IMPROVING TRANSITIONAL CARE POST OSSEOINTEGRATION

DEPARTMENT OF DEFENSE (DOD)/VETERANS AFFAIRS (VA)

By Dixie Johnson, MSN, RN, CRRN, CCM &
Selina Doncevic, MSN, RN, CRRN

OBJECTIVES

- ✓Comprehend the complexity of OI patient population
- ✓Realize the challenges post OI surgery
- ✓Recognize the importance of multidisciplinary care and communication between OI team and all healthcare facilities/providers
- ✓Expand awareness of VA's amputee system of care levels and VA's stance on OI surgery

WHERE CAN I GO FOR OSSEOINTEGRATION (OI)?

"Presently, OI is not a generally accepted standard of medical practice within the United States where use of these implants for the direct skeletal attachment of prosthetic limbs is still considered experimental. Consequently, OI is not a blanket covered TRICARE benefit, nor is the procedure covered by VA" (www.health.mil.EACE, 2017)

- **DoD Osseointegration Program-**WRNMMC is the only DoD facility performing osseointegration surgeries at this time
- DoD beneficiaries can receive OI (if meet criteria) under MHS research protocol or Humanitarian Device Exemptions (HUD)
- DoD beneficiaries who received OI outside the military health system(MHS) are able to be seen at MHS for follow-on care and treatment
- VA will provide follow-on care (outside of research protocols) for eligible Veterans

OI PATIENT POPULATION

- Amputee (TFA/THA) (>1 year), difficulties with socket wear
- Veterans, active duty members, dependents (DoD beneficiaries)
- Use multiple healthcare systems (DoD, VA, community)
- Scattered demographically-many from rural communities
- Psychosocial issues-family problems, PTSD, lack of support

INITIAL INTAKE

- Establish Eligibility for care
- Demographics/Job/School
- Healthcare facility/Health history/Medications/Primary Insurance
- Family dynamics-will they have a care giver?
- Why do they want OI? Goals once they have OI?
- Rehab plans
- What additional services will they need while here?

CHALLENGES POST OSSEOINTEGRATION

- Travel/lodging needs
- Loss of independence
- Lack of support
- Transient population-behavioral health and medical support not readily available (space available basis)
- Pain Management/medication management
- Durable Medical Equipment needs at WRNMMC and for home
- Coordination for transition home-where are they wanting to rehab? Are they able to provide OI rehab care? Who is paying for care?
- Increased risk for infection (lifetime)-OI skincare protocol

COORDINATION FOR COMMUNITY CARE

"A hand-off is a transfer and acceptance of patient care responsibility achieved through effective communication. It is a real-time process of passing patient-specific information from one caregiver to another, or from one team of caregivers to another for the purpose of ensuring the continuity and safety of the patient's care." (Collins, R., 12/2017)

- Identify/contact PCM/rehabilitation clinic/facility and provide effective hand-off communication, including medical records with good patient history, medications, OI protocols, and points of contact at both out-going and incoming facilities
- Determine insurance coverage for care and paperwork requirements, authorizations prior to transfer, and schedule initial appointment
- Provide patient with POC's at both facilities and if eligible, at local VAMC

COORDINATION WITHIN THE DOD

DoD Advanced Rehabilitation Center Coordinators

Military Advanced Training Center (MATC), WNMMC, Bethesda, MD

Dixie Johnson 301 400-1482, dixie.l.johnson6.civ@mail.mil

Steve Springer 301 295-8958, steven.r.springer.civ@mail.mil

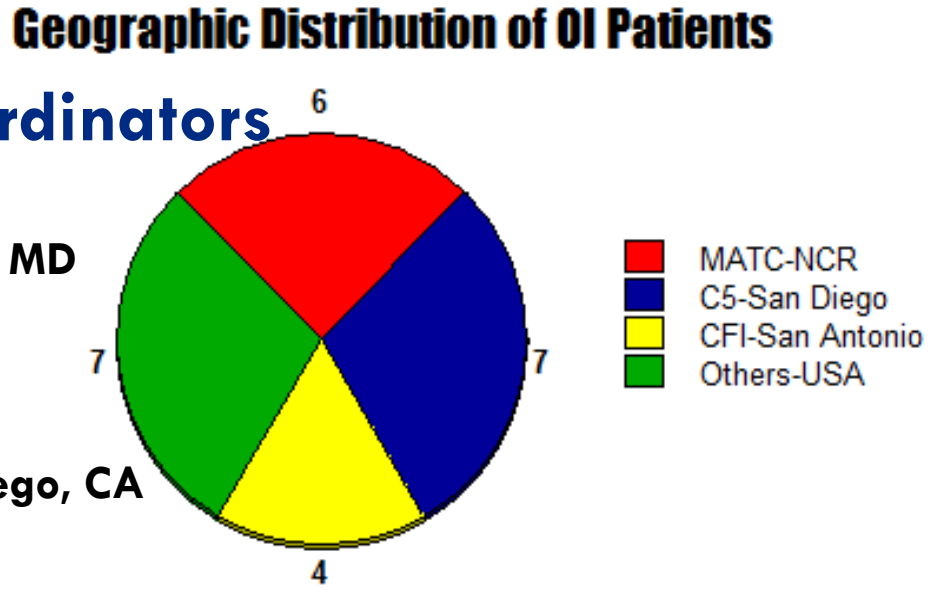
Comprehensive Combat & Complex Casualty Care (C5), San Diego, CA

Teresa Miller (619) 532-6044, teresa.t.miller2.civ@mail.mil

Angela Pugh (619) 532-7110, angela.c.pugh.civ@mail.mil

Center for the Intrepid (CFI), San Antonio, TX

Cheryl Sills (210) 916-5463, cheryl.l.sills.ctr@mail.mil



COORDINATION BETWEEN DOD AND VA CLINICIANS

- If known-directly contact VA case manager/PCM/amputee clinic for patient hand off
- If veteran is not a frequent VA healthcare consumer, contact VA amputee rehabilitation coordinator (ARC) to provide awareness of patient and ensure patient has ARC's contact information
- If having difficulty finding point of contact or in getting assistance for veteran, contact VA/DoD Polytrauma Rehabilitation Nurse Liaison: selina.doncevic@va.gov Offices at DC VA Medical Center and Walter Reed National Military Medical Center

VA/DOD POLYTRAUMA REHAB NURSE LIAISON

❖**OI is not a VA covered procedure- Must be DoD eligible beneficiary**

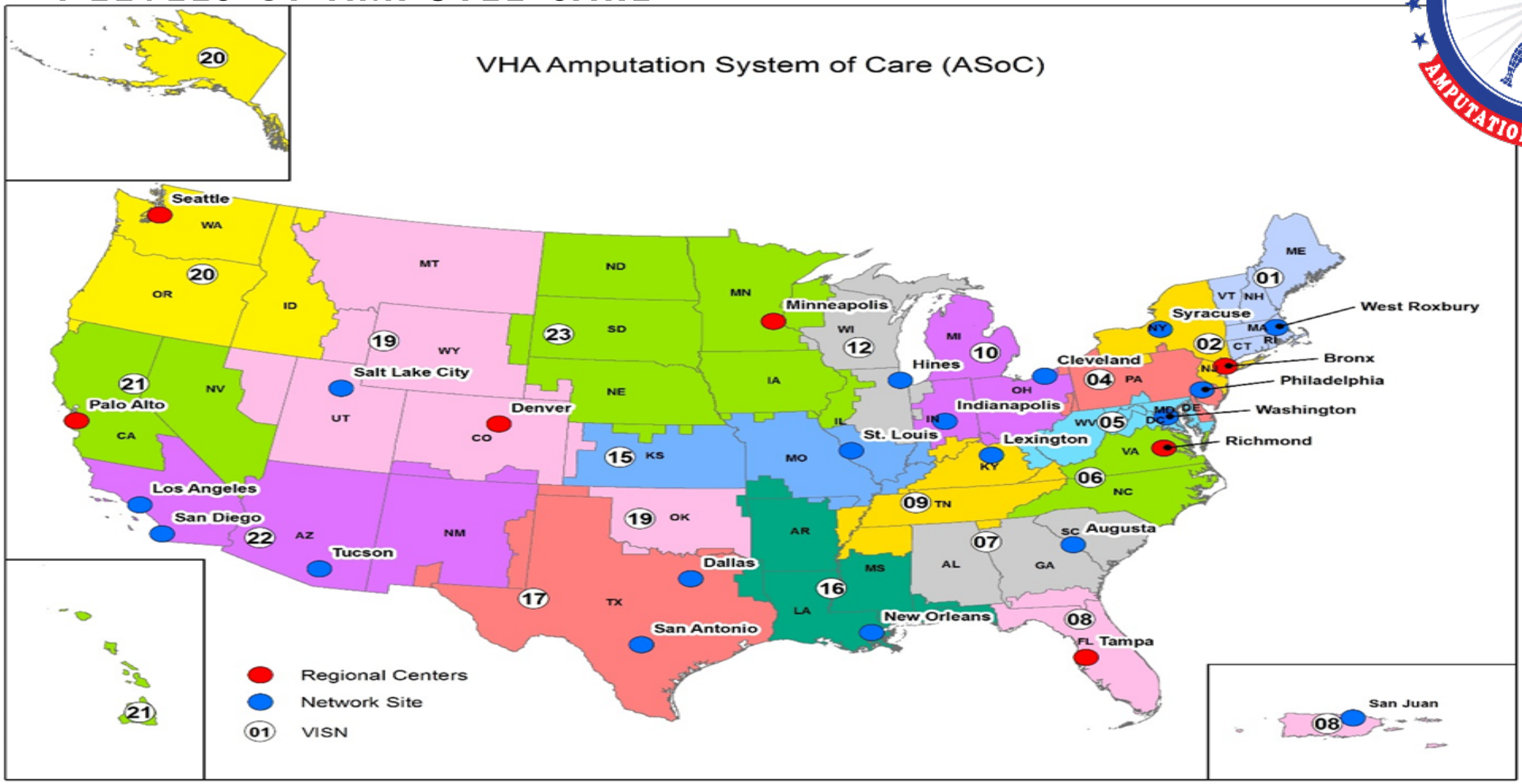
VA/DO polytrauma rehabilitation nurse liaison-

- Meets with OI Veterans as needed to assure excellent communication shared across continuum of care between DoD and VA health care systems
- Updates VA Amputee Program leadership
- Assures home VA team is tracking OI procedure (Awareness for 2 ASoC team members- ARC and local Case manager- for full visibility of care and rehabilitation needed)
- Expedites process for DME requests, VA enrollment (if not already), VA care assistance

❖**Clinical concerns should be communicated between treating VA & DoD providers**

VA AMPUTATION SYSTEM OF CARE

4 LEVELS OF AMPUTEE CARE



https://www.prosthetics.va.gov/asoc/index.asp

VA AMPUTATION SYSTEM OF CARE LEVELS

- Regional Centers I-specialized care and technology, comprehensive rehab care for complex amputees, resource for other VAMC's
- Polytrauma Network Sites (PANS) II-in/outpatient amputee care, prosthetics lab closer to Veteran's home, long term care, access to specialized services
- Amputation Clinic teams III-amputation care team, do not have full scope of amputee services
- Amputation Point of Contact IV-POC for consults and assessments, able to refer patients to facility that can provide needed services

VA REGIONAL AMPUTEE REHAB COORDINATORS

(HANDOUT AVAILABLE UPON REQUEST)

VISN	Facility	Amputation Rehabilitation Coordinator	Phone Number	Email
1	Boston	Randi Woodrow	857-364-4863	Randi.Woodrow@va.gov
2	Syracuse	Karen Hughes	315-425-4400 x52385	Karen.Hughes@va.gov
2	Bronx	Irina Agranova-Breyter	718-584-9000 x1325	Irina.Agranova-Breyster@va.gov
4	Philadelphia	Kathleen Weisbond	215-823-4341	Kathleen.Weisbond@va.gov
5	Washington DC	Lindsay Crowell	202-745-8000 x57613	Lindsay.Crowell@va.gov
6	Richmond	Patty Young**	804-675-5000 x3292	Patricia.Young8@va.gov
7	Augusta	Melanie Rahn	706-733-0188 x6982	Melanie.rahn@va.gov
8	Tampa	Marilyn Rodriguez-Perez	813-972-2000 x2355	Marilyn.Rodriguez-Perez.gov
8	Puerto Rico	Lydia Rosario	787-641-7582 x11357	Lydia.Rosario@va.gov
9	Lexington	Frank Levy	859-233-4511 x5209	Frank.Levy@va.gov
10	Cleveland	Joseph Boncser	216-791-3800 x1170	Joseph.Boncser@va.gov
11	Indianapolis	Anita Munoz-Boyle	317-988.4823	Anita.Munoz-Boyle@va.gov
12	Hines	Virgil Drumgole	708. 202-2407	Virgil.Drumgole@va.gov
15	St Louis	Nicole Bormann	314-894-6629	Nicole.Longabach@va.gov
16	New Orleans			
17	Dallas	Ronilza Tobias	214-857-2342	Ronilza.Tobias@va.gov
17	San Antonio	Arthur McField	210-617-5300 x17178	Arthur.McField2@va.gov
19	Denver	Lea Lew	303.283.5405	Lea.Lew@va.gov
19	Salt Lake City	Bart Gillespie	801.582.1565 x1424	Bart.Gillespie@va.gov
20	Seattle	Ellen Ferris	206.277.3721	Ellen.Ferris@va.gov
21	Palo Alto	Daniel McGrath	650.493.5000 x67682	Daniel.McGrath@va.gov
21	San Diego	Robert Hanly	858.642.3082	Robert.Hanly@va.gov
22	West LA	Kaye Harmston	310.478.3711 x43574	Kaye.Harmston@va.gov
22	Tucson	Timothy Cook	520.792.1450 x6522	Timothy.Cook2@va.gov
23	Minneapolis	Jessica Kiecker	612.467.1887	Jessica.Kiecker@va.gov

ADVANCES IN CARE TRANSITIONS

- Multidisciplinary Clinical teams (VA, DoD & community care) work closely together to support excellent rehabilitative transition for patients along continuum of care
- WRNMMC OI Team-weekly meetings to discuss current research protocols/updates, patient updates/concerns
- Monthly calls between DoD OI teams/amputee centers to discuss concerns and current initiatives
- Development of standardized aftercare protocols
- Weekly VA national amputee leadership calls
- Regular trainings and education in OI management care (DoD & VA)

REFERENCES

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