Interagency Care Coordination Committee (IC3)

Issue: Many Resources - Little Coordination

Background

Over a decade of combat has placed enormous demands on a generation of Service members, Veterans (SM/Vs), and their families – particularly our wounded, ill, and injured. These individuals require the complex coordination of medical and rehabilitation care, benefits, and other services to successfully transition from active duty to Veteran status, and to optimally recover from their illnesses or injuries. Their well-being is our highest priority and both of our Departments share this common mission. In order to meet these demands and this mission, program offices and staff in both Departments have grown exponentially. While these efforts are well-intentioned, we must now better harmonize our efforts, simplify processes, and reduce confusion for those we serve.

Identified Challenges

Reports from Government Accountability Office (GAO), Inspector General (IG), and focus groups identified several challenges with past care coordination:

- There are excellent services being provided throughout DoD and VA but in an asynchronous and uncoordinated way
- There was no common, integrated comprehensive plan for warriors in transition
    - Sub-optimal visibility of the multitude of plans
    - Sub-optimal transitions in the Continuum of Care
    - No single point of contact for the recovering Service members and families/caregivers

Solution: One Mission - One Policy - One Plan

To assess and improve Warrior care and coordination, in May 2012 VA Secretary Eric Shinseki and DoD Secretary Leon Panetta established a VA/DoD Warrior Care and Coordination Task Force. In late 2012, the Secretaries signed an intent memo to achieve: **One Mission – One Policy – One Plan**. Soon after, the Interagency Care Coordination Committee (IC3) was formed under the Joint Executive Committee (JEC). The IC3 is co-chaired by the DoD Principal Deputy Assistant Secretary of Defense for Health Affairs (PDASD) and the VA Assistant Secretary for Policy and Planning.

Goal of Interagency Care Coordination Committee

The goal of the IC3 is to streamline, synchronize, coordinate, and integrate the full spectrum of care, benefits, and services provided to Service Members and Veterans (SM/Vs) and their families as they transition between the two Departments and into the civilian community. IC3 is tasked with developing:

1. A common, interagency, overarching guidance
2. A Community of Practice (CoP), connecting the DoD and VA clinical and non-clinical case managers of recovering SM/Vs
3. A single, shared comprehensive plan for each SM/V
4. The Interagency Comprehensive Plan (ICP) information technology (IT) solution for care coordination to enable data exchange between VA and DoD care coordinators
5. The Lead Coordinator (LC) role to serve as a single point of contact for SM/Vs and their caregivers during recovery and transition between DoD and VA

The IC3 is built on the foundation of Trust, Teamwork, Adaptability, Accountability, and Outcomes-Focused; participants at every level are expected to work by these guiding principles. All DoD Services and both VA Administrations are fully represented.

COMMUNITY OF PRACTICE PROGRAMS

DoD (27)

- Air Force Clinical Case Management
- Air Force Warrior and Survivor Care
- Army Wounded Warrior (AW2) Program
- Behavioral Health System of Care
- Community Counseling and Prevention
- Computer/Electronic Accommodations Program (CAP)
- Defense and Veterans Brain Injury Center (DVBIC)
- Defense Health Agency, Clinical Support Division - Health Promotion and Disease Prevention
- Families Overcoming Under Stress (FOCUS)
- Headquarters Marine Corps (Health Services)
- inTransition
- 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
- United States Army Reserve Recovery Care Coordination
- US Marines Corps and Navy Reserves Psychological Health Outreach Program (PHOP)
- US Special Operations Command Care Coalition (USSOCOM)
- USMC Wounded Warrior Regiment
- Yellow Ribbon Reintegration Program

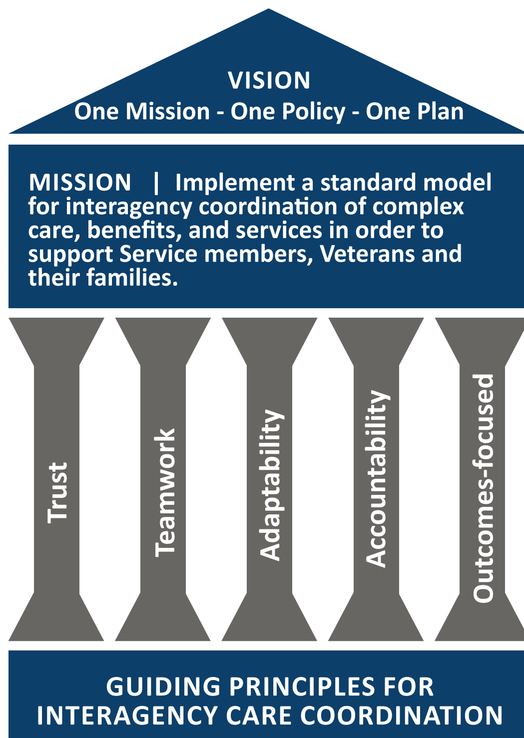
VA (26)

- Blind Rehabilitation Services - VHA
- Federal Recovery Coordination Program (FRCP)
- Mental Health Intensive Case Management Program (MHICM) – VHA
- National Call Center for Homeless Veterans (NCCHV) - VHA
- Patient Aligned Care Teams (PACT) - VHA
- Polytrauma/Traumatic Brain Injury - VHA
- Specially Adapted Housing Grants for Disabled Veterans - VBA
- Spinal Cord Injury/Disorders (SCI/D) Programs - VHA
- Transition Assistance Program - VHA
- VA Caregiver Support Program - VHA
- VA Liaison for Healthcare - VHA
- VA Life Insurance Special Outreach to Disabled Veterans - VBA
- VA National Chaplain Services
- VA Suicide Prevention Program - VHA
- VA Transition and Care Management (OEF/OIF/OND) - VHA
- VA Vet Center Program - 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

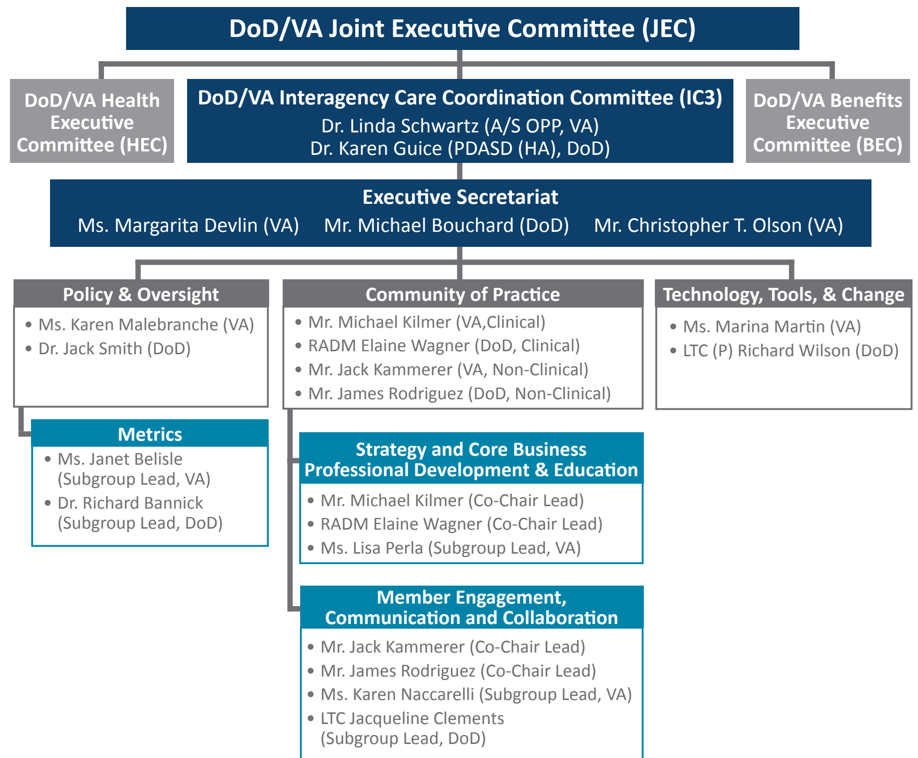
Interagency (1)

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

Pillars of Excellence



IC3 Structure



How IC3 is Improving Care Coordination

	ACCOMPLISHMENTS	NEXT STEPS
Community of Practice (CoP): Strengthen care community across DoD and VA; increase awareness of resources	• Established and facilitated the national CoP for care coordinators, case managers, and other providers from 50+ DoD/VA Wounded Warrior care programs • Designed, built, and launched the IC3 “Co-Lab” website for care coordinators to learn more about each other’s programs, find each other, work collaboratively, and share best practices • Creation and implementation of an overarching IC3 communications plan	• Expand CoP membership and engagement • Continue to develop and implement tools to meet the needs of care coordinators
Lead Coordinator (LC): Designated care management team member serves as SM/V’s primary POC	• Created the LC concept • Completed the LC implementation feasibility assessment • Developed the LC Checklist to facilitate transfer of clients	• Implement national LC roll out • Fully implement the LC checklist • Socialization of the master paper ICP document, and prepare for the LCs to use the electronic ICP
Electronic Interagency Comprehensive Plan (ICP): Interoperability to track SM/V’s care	• Developed the requirements to build online capability for DoD and VA care coordinators to track all care, benefits, and services associated with a SM/V’s recovery, rehabilitation, and reintegration	• Develop a DoD and VA electronic ICP interoperable solution
Policy and Oversight: Updating & synchronizing all DoD and VA policies to direct implementation of new complex care coordination processes across all wounded warrior programs	• On July 29, 2014, DepSecVA and DoD OSD (P&R), signed IC3 MOU between VA and DoD • Identified 250+ DoD and VA policies; conducted impact analysis of existing policies and identified priority areas for modification, sunset, or creation • Signed DoD Instruction and VA Directive which provides the overarching policy on complex care coordination as outlined in the MOU	• Align existing policies with MOU and begin to create new, cascading policies
Measuring IC3 Performance: Show IC3 progress, improvements in complex care coordination and improved outcomes	• Created near and long-term performance metrics to show progress of interagency care coordination	• Implement IC3 performance management process • Share metrics and results with leaders and stakeholders, and use to continuously improve processes

IC3 Videos

The IC3 Community of Practice: http://bit.ly/1fu2YZF | Lead Coordinator Success Story: http://bit.ly/1N1ActT

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