

The Veteran Health Administration's Response to Meeting the Unique Needs of the Returning Operation Enduring Freedom/Operation Iraqi Freedom Veteran

Introduction

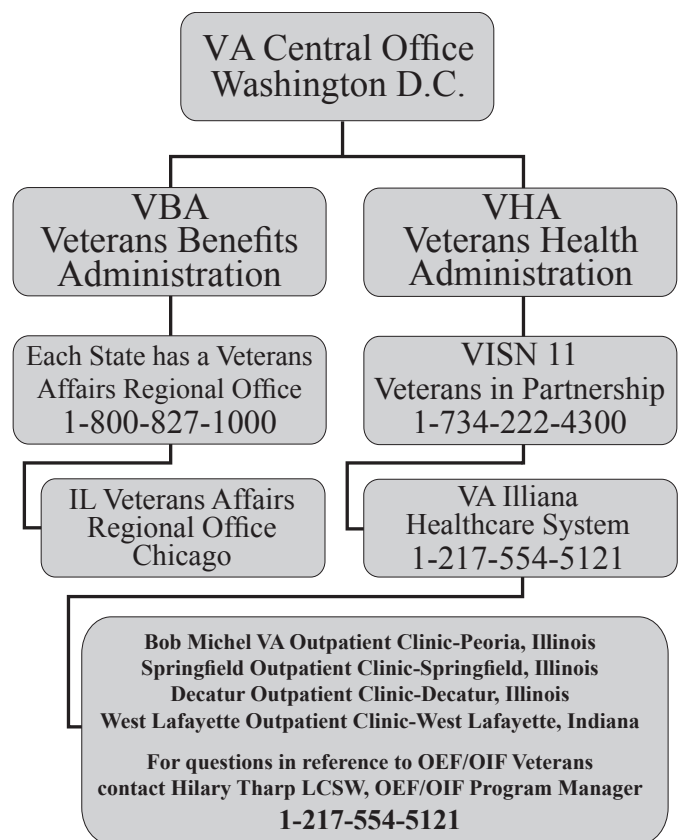
The Veterans Health Administration (VHA)* is the largest healthcare provider in the world. An organization that represents the greatest potential for providing healthcare for the 11 million veterans who served in the armed forces, the VHA provides inpatient and outpatient care between 171 medical centers, 354 outpatient clinics and 119 nursing home care units. The VHA is divided into 22 components termed Veterans Integrated Service Network (VISN). The VA Illiana Healthcare System (VAIHCS) located in Danville, IL, serves veterans from central Illinois and west central Indiana. The VAIHCS is a part of VISN 11 which serves central Illinois, Indiana and most of Michigan.^{1,2}

Local VHA Services

The VHA system faces a daunting new challenge in meeting the unique needs of the Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans. In addition to the 30,000 veterans already served, VAIHCS has developed a specialized multi-disciplinary team to manage the distinctive requirements of our newest returning veterans. The VAIHCS consists of one main campus located in Danville, IL with four community-based outpatient clinics (CBOC): Decatur, Springfield and Peoria, IL and West Lafayette, IN. (Figure 1) Inpatient services provided at the Danville campus are psychiatry, rehabilitation, palliative care, medical, surgical and long-term care. In addition, VAIHCS has a large primary care service and several subspecialty services. Tertiary services are referred to the Richard Roudebush VA Medical Center in Indianapolis, IN.

*For the reader's convenience a table of acronyms appears on page 10. (Table 4)

Figure 1.



The VHA is committed to providing efficient, high-quality care to the returning OEF/OIF veterans. As of December 2006 over one million soldiers have returned from overseas and are eligible to receive healthcare within the VHA. Nationally the VHA has already provided care for over 260,000 of them. Locally, VAIHCS has provided healthcare to over 1300 veterans who have been discharged from military service. Prevalent concerns for this new generation of veterans include psychiatric issues, traumatic brain injury (TBI), and polytrauma.²

Psychiatric Issues

It is estimated that 50% of OEF/OIF veterans will present to either a community or VA healthcare provider with one or more of the following psychiatric conditions: post traumatic stress disorder (PTSD), depression and/or substance abuse. Returning OEF/OIF veterans with a psychiatric illness withdraw from familiar relationships leading to estrangement and isolation. Even if the returning veteran is not diagnosed with psychiatric illness their character is changed from redeployment. While PTSD is defined as a complex, somatic and cognitive abnormality effecting behavior caused by psychological trauma, there are six criteria that must be present to receive a diagnosis of PTSD. (Table 1) If a veteran does not meet all of the criteria but is distressed from a traumatic event, this is termed an acute stress reaction which may later be diagnosed as PTSD. Also of significant interest to the VA is veteran suicide. The VA has responded by increasing the number of mental health professionals through the creation of a national hotline and maintaining close contact with those at greatest risk.^{4,5}

Table 1. Criteria for Diagnosing PTSD.

Subjective and Objective Components of Trauma
No experience of the trauma
Persistent avoidance of the trauma
Increased arousal
Duration of one month
Disturbance causes social and vocational impairment

Polytrauma

The VHA has defined polytrauma as two or more injuries to physical regions, or one life-threatening injury resulting in cognitive, emotional or physical distress. In March of 2003 the VHA, in collaboration with the Department of Defense (DOD), created four polytrauma rehabilitation centers with specific expertise in managing TBI.

The polytrauma rehabilitation center (PRC) closest to VAIHCS is in Minneapolis, MN. The major responsibility of the PRC is to provide comprehensive medical, surgical and restorative care to the severely injured polytrauma veteran. Once the polytrauma veteran is stabilized, care is transferred to either a polytrauma network site (PNS) or polytrauma service care teams (PSCT). Each of the 22 VISNs has one designated PNS. The PNS provides ongoing subacute care for polytrauma veterans injured during the current conflict in Afghanistan and Iraq. The designated PNS

for VISN 11 is in Indianapolis, IN. There can be several PSCTs within a VISN, which are responsible for managing stable complications resulting from the initial polytrauma incident. The VAIHCS is the PSCT for central IL.⁶

To meet the increased demand for healthcare services for this population, the VA has recruited highly trained healthcare professionals. With the addition of these professionals VAIHCS has developed a multi-disciplinary team to provide comprehensive care to OEF/OIF veterans. (Table 2) The program and case management is coordinated by the social workers who have received extensive special training to manage the unique needs of this new generation of veterans. The psychology and neuropsychology staff assesses and treats the cognitive and mental health aspects of the veteran's care. The clinical staff, which consists of an internist and physician assistant, manages the ongoing medical needs of the veteran. Rehabilitation needs are addressed in a cohesive manner by the physical, occupational, and speech therapists that assess and modify obstacles in a veteran's activity of daily living. Routine communication occurs between the PSCT at VAIHCS and the PNS. Frequent education is available to the staff from national and VISN sources. A national Web site, www.va.gov/oef-oif, has been developed and is available to disseminate needed information to veterans and families on services the VA provides.

Table 2. VA Illiana Healthcare System

Polytrauma support care team members
Program manager
Care manager
Outreach worker
Neuropsychologist
Psychologist
Speech Therapist
Occupational Therapist
Physical Therapist
Rehabilitation Specialist
Medical Specialist

Traumatic Brain Injury

Traumatic Brain Injury (TBI) has been defined as the signature wound sustained in the current conflict with Afghanistan and Iraq. Due to the advanced technology of body armor, mortality from TBI has markedly decreased. The increased survival from

this conflict has caused some mild TBI cases to be categorized as head and neck injuries. Research has demonstrated the expedient care of TBI improves overall function. Therefore maximal recovery of function has become a priority of developing VHA policy. The American Congress of Rehabilitation defines TBI as a psychological disruption of the brain caused by a traumatic event with the presence of one of the following: loss of consciousness, amnesia, and/or altered mental status on focal neurological deficit.¹⁻³

The most common mechanism of a TBI is from a blast injury. A blast wave occurs when pressure suddenly rises, having two distinct components; a shock wave of high pressure followed by a blast of wind. There are four identified levels of a blast injury, each with distinct characteristics that define it: primary, secondary, tertiary and quaternary. This represents different levels of impairment or injury as a result of the blast wave. The TBI symptoms from a blast injury affect a returning veteran's life in four ways: physically, cognitively and emotionally, and in community integration. (Table 3) The VHA developed two separate methods to screen and identify blast exposure and presence of TBI in returning OEF/OIF veterans. The initial TBI screen can be administered by a primary care provider, staff nurse or social worker who identifies whether the veteran has endured a blast exposure. Every attempt is made to administer this screen early in the veteran's management to identify and initiate prompt treatment to those afflicted. For the veterans who have a positive initial screen, a second level evaluation is offered to identify whether there is a TBI and to assess the symptoms needing treatment. This is a comprehensive history and physical exam, lasting approximately 90 minutes and focusing on the mechanism of injury. It is conducted by medical staff members who have received specialized training.^{2,3,7}

Table 3. Symptoms of TBI

Anger	Fatigue
Frustration	Sleep disorder
Depression	Seizures
Inappropriate behavior	Memory loss
Socially withdrawn	Local neurological deficits
Thought disorder	Cognition deficits
Pain	PTSD like symptoms

Seamless Transition

It is the combined goal of the VHA and DOD to efficiently transfer the medical care of the soldiers once they leave active duty. Injured soldiers evacuated from the field enter a combat hospital, then are transferred to Landstuhl Regional Medical Center in Germany. Once stabilized, injured soldiers are transferred to Walter Reed Medical Center or another appropriate DOD medical facility. From there, should ongoing inpatient care be needed, the patient is transferred to one of the PRCs within the VA system. All returning soldiers participate in the post-deployment health clinic which is a combined effort between VHA and DOD. This is the first exposure that the returning soldier has to the VA healthcare system. The post-deployment clinic was created to identify TBI, polytrauma and PTSD in veterans upon return from the theater. The VHA also works closely with the Veterans Benefit Administration (VBA) to determine eligible benefits such as compensation from disabilities encountered in the service. The VBA uses the health information found in the records from the VHA to assist in making this determination. Nationally the VHA and local VA facilities are prepared to serve our veterans as they have served our country.^{2,6}

Table 4. Acronyms

VHA	Veterans Health Administration
OEF/OIF	Operation Enduring Freedom/ Operation Iraqi Freedom
VAIHCS	Veteran Affairs Illiana Health Care System
VISN	Veterans Integrated System Network
CBOC	Community Based Outpatient Clinic
VA	Veterans Affairs
PTSD	Post Traumatic Stress Disorder
PRC	Polytrauma Rehabilitation Center
PNS	Polytrauma Network Site
PSCT	Polytrauma Support Care Team
VAMC	Veteran Affairs Medical Center
TBI	Traumatic Brain Injury
DOD	Department of Defense
VBA	Veterans Benefits Administration

Richard Jones, MS, PA-C is a physician assistant at the Illiana Veterans Healthcare System in Danville, IL.

Hillary Tharp, LCSW is the Operation Enduring Freedom/Operation Iraqi Freedom Program Manager at the Illiana Veterans Healthcare System in Danville, IL.

William Marshall, MD is a physician at the Illiana Veterans Affairs Hospital in Danville, IL and is Associate Chief of Staff for Education and Research.

Acknowledgement: The authors would like to thank Mrs. Debra Gouard and Mr. Blake Jones for their efforts in preparing this manuscript.

The opinions expressed in this manuscript are the authors and do not reflect the opinion or policies of the VA Illiana Health Care System or the VHA.

References

1. Rivers PA, Glover SH, Agho A. Emerging factors shaping the future of the Veterans Health Administration. *Health Serv Manage Res* 2002;15(1):27-39.
2. Martin Em, Lu WC, Helmick K, French L, Wanden DL. Traumatic brain injuries sustained in the Afghanistan and Iraq Wars. *Am J Nurs* 2008;108(4):40-6.
3. Wanden D. Military TBI during the Iraq and Afghanistan wars. *J Head Trauma Rehabil* 2006;21(5):398-402.
4. Doll D, Bowley DM. Veterans' health-surviving acute injuries is not enough. *Lancet* 2008;371(9618):1053-5.
5. Ciechanowski P, Keaton W. Overview of post traumatic stress disorder. Retrieved from www.uptodate.com on June 30, 2008.
6. 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 Med Rehab* 2008;89(1):160-2.
7. Lew HL, Poole JH, Guillory SB, Salerno RM, Leskin G, Sigford B. Persistent problems after traumatic brain injury: the need for long-term follow-up and coordinate care. *J Rehabil Res Dev* 2006;43(2):vii-x.