

FUNCTIONAL CHART - GERIATRICS & EXTENDED CARE SERVICE LINE VA MEDICAL CENTER WHITE RIVER JUNCTION, VERMONT

Operation Enduring Freedom Operation Iraqi Freedom Operation New Dawn

Establish procedures in the transition of care, coordination of services, care and case management of OIF/OEF active duty service members and veterans. Develop partnership between VA and DoD to seamlessly transition health care of injured and ill returning combat service members from DoD to VA health care system.

Office of Local Service Line Manager Geriatrics & Extended Care (GEC)

Responsible for all strategic aspects of the GEC Service Line to include budget, personnel, workload, space, equipment, communication, program oversight, planning & business integrity

Administrative Officer

Responsible for all administrative operational aspects of the GEC Service Line, its personnel, fiscal accountability and programs

Home Based Primary Care (HBPC)

Provision of in home primary care by a team of VA clinicians and support staff to meet the needs of aging veterans who have chronic disabling conditions. Services are provided within a 30-40 mile radius of the Medical Center and its CBOC's. The team also coordinates sub specialty care, while supporting and teaching home caregivers care for the patient.

Community Contract Nursing Home Care (CNH)

VA contract approved community nursing facilities provide appropriate skilled care/rehab services to eligible veterans. Follow-up care is provided to all patients monthly "on site" by a VA nurse or Social Worker. Nurse and Social Worker to provide the following functions: serve as concerned consumers for VA; liaison between facility and VA; consultant to facility on patient care matters; advocate for patient and family; and lastly as the VA's "eyes and ears" in community concerning VA and other health care matters.

Contract Adult Day Healthcare (CADHC)

VA contract approved community facilities provide medical/nursing/rehab adult day health care services. Veterans live at home or in a community setting; receive round trip transport to the facility; participate in supervised activities; receive rehab and/or skilled nursing care services; receive appropriate medical oversight and receive a hot lunch. Veteran caregivers are integrated into the CADHC activities/care plans to assure continuity of care and to allow them respite from their patient. VA staff provides "on site" follow-up quarterly to all patients in CADHC.

Community Home Health Care (CHHC)

Eligible veteran patients are referred to community Visiting Nurse Agencies (VNA). VNA's provide assessment of skilled home nursing care needs, case management and monitoring of delivered services. Services provided include: skilled nursing care, PT/OT, speech therapy, social work, bowel & bladder care, home health aide and homemaker services. Socialization is also included using trained community volunteers via the "Friendly Visitors" program.

**Tele-health
Coordination**
Coordination of healthcare service for patients located at distances from the Medical Center or its CBOC's. Patients access services via use of health technology devices that include:

- Home Telehealth
- Clinical Video Telehealth
- Store Forward
Use of the devices allows patients to receive healthcare closer to where they live, allows access to specialty care and obviates the need for patients to travel great distances to the Medical Center to be seen by clinicians.

Respite Care

Veteran patients are placed into various settings for up to 30 days/yr to allow caregivers a break from the daily grind of caring for their chronically ill or debilitated veteran.

Hospice & Palliative Care Services (HPC)

Veterans eligible for hospital services and suffering from a terminal or advanced illness are eligible for HPC services. The goal of this care is to provide a planned and collaborative interdisciplinary approach to the care of patients and their families. Functions include: consult service comprised of physicians, nurses, case managers, social workers and chaplains to address symptom management, patient/family education about HPC, advanced directives, care coordination, collaboration with community providers, bereavement care and referral for patients and families. Support is also provided to health care personnel caring for this patient population.

State Veteran Home Oversight

Medical Center staff provides annual and ongoing oversight to the local State Veterans Home in Bennington, Vermont. The facility participates in the VA's National State Home program. A VA multi-disciplinary team inspects the facility on an annual basis. The team utilizes a standardized VA inspection tool to monitor patient care and life safety code issues at the facility. Areas found to be deficient require specific Plans of Correction with definitive time lines for accomplishment. Inspection results are shared with local management. VA Central Office and the State of Vermont.

Veteran's Independence Program (VIP)

A Veteran (participant) directed program designed to keep eligible Veterans in their own homes. The program is operationalized by the Vermont Association of Area Agencies on Aging, with funding from the VHA. The Veteran employer, with assistance from an AAA Care Advisor receives a need-based monthly budget amount and creates a service plan. Veteran hires service providers to perform the needed tasks and services listed in the Veteran's created service plan. Ongoing support and monitoring is available from the AAA Care Advisor.

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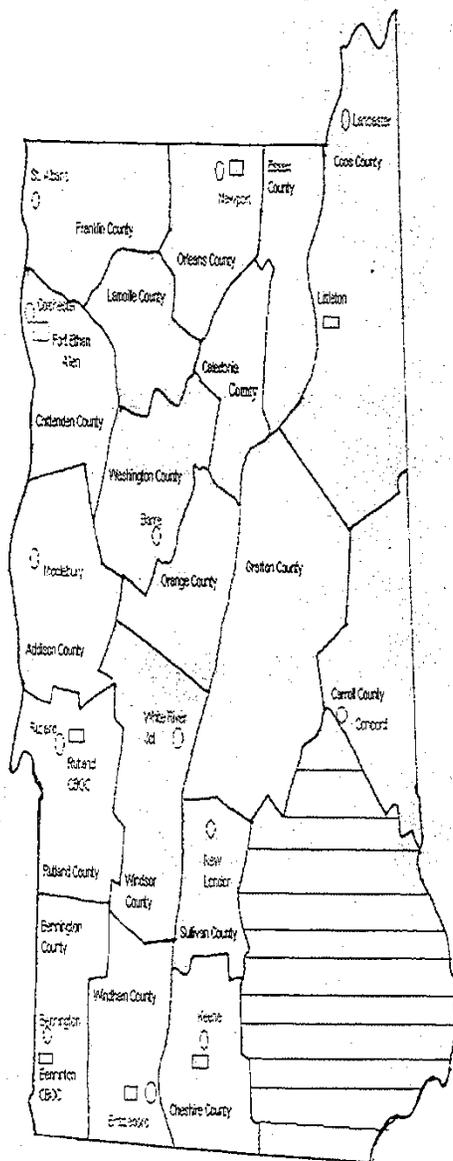
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