

## POLYTRAUMA SYSTEM OF CARE

**1. REASON FOR ISSUE:** This Veterans Health Administration (VHA) directive defines policy, staffing requirements, and procedures for the operation of the Polytrauma System of Care (PSC).

**2. SUMMARY OF CHANGES:** This is a new VHA directive which:

- a. Replaces VHA Handbook 1172.01, Polytrauma System of Care, dated March 20, 2013.
- b. Updates the policy statement.
- c. Updates roles and responsibilities in the operations of the PSC.
- d. Updates the required core staffing models for the polytrauma interdisciplinary rehabilitation teams.

**3. RELATED ISSUES:** VHA Directive 1184, Screening and Evaluation of Traumatic Brain Injury in Operation Enduring Freedom (OEF), Operation IRAQI Freedom (OIF), and Operation New Dawn (OND) Veterans, dated April 6, 2017.

**4. RESPONSIBLE OFFICE:** The Deputy Chief Patient Care Services Officer for Rehabilitation and Prosthetic Services (10P4R) is responsible for the contents of this VHA directive. Questions may be referred to the National Director, Physical Medicine and Rehabilitation Service (PM&RS), [Joel.Scholten@va.gov](mailto:Joel.Scholten@va.gov) or at 202-461-7444.

**5. RECISSIONS:** VHA Handbook 1172.01, Polytrauma System of Care, dated March 20, 2013.

**6. RECERTIFICATION:** This VHA directive is scheduled for recertification on, or before, the last working day of January 2024. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

/s/ Lucille B. Beck, PhD.  
Deputy Under Secretary for Health for Policy  
and Services

**NOTE:** All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.

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## POLYTRAUMA SYSTEM OF CARE

### 1. PURPOSE

This Veterans Health Administration (VHA) directive establishes policy for the operation of the Polytrauma System of Care (PSC) organized under Physical Medicine and Rehabilitation Service (PM&RS) Program Office within VHA's Office of Rehabilitation and Prosthetic Services. **AUTHORITY:** Title 38 United States Code (U.S.C.) 1710C, 1710D, 1710E, 7327, 8111, 8153.

### 2. BACKGROUND

a. VHA's PSC is a nationwide integrated network of 124 specialized programs for the treatment and rehabilitation of Veterans and Servicemembers with polytrauma and traumatic brain injury (TBI). VHA has a long and distinguished tradition of providing rehabilitation care for Veterans with disabilities. Yet, the complex medical, rehabilitation, and psychosocial needs of a new generation of Veterans and Servicemembers with combat and non-combat associated injuries from Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) brought to the forefront the need for a continuum of integrated specialized clinical and support services.

b. Title 38 U.S.C. 7327, Centers for research, education, and clinical activities on complex multi-trauma, led to the establishment of VHA's PSC beginning in 2005. Since then, PSC has grown through a coordinated effort to improve clinical care, clinician education and training, research, and collaborations with the Department of Defense, academic partners and private industry. As with other health conditions frequently occurring in Veterans, VA is leading the way in studying, developing, and implementing real-world solutions that benefit Veterans with TBI and polytrauma today and in the future.

### 3. DEFINITIONS

a. **Polytrauma.** Polytrauma is defined as two or more injuries sustained in the same incident, one of which may be life threatening, which affect multiple body parts and organ systems and result in physical, cognitive, emotional, and behavioral impairments and functional disabilities. TBI frequently occurs in polytrauma in combination with other disabling conditions, such as: traumatic amputations, open wounds, musculoskeletal injuries, burns, pain, auditory and visual impairments, post-traumatic stress disorder (PTSD), and other mental health problems. When present, injury to the brain often leads the course of rehabilitation due to the complexity of the related cognitive, emotional, and behavioral deficits.

b. **Traumatic Brain Injury.**

(1) Traumatic Brain Injury (TBI) is defined as a traumatically induced structural injury and/or physiological disruption of brain function as a result of an external force and is

indicated by new onset or worsening of at least one of the following clinical signs immediately following the event.

- (a) Any period of loss of or a decreased level of, consciousness;
- (b) Any loss of memory for events immediately before or after the injury (post-traumatic amnesia);
- (c) Any alteration of mental state at the time of the injury (for example, confusion, disorientation, slowed thinking, alteration of consciousness/mental state);
- (d) Neurological deficits (for example, weakness, loss of balance, change in vision, praxis, paresis/plegia, sensory loss, aphasia) that may or may not be transient; and
- (e) Intracranial lesion.

(2) The above criteria define the event of TBI. Not all individuals exposed to an external force to the head will sustain a TBI, but any person who has a history of such an event with immediate manifestations of any of the above signs and symptoms can be said to have had a TBI.

(3) TBI severity is divided into mild, moderate, and severe, based on the length of Loss of Consciousness (LOC) or Alteration of Consciousness (AOC), duration of Post Traumatic Amnesia (PTA), and the Glasgow Coma Scale (GCS) results. The majority of TBIs are mild (mTBI), also known as concussion. All penetrating brain injuries are considered severe (see appendix A: Classification of TBI Severity).

c. **Blast Injuries.** Exposure to blasts or explosions is a frequent cause of combat injuries and polytrauma. The mechanisms of blasts that contribute to injuries are the over-pressurization wave, the impact of blast-energized debris, being physically thrown into environmental hazards, and inhalation of gases and vapors.

#### **4. POLYTRAUMA SYSTEM OF CARE**

a. VHA's PSC delivers world-class medical and rehabilitation services for Veterans and Servicemembers with TBI and associated polytrauma. Through this program, VHA continues to advance the diagnosis, evaluation, treatment, and understanding of TBI in a variety of ways, including but not limited to:

- (1) Establishing standardized diagnostic and assessment protocols;
- (2) Developing and implementing best clinical practices for care;
- (3) Educating and training clinicians in TBI-related care and rehabilitation;
- (4) Collaborating with strategic partners; and

(5) Conducting, interpreting, and translating research findings into improved patient care and caregiver support.

b. PSC balances access and expertise to provide specialized polytrauma and TBI care at locations across VA medical centers. Services are organized into four levels of care spanning from regional referral centers, to network sites, to local VA medical facilities (see paragraphs 10.g. and 10.h. for PSC program descriptions, locations, and designations:

<http://vaww.vssc.med.va.gov/ClinicalInventory/FacilitySearch/FacilitySearch.aspx>).

(1) **Polytrauma Rehabilitation Center (PRC).** PSC has five PRCs located at the Hunter Holmes McGuire Hospital in Richmond, VA; James A. Haley Veterans' Hospital in Tampa, FL; Audie L. Murphy Memorial Veterans' Hospital in San Antonio, TX; Palo Alto VA Medical Centre in Palo Alto, CA; and Minneapolis VA Medical Center in Minneapolis, MN. The PRCs serve as regional referral centers for comprehensive acute inpatient rehabilitation. A dedicated staff of specialized rehabilitation professionals and consultants is available to address complex and severe TBI and associated polytrauma. The PRCs function as resources for consultations and care coordination in their regions. Their staff participates in the development of clinical guidance and best practices, and integration of research activity and findings into the care system through education and training. The PRCs are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) using Brain Injury Specialty standards (see paragraphs 7.f. (3) and 10.j.).

(2) **Polytrauma Network Site (PNS).** One or two PNSs are distributed in each Veterans Integrated Service Networks (VISN). Rehabilitation care at the PNSs focuses on outpatient services, but inpatient bed units are also available to address post-acute and chronic complications. PNSs maintain a full complement of rehabilitation professionals on staff to address complex TBI and polytrauma-related symptoms and functional deficits. PNS staff provide clinical oversight of the PSC programs within their VISN including care coordination, managing referrals and consultations, and advising on the collection and reporting of data (see paragraphs 7.g. and 7.h.). The inpatient rehabilitation bed units at the PNSs maintain CARF accreditation for Comprehensive Integrated Inpatient Rehabilitation (see paragraphs 7.f.(3) and 10.j.).

(3) **Polytrauma Support Clinic Team (PSCT).** The PSCTs provide outpatient interdisciplinary rehabilitation services that include comprehensive evaluations and development of individualized rehabilitation plans of care.

(4) **Polytrauma Point of Contact (PPOC).** The PPOCs deliver a more limited range of outpatient rehabilitation services for TBI and polytrauma-related problems. For clinical cases that exceed local expertise, the PPOC works with the PNS in their VISN for consultations and service delivery using telehealth solutions.

c. **Polytrauma Transitional Rehabilitation Program (PTRP).** Five residential PTRPs are currently in operation at the PRCs. PTRPs provide inpatient rehabilitation services in a residential type environment for individuals who benefit from physical,

cognitive, communicative, behavioral, and psychosocial therapies to facilitate return to home, school, work, or military service after significant injury or illness. Therapy services are provided by interdisciplinary teams of rehabilitation specialists using a combination of group and individual formats. Services address a broad range of vocational, leisure, and spiritual needs with focus on community reintegration goals. Family and caregiver are encouraged to participate in all phases of the rehabilitation process whenever appropriate and practicable. The PTRPs are CARF accredited for residential rehabilitation with brain injury specialty programming.

d. **Emerging Consciousness (EC) Program.** Nationally-recognized rehabilitation specialists from VA developed the EC program in collaboration with experts from the academic community and the private sector. The EC program is a highly-specialized protocol for the rehabilitation of the Veterans and Servicemembers who are slow to recover consciousness after severe injuries. The goal of the program is to deliver the right balance of medical and therapeutic interventions to improve responsiveness and return to consciousness, to minimize complications, and to facilitate progress towards the next level of rehabilitation care. The EC Program is part of the continuum of rehabilitation services offered at the 5 PRCs.

e. **Assistive Technology (AT) Lab.** The AT Labs at the 5 PRCs provide services directly to Veterans and Servicemembers and serve as expert resources to support the application of AT across VHA. The AT Labs are responsible for evaluation, development, and implementation of appropriate AT services, strategies, devices, and/or practices to improve the functional challenges faced by Veterans and Servicemembers in their daily life roles. Types of devices prescribed may include adapted automotive equipment, adapted sports and recreation equipment, aids for daily living, wheelchairs, and communication aids. When necessary, the AT specialists have the skills and equipment to modify or design devices that serve specific needs of Veterans. The AT teams include rehabilitation engineers and other rehabilitation providers with specialized AT expertise.

## 5. POPULATION SERVED

a. VHA's PSC provides a full range of rehabilitation services for eligible Veterans, and Active Duty Servicemembers covered by Defense Health Agency Great Lakes (DHA-GL) or TRICARE authorization, who sustained polytrauma and TBI. This includes persons with:

(1) TBI (whether deployment related or not);

(2) Blast and non-blast related traumatic injuries including but not limited to amputations, musculoskeletal injuries, open wounds;

(3) Other acquired brain injuries including, but not limited to, stroke, brain tumors, infection, poisoning, hypoxia, ischemia, encephalopathy, or substance abuse, as appropriate for specific cases;

(4) Physical, cognitive, emotional, and behavioral impairments related to the brain injury;

(5) Impairments that are clinically and functionally significant and lead to activity and participation restrictions; and

(6) Potential to benefit from the specialized rehabilitation services provided by the PSC.

## 6. POLICY

It is VHA policy that eligible Veterans and Servicemembers with TBI and polytrauma have access to all medical and rehabilitation services provided through the Polytrauma System of Care as clinically indicated.

## 7. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring VHA compliance with this directive.

b. **Deputy Under Secretary for Health for Operations and Management.** The Deputy Under Secretary of Health for Operations and Management is responsible for:

(1) Communicating the contents of this directive to each of the VISN Directors.

(2) Ensuring that each VISN Director has the resources required to support the fulfillment of the terms of this directive in all VA medical facilities with PSC programs within that VISN.

(3) Providing oversight of VISNs to assure compliance with this directive.

c. **Deputy Chief Patient Care Services Officer for Rehabilitation and Prosthetic Services.** The Deputy Chief Patient Care Services Officer for Rehabilitation and Prosthetic Services is responsible for:

(1) Ensuring support and resources for successful implementation of the PSC consistent with this directive.

(2) Reviewing proposed changes to PSC with the National Director, PM&RS, and approving proposed changes.

(3) Communicating programmatic changes to PSC to the Deputy Under Secretary for Health for Policy and Services.

d. **National Director, Physical Medicine and Rehabilitation Service.** The National Director, Physical Medicine & Rehabilitation Service, is responsible for;

(1) Ensuring development and maintenance of policy and the rehabilitation standards of care for PSC (see appendix B).



(2) Providing operational consultation and policy guidance to VISNs and VA medical facilities for the development and operation of PSC services.

(3) Developing program evaluation procedures and monitoring performance on a quarterly basis in collaboration with VISN and medical center leadership. Priority performance metrics are consolidated into a dashboard (see appendices G and H).

(a) Reviewing all PSC program change requests and providing consultation and recommendations to program, VA medical facility, VISN, and VHA leadership.

(b) Responding to inquiries from internal and external stakeholders about PSC operations and services.

e. **Veterans Integrated Service Network (VISN) Director.** Each VISN Director is responsible for:

(1) Ensuring that PSC services are accessible to eligible Veterans and Active Duty Servicemembers covered by DHA-GL or TRICARE authorization. The entire continuum of care and clinical services may not be present in a single VA medical facility, but must be available to all Veterans treated within a VISN. **NOTE:** *Some components of the continuum may be provided in coordination with neighboring VISNs.*

(2) Ensuring that programs are operated in compliance with this VHA directive.

(3) Ensuring appropriate staffing levels according to appendices C, D, E, and F.

f. **VA Medical Facility Director.** Each VA medical facility Director is responsible for:

(1) Ensuring that VA medical facilities have the necessary staff and resources to support specialized PSC program operations (see appendices C, D, E, and F for the Required Core Staffing for the PSC components).

(2) Providing and maintaining oversight of the PSC program(s) within their respective VA medical facility to ensure access, quality services, and compliance with this VHA policy.

(3) Ensuring that PRC and PNS programs achieve and maintain CARF accreditation under standards appropriate for the level and types of care provided.

(4) Providing safe, well-maintained, and appropriately-furnished facilities that support and enhance the recovery efforts of Veterans being treated for polytrauma and TBI.

(5) Ensuring the timely completion of all mandated reporting, monitoring, and other requirements of the PSC programs as communicated to facilities and network directors through the office of the Deputy Under Secretary for Health for Operations and Management.

g. **PSC Program Medical Director.** Each PSC Program Medical Director is responsible for:

(1) Serving as clinical leader for TBI and polytrauma rehabilitation care and functioning as the subject matter expert at the regional (PRC and PTRP Medical Directors), VISN (PNS Medical Director) and local facility levels (PSCT Medical Director).

(2) Collaborating with other VA, governmental, state, academic and private entities within the region, VISN, and facility, to ensure that appropriate services are available for Veterans and Servicemembers with TBI and polytrauma.

(3) Ensuring the implementation of the rehabilitation standards of care throughout the PSC program under their leadership.

(4) Working with case managers to optimize care coordination within the region (PRC and PTRP Medical Directors) and VISN (PNS Medical Director).

(5) Collaborating with the case manager to develop and implement the Interdisciplinary Rehabilitation and Community Reintegration (IRCR) plan of care (see appendix B, paragraph e.).

(6) Ensuring that care is provided in a timely, effective, and efficient manner.

(7) Establishing local procedures for monitoring and evaluating the effectiveness of polytrauma rehabilitation services, which are congruent with national guidance on program evaluation.

(8) Communicating to upper-level management the resource needs to accomplish the polytrauma program's mission, using policies and evidence-based data to justify requests.

h. **PSC Program Manager.** Each PSC Program Manager is responsible for:

(1) Acting as the point of contact for information about the PSC and rehabilitation care for their region (PRC Program Manager), VISN (PNS Program Manager), and facility (PSCT Program Manager).

(2) Educating Veterans, family members, referral sources and external payers regarding the effective and efficient utilization of PSC program services and available resources.

(3) In collaboration with the VA medical facility Director, overseeing data management including data input and tracking of local and national performance measures (see appendices G and H).

(4) Completing all mandated reporting, monitoring, evaluation, and accreditation requirements relevant to the local and outreach polytrauma programs (see appendices G and H).

(5) Coordinating periodic communication and maintaining a contact list with other PSC programs in their VISNs (PNS Program Manager), and region (PRC and PTRP Program Managers) to review TBI rehabilitation related practices, and requirements.

(6) Ensuring that polytrauma health care professionals receive TBI specific training and function at the highest level of their competency (see paragraph 8).

i. **Polytrauma Case Manager.** The polytrauma case manager is responsible for:

(1) Serving as the Lead Case Manager for Veterans and Servicemembers receiving rehabilitation services in one of the PSC programs (see VHA Directive 1010, Transition and Care Management of Ill or Injured Servicemembers and new Veterans, dated November 21, 2016).

(2) Acting as the conduit between the Veteran and their family, and the interdisciplinary team (IDT) for communication and care coordination (see appendix B, paragraph b. for the definition of IDT).

(3) Ensuring that Veterans' and their family's goals and preferences are included in the IRCR plan of care and that the plan is communicated to the patient.

(4) Ensuring smooth transition between components of the PSC, between VA and DoD, and between hospital and home environment.

(5) Coordinating follow up care with the IDT to meet the needs of the Veteran, Servicemember, and their family.

## **8. TRAINING REQUIREMENTS**

a. Rehabilitation professionals working in PSC programs have specialized skills and knowledge, based on their education, clinical training, and experience. These are necessary to address the complex needs of individuals with polytrauma and TBI. VHA has invested significant resources to support educational development of current and future potential staff in the PSC. Specialized skills and knowledge must be reflected through one or more of the following:

(1) Functional Statement or Position Description;

(2) certifications;

(3) Continuing education records;

(4) Competencies;

- (5) Orientation training; and
- (6) Scope or standards of practice.

b. All clinicians performing TBI screening, evaluation and treatment are required to complete the "VHI: TBI web course," VA TMS item #VA 5377, within 90 days of employment. **NOTE:** *This is an internal VA Web site that is not available to the public.*

## 9. RECORDS MANAGEMENT

All records regardless of format (paper, electronic, electronic systems) created by this directive shall be managed per the National Archives and Records Administration (NARA) approved records schedules found in VA Records Control Schedule 10-1. If you have any questions regarding any aspect of records management you should contact your facility Records Manager or your Records Liaison.

## 10. REFERENCES

- a. VHA Directive 1010, Transition and Care Management of Ill or Injured Servicemembers and New Veterans, dated November 21, 2016.
- b. VHA Directive 1160.03. Programs for Veterans with Post-Traumatic Stress Disorder, dated November 16, 2017.
- c. VHA Directive 1184, Screening and Evaluation of Traumatic Brain Injury (TBI) in Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) Veterans, dated April 6, 2017.
- d. VHA Directive 1351, Staffing Methodology for VHA Nursing Personnel, dated December 20, 2017.
- e. Commission on Accreditation of Rehabilitation Facilities (CARF) <http://vaww.ogsv.med.va.gov/functions/integrity/accred/carf.aspx>. **NOTE:** *This is an internal VA Web site that is not available to the public.*
- f. Commission on Accreditation of Rehabilitation Facilities (CARF) using Brain Injury Specialty standards. Available at <http://www.carf.org/Programs/Medical/>
- g. Health Information Management, Office of Information Governance, Fact Sheet: Coding Guidance for Traumatic Brain Injury (TBI), May 2017. Available at [https://vaww.vha.vaco.portal.va.gov/sites/HDI/HIM/vaco\\_HIM/subsite5/subsite3/Practice%20Briefs%20and%20Fact%20Sheets/2017\\_0501\\_FactSheet\\_TBI%20Coding.docx](https://vaww.vha.vaco.portal.va.gov/sites/HDI/HIM/vaco_HIM/subsite5/subsite3/Practice%20Briefs%20and%20Fact%20Sheets/2017_0501_FactSheet_TBI%20Coding.docx). **NOTE:** *This is an internal VA Web site that is not available to the public.*
- h. Malec, J. (2005). The Mayo-Portland Adaptability Inventory. *The Center for Outcome Measurement in Brain Injury*. Available at: <http://tbims.org/combi/mpai>

i. Memorandum of Agreement between Department of Veterans Affairs and Department of Defense for Medical Treatment Provided to Active Duty Servicemembers with Spinal Cord Injury, Traumatic Brain Injury, Blindness or Polytraumatic Injuries available at:

<http://vaww.dodcoordination.va.gov/docs/MOAMOUspinalCordInjuryTraumaticBrainInjury2.pdf>. **NOTE:** *This is an internal VA Web site that is not available to the public.*

j. VA/DoD Clinical Practice Guideline for Management of Concussion/mTBI, 2016. Available at:

<https://www.healthquality.va.gov/guidelines/Rehab/mtbi/mTBICPGFullCPG50821816.pdf>

k. VA Polytrauma/TBI System of Care. Available at: <https://www.polytrauma.va.gov/>

l. VA Polytrauma System of Care locations and designation. Available at: <http://vaww.vssc.med.va.gov/ClinicalInventory/FacilitySearch/FacilitySearch.aspx> (Check Rehabilitation Services> Program Details>Choose the desired PSC level of program, i.e., PRC, PTRP, PNS, PSCT, PPOC). **NOTE:** *This is an internal VA Web site that is not available to the public.*

m. Veterans Health Initiative: Traumatic Brain Injury Web Course. VA 53377, available at: <https://www.tms.va.gov/SecureAuth35/>. **NOTE:** *This is an internal VA Web site that is not available to the public.*

## CLASSIFICATION OF TBI SEVERITY

If a patient meets criteria in more than one category of severity, the higher severity level is assigned.

All penetrating brain injuries are considered severe.

Criteria	Mild	Moderate	Severe
Structural imaging	Normal	Normal or abnormal	Normal or abnormal
Loss of Consciousness (LOC)	0-30 minutes	>30 min and <24 hours	>24 hours
Alteration of consciousness/mental state (AOC)*	up to 24 hours	>24 hours; severity based on other criteria	>24 hours; severity based on other criteria
Posttraumatic amnesia (PTA)	0-1 days	>1 and <7 days	>7 days
Glasgow Coma Scale (GCS) (best available score in first 24 hours)	13-15	9-12	<9

\*Alteration of mental status must be immediately related to the trauma to the head.

**NOTE:** Typical symptoms would be looking and feeling dazed and uncertain of what is happening, confusion and difficulty thinking clearly or responding appropriately to mental status questions, and being able to describe events immediately before or after the trauma event (see VA/DoD Clinical Practice Guideline for Management of Concussion/mTBI, 2016. Available at: <https://www.healthquality.va.gov/guidelines/Rehab/mtbi/mTBICPGFullCPG50821816.pdf>).

**REHABILITATION STANDARDS IN THE POLYTRAUMA SYSTEM OF CARE**

a. Rehabilitation for Veterans and Servicemembers with polytrauma and TBI is individualized, comprehensive and interdisciplinary, and is directed towards optimizing activity participation, functional independence, and community reintegration.

b. The Interdisciplinary Team (IDT) is the hallmark of rehabilitation care in PSC. Due to the frequency of physical, behavioral, and psychosocial problems associated with TBI and polytrauma, rehabilitation care is optimally delivered by dedicated IDTs. Rehabilitation specialists and medical consultants collaborate in the assessment, planning, and implementation of the plan of care for each patient served in the PSC. Regular communication among team members ensures integration of treatments to achieve patient goals. The IDT for each patient is determined by their rehabilitation and medical needs.

c. The Veteran, Servicemember, and their family are integral members of the rehabilitation team. They participate in all aspects of the rehabilitation process to the maximum extent practicable including evaluation, development, and implementation of the plan of care, and transition to another level of care and to community.

d. **Comprehensive Assessment.** Assessment is a dynamic process that is conducted at intake into rehabilitation and repeated, as necessary, throughout treatment. The initial assessment leading to a diagnostic decision is conducted by a medical provider with specialized TBI training and skills such as physiatrist, neurologist, or neuropsychiatrist. Other members of the IDT participate in the comprehensive evaluation to address physical, cognitive, emotional, environmental, and psychosocial factors relevant for rehabilitation. The comprehensive evaluation forms the foundation for the individualized plan of care and treatment approach for each patient. **NOTE:** *VHA Directive 1184, Screening and Evaluation of Traumatic Brain Injury (TBI) in Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) Veterans, dated April 6, 2017, mandates procedures for the Comprehensive TBI Evaluation of deployment related injuries.*

e. **Individualized Rehabilitation and Community Reintegration (IRCR) Plan of Care.** PSC programs develop IRCR plans of care for every Veteran and Servicemember who receives inpatient or outpatient rehabilitation services in accordance with the requirements of Title 38 U.S.C. 1710C – “Traumatic brain injury: plans for rehabilitation and reintegration into community.” The Veteran, Servicemember and their family or caregiver collaborate in the development of the plan of care. The IRCR plan of care follows from the comprehensive assessment and addresses the following elements: rehabilitation goals, access to care, treatments, timing of the periodic reviews and supports necessary to achieve rehabilitation goals.

f. **Treatment.** A spectrum of treatment options based on the VA/DoD Clinical Practice Guidelines is available for Veterans with TBI in all PSC programs. These

include but are not limited to: health care services, individual and group therapy, education and counseling, vocational and employment services, social and independent living skills, healthy living recommendations and telerehabilitation. Services are provided based on the individual Veteran's preferences and needs.

**g. Standardized monitoring of progress.** Rehabilitation progress and outcomes are tracked using psychometrically sound, standardized measures and documented using the TBI Instruments. These measures provide a solid basis for evaluation of progress by providers and for discussion with participants (see appendix G).

**h. Long Term Management of TBI/polytrauma Related Disabilities.** For Veterans with moderate to severe disabilities related to TBI and those who experience functional decline, PSC provides long-term rehabilitation services to sustain, and prevent loss of functional gains and to maximize independence and quality of life. Long term rehabilitation care for Veterans and Servicemembers with TBI and polytrauma is coordinated through their primary care clinicians and supported by teams of rehabilitation specialists with TBI training and experience. The longitudinal examination of the plans of care and outcome measures available through the TBI Instruments ensures that chronic problems related to TBI are addressed proactively (see appendix G).

**i. Co-occurring TBI and Mental Health Conditions.** Mental health conditions including Post Traumatic Stress Disorder (PTSD), Substance Use Disorder (SUD), and depression are examples of co-morbidities that may be anticipated in the TBI population, along with sub-diagnostic behavioral problems, such as impulsivity, agitation, or cognitive impairment. Concurrent treatment of the TBI-related symptoms and mental health conditions is achieved whenever applicable and appropriate, through IDT collaborations or through coordination between rehabilitation and specialized mental health clinics. Rehabilitation and mental health specialists will collaboratively determine the optimal environment of care that facilitates patient recovery while maintaining safety. **NOTE:** *VHA Directive 1160.03, Programs for Veterans with PTSD, dated November 16, 2017, establishes policy for a continuum of programs for Veterans with PTSD.*



**REQUIRED CORE STAFFING FOR THE POLYTRAUMA REHABILITATION CENTER (PRC) PER 12-BED INPATIENT UNIT**

PRC inpatient Nursing Hours Per Patient Day (NHPPD) are based on the care needs associated with the patient’s functional status, complications, co-morbidities, and condition. Staffing methodology at the PRCs should be modeled similarly to the NHPPD ranges described in VHA Directive 1351, Staffing Methodology for VHA Nursing Personnel, dated December 20, 2017, Appendix A, to ensure these factors are included in staffing ratio decisions for polytrauma patients.

<b>DISCIPLINE*</b>	<b>FTE**</b>
PRC Medical Director	1.0
PRC Clinical/Program Manager	1.0
PRC Telehealth Coordinator	0.5
TBI Model Systems Project/Data Manager	1.0
PRC Research Coordinator ***	0.5***
PRC Education Coordinator***	0.5***
AT Lab Director	1.0
Admissions/Discharge Nurse Case Manager	1.0
Social Work Case Manager	2.5
Speech-Language Pathologist	2.5
Pharmacist	0.5
Physical Therapist	3.0
Occupational Therapist	3.0
Recreation Therapist	2.0

DISCIPLINE*	FTE**
Neuropsychologist	1.0
Psychologist	1.0
Rehabilitation Engineer	1.0
Blind Rehabilitation Outpatient Specialist	0.5

\* Variances from the staffing model must be approved by the Physical Medicine and Rehabilitation Service Program Office.

\*\* FTE assignment reflects required rehabilitation staffing availability for the PRC team. Staffing assignment can be flexed up or down to meet workload demand.

\*\*\* Research and Education Coordinator positions can be combined to reflect emphasis on knowledge translation and dissemination.

**REQUIRED CORE STAFFING FOR POLYTRAUMA TRANSITIONAL  
REHABILITATION PROGRAM (PTRP) PER 10-BED INPATIENT UNIT**

PTRP inpatient Nursing Hours Per Patient Day (NHPPD) are based on the care needs associated with the patient’s functional status, complications, co-morbidities, and condition. Staffing methodology at the PTRPs should be modeled similarly to the NHPPD ranges described in VHA Directive 1351, Staffing Methodology for VHA Nursing Personnel, dated December 20, 2017, Appendix A, to ensure these factors are included in staffing ratio decisions for polytrauma patients.

<b>DISCIPLINES*</b>	<b>FTE**</b>
PTRP Medical Director	1.0
PTRP Clinical/Program Manager	0.5
PTRP Telehealth Coordinator	0.5
Admission/Follow up Nurse Manager	0.5
Social Work Case Manager	1.0
Psychiatrist	0.5
Speech Language Pathologist	1.5
Occupational Therapist	2.0
Physical Therapist	1.0
Recreation Therapist	2.0
Neuropsychologist	0.5
Psychologist	1.0
Vocational Rehabilitation Specialist/Counselor***	1.0

DISCIPLINES*	FTE**
Optometrist/Blind Rehabilitation Outpatient Specialist	0.5

\* Variances from the staffing model must be approved by the Physical Medicine and Rehabilitation Service Program Office.

\*\* FTE assignment reflects required rehabilitation staffing availability for the PTRP team. Staffing assignment can be flexed up or down to meet workload demand.

\*\*\* FTE requirement can be met with staff assigned directly to the PTRP or with staff from collaborating services such as Compensated Work Therapy.

**REQUIRED CORE STAFFING FOR POLYTRAUMA NETWORK SITES (PNS)**

<b>DISCIPLINES*</b>	<b>FTE**</b>
PNS Medical Director	1.0
PNS Clinical/Program Manager	0.5
PNS Telehealth Coordinator	0.5
Nurse Case Manager	1.0
Social Work Case Manager	1.5
Speech-Language Pathologist	1.0
Physical Therapist	1.0
Occupational Therapist	1.0
Recreation Therapist	1.0
Neuropsychologist	0.5
Psychologist	1.0
Optometrist/Blind Rehabilitation Outpatient Specialist	0.5
Vocational Rehabilitation Specialist/Counselor***	1.0

\* Variances from the staffing model must be approved by the Physical Medicine and Rehabilitation Service Program Office.

\*\* FTE assignment reflects required rehabilitation staffing availability for the PNS team. Staffing assignment can be flexed up or down to meet workload demand.

\*\*\* FTE requirement can be met with staff assigned directly to the PNS or with staff from collaborating services such as Compensated Work Therapy.

**REQUIRED CORE STAFFING FOR THE POLYTRAUMA SUPPORT CLINIC  
TEAM (PSCT)\***

<b>DISCIPLINE**</b>	<b>FTE***</b>
Rehabilitation Physician	0.5
Registered Nurse	0.5
Social Work Case Manager	0.5
Speech-Language Pathologist	0.5
Physical Therapist	0.5
Occupational Therapist	0.5
Psychologist	0.5

\* Partnering with additional services and disciplines such as neuropsychologist, audiologist, vocational rehabilitation specialist is encouraged based on the clinical needs of the Veteran population served.

\*\*Variances from the staffing model must be approved by the Physical Medicine and Rehabilitation Service Program Office.

\*\*\* FTE assignment reflects required rehabilitation staffing availability for the PSCT team. Staffing assignment can be flexed up or down to meet workload demand.

**REPORTING REQUIREMENTS IN POLYTRUAMA SYSTEM OF CARE**

**1. National PM&RS Program Office Reports.** Reports are submitted to the PM&RS Program Office through secure SharePoint site and web applications which collect information detailing staffing and salaries, inpatient and outpatient tracking logs, patient outcomes, and other programmatic areas. Reporting requirements vary depending on the facility's designation in the PSC. Access to the reporting applications is provided through PM&RS National Program Office.

**2. Treating Specialty Code.** A treating specialty code is the numeric code used to identify the bed section or care area of the facility (such as general medicine, orthopedics, or psychiatry) on which patients are treated. Each day of inpatient stay has an assigned treating specialty, based on the Patient Treatment File (PTF) field treating specialty. The following Treating Specialty Codes are used to identify inpatient rehabilitation services within the PSC:

**a. Treating Specialty Code 1N (Polytrauma Rehabilitation Unit).** Code 1N is used to designate specialty inpatient rehabilitation treatment provided at the PRCs. Polytrauma beds are classified separately from the general rehabilitation beds (classified as bed section 20) operating at the medical centers with PRCs. Use of the Polytrauma Rehabilitation treating specialty code is limited to the dedicated PRC beds. These programs must be CARF accredited.

**b. Treating Specialty Code 20 (Rehabilitation Medicine).** Code 20 is used to identify an admission for rehabilitation services in a PM&RS bed section that provides acute rehabilitation services and located in acute hospital beds. These programs must be CARF accredited.

**c. Treating Specialty Code 64 (Community Living Center Short Stay Rehabilitation).** Code 64 is used to identify an admission to a VA Community Living Center where, on admission, the Veteran's expected length of stay is 90 days or less. The admission for short-stay rehabilitation signifies time-limited, goal-directed care for the purpose of returning the Veteran or Servicemember to functioning as independently as possible. These bed units are available for severely-injured Veterans, such as those returning from OEF/OIF/OND who may require comprehensive rehabilitation services beyond the acute rehabilitation phase.

**d. Treating Specialty Code 82 (PM&RS Transitional Rehabilitation Bed Section).** Code 82 is used to identify admissions to the PTRP. These programs maintain CARF accreditation under the Medical Rehabilitation standards.

**3. Functional Status and Outcomes Database (FSOD).** FSOD, which uses the Functional Independence Measure (FIM) as its assessment tool, is VHA's standard outcomes management tool for rehabilitation. Patient specific functional data is documented and tracked using the FIM tool within FSOD, stored at the Austin Information Technology Center. Reporting features within FSOD make the data

available for user access through various formats at the facility, VISN, and national levels. All Veterans and Servicemembers with TBI and/or polytrauma receiving inpatient care on a PRC or other PM&RS bed unit must be entered into FSOD.

**4. TBI Instruments.** Standardized evaluation templates and outcome measures are available to assist with data collection in the Polytrauma system of care. TBI Instruments is accessible through the tools menu in CPRS and allows the clinician to complete a standardized template, saving the data in the TBI Registry and sending an unsigned note to CPRS through a single entry. Reference and installation documents for TBI Instruments can be accessed at:

<https://www.va.gov/vdl/application.asp?appid=198>. The following instruments are currently available on TBI Instruments in support of the Polytrauma System of Care:

- a. Comprehensive TBI Evaluation (CTBIE)
- b. TBI Follow Up Assessment
- c. Individualized Rehabilitation and Community Reintegration Care Plan (IRCR)
- d. Mayo-Portland Adaptability Inventory-4 Participation Index (M2PI)
- e. Mayo-Portland Adaptability Inventory-4 (MPAI-4)
- f. Neurobehavioral Symptom Inventory (NSI)

**5. PSC Performance Measures.** Priority performance metrics for the PSC are consolidated into a dashboard available on the Rehabilitation and Prosthetic Services SharePoint site (see:

<https://vaww.infoshare.va.gov/sites/rehab/Data%20References/Forms/AllItems.aspx>).

**NOTE:** *This is an internal VA Web site that is not available to the public.*



## DECISION SUPPORT SYSTEM IDENTIFIERS (CLINIC STOP CODES)

**1. Clinic Stop Codes.** The following Decision Support System (DSS) Identifiers (ID) are used to specify outpatient care provided by designated PNS and PSC Teams. These stop codes can only be used in the primary position.

- a. 195 – PTRP Individual;
- b. 196 – PTRP Group;
- c. 197 – Polytrauma Individual;
- d. 198 – Polytrauma Group;
- e. 199 – Polytrauma Telephone; and
- f. 240 – Physical Medicine and Rehabilitation Assistive Technology Clinic.

**2. Credit Stop Codes.** Credit stop codes are used in the secondary position to identify the clinical specialty (i.e. PM&RS Physician or Speech Language Pathologist) of the provider associated with the outpatient care provided by the Polytrauma team.

**NOTE:** VA's Managerial Cost Accounting Office (MCAO) maintains a current list of active stop codes and definitions which can be accessed at:

[http://vaww.dss.med.va.gov/programdocs/pd\\_oident.asp](http://vaww.dss.med.va.gov/programdocs/pd_oident.asp). **NOTE:** This is an internal VA Web site that is not available to the public.