Program

VA
- Federal Recovery Coordination Program (FRCP)
- National Call Center for Homeless Veterans (NCCHV) - VHA
- Patient Aligned Care Teams (PACT) - VHA
- Polytrauma/Trameric Brain Injury - VHA
- Specially Adapted Housing Grants for Disabled Veterans - VBA
- Spinal Cord Injury/Disorders (SCI/D) Programs - VHA
- Transition Assistance Program - VHA
- Blind Rehabilitation Services - VHA
- VA Caregiver Support Program - VHA
- VA Liaison for Healthcare - VHA
- VA Life Insurance Special Outreach to Disabled Veterans - VBA
- VA Suicide Prevention Program - VHA
- VA Transition and Care Management (OEF/OIF/OND) - VHA
- VBA Homeless Program
- VBA OEF/OIF/OND Program
- VBA Vocational Rehabilitation and Employment
- Veteran-Directed Home and Community Based Services Program - VHA
- Veterans Integration to Academic Leadership (VITAL) - VHA
- VetSuccess on Campus (VSOC) - VBA
- VHA Home Improvement and Structural Alterations (HISA)
- VHA Homeless Veterans Services / Health Care for Homeless Veterans (HCHV) Outreach
- VHA Therapeutic and Supported Employment Services (TSES)
- VHA Women’s Veterans Programs
- VA Vet Center Program - VHA

Interagency
- Integrated Disability Evaluation System (IDES)
  - Physical Evaluation Board Liaison Officer (PEBLO)
  - Military Service Coordinator (MSC)
ONE MISSION (CONT)

• The CoP opened a virtual venue for DoD and VA care coordinators by standing up the CoP Co-Lab website. The Co-Lab is an interagency care coordination website that allows DoD and VA care coordinators to learn more about existing programs and services, find each other, and connect quickly to coordinate care.

• Members of the CoP are spearheading the national implementation of the Lead Coordinator (LC) role to all DoD military treatment facilities (MTF) and VA medical centers (MC).
ONE POLICY

• MOU between DoD and VA signed 29 July 2014: “Interagency Complex Care Coordination Requirements for Service Members and Veterans

• A VA Directive was signed in January 2015

• DoDI 6010.24 “Interagency Complex Care Coordination”, signed 14 May 2015
ONE PLAN

• Comprehensive Plan Work Group members created an Interagency Comprehensive Plan (ICP), a SM/V-centered plan with identified goals to facilitate care, recovery, rehabilitation, transition and community reintegration. This work group was succeeded by the Technology, Tools and Change Work Group, which is working to automate this and other care coordination tools and metrics.

• Care coordinators are already using the ICP and the Lead Coordinator Checklist, a 3 page document that supplements the ICP and assists LCs in managing tasks to ensure timely transition and hand-offs. It lists common care, benefits and services categories that should be considered throughout recovery, rehab, & reintegration.
Interagency Complex Care Coordination Model

- Key features of Interagency Complex Care Coordination model
  - Patient-centered and needs based
  - Care management team convenes when a need for complex care coordination is identified and appoints a lead coordinator, who will be the primary POC for the SM/V and Family and will maintain the ICP
  - Team creates and maintains an up to date Interagency Comprehensive Plan (with participation of the SM/V to the extent possible)
  - Team monitors recovery progress on an ongoing basis, and any transitions of care require a “warm hand-off”
WHICH PATIENTS NEED COMPLEX CARE COORDINATION?

- The need for complex care coordination is determined by factors including both severity of a wound, illness, or injury that is expected to result in prolonged recovery time, or extensive rehabilitation and complexity of care coordination needs involving health care, benefits, and services, including military, federal, or other governmental or community resources.

- Examples include (but are not limited to):
  - Those with multiple, complex, severe conditions such as polytrauma injuries, spinal cord disorders, blindness, amputations, significant burns, complex wounds, traumatic brain injuries, psychological trauma, or other cognitive, psychological, or emotional disorders
  - Those for whom, due to a serious or catastrophic wound, injury, or illness, it is unlikely to highly unlikely that the Service member will return to duty, and may, or will, be medically separated/retired from the military, or it is unlikely to highly unlikely that a Veteran will return to independent living or employment
  - Other SM/Vs who do not meet above criteria but who may benefit from complex care coordination (resources permitting)
WHO DECIDES WHEN TO USE THE CCC MODEL?

• The responsibility for assessment of the need for complex care coordination is made by the attending physician in conjunction with other members of the interdisciplinary Care Management Team (CMT), which includes the command representative.

• This is usually accomplished during the acute/stabilization stage, but may occur at any time during the course of recovery.

• Complex care coordination is a SM/V-centered, needs-based system designed to support the recovering SM/V and their family or caregiver until the criteria for discontinuation have been met:
  – SM/V returns to duty or employment with minimal or no limitations
  – SM/V has reached a level of stability making continued formal complex care coordination unnecessary
  – SM/V requests discontinuation of services
  – SM/V expires or other conditions make complex care coordination unnecessary.
**Participant Role Key**

CCM – Clinical Case Manager

CR - Command Representative

JRC – Joint Recovery Consultant

HCPs – Health Care Provider(s)

LC – Lead Coordinator (Role of a member of the Care Management Team)

NCCM – Non-Clinical Case Manager

SM/V – Service Member/Veteran
Recovery / Rehabilitation
Transition, Cont.

Acute / Stabilization
Interagency Comprehensive Plan (ICP) Development

Recovery / Rehabilitation
CMT review and update of Interagency Comprehensive Plan

Transition
Retirement; Or
Discharge

DD214
Major administrative transition points (e.g., entry into the Integrated Disability Evaluation System, Separation from the Service, and establishment of stable living arrangements in a community post-separation)

Ongoing Care Coordination

Lead Coordinator (LC) (Selected at various points from among the Care Management Team)
The LC is best described as the primary point of contact within a Care Management Team.

The LC will be assigned to recovering Service members and their families and caregivers during their recovery, rehabilitation, transition, and ongoing care coordination.

- LC assignment may transition from one LC to another as the site and/or level of care changes.
LC is *Not a New Position*

– The LC is definitely not a new position. LC functions are formalized responsibilities conducted by an existing member of the Care Management Team.

– The LC function may be performed by a clinical or non-clinical (DoD only) member of the team.
Key Points

• The LC is not responsible for executing all care, benefits, and services offered to the SM/V; LC is responsible for ensuring that all necessary services outlined in the LC Checklist are being addressed, documented, and coordinated as well as completing the ICP.

• The LC should not be the only point-of-contact for the patient and their family, but they should maintain visibility of all communication with the SM/V.
Who serves as the LC?

• LC function may be performed by a clinical or non-clinical (DoD only) member of the CMT, depending on the needs of the SM/V, department/service policy, care continuum, and workload
LC-to-LC Transfer Paths

• There are several transfer possibilities:
  DoD → VA
  VA → DoD
  VA → VA
  DoD → DoD

• In most cases:
  **Inpatients**
  DoD = Clinical LC
  VA = Clinical LC

  **Outpatients**
  DoD = Non-Clinical LC
  VA = Clinical LC
The “Warm Handoff”

It is vitally important that the transfer of duties between the current LC and the receiving LC be as smooth and efficient as possible. A “warm handoff” will:

- Set up the new LC for success
- Ensure care is provided during a critical transition point
- Include Face-to-Face, Email, and Telephone communication as well as Secure transmission of documents
- When transferring from DoD to VA, include a referral packet to the VA Liaison for Healthcare (or to the TCM Program Manager in the absence of a VA Liaison)
  - Referral packets include detailed information to ensure the receiving CMT can continue the SM/V’s ICP including, but not limited to:
    - Referral Form, LC Checklist, IDES Ratings, Supporting Medical Records (including medication list), Print-out from existing ICP (CTP, CRP, etc.)
  - When ICP is electronically interoperable, the Warm Handoff will include sharing the electronic ICP
The tools and documentation associated with LCs are vitally important to the LC transfer process.

There are six basic tools:

1. LC Checklist
2. Interagency Comprehensive Plan (ICP) Document
3. Co-Lab
4. Lead Coordinator Script
5. Fact Sheet
6. (Documentation) Print-outs from existing DoD/VA systems
NEXT STEPS

• Facilitate the successful transition of SM/Vs who require complex care coordination between DoD and VA through an integrated, interagency CoP.
  – Provide consistent training and information for individuals involved in complex care coordination.
  – Optimize use of an online knowledge exchange portal to facilitate information exchange and provide access to resources and tools.
  – Conduct an in-depth review of VA and DoD CoP programs to identify gaps and rationalize redundancies.

• Ensure DoD & VA policies are congruent for delivering complex care, benefits and services in accordance with VA-DoD interagency overarching guidance
  – Monitor the identification, review, rationalization, and revision (as necessary) of VA and DoD care coordination policies.
  – Implement an oversight process and mechanism to track IC3 performance and outcomes.
NEXT STEPS (cont.)

- Ensure effective utilization of a single, shared comprehensive plan for SM/Vs in need of complex care, benefits and services.
  - Integrate and improve existing VA and DoD processes for complex care coordination.
  - Deploy an interoperable technology solution for managing the ICP.
  - Build a mechanism for capturing, analyzing and incorporating feedback into the care coordination process.
SUMMARY

• DoD and VA leadership established IC3 to ensure that the needs of seriously wounded, ill and injured SM/Vs for complex coordination of care, benefits and services are met—One Mission—One Policy—One Plan

• Interagency Complex Care Coordination is a patient-centered, needs based model consisting of an interdisciplinary care management team led by a Lead Coordinator (a role for a member of the CMT).

• The CMT produces an Interagency Comprehensive Plan (with participation of the SM/V, if possible) to guide the treatment and recovery plan

• Care transitions require a “Warm Hand-off” between transferring and receiving CMTs

• Care coordination continues as long as needed, and in some cases for life
Questions?

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