

POLYTRAUMA SYSTEM OF CARE

1. REASON FOR ISSUE. This Veterans Health Administration (VHA) Handbook defines policies and procedures for the operation of the Polytrauma System of Care (PSC).

AUTHORITY: Title 38 United States Code §§ 1710, 1710C, 1710D, 1710E, 8111, and 8153.

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

- a. Defines policies and procedures for the operation of the PSC;
- b. Establishes responsibilities for the operation of the PSC;
- c. Clarifies requirements for clinical care and management of clinical processes throughout the PSC.

3. RELATED ISSUES. VHA Directive 2010-012, Screening and Evaluation of Possible Traumatic Brain Injury in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans, dated March 8, 2010; and VHA Directive 2012-008, Social Work Case Management in VA Polytrauma Rehabilitation Centers, dated February 14, 2012.

4. RESPONSIBLE OFFICE. The Chief Consultant, Rehabilitation and Prosthetic Services (10P4R) is responsible for the contents of this VHA Handbook. Questions may be referred to the National Program Director, Physical Medicine and Rehabilitation Service (PM&RS) at 804-675-5597.

5. RECISSIONS. VHA Handbook 1172.1, Polytrauma Rehabilitation Procedures, dated September 22, 2005; VHA Directive 2009-028, Polytrauma-Traumatic Brain Injury (TBI) System of Care, date June 9, 2009; and VHA Directive 2005-024, Polytrauma Rehabilitation Centers, dated June 8, 2008 are rescinded.

6. RECERTIFICATION. This VHA Handbook is scheduled for recertification on or before the last working day of March 2018.

Robert A. Petzel, M.D.
Under Secretary for Health

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POLYTRAUMA SYSTEM OF CARE

1. PURPOSE

This Veterans Health Administration (VHA) Handbook defines policies and procedures 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.

2. BACKGROUND

a. One of the biggest challenges for VHA in recent years has been meeting the complex medical, rehabilitation, and psychosocial needs of the new generation of Veterans and Servicemembers from Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND). The methods of warfare used in OEF/OIF/OND, such as improvised explosive devices, can inflict serious injuries to multiple body parts and organ systems, which have come to be known as polytrauma. Optimal health care services for Veterans and Servicemembers with polytrauma emphasize the importance of rehabilitation and a comprehensive continuum of integrated clinical and support services.

b. The Department of Veterans Affairs (VA) has a proven history of excellence in rehabilitation care and is committed to providing the best of both modern medicine and integrative therapies for Veterans and Servicemembers who are injured in combat and non-combat related incidents (motor vehicle accidents, falls, etc). This Handbook assists facilities and Veterans Integrated Service networks (VISN) to carry out VA's rehabilitation programs for Veterans and Servicemembers with polytrauma. It also promotes compliance with VA's duty under the treatment authorities of title 38 United States Code (U.S.C.) sections 1710C, 1710D, and 1710E to enhance the continuum of rehabilitation services and the coordination of care for Veterans and Servicemembers with traumatic brain injury.

c. Beginning in 2005, VHA developed an integrated nationwide PSC that provides world-class rehabilitation services, and ensures Veterans and Servicemembers with polytrauma transition seamlessly between Department of Defense (DoD) and VHA, and back to their home communities. This integrated network of over 100 programs across four echelons of care specializes in clinical rehabilitation services, including: assessments and treatments by interdisciplinary teams of rehabilitation specialists; specialty care management; patient and family education and training; psychosocial support; and advanced rehabilitation and prosthetic technologies.

3. DEFINITIONS

a. **Polytrauma.** Polytrauma is defined as two or more injuries, one of which may be life threatening, sustained in the same incident that affect multiple body parts or organ systems and result in physical, cognitive, psychological, or psychosocial impairments and functional disabilities. Traumatic Brain Injury (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 dictates the course of rehabilitation due to the complexity of the related cognitive, emotional, and behavioral deficits. Veterans and Servicemembers with Spinal Cord Injury, as part of polytrauma, generally receive services within the Spinal Cord Injury and Disorders System of Care (VHA Handbook 1176.01, *Spinal Cord Injury and Disorders System of Care*, dated February 8, 2011).

b. **Traumatic Brain Injury (TBI).**

(1) TBI refers to a traumatically induced structural injury and/or physiological disruption of brain function as a result of an external force that is indicated by new onset or worsening of at least one of the following clinical signs, immediately following the event (VA/DoD Clinical Practice Guideline for Management of Concussion/mTBI, 2009):

- (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 consciousness or mental state at the time of the injury (confusion, disorientation, slowed thinking, etc.);
- (d) Neurological deficits (weakness, loss of balance, change in vision, praxis, paresis, plegia, sensory loss, aphasia, etc.) that may or may not be transient; and
- (e) Intracranial lesion.

(2) 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. Appendix A summarizes the classification of TBI severity (VA/DoD Clinical Practice Guideline for Management of Concussion/mTBI, 2009).

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. SCOPE

a. The mission of VHA's PSC is to enhance, preserve and restore the quality of life of Veterans and Servicemembers with polytrauma and TBI through the use of rehabilitation services. These services are provided in partnership with Veterans and their families, and address the goals of recovery, rehabilitation, improved quality of life, and community integration through:

- (1) Specialized medical, physical, cognitive, and psychosocial treatments and interventions;

- (2) Integrated interdisciplinary team approach to care;
- (3) Specialty case management and care coordination;
- (4) Patient and family education and support;
- (5) Development and support of a TBI registry and a clinical outcomes data system;
- (6) Clinical research;
- (7) Development and deployment of clinical practice guidelines, consensus positions and guidance on best practices; and
- (8) Professional training in the continuum of care for persons with polytrauma and TBI.

5. NATIONAL POLYTRAUMA SYSTEM OF CARE

a. VHA's PSC is an integrated nationwide system of specialized rehabilitation programs for Veterans and Servicemembers with polytrauma and TBI. PSC either directly provides, or formally links with, key components of care that address the lifelong needs of individuals with disabilities due to polytrauma and TBI. Such services include, but are not limited to:

- (1) Specialized inpatient and outpatient rehabilitation;
- (2) Emerging consciousness program;
- (3) Transitional rehabilitation;
- (4) Assistive technology labs;
- (5) Polytrauma telerehabilitation;
- (6) Vocational services; and
- (7) Community re-entry programs.

b. PSC balances access and expertise to provide specialized polytrauma and TBI care at the location closest to the Veteran's home with the expertise necessary to manage his/her rehabilitation, medical, and psychosocial needs. Services are organized in four levels of care spanning from regional referral centers, to network sites, to local VA medical centers, and to community based outpatient clinics (CBOC). Appendix B lists locations and designation of PSC programs. PSC levels of care include:

(1) **Polytrauma Rehabilitation Center (PRC)**. A PRC is located at each of the VA medical centers in Minneapolis, MN; Palo Alto, CA; Richmond, VA; San Antonio, TX; and Tampa, FL. The PRCs serve as regional referral centers for the comprehensive acute rehabilitation for Veterans and Servicemembers with complex and severe polytrauma. They

maintain a full staff of dedicated rehabilitation professionals and consultants from other medical specialties to address the complex medical and psychosocial needs of patients with polytrauma. The PRCs serve as a resource for educational programs and best practice models for other facilities across the PSC. They are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) using Brain Injury Program standards.

(2) **Polytrauma Network Site (PNS).** A PNS is located at least 1 VA medical center in each Veterans Integrated Service Networks (VISN); VISNs 8 and 17 each have 2 facilities with a PNS program. The PNS provides inpatient and outpatient rehabilitation care and coordinates polytrauma and TBI services throughout the VISN. The inpatient rehabilitation bed units at each PNS maintain CARF accreditation for Comprehensive Integrated Inpatient Rehabilitation.

(3) **Polytrauma Support Clinic Team (PSCT).** PSCTs provide and coordinate interdisciplinary rehabilitation services for Veterans and Servicemembers within the catchment area of their medical facility. PSCTs also conduct comprehensive evaluations of patients with positive TBI screens, and develop and implement rehabilitation and community reintegration plans.

(4) **Polytrauma Point of Contact (PPOC).** At VAMCs without a PSC program, the OEF/OIF/OND Program Manager ensures that Veterans and Servicemembers needing specialized rehabilitation services are referred to a facility or program capable of providing the appropriate level of care.

6. RESPONSIBILITIES OF THE UNDER SECRETARY FOR HEALTH

The Under Secretary for Health is responsible for approving any proposed change to the PSC including, but not limited to changes in: mission, staffing, bed level, reduction of clinical services, reorganization, and clinical staff.

7. RESPONSIBILITIES OF THE CHIEF CONSULTANT, REHABILITATION AND PROSTHETIC SERVICES

The Chief Consultant, Rehabilitation and Prosthetic Services is responsible for:

- a. Providing national program leadership for PSC rehabilitation services; and
- b. Reviewing significant proposed changes with the Chief Patient Care Services Officer (10P4), and other relevant offices, as appropriate.

8. RESPONSIBILITIES OF THE NATIONAL PROGRAM DIRECTOR, PHYSICAL MEDICINE AND REHABILITATION SERVICES

The National Program Director, PM&RS is responsible for:

- a. Providing national program leadership for PSC;
- b. Identifying the scope of rehabilitation services provided by PSC;

- c. Providing referral and clinical care guidance;
- d. Representing VHA on matters concerning polytrauma and TBI rehabilitation;
- e. Monitoring PSC with regard to capacity, clinical care outcomes, and costs;
- f. Ensuring involvement with VISN leadership in designating the facilities and programs participating in PSC;
- g. Reviewing and recommending approval for new programs; and
- h. Reviewing proposed program changes with Chief Consultant, Rehabilitation and Prosthetic Services.

9. RESPONSIBILITIES OF THE VETERANS INTEGRATED SERVICES NETWORK DIRECTOR

The Veterans Integrated Services Network (VISN) Director, or designee, provides a critical juncture in implementation and support of the PSC, balancing needs for local responsiveness for timely and full access to care with coordination and consistency across the national PSC. The VISN Director is responsible for:

- a. Supporting all components and services in the PSC continuum of care described in this Handbook;
- b. Facilitating smooth and efficient transfers for care between VA facilities;
- c. Providing and facilitating necessary communication, resources, and quality improvement efforts to maintain expertise and quality services;
- d. Facilitating travel and access to PRC and PNS services in their designated catchment areas, in accordance with national policy for inter-facility transfers, established criteria for travel eligibility, and use of hardship criteria, as appropriate;
- e. Facilitating required continuing education of health care providers about the PSC, and about polytrauma and TBI health care issues; and
- f. Submitting proposed changes to the PSC for review and approval through the National Program Director, PM&RS (10P4R).

10. RESPONSIBILITIES OF THE FACILITY DIRECTOR

The facility Director, or designee, is responsible for:

- a. Providing resources and policies for the provision of specialty polytrauma and TBI rehabilitation services as described in this Handbook;

- b. Having final authority over, and responsibility for the specific PSC program within the organizational structure;
- c. Ensuring timely completion of all mandated reporting, monitoring, and accreditation requirements;
- d. Providing safe, well-maintained, and appropriately furnished facilities that support and enhance the recovery of Veterans and Servicemembers with polytrauma and TBI ;
- e. Ensuring consultation with the PM&RS National Program Office on program changes that may affect access of Veterans and Servicemembers for PSC services; and
- f. Requiring specific training and competencies to managers and clinicians to address the rehabilitation needs of Veterans, Servicemembers and their families.

11. RESPONSIBILITIES OF THE POLYTRAUMA SYSTEM OF CARE PROGRAM DIRECTOR

The PSC Program Director at each level of the PSC (PRC, PNS, or PSCT) is responsible for:

- a. Providing and maintaining polytrauma program oversight to ensure access, quality, and compliance with VHA policy and procedures;
- b. Planning, monitoring, and evaluating the program to ensure proper coordination within the service, and with other services within the facility;
- c. Ensuring that care is provided in a timely, effective, and efficient manner;
- d. Establishing local procedures for the monitoring and evaluation of the effectiveness of polytrauma rehabilitation services, which are congruent with national guidance on program evaluation;
- e. Ensuring that all polytrauma health providers possess the needed competencies, and are functioning at the highest level of their competency;
- f. Completing all mandated reporting, monitoring, evaluation and accreditation requirements relevant to the polytrauma program;
- g. Providing in-service training and support for professional continuing education and professional development;
- h. Communicating to upper-level management the resource needs to accomplish the polytrauma program's mission, using policies and evidence-based data to justify requests; and
- i. Ensuring that cooperative partnerships exist among Veterans, Servicemembers, their families, VHA rehabilitation providers, community providers and other stakeholders to support a comprehensive polytrauma program structure.

12. POPULATION SERVED

a. VHA's PSC provides a full range of rehabilitation services for all enrolled Veterans, and for Servicemembers covered by Military Medical Support Office (MMSO) or Tricare authorization, who have sustained polytrauma and TBI and have potential to benefit from rehabilitation services. This includes persons with:

(1) TBI;

(2) Blast and non-blast related traumatic injuries including amputations, musculoskeletal injuries, open wounds; and

(3) Other acquired non-progressive brain injuries.

b. The following principles and conditions describe the population served:

(1) Have sustained physical, cognitive, or emotional injuries secondary to trauma;

(2) The consequences of the trauma are clinically and functionally significant and result in activity and participation restrictions;

(3) The patient is medically stable enough to allow safe transport to, and management by, the PSC program and can tolerate his/her planned rehabilitation program; and

(4) The patient has the potential to benefit from the rehabilitation services provided by the program.

13. AMPUTATION CARE WITHIN THE POLYTRAUMA SYSTEM OF CARE

The integration of the VA's PSC and the Amputation System of Care (ASoC) represents the largest coordinated programmatic approach to the rehabilitation of individuals with complex, multi-system disabilities. While each of these systems represents outstanding, comprehensive resources for Veterans and Servicemembers with acute and ongoing disability, care must be optimized and provided as a single, integrated rehabilitation program. This seamless linkage of the PSC and ASoC provides a unified service delivery model for the patient that eases access to care, and leverages all of the specialized resources into a single, efficient, interdisciplinary model of rehabilitation for some of the most complex disabling medical conditions.

a. Individuals with acute traumatic amputations who require inpatient rehabilitation services need to be managed at a VA PRC under the leadership of the PRC Medical Director and the interdisciplinary rehabilitation team.

b. Team members for the Amputation Rehabilitation Center need to be included on the PRC team based on the medical and rehabilitation readiness of the patient (e.g., to guide appropriate residual limb care and preparation, to guide procurement of preparatory prostheses), just as other specialty care clinicians are integrated into the rehabilitation team (e.g., orthopedic surgeons, ophthalmologists).

c. Upon transition from inpatient care to outpatient or residential care, patients need to receive therapy services from members of the polytrauma (PNS or PSCT) and/or amputation team depending on the specificity of their remaining functional deficits, and the expertise and availability of team members.

d. Follow-up appointments need to be coordinated through either a single clinic with members of both teams (for Polytrauma and Amputation care) present, or through two separate clinic appointments on the same day, if needed.

e. Physician follow-up care must be led by the PSC clinician, with the ASoC physician providing specialty consultation.

f. If the Veteran or Servicemember requires more intensive services or follow-up in one of the two body systems or only requires ongoing care or follow-up in one system, then these visits need to be coordinated separately, as with any specialty clinic care.

14. REFERRAL GUIDELINES

a. Referrals for admission to PSC programs are accepted from sources within the VA medical center where the PSC program is located, other VA medical centers, the Department of Defense (DoD), self-referral or family referral, and non-VA community providers and facilities.

b. Active duty Servicemembers require an authorization to receive care at the VA:

(1) Medical treatment for Servicemembers with spinal cord injury (SCI), TBI, blindness, or polytrauma is covered under a DoD/VA Memorandum of Agreement (MOA). Special reimbursement rates and billing submission procedures are prescribed under the MOA. Authorization for care for Servicemembers covered under the MOA is obtained from the MMSO for TRICARE;

(2) For Servicemembers with medical diagnoses not covered under the MOA, authorization for care is obtained from the military Case Manager who coordinates the patient's care;

c. Geographical distribution of referrals within the PSC follow the pattern described below:

(1) PRCs serve as regional referrals centers, accepting referrals from other VA facilities, DoD, self-referral, and community health care providers and facilities. PRCs coordinate patient referrals in a systematic and equitable manner, while making allowances for patient preferences with regard to proximity to family and home. The PRCs regional areas of responsibility are:

(a) Richmond PRC accepts referrals for patients in VISNs 1 – 6;

(b) Tampa PRC accepts referrals for patients in VISNs 7 – 9;

(c) San Antonio PRC accepts referrals for patients in VISNs 16 – 18;

(d) Palo Alto PRC accepts referrals for patients in VISNs 19 – 22; and

(e) Minneapolis PRC accepts referrals for patients in VISNs 10 – 12, 15, and 23.

(1) PNSs serve as VISN wide referral resources.

(2) PSCTs accept referrals for individuals with polytrauma and TBI who live within the catchment area of their facility.

d. Clinical guidelines for referrals to PSC programs include (see Appendix C for details):

(1) All referrals for acute inpatient admissions are to be directed to the PRCs. The PRCs collaborate with other levels of care to determine the most appropriate care setting for the Veteran or Servicemember.

(2) As a general rule, referrals for Veterans and Servicemembers with acute moderate to severe polytrauma and TBI need to be directed to the PRCs, while referrals for patients with chronic problems need to go to a PNS or PSCT. Referrals for problems related to mild TBI can be addressed at all levels within the PSC, although consultation with the next higher level of care may be indicated for persons with intractable symptoms.

(3) Referral to a PSC program ensures, at a minimum, that the patient is integrated into the PSC and receives the appropriate rehabilitation services.

e. Referrals of Veterans and Servicemembers with polytrauma and TBI are to be given the highest priority and the scheduling process must be expedited to ensure that there are no delays in the initiation of services.

f. A consistent process for managing referrals needs to be established within each PSC program to include:

(1) Identification of person (e.g., nurse or social worker case manager) who serves as the point of contact for referrals, communication with referral sources, and collection of relevant clinical and administrative information;

(2) The medical provider reviews the referral and makes an initial determination of the type and level of services required;

(3) Prior to admission for inpatient care or first appointment for outpatient care, the patient and/or family receive information regarding expected type, length, and intensity of services to be provided; and

(4) The social worker case manager maintains communication with the referral source regarding the patient's progress in rehabilitation.

15. REHABILITATION STANDARDS

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 PSC is designed to provide rehabilitation services in the most appropriate and least restrictive setting possible.

c. Family and caregiver education and support are integral to the rehabilitation and community reintegration process.

d. PSC personnel make every effort to ensure a smooth transition of Veterans and Servicemembers from DoD to VA, between VA facilities, and throughout the continuum of rehabilitation and community reintegration services.

16. INTERDISCIPLINARY TEAM

The hallmark of rehabilitation care provided in the PSC is the collaboration of specialists from different disciplines in the evaluation and treatment of Veterans and Servicemembers with polytrauma and TBI. Dedicated interdisciplinary teams (IDT) of rehabilitation specialists participate 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 team goals. The IDT for each patient is determined by their rehabilitation and medical needs.

a. IDT Membership

(1) **Patient and Family.** The patient and the patient's 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, transition to another level of care, and community re-integration.

(a) The patient and family receive education, training, and support that facilitate informed decision making and active participation in the provision of care.

(b) The patient and family participate in the IDT communication processes, including team rounds and patient/family conferences, and receive a written copy of the Individualized Rehabilitation and Community Reintegration Plan of Care.

(c) The polytrauma case managers serve as the liaisons between patient, family, and members of the IDT.

(2) **Rehabilitation Specialists.** Based on the individual rehabilitation needs of the patient, the IDT team may include the following rehabilitation specialists:

(a) **Physiatrist;**

- (b) Rehabilitation Nursing Staff;
- (c) Social Worker;
- (d) Clinical Neuropsychologist;
- (e) Rehabilitation Psychologist;
- (f) Occupational Therapist;
- (g) Pharmacist;
- (h) Physical Therapist;
- (i) Recreation Therapist;
- (j) Speech-Language Pathologist;
- (k) Family Counselor;
- (l) Driver Rehabilitation Specialist;
- (m) Kinesiotherapist;
- (n) Blind Rehabilitation Specialist;
- (o) Prosthetist;
- (p) Orthotist; and
- (q) Vocational Rehabilitation Specialist.

(3) **Consult Services.** Individuals with polytrauma and TBI often have complex health problems that require the expertise of other medical and support specialties. Depending on the needs of the patient, consultants may need to participate as active members on the IDT. Consultants need to have specialized expertise in polytrauma and TBI. Clinical specialties that are identified as PSC Consultative Services include, but are not limited to:

- (a) Audiology;
- (b) Assistive Technology;
- (c) Chaplaincy;
- (d) Dentistry and oral and maxillofacial surgery;
- (e) Dietician;

- (f) Endocrinology;
- (g) Gastroenterology;
- (h) General and Internal Medicine;
- (i) General Surgery;
- (j) Hospitalist;
- (k) Infectious Diseases;
- (l) Intensivist;
- (m) Neurology;
- (n) Neuro-ophthalmology;
- (o) Neurosurgery;
- (p) Optometry;
- (q) Orthopedic Surgery;
- (r) Otolaryngology;
- (s) Pain Specialist;
- (t) Plastic Surgery;
- (u) Psychiatry;
- (v) Respiratory Therapy;
- (w) Urology; and
- (x) Wound care nursing.

b. **IDT Responsibilities.** IDT responsibilities include:

- (1) Reviewing relevant medical records and reports to facilitate assessment;
- (2) Performing comprehensive interdisciplinary assessments (as described in paragraph 17);
- (3) Rendering a definitive diagnosis following a positive TBI screening or in cases where the Compensation and Pension Department does not have the required expertise to perform this function;

- (4) Identifying strengths and barriers that could impact the rehabilitation plan;
- (5) Collaborating with the patient and family in the development of the plan of care;
- (6) Developing the Individualized Rehabilitation and Community Reintegration (IRCR) Plan of Care that coordinates input from all IDT members and integrate patient and family's goals (as described in paragraph 18);
- (7) Documenting the individualized rehabilitation plan in the patient's electronic medical record;
- (8) Reviewing the IRCR Plan of Care with the Veteran and their family providing them a copy within 24 hours after the plan is entered in the medical record for Veterans in inpatient rehabilitation, and within one week for Veterans in outpatient care.;
- (9) Ensuring that all individuals involved in the care of the patient and the family are aware of the IRCR Plan of Care, including adjustments to the plan as goals are met and new goals are established;
- (10) Conducting interdisciplinary team rounds as often as needed to monitor progress and update the treatment plan to reflect progress and new goals;
- (11) Identifying patient and family needs and stressors, establishing a plan to address these, and communicating the plan to all appropriate staff;
- (12) Determining community reintegration goals and developing a plan that ensures smooth transition to the next level of care;
- (13) Securing the necessary resources and providing training and education that supports the patient and family during the transition process and facilitates positive reintegration outcomes;
- (14) Participating in performance improvement activities; and
- (15) Maintaining regular communication with the referral sources.

c. **IDT Education and Competencies.** Rehabilitation professionals working in PSC programs have specialized skills and knowledge, based on their education, clinical training, and experience necessary to address the complex needs of individuals with polytrauma and TBI. More specifically,

- (1) IDT members must have or be willing to acquire appropriate knowledge and skills in the following areas:
 - (a) Physical, psychosocial, cognitive, behavioral and emotional consequences of polytrauma and TBI;
 - (b) Polytrauma and TBI rehabilitation;

- (c) Structure and services available in the PSC;
 - (d) Amputation care and the structure and services available in the ASoC;
 - (e) Age-appropriate rehabilitation interventions;
 - (f) Assistive technology;
 - (g) Blast injuries;
 - (h) Blind rehabilitation system of care;
 - (i) Community reintegration, i.e., vocational rehabilitation and community participation;
 - (j) Cultural diversity, including the military culture;
 - (k) Pain management;
 - (l) Prosthetic services and prosthetic equipment;
 - (m) Psychosocial implications of polytrauma and TBI for the family and caregivers;
 - (n) Psychosocial issues surrounding transition from active duty to civilian life;
 - (o) PTSD and other combat stress-related problems;
 - (p) Sensory impairments following polytrauma and TBI, including hearing and vision loss;
 - (q) Sexuality and issues related to trauma; and
 - (r) VHA directives, handbooks, and clinical practice guidelines affecting services for Veterans and Servicemembers with polytrauma and TBI.
- (2) Specialized TBI and polytrauma training and experience must be reflected through one or more of the following: Functional Statement or Position Description, certifications, continuing education record, competencies, orientation training, and scope or standards of practice.
- (3) IDT staff serve as resources for education and training in their areas of expertise for other health care providers including trainees, staff from other VA facilities, and health care personnel from Military Treatment Facilities (MTF), and non-VA facilities.
- (4) IDT staff participate in PSC conference calls, as appropriate, based on their level of involvement and responsibility within the program.
- (5) IDT staff participate in PSC sponsored educational and training events to the highest level possible.

17. ASSESSMENT

Assessment forms the foundation for the individualized plan of care and treatment approach for each patient. Assessment is a dynamic process that is initially conducted during the intake into rehabilitation and repeated, as necessary, throughout treatment. Reassessments can occur at regular intervals (e.g., weekly in acute inpatient rehabilitation) or whenever changes in the patient's condition require reassessment. Results of the assessment and reassessments are documented in the patient's electronic medical record and communicated to the patient and family. The comprehensive assessment addresses, but is not limited to, the following elements:

a. **Impairments.** A determination of current level of problems in body functions or structures, such as a significant deviation or loss. Assessment tools include:

- (1) Review of medical history;
- (2) Interview;
- (3) Observation;
- (4) Diagnostic tests; and
- (5) Physical exam.

b. **Activity Limitations.** An account of the difficulties an individual may have in executing activities of daily living (ADL) and instrumental ADLs (IADL). Areas targeted for assessment include:

- (1) Cognitive skills;
- (2) Communication;
- (3) Mobility;
- (4) Self care (including meal preparation, household management, and finances); and
- (5) Interpersonal skills.

c. **Participation Restrictions.** A statement of problems an individual may experience in everyday living, including:

- (1) Education;
- (2) Work and employment;
- (3) Economic life; and
- (4) Community, social, and civic life.

d. **Environmental Factors.** A report of the physical, social and attitudinal conditions in the person's environment that may interfere with their ability to participate in everyday living.

e. **Family Needs.** An assessment of family and/or caregiver education, psychosocial, and resource needs and how they impact the community reintegration goals.

18. INDIVIDUALIZED REHABILITATION AND COMMUNITY REINTEGRATION PLAN OF CARE

An IRCR Plan of Care is developed for each Veteran and Servicemember receiving inpatient and outpatient rehabilitation services in one of the PSC programs. The individual and their family or caregiver collaborates in the development of the individualized plan of care to the maximum extent practicable. The IRCR Plan of Care follows from the comprehensive interdisciplinary assessment and addresses the following elements:

a. **Rehabilitation Goals.** Rehabilitation goals target improvement of the physical, cognitive, vocational, and psychosocial functioning of the individual. They are designed to maximize the independence and reintegration of the individual into the community. Goals must be interdisciplinary, functional, and measureable.

b. **Access to Care.** The individualized plan addresses access to all appropriate rehabilitative components of the polytrauma and TBI continuum of care, including community reintegration options and services.

c. **Treatments.** A description of specific rehabilitative treatments and other services necessary to achieve the rehabilitation goals, including the type, frequency, estimated duration and location of such treatments and services.

d. **Plan Reviews.** The effectiveness of the plan of care is reviewed periodically and modified, as necessary. Additional reviews of the plan may be conducted at the request of the individual or, in the case of an individual who is incapacitated, at the request of the individual's guardian or designee.

e. **Responsible Person.** The psychiatrist on the team is responsible for overseeing the implementation of the plan of care. The polytrauma case manager is responsible for coordinating the implementation of the plan of care, and for communicating its content to the person served, his family and caregiver, and other individuals, as appropriate.

19. TREATMENT

a. **Medical Treatment.** The psychiatrist on the PSC team is responsible for managing the medical treatment of the patients, and for ensuring that all appropriate specialists are consulted and actively participate in the medical care of the patient.

(1) Consultants from different medical services are expected to be actively involved in the care of the patient until the reason for the consultation is resolved. Consultative service providers are encouraged to participate in IDT meetings. Their assessments and

recommendations must be documented in the patient's electronic medical record according to medical center policies.

(2) In the case of inpatients whose medical condition requires transfer of care to a different specialty, the PSC team must remain actively involved in care whenever there are ongoing rehabilitation goals.

(3) The physiatrist or physician extender on the PSC team must be accessible to the patient and family for the provision of care and consultation.

b. **Rehabilitation Treatment.**

(1) Rehabilitation services and treatments provided by the IDT may include, but are not limited to:

- (a) ADLs;
- (b) Assistive technology;
- (c) Augmentative communication ;
- (d) Cognitive rehabilitation ;
- (e) Communication ;
- (f) Community reintegration;
- (g) Counseling;
- (h) Driving;
- (i) Durable medical equipment;
- (j) Gait training;
- (k) Hearing rehabilitation;
- (l) IADLs (such as housekeeping, managing finances, transportation, etc.);
- (m) Medication management;
- (n) Mobility;
- (o) Neurobehavioral management;
- (p) Orthotics;
- (q) Physical performance and conditioning;

- (r) Prosthetic fitting and training;
- (s) Psychosocial skills training;
- (t) Sexuality;
- (u) Swallowing;
- (v) Vestibular rehabilitation;
- (w) Visual motor and low vision rehabilitation;
- (x) Vocational rehabilitation; and
- (y) Wheeled mobility prescription and training.

(2) Co-treatment and group treatments are encouraged as effective practices in rehabilitation treatment.

(3) Age appropriate activities and materials must be incorporated into rehabilitation treatments.

c. **Community Reintegration**

(1) Community reintegration refers to the individual's ability to resume age, gender, and culturally appropriate roles in the family, community and workplace. Community reintegration must emphasize a multidisciplinary approach, which includes peers and family, in order to close the gap between treatment activities and functional competence in the individual's natural environment. The primary focus of community reintegration is on the skills and adaptations that the individual recovering from polytrauma and TBI needs to achieve in order to return to their chosen roles at home, work, school, and community. Ongoing assessment of progress and modification of goals is critical to the success of any community reintegration program.

(2) The IDT identifies the skill set and resources needed to attain the individual's optimal level of functioning in the community. Areas to be addressed that are relevant to community reintegration include, but are not limited to:

(a) Independent Living Skills. (Ability to care for personal needs as well as maintain household functioning):

1. Community access;
2. Meaningful life activities (work, school, leisure);
3. Social networks and connections;
4. Safety;

- 5. Health and wellness;
- 6. Maintenance of rehabilitation gains; and
- 7. Individual and family supports.

(b) Resources for Community Living Support. (Available through VA, other Federal and state supported programs, private providers and community resources):

- 1. In-home services for healthcare or household maintenance;
- 2. Individual and family support groups;
- 3. Independent living programs;
- 4. Life skills coach;
- 5. Day activity programs;
- 6. Volunteer work; and
- 7. Assistive technology.

(c) Vocational Rehabilitation. (Services may include):

- 1. Assistance with application for VA benefits services and community-based resources;
- 2. Vocational evaluation;
- 3. Vocational training;
- 4. Functional capacity evaluation;
- 5. Work hardening;
- 6. Job site evaluation;
- 7. Job coaching; and
- 8. Supported employment.

(3) Polytrauma Case Managers have overall responsibility to coordinate community reintegration services for Veterans and Servicemembers who receive specialty care related to polytrauma and TBI. These responsibilities include participation in the development of the IRCR Plan of Care, communication of the plan in writing to the Veteran, Servicemember and family, and coordination of community reintegration supports and resources.

20. DISCHARGE PLANNING

Discharge planning begins upon admission to rehabilitation. The partnership with the patient and family as well as interfacing with the Patient Aligned Care Team (PACT) is essential to an effective discharge plan.

a. **Discharge Criteria.** The decision to discharge is made in collaboration with the patient, the family, and the referral source or other stakeholders as appropriate (e.g. the Patient Aligned Care Team, DoD). The following considerations typically lead to discharge decisions:

- (1) The patient met his or her rehabilitation goals;
- (2) The patient has achieved maximum benefit from the specific level of care; and
- (3) The patient is no longer able or willing to participate in the rehabilitation program.

b. **Pre-discharge Procedures.** The IDT actively participates in the execution of different aspects of the discharge plan, however, the responsibility for the overall coordination of all elements of the plan rests with the polytrauma case manager. This includes:

(1) Assessing the intended discharge location for access, barriers, safety, required durable medical equipment, and other relevant characteristics. For patients that will be discharged to home in the local community, a home evaluation may be conducted by appropriate IDT members to make recommendations for home modifications, and to ensure that the home environment meets the needs of the patient upon discharge. For patients discharged to home remote from the medical center, other options, including referral to the local VA for a home visit, need to be considered;

(2) Identifying any physical, emotional or financial limitations of the family or caregiver that may impact the discharge plan;

(3) Identifying resources for follow-up medical and rehabilitation care including effective collaboration with the PACT regarding follow-up care;

(4) Providing the family or caregiver with contact information and resources related to the planned discharge location that can be explored prior to the transition of care. Information about local, state and national resources for education, advocacy and support need to be provided; and,

(5) Providing structured opportunities during daily care and therapy sessions for the family to become comfortable and skilled in managing the patient's ongoing care needs.

c. **Discharge Summary.** An integrated discharge summary is required for each individual served in the PSC at every point of transition across the continuum. It includes: the medical, functional, and psychosocial status of the patient at the time of discharge; progress in treatment; goals achieved; activity restrictions; current medications; adaptive and prosthetic equipment;

discharge setting; family and support system needs; education provided; continued care needs; and follow-up services arranged, as appropriate.

(1) Discharge recommendations and other appropriate discharge records are provided to the patient and family in writing upon discharge. All medical restrictions are clearly documented and, when applicable, a 30-day supply of medications and other necessities are provided.

(2) Upon request, the IDT provides recommendations for patients who are Servicemembers regarding their potential to return to military duty, including clinical information necessary for the military medical examination board (MEB) process.

d. Discharge Procedures. The polytrauma case manager's responsibilities during the discharge process include:

(1) Reviewing the discharge plan with the patient and family or caregiver and providing any needed clarification;

(2) Partnering with the PACT to ensure the Veteran experiences a smooth and safe transition from inpatient to outpatient care, as well as a clear understanding of the follow up care plan;

(3) Providing the patient and family with the names and phone number of the VA or military case manager who will take over the case management duties;

(4) Providing the discharge recommendations to the appropriate entities at the receiving facility;

(5) Confirming that all adaptive devices, durable medical equipment, and requests for home modifications have been completed;

(6) Notifying the OEF/OIF/OND Program Manager at the patient's home VA facility of the planned discharge;

(7) Ensuring that follow up services and treatments are in place for the patient to receive services as per the IRCR Plan of Care; and

(8) Forwarding legal documents such as guardianship or power of attorney to the appropriate point of contact.

21. PATIENT AND FAMILY EDUCATION

The health care environment within the PSC promotes participation of family members and caregivers in the rehabilitation process throughout the continuum of care. This includes, but is not limited to providing education, training, and support.

a. The patient, family, and/or caregiver must receive appropriate education and training about the patient's medical condition, impairments, and treatment needs. Education and training

will also address skills and behaviors that promote recovery, maximize function, and minimize the risk of further injury.

b. An assessment of the patient's and family's learning style, educational needs, and readiness to learn must be completed and documented in the medical record so that educational efforts are timely, appropriate and effective.

c. All IDT members are responsible for providing education to patients and their families as appropriate to their specific disciplines, and for documenting such education in the electronic medical record.

d. Education can be provided as a part of ongoing therapy, through patient and family meetings, through written information (family guides, patient handouts and booklets), and through the medical center's ongoing televised Patient Education Series.

e. Education may include, but is not limited to:

(1) Rehabilitation techniques to facilitate adaptation to and functional independence in the anticipated discharge environment;

(2) Recommendations for accessing available community resources;

(3) Safe and effective use of prosthetic, orthotic and durable medical equipment;

(4) Safe and effective use of medication;

(5) Skills required to meet the medical and other care needs of the patient;

(6) Polytrauma sequelae and conditions as appropriate to the patient;

(7) Restrictions and precautions, e.g., driving, alcohol, swallowing, physical activity level, use of safety devices or equipment;

(8) Re-injury prevention;

(9) Behavior management techniques;

(10) Home safety; and

(11) Instructions on how to handle emergencies.

f. Education provided will be specific and appropriate to the assessed needs, educational level, cultural background, and readiness to learn of the patient, family, and/or caregiver.

g. In addition to education and training, the Veteran's and Servicemember's family may also receive mental health services, professional counseling, and marriage and family counseling as

are needed in connection with the underlying treatment of the Veteran (and as discussed further in paragraph 22).

22. FAMILY SUPPORT

a. Families and caregivers of patients with polytrauma and TBI have unique psychosocial needs related to the physical, emotional, and cognitive changes that their family member has experienced, and the possible lifelong consequences of these changes. The IDTs in the PSC are responsible for ensuring that families and caregivers receive the necessary support services to minimize stress and to optimize development of successful coping strategies. PSC support services include, but are not limited to:

- (1) Assessment of psychosocial needs;
- (2) Maintaining regular communication to keep families informed about the rehabilitation care plan and to monitor stress level;
- (3) Working with Voluntary Service and community resources to assist families with logistics, e.g., temporary lodging, transportation, meals, child care, when appropriate;
- (4) Providing or assisting with locating appropriate mental health or medical resources, as needed;
- (5) Helping to identify VA and non-VA resources and benefits, including those available through DoD, Veterans Benefits Administration, Voluntary Service, non-profit organizations, state and local government;
- (6) Ensuring that representatives from Chaplain Service are available, as needed;
- (7) Interfacing with DoD to facilitate resolution of military issues; and
- (8) Identifying if the Veteran and caregiver are potential candidates for VA's Program for Comprehensive Assistance for Family Caregivers.

b. Veterans and Servicemembers who receive service in the PSC must have a designated case manager who has the responsibility for ensuring that psychosocial needs of the family are identified and addressed including:

- (1) Ensuring that the patient and family receive an orientation to the PSC program, including personnel, services, location, and schedules;
- (2) Assessing patient and family support needs and documenting the results and the plan of care in the medical record;
- (3) Establishing a regular schedule for communication that meets the needs of the family;
- (4) Documenting the content of communications with the family in the Veteran's and Servicemember's electronic medical record;

- (5) Facilitating family involvement in rehabilitation treatments;
- (6) Providing the family with updates on progress and adjustments to the plan of care in a timely fashion; and
- (7) Working closely with identified resources for support services to meet family needs.

23. POLYTRAUMA REHABILITATION CENTERS

a. Designation

(1) Polytrauma Rehabilitation Centers (PRC) are designated by the Under Secretary for Health. They serve as regional referral centers for acute medical and rehabilitation care, and as hubs for research and education related to polytrauma and TBI. Five existing PRCs are located at the VA medical centers in Minneapolis, MN; Palo Alto, CA; Richmond, VA; San Antonio, TX; and Tampa, FL.

(2) The PRC designation requires that the facility meets staffing, scope of services, and accreditation and certification requirements outlined in this Handbook.

(3) PRCs are organized under the PM&RS and report to the Chief of Staff, or equivalent, at the facility. PRC beds are identified and tracked by treating specialty code 1N.

(4) Requests for designation of a new PRC facility or changes in existing designation must be addressed to the Under Secretary for Health. Requests are routed through the Chief Consultant, Rehabilitation and Prosthetic Services, and the Deputy Under Secretary for Health for Operations and Management.

b. Scope of Services

(1) **Comprehensive Integrated Inpatient Rehabilitation.** The focus of this program is to provide intensive interdisciplinary rehabilitation treatments for Veterans and Servicemembers during initial stages of recovery from moderate to severe polytrauma and TBI. This is a highly specialized level of care designed to treat patients as soon as they are sufficiently medically stable to tolerate initial rehabilitation programming. Evaluation and treatment address medical, physical, cognitive, psychosocial, emotional adjustment, behavioral, vocational, educational, health and wellness, and recreational issues. Though rehabilitation services are generally directed toward treatment of impairments of new onset, persons requiring treatment for complications or exacerbation of their condition, as well as those needing reevaluation, are also eligible for admission.

(2) **Comprehensive Interdisciplinary Inpatient Evaluations.** This is a short-stay (2 weeks or less) admission for patients who could benefit from interdisciplinary assessment and observation in an inpatient setting, and who do not always require the full complement of interdisciplinary rehabilitation treatments. Patients with varying levels of acuity and severity are admitted into this program with the goal of evaluating their potential to benefit from therapy

services. Results of the evaluation are then used to make recommendations for types of rehabilitation services, therapy, medication management, assistive technologies, and appropriate community reintegration goals.

(3) **Emerging Consciousness Program (ECP).** The ECP serves patients with disorders of consciousness, including coma or near coma. This is a unique and complex level of care for Veterans and Servicemembers who sustained severe brain injuries and remain in a prolonged state of reduced consciousness. The program utilizes innovative assessments and treatments designed to improve responsiveness and return to consciousness, to optimize long-term outcomes, and to facilitate advancement to the next phase of rehabilitation care. The interconnected components of the ECP include:

- (a) Comprehensive rehabilitation nursing and specialized medical services;
- (b) Individualized sensory and neurocognitive stimulation programs;
- (c) Active rehabilitation therapy involvement;
- (d) Intensive social work and case management;
- (e) Family involvement, education, and support; and
- (f) Research and program evaluation.

c. **PRC Responsibilities within PSC.** PRCs are the flagship facilities of the integrated PSC. They provide national leadership for clinical, educational, research and administrative services related to polytrauma and TBI rehabilitation. Within the PSC, the PRCs:

- (1) Serve as referral and consultation resources for patients with complex medical conditions and rehabilitation needs across their regions;
- (2) Serve as coordinating centers for polytrauma and TBI care within their region;
- (3) Provide teleconsultation to the other components of the PSC and to facilities without PSC services;
- (4) Collaboratively develop and conduct national-level educational programs for VA and DoD providers in the areas of polytrauma and TBI;
- (5) Develop educational and training materials for patients and their families;
- (6) Collaborate with other agencies and institutions to develop clinical practice guidelines and best practice models; and
- (7) Participate in collaborative research on polytrauma and TBI.

d. **Accreditation and Certification.** PRC Rehabilitation programs are CARF accredited for Brain Injury Program and Comprehensive Integrated Inpatient Rehabilitation (see

<http://vaww.oqsv.med.va.gov/functions/integrity/accred/carf.aspx>). *NOTE: This is an internal VA Web site and is not available to the public.*

e. **Staffing**

(1) **Rehabilitation Staffing**

(a) PRCs have a dedicated interdisciplinary team of rehabilitation specialists. Required staffing for a twelve-bed acute inpatient bed unit is listed in Appendix D. Due to the specialized expertise necessary to manage these patients, it is important that staff be dedicated and non-rotating.

(b) Each PRC must ensure that the appropriate disciplines are available and at sufficient levels to meet the needs of patients with polytrauma and TBI.

(c) Members of the PRC IDT must demonstrate specialized education and training in the care of patients with polytrauma and TBI by way of their educational degree or certification, clinical training, continuing education, and experience, as detailed in subparagraph 16c.

(2) **Dedicated Consultative Specialties.** The dedicated specialty consultant:

(a) Consults to the appropriate medical specialists and clinical disciplines will be made based on the complexity of the patient's needs and goals. The clinical specialties considered integral to the PRC are listed in subparagraph 16a(3).

(b) Due to the severity of injuries of individuals admitted to the PRCs, attending staff from medical consultative services at these facilities must be available 24 hours a day, 7 days a week (24/7) to respond to urgent requests or emergent needs.

(c) Depending on the needs of the patient, consultants may need to participate as active members on the rehabilitation IDT.

f. **Admission of Active Duty Servicemembers to the PRC**

(1) **Memorandum of Agreement (MOA).** A "Memorandum of Agreement between the Department of Veterans Affairs and the Department of Defense for Medical Treatment Provided to Active Duty Servicemembers with Spinal Cord Injury, Traumatic Brain Injury, Blindness, or Polytraumatic Injuries" is in effect. *NOTE: Refer to the current VA-DOD MOA for criteria for safe and effective transfer, operational specifics, and expectations at:*

<http://vaww.dodcoordination.va.gov/docs/MOAMOUSpinalCordInjuryTramauticBrainInjury2.pdf>. *This is an internal VA Web site and is not available to the public.*

(2) When the patient is ready for transfer, arrangements are to be effected immediately.

(3) The PRCs will assist the referring medical facility to select the most appropriate center to provide treatment to prospective Servicemembers under the VA-DoD MOA. Consideration will be given to selecting the PRC closest to the Servicemember's home of record or other location

requested by the Servicemember (guardian, conservator, or designee), subject to availability of beds at the medical center and approval by Tricare Management Activity (TMA). If the preferred PRC is unable to accept the patient, it will assist in locating an appropriate VA medical center for placement of the patient.

g. **Admission of Veterans to a PRC**

(1) As a general rule, referrals for admissions of Veterans with acute moderate to severe polytrauma and TBI must be directed to the PRCs, as described in subparagraph 14c.

(2) The referring physician must provide a patient history and physical examination note, pertinent progress notes, and physician interim or discharge summary for review by the PRC that is considering the patient for transfer. An inter-facility consult must be entered in the patient record to document the request and track its completion at the receiving facility.

(3) Agreement on the transfer or admission date must be coordinated by the PRC admissions coordinator and the referring clinic. *NOTE: The logistics and timing of the transfer are assessed based upon physician-to-physician contact.*

h. **Responsibilities During the Admissions Process**

(1) **PRC Medical Director.** The PRC Medical Director is responsible for the admission of Veterans and Servicemembers with polytrauma and TBI. Admissions must be predicated on mission, scope of services, evaluation, and/or determination of diagnostic etiology (see pars. 12, 13, and 14), and the medical and functional needs of the patient.

(2) **VA Liaison for Healthcare.** Where assigned, the VA Healthcare Liaison facilitates the referral and admission process for active duty Servicemembers by:

(a) Providing the patient and family with VA-developed informational materials describing the polytrauma program and the facility to which the patient has been referred;

(b) Facilitating communications between the Military Treatment Facilities (MTF), the patient's family, and the PRC during the transition process;

(c) Ensuring that any new information is shared with appropriate staff;

(d) Ensuring that the PRC has all of the required medical and administrative information to transfer care of the Servicemember; and

(e) Assisting with any transition issues.

(3) **VA Polytrauma Rehabilitation Nurse Liaison.** Where assigned, the VA Polytrauma Rehabilitation Nurse Liaison facilitates the referral and admission process for active duty Servicemembers by:

(a) Monitoring potential referrals to the PRCs for progress and readiness for rehabilitation;

(b) Monitoring complications that may impact readiness for transfer to a rehabilitation setting;

(c) Providing education and preparing the patient and family for the rehabilitation phase in the VA PRC;

(d) Collaborating with MTF case manager, the VA Liaisons for Healthcare and the PRC admissions coordinator to facilitate transfers to VA;

(e) Providing clinical information to VA admissions coordinator to assure the smooth transition of clinical care; and

(f) Participating in the pre-admission video and telephone conferences between the PRC and MTF clinical teams.

(4) **PRC Admissions Coordinator.** The PRC admissions coordinator performs the following functions:

(a) Reviewing all clinical information with the PRC attending physician, and assessing factors surrounding readiness for inpatient rehabilitation;

(b) Monitoring the patient's medical and rehabilitation status until transfer occurs, and appraising the PRC attending physician of any changes in the patient's condition;

(c) Informing the interdisciplinary teams (IDT) of the planned admission and documenting the pre-admission screening information in the patient's electronic medical record;

(d) Confirming with the referring facility, prior to transfer, that authorization for care has been obtained from MMSO or TRICARE; and

(e) When the referral information indicates that a treatment setting other than the PRC is more appropriate for the patient, the admissions coordinator (based on the recommendations of the attending physician at the PRC) recommends the most appropriate care setting, and assists with locating that setting.

(5) **PRC Case Manager.** The PRC Case Manager coordinates transfers in collaboration with the admissions coordinator and is responsible for:

(a) Contacting the family prior to admission to establish communications and begin orientation and transition to the PRC;

(b) Providing the family with information concerning rehabilitation approach to care, expectation for services, IDT members, average length of stay, and any additional information requested by the family;

(c) Coordinating the pre-admission video teleconferences, whenever feasible;

(d) Communicating with DoD and VA liaison counterparts to ensure a smooth transition of care; and

(e) Notifying the local OEF/OIF/OND Program Manager of the patient admission.

i. **PRC Environment of Care**

(1) **Health and Safety.** PRCs have safety and security measures that are consistent with the physical, cognitive, and behavioral needs of patients with polytrauma and TBI including:

- (a) Agitation and confusion;
- (b) Chemical use, abuse, and dependency;
- (c) Elopement risks;
- (d) Equipment risks;
- (e) Handicap accessibility;
- (f) Physical hazards;
- (g) Physically aggressive behaviors;
- (h) Self-injurious behaviors;
- (i) Suicidal ideation; and
- (j) Social vulnerability.

(2) **PRC Inpatient Space Requirements.** PRCs maintain a minimum of 12 acute inpatient beds that are located in a designated area and are contiguous to each other.

(a) The establishment of a new PRC must follow VA's Office of Construction and Facilities Management - Space Planning Criteria - Polytrauma Rehabilitation Center (PRC) 111 (see <http://www.cfm.va.gov/til/space.asp>). This design includes:

1. Private rooms with space to accommodate families and equipment;
2. Therapy clinics;
3. Distraction-free quiet rooms;
4. Group dining;
5. Leisure room;

6. Training apartment;
7. Family Living Center;
8. Computer laboratory; and
9. IDT offices.

(b) Access to other treatment spaces in the facility need to be made available, as necessary, e.g., therapeutic pool, driver training and therapy clinics.

(3) **Equipment.** PRCs have the specialized equipment necessary to meet the rehabilitation needs of the complex clinical population they serve. This equipment includes, but is not limited to:

- (a) Specialized technologies to facilitate rehabilitation interventions;
- (b) Specialized beds, wheelchairs, and seating systems;
- (c) Specialized patient lifts and transfer equipment;
- (d) Gait and balance evaluation equipment;
- (e) Age-appropriate recreation materials;
- (f) Exercise, sports, and fitness equipment;
- (g) Specialized equipment associated with a Prosthetic and Orthotic Laboratory; and
- (h) Computer-aided Design (CAD) and Computer-aided Manufacturing (CAM).

24. POLYTRAUMA TRANSITIONAL REHABILITATION PROGRAM

a. Overview

(1) Polytrauma Transitional Rehabilitation Program (PTRP) is a time-limited and goal-oriented program designed to maximize each individual's level of functioning and social participation so that he or she is able to participate in a meaningful and satisfying life.

(2) PTRP offers a progressive return to independent living for patients in the post-acute stages of rehabilitation through a structured program focused on restoring home, community, leisure, psychosocial, and vocational skills in a controlled, therapeutic setting.

(3) Administratively, the PTRPs are organized under PM&RS.

(4) Currently, there are 5 PTRPs operating nationally at the VA medical centers in Minneapolis, Palo Alto, Richmond, San Antonio, and Tampa.

b. **Bed Unit Capacity and Accreditation**

(1) PTRPs must maintain a minimum of 10 inpatient beds;

(2) PTRP beds are identified and tracked by treating specialty code 82; and

(3) PTRPs must be CARF accredited for Brain Injury Program and Residential Rehabilitation Program. (See <http://vaww.oqsv.med.va.gov/functions/integrity/accred/carf.aspx>)

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

c. **Scope of Services**

(1) 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.

(2) Referrals to the PTRPs often include individuals in need of neurobehavioral rehabilitation after brain injury and polytrauma.

(3) Therapy services are provided by interdisciplinary teams of rehabilitation specialists using a combination of group and individual formats. Services address a broad range of functional, emotional and behavioral, physical, cognitive, psychosocial, vocational, leisure, and spiritual needs.

(4) Treatment and therapeutic activities are provided 7 days per week.

(5) Family and caregiver are encouraged to participate in all phases of the rehabilitation process, with the Veteran's or Servicemember's consent.

d. **Staffing**

(1) Each PTRP has a dedicated IDT of rehabilitation specialists. Required staffing for a ten-bed inpatient unit is listed in Appendix E. Due to the specialized expertise necessary to manage PTRP patients, it is important that staff be dedicated and non-rotating.

(2) Each PTRP must ensure that the appropriate disciplines are available and at sufficient levels to meet the needs of patients with polytrauma and TBI.

(3) Members of the PTRP IDT must demonstrate specialized education and training in the care of patients with polytrauma and TBI by way of their educational degree or certification, clinical training, continuing education, and experience, as detailed in subparagraph 16c.

(4) The IDT includes the person served and: rehabilitation providers; hospital consultants, as needed; external stakeholders, as appropriate; and his/her family and support system. The

disciplines and specialties included on any given team roster are not static, and may change as the participant progresses through the rehabilitation program.

e. **Admission Criteria**

Admitted participants are Veterans and Servicemembers with:

(1) Clearly defined disability limiting their ability to live independently in the community or to participate in family roles and in work related activities;

(2) Deficits from traumatic or acquired brain injury, polytrauma, or other neurologic injury or disorders that are treatable within the scope of services provided by the program;

(3) Clinical needs that can be addressed within the PTRP Scope of Services;

(4) Potential to successfully participate in group therapies and benefit from interdisciplinary services with PM&R oversight;

(5) Capacity to benefit from rehabilitation nursing and requiring no more than supervision/set up for basic activities of daily living (ADL), or having the potential to become independent with basic ADLs; and

(6) No behaviors that pose a risk or safety threat to self or others. In cases of behavioral instability, the rehabilitation and mental health teams will meet to determine the optimal environment of care that will facilitate recovery while maintaining safety.

f. **Admission Process**

(1) Referrals for admission to the PTRP are accepted from the home medical facility, from other VA medical centers, DoD, and from non-VA hospitals and facilities;

(2) Referrals undergo a pre-admission screening processed by the PTRP admissions coordinator. Positively screened candidate information is then forwarded to the PTRP medical Director and other members of the IDT, as necessary, for a formal intake evaluation;

(3) The intake evaluation includes: review of medical records; requests for further information; further assessment of the needs of the potential participant and their support system; and, review of eventual disposition plans. Communication with the applicants and their families and caregivers may also take place as part of the admissions intake or transfer process;

(4) Following review of the information detailed in subparagraphs 24f(1)-(3), a decision to accept or defer a referral is made; and

(5) The referring source and the applicant receive notice of the acceptance or an explanation for the denial. For those denied, the admissions coordinator makes recommendations for alternate services.

g. **Discharge Criteria and Process**

(1) A participant is discharged from the PTRP when he or she:

(a) Has reached his or her rehabilitation goals within the scope of the program;

(b) Is no longer able or willing to participate in the program, or is no longer adhering to the program and facility rules;

(c) Exhibits behavior posing a risk or safety threat to self or others, in which case, the rehabilitation and mental health teams will meet to determine the optimal environment of care that will facilitate recovery while maintaining safety; or

(d) Becomes medically or psychiatrically unstable, in which case, the rehabilitation and the medical or mental health teams will meet to recommend the environment of care that will promote medical and psychiatric stability.

(2) The discharge process is initiated in collaboration with the participant, the family, and the referral source or other stakeholders, as appropriate (e.g. DoD):

(a) PTRP case manager has the primary responsibility for discharge planning and coordination;

(b) Clinical follow up is arranged either locally or in the person's home community; and

(c) Discharge plans are summarized in the Discharge Summary.

h. **Environment of Care**

(1) The residential space is designed to mirror community living environments (e.g. dorm or barracks) and the setting accommodates up to 10 participants in semi-private and private rooms. Common areas and treatment space are included in the residential area. The designated space needs to include:

(a) Individual patient rooms with baths;

(b) Group kitchen, dining, laundry, and living rooms;

(c) Therapy gym;

(d) Activities and computer room;

(e) Individual therapy rooms;

(f) Nursing station; and

(g) IDT offices.

(2) Rehabilitation services focus on community integration and often occur outside the PTRP designated space. Sites of intervention include other medical center areas and various community settings.

(3) Design and space planning for the PTRP need to follow VA's Office of Construction and Facilities Management Space Planning Criteria - Polytrauma Rehabilitation Center (PRC) 111 (see: <http://www.cfm.va.gov/til/space.asp>).

25. ASSISTIVE TECHNOLOGY LABS

a. **Overview.** The mission of the Assistive Technology (AT) Labs is to effectively support Veterans and Servicemembers with cognitive, sensory, and physical disabilities to enhance their independence, comfort, and general quality of life through the use of assistive technology. An interdisciplinary team of specialists work together with the patient and his or her caregiver to assess, identify and recommend appropriate assistive devices. These include any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities.

b. **Scope of Services**

(1) AT Labs provide services that directly assist individuals with disabilities in the selection, acquisition, or use of AT devices. Services include:

(a) Evaluation of the AT needs of the individual with disability, including a functional evaluation of the impact of the provision of appropriate AT;

(b) Selecting, designing, fitting, customizing, adapting, applying, updating, or replacing AT devices;

(c) Coordination and provision of necessary therapies, interventions, or services with AT devices; and

(d) Training or technical assistance for the individual with disabilities or, where appropriate, the family members, guardians, advocates, or authorized representatives of such an individual.

(2) Categories of devices that typically fall under AT include: sensory aids; home and worksite modifications; environmental control systems; communication aids; cognitive aids; computer access; recreational adaptations; mobility aids; aids for daily living; adaptive driving; and, seating and positioning aids.

c. **Referrals**

AT Labs at the PRCs serve as regional referral centers (as per the PRC referral guidance in paragraph 14c) for Veterans and Servicemembers who:

(1) Have cognitive, sensory, and physical disability resulting in diminished ability to function independently or optimally at home, at work, or in the larger environment;

- (2) The effects of the disability can be reduced by using assistive devices; and
- (3) Are interested in using assistive devices to improve level of function.

d. **AT Labs Role and Responsibilities within the PSC**

(1) AT Labs are organized under PM&RS at the PRCs in Minneapolis, MN; Palo Alto, CA; Richmond, VA; San Antonio, TX; and Tampa, FL.

(2) AT Lab specialists provide consultation services for Veterans and Servicemembers with disabilities that could benefit from AT adaptations and serve as members of the IDTs for these patients;

(3) AT Labs support other programs in their PRC referral region by providing access to:

(a) AT devices for trial by Veterans, Servicemembers and providers so they can learn how the equipment works and which best fit their needs;

(b) Education and professional development services, including education and training for people with disabilities, their families and caregivers, service providers, professionals, as well as the community at large;

(c) Outreach and information services, including matching people with new technology and assistance in securing appropriate AT services in the home communities of Veterans and Servicemembers;

(d) Model templates for comprehensive AT evaluations and prescriptions;

(e) Data collection and management tools for AT outcomes; and

(f) Information regarding new AT devices and services.

e. **Accreditation and Certification**

AT Labs must be accredited (or work towards accreditation) by CARF under the standards in the Community Services Section of the Employment and Community Services Manual (see, <http://vaww.oqsv.med.va.gov/functions/integrity/accred/carf.aspx>). *NOTE: This is an internal VA Web site and is not available to the public.*

f. **Staffing**

Recommended clinical team for the AT Lab includes:

- (1) Physician;
- (2) Rehabilitation Engineer;

- (3) Physical Therapist;
- (4) Occupational Therapist;
- (5) Vocational Rehabilitation Specialist;
- (6) Therapeutic Recreation Specialist;
- (7) Speech Language Pathologist; and
- (8) Driving Rehabilitation Specialist.

g. **Equipment**

Equipment purchased for the AT Labs is considered a medical, non-Information Technology (IT) acquisition. Examples of this equipment are diverse and include, but are not limited to: cameras, laptops, voice recorders, tablet computers, e-readers and desktop computers. There is also an array of software that augments or builds communication skills or assists with other specific medical needs. This equipment is in support of direct patient care, is not used for other than AT, is not linked or interfaced to VA IT systems, and does not hold sensitive personally identifiable patient information.

h. **Space Requirements**

(1) Every effort must be made to co-locate AT Lab staff and resources in a contiguous space dedicated to the needs of the patients with polytrauma and TBI and their families.

(2) Space redesign or remodeling needs to be conducted in accordance with the VA Office of Construction and Facilities Management – Space Planning Criteria - Polytrauma Rehabilitation Center (PRC) 111 (see: <http://www.cfm.va.gov/til/space.asp>).

26. POLYTRAUMA TELEHEALTH NETWORK

Polytrauma Telehealth Network (PTN) is a virtual network of care utilizing dedicated lines of telecommunication technology to link PRC and PNS sites, as well as other VA medical facilities, MTFs, and Community Based Outpatient Clinics (CBOC). PTN is used to promote seamless delivery of care, improve access to the appropriate level of expertise, and to facilitate service provision closer to home. **NOTE:** *Additional information regarding the PTN is available at <http://vaww.telehealth.va.gov/clinic/trh/ptn/index.asp>. This is an internal VA Web site and is not available to the public.* Clinical services provided through the PTN include:

- a. Pre-admission interdisciplinary team conferences when the patient is referred from a distant location;
- b. Site-to-site team conferences with families;

- c. Discharge planning to the next care setting;
- d. Post-discharge follow-up;
- e. Consultation for assessment and treatment recommendations;
- f. Consultation concerning new and emerging problems; and
- g. Continuing professional education.

27. POLYTRAUMA NETWORK SITES

a. Designation

(1) Polytrauma Network Sites (PNS) are designated by the Deputy Under Secretary for Health for Operations and Management (10N). They provide services and coordinate key components of post-acute rehabilitation care for individuals with polytrauma and TBI in each VISN (see Appendix B for a listing of VA facilities with PNS programs).

(2) The PNS designation requires that the facility meets staffing, scope of services, and accreditation and certification requirements outlined in this Handbook.

(3) PNSs are organized under PM&RS and report to the Chief of Staff, or equivalent, at the facility.

(4) Requests for designation of new PNS facilities or changes in existing designation must be addressed to the Deputy Under Secretary for Health for Operations and Management, and routed through the Chief Consultant, Rehabilitation and Prosthetic Services.

b. Scope of services

(1) **Comprehensive Integrated Inpatient Rehabilitation.** PNS inpatient rehabilitation is generally indicated for patients who have completed acute inpatient rehabilitation at a PRC, but continue to have significant activity limitations that make it unsafe for them to return to the community independently, or difficult to be cared for at home. These patients may require ongoing management in an inpatient setting for complex, residual physical, cognitive or behavioral difficulties. Post-acute rehabilitation typically includes interdisciplinary treatment programs with an emphasis on daily functioning, medication adjustments, caregiver support and education, and prevention of further injury.

(2) **Comprehensive Interdisciplinary Outpatient Rehabilitation.** Outpatient PNS programs provide comprehensive interdisciplinary rehabilitation care led by a rehabilitation physician. These programs are designed for Veterans and Servicemembers that are able to live at home, but continue to require rehabilitation interventions to maximize their level of function and participation in life activities. These individuals may present with a broad range of challenges in body structures or functions due to polytrauma and TBI. Outpatient PNS services are directed towards the treatment of impairments or limitations of new onset, but may also attend to chronic

impairments if new interventions are thought to be beneficial. Based on the individual needs of the patient, IDTs provide outcome-focused services, including: rehabilitation medicine; therapies; education; case management; and psychosocial treatment and support to patients and their families who live in their local service areas, or are referred from other facilities within the VISN.

c. **PNS Responsibilities within the PSC.** The PNS represents a vital link in the continuum of PSC rehabilitation services between the regional referral center at the PRC and the local resources at the PSCTs and the PPOCs. They provide leadership for clinical, educational, and administrative services related to polytrauma and TBI rehabilitation within their VISN including:

- (1) Coordination of polytrauma and TBI services;
- (2) Specialty consultations for patients with polytrauma and TBI;
- (3) Developing and maintaining an inventory of VA and non-VA sources for polytrauma and TBI services available across the VISN, and making them available to patients and families, and to the VA facilities with a PSCT and PPOC;
- (4) Developing and conducting VISN-level educational programs for providers, as well as patients and families in the areas of polytrauma and TBI; and
- (5) Collaborating in tracking VISN-level outcome data and performance monitors for polytrauma and TBI.

d. **Accreditation and Certification.** PNS inpatient rehabilitation program must be CARF accredited for Comprehensive Integrated Inpatient Rehabilitation.

e. **Staffing**

(1) Each PNS has a dedicated IDT of rehabilitation specialists (see Appendix F) that provide services for Veterans and Servicemembers with polytrauma and TBI. Due to the specialized expertise necessary to manage these patients, it is important that staff be dedicated and non-rotating.

(2) Each PNS must ensure that the appropriate disciplines are available and at sufficient levels to meet the needs of patients with polytrauma and TBI.

(3) The primary focus of the IDT at the PNS is the outpatient program. However, when polytrauma and TBI patients are admitted for inpatient care, the PNS teams will have the lead in the development and management of the rehabilitation plan of care.

(4) Members of the PNS IDT must demonstrate specialized education and training in the care of patients with polytrauma and TBI by way of their educational degree or certification, clinical training, continuing education, and experience, as detailed in subparagraph 11c.

(5) In addition to the core team, other rehabilitation providers, hospital consultants, external stakeholders, and the person served and his or her family and support system, need to be included in the IDT depending on the needs of the individual.

f. **Referrals**

(1) **Reasons for Referral.** Referrals to a PNS are accepted for:

(a) Comprehensive rehabilitation evaluation after polytrauma and TBI;

(b) Interdisciplinary rehabilitation treatment after polytrauma and TBI;

(c) Improving activity participation and level of functional independence after polytrauma and TBI; and,

(d) Aid with adapting to loss of independence after polytrauma and TBI, including caregiver training and education.

(2) **Referral Sources.** Referrals for admission to the outpatient PNS programs are accepted from sources within the VA medical centers where the programs are located, other VA medical centers in the VISN, DoD, self-referral, and other sources in the community.

g. **Admission Criteria**

(1) History of polytrauma and TBI as determined during the initial physician evaluation, with associated rehabilitation goals that are best addressed by the rehabilitation IDT;

(2) Ability to successfully participate in interdisciplinary rehabilitation services, in an outpatient setting;

(3) Absence of behaviors posing immediate safety threat to self or others; and

(4) Ability to engage with the rehabilitation IDT and potential for successful rehabilitation outcomes.

h. **Rehabilitation Treatment Process**

(1) Each person's rehabilitation program is based on an interdisciplinary assessment of their medical problems and rehabilitation needs/goals, as well as their strengths, resources, interests, and preferences.

(2) An IRCR Plan of Care is developed for every Veteran and Servicemember receiving outpatient rehabilitation services for TBI and polytrauma at a PNS. The participant, family and caregiver are integral members of the rehabilitation team, and collaborate in the development and implementation of the plan.

(3) The IDT meets regularly to review and modify the Plan of Care and to address issues

related to discharge planning.

i. **Discharge Criteria and Process**

(1) Participants are discharged from the outpatient PNS program when either of the following occurs:

(a) Interdisciplinary goals are met; or

(b) The participant is no longer making progress toward their identified goals or is unable to actively engage in programming.

(2) Once discharge criteria are met, arrangements for discharge and recommendations for follow-up are made in collaboration with the Veteran and Servicemember, and other stakeholders. The process includes:

(a) Discharge arrangements from the PNS program are coordinated by the assigned case manager;

(b) All discharge planning is done in a coordinated fashion with IDT members to ensure that the person served is discharged to a situation that maximally addresses his or her current level of function and continued needs;

(c) Appropriate follow-up services are arranged at the VA medical center or in the person's home community by the assigned Polytrauma Case Manager, and confirmed by the referring Polytrauma Case Manager; and

(d) Discharge plans are summarized in the Discharge Summary and communicated to the Veteran, Servicemember, and other stakeholders by the case manager.

j. **Environment of Care.** The PNS provides a safe and comfortable environment of care that meets the expectations of all era Veterans and, in particular, the new generation of Veterans and Servicemembers who served post 9-11.

(1) The PNS program must make every effort to co-locate its staff and resources in a contiguous space dedicated to the needs of the patients with polytrauma and TBI and their families;

(2) Space redesign or remodeling needs to be conducted in accordance with the VA Office of Construction and Facilities Management – Space Planning Criteria - Polytrauma Rehabilitation Center (PRC) 111 (see: <http://www.cfm.va.gov/til/space.asp>);

(3) The PNS must maintain state-of-the-art equipment and technology for advanced rehabilitation practice. The PNS is expected to utilize equipment that has been recommended and funded by VA Central Office Rehabilitation and Prosthetic Services, as well as other equipment identified as necessary to meet the needs of their patients;

(4) The PNS must have safety and security measures in place that are consistent with the physical, cognitive, and behavioral needs of patients they serve. Safety and security measures include, but are not limited to:

- (a) Environmental modification;
- (b) Training;
- (c) Staffing levels; and
- (d) Routine monitoring of the adequacy of the measures in place.

28. POLYTRAUMA SUPPORT CLINIC TEAMS

a. Designation

(1) Polytrauma Support Clinic Teams (PSCT) are designated by the Deputy Under Secretary for Health for Operations and Management (10N). They provide services and coordinate key components of post-acute rehabilitation care for Veterans and Servicemembers with polytrauma and TBI within their facility's catchment area (see Appendix B for a listing of VA facilities with PSCT programs);

(2) The PSCT designation requires that the facility meets staffing and scope of services requirements outlined in this Handbook;

(3) PSCTs are organized under the PM&RS; and

(4) Requests for designation of new PSCT facilities or changes in existing designation must be addressed to the Deputy Under Secretary for Health for Operations and Management, and routed through the National Program Director, PM&RS.

b. Scope of Services

(1) **Comprehensive Interdisciplinary Outpatient Rehabilitation.** The PSCT provides interdisciplinary outpatient rehabilitation services within their catchment areas for Veterans and Servicemembers with mild or stable functional deficits due to polytrauma and TBI. PSCT outpatient services include:

(a) Comprehensive interdisciplinary evaluations of Veterans with positive TBI screens and of other Veterans and Servicemembers with functional problems related to, or suspected to be related to polytrauma and TBI;

(b) Developing an IRCR Plan of Care to coordinate interdisciplinary treatments for patients who could benefit from rehabilitation services;

(c) Managing the IRCR Plan of Care for Veterans and Servicemembers who received rehabilitation care at a PRC or PNS, and were referred to the PSCT for services closer to home;

(d) Supporting Veterans' successful reintegration into their home communities by providing and coordinating vocational and independent living services;

(e) Addressing changes in function related to changes in health, psychosocial conditions, and aging;

(f) Exploring ways in which new technologies or treatments can benefit Veterans and Servicemembers with polytrauma and TBI; and

(g) Providing opportunities for Veterans, Servicemembers, and their caregivers to receive education regarding their medical conditions and suggestions for self-management that promote health and activity participation.

(2) **Comprehensive Integrated Inpatient Rehabilitation.** Facilities with PSCT programs may have capacity for Comprehensive Integrated Inpatient Rehabilitation, but this is not a requirement for the PSCT designation.

c. **Responsibilities within PSC**

The PSCT provides specialized rehabilitation services for Veterans and Servicemembers with polytrauma and TBI who reside within their catchment area. They are responsible for:

(1) Developing and maintaining an inventory of VA and non-VA sources for polytrauma and TBI services that are available within their catchment area, and making them available to patients, their families and to other providers;

(2) Collaborating with Federal and state agencies (Vocational Rehabilitation and Employment, state vocational rehabilitation), with other services within their facility (mental health, primary care, long-term care), with the private sector (local rehabilitation programs or providers), and with community resources (local chapters of the Brain Injury Association, or local educational institutions) to meet Veterans' and Servicemembers' rehabilitation and reintegration goals, as identified in the IRCR Plan of Care;

(3) Consulting with PNS and PRC specialists for conditions that do not improve in a reasonable amount of time, for atypical symptom presentations, and for all acute moderate to severe injuries;

(4) Conducting facility-level educational programs regarding polytrauma and TBI; and

(5) Tracking facility level outcome data and performance monitors for polytrauma and TBI.

d. **Staffing**

(1) PSCTs have an IDT of rehabilitation specialists (see Appendix G) that provide services for Veterans and Servicemembers with polytrauma and TBI. Due to the specialized expertise necessary to manage these patients, it is important that staff be non-rotating.

(2) Each PSCT must ensure that the appropriate disciplines are available at staffing levels necessary to meet the needs of Veterans and Servicemembers with polytrauma and TBI.

(3) In addition to the core team members, other rehabilitation and medical disciplines may be added to the PSCT to meet individual patient needs.

(4) Members of the PSCT IDT must demonstrate specialized education and training in the care of patients with polytrauma and TBI by way of their educational degree or certification, clinical training, continuing education, and experience, as detailed in subparagraph 16c.

e. **Referrals**

(1) **Reasons for Referral.** Referrals to the PSCT are accepted for:

(a) Comprehensive rehabilitation evaluation after polytrauma and TBI;

(b) Interdisciplinary rehabilitation treatment after polytrauma and TBI;

(c) Improving activity participation and level of functional independence after polytrauma and TBI; and

(d) Aid with adapting to loss of independence after polytrauma and TBI, including caregiver training and education.

(2) **Referral Sources.** Referrals for admission to the outpatient PSCT programs are accepted from sources within the VA medical center, other PSC programs, DoD, self-referral, and other sources in the community.

f. **Admission Criteria**

(1) History of polytrauma and TBI as determined during the initial physician evaluation, with associated rehabilitation goals that are best addressed by the rehabilitation IDT;

(2) Ability to successfully participate in interdisciplinary rehabilitation services, in an outpatient setting;

(3) Absence of behaviors posing immediate safety threat to self or others; and

(4) Ability to engage with the interdisciplinary rehabilitation team and potential for successful rehabilitation outcomes.

g. **Rehabilitation Treatment Process**

(1) Each person's rehabilitation program is based on an interdisciplinary assessment of their medical problems, rehabilitation needs and goals, as well as their strengths, resources, interests, and preferences.

(2) An IRCR Plan of Care is developed for every Veteran and Servicemember receiving outpatient rehabilitation services for TBI/Polytrauma by a PSCT. The participant, family and/or caregiver are integral members of the rehabilitation team, and collaborate in the development and implementation of the plan of care.

(3) The IDT meets regularly to review and modify the Plan of Care and to address issues related to discharge planning.

h. Discharge Criteria and Process

(1) Participants are discharged from a PSCT program when either of the following occurs:

(a) Interdisciplinary goals are met; or

(b) The participant is no longer making progress toward their identified goals or is unable to actively engage in programming.

(2) Once discharge criteria are met, arrangements for discharge and recommendations for follow-up are made in collaboration with the Veteran and Servicemember, and other stakeholders. The process includes:

(a) Discharge arrangements from the PSCT program are coordinated by the assigned Polytrauma Case Manager;

(b) All discharge planning is done in a coordinated fashion with the IDT to ensure that the person served is discharged to a situation that maximally addresses his or her current level of function and continued needs;

(c) Appropriate follow-up services are arranged at the VA medical center or in the person's home community by the assigned Polytrauma Case Manager; and

(d) Discharge plans are summarized in the Discharge Summary and communicated to the Veteran, Servicemember, and other stakeholders by the Polytrauma Case Manager.

i. **Environment of Care.** The PSCT program provides a safe and comfortable environment of care that meets the expectations of all era Veterans and, in particular, the new generation of Veterans and Servicemembers who served post 9-11.

(1) The PSCT program must make every effort to co-locate its staff and resources in a contiguous space dedicated to the needs of the patients with polytrauma and TBI and their families.

(2) Space redesign or remodeling needs to be conducted in accordance with the VA Office of Construction and Facilities Management – Space Planning Criteria - Polytrauma Rehabilitation Center (PRC) 111 (see: <http://www.cfm.va.gov/til/space.asp>).

29. POLYTRAUMA POINTS OF CONTACT

The Polytrauma Points of Contact (PPOC) is located at VA medical facilities without a PNS or PSCT program. The role of the PPOC is to help ensure that Veterans and Servicemembers with polytrauma and TBI who would benefit from specialized rehabilitation interventions are referred to the appropriate PSC program or local VA and non-VA specialty care resources. The PPOC function is carried out through existing Care Management roles and functions, as per VHA Handbook 1010.01, Care Management of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans, paragraph 10:

a. **OEF/OIF/OND Program Manager.** The role of the OEF/OIF/OND Program Manager at VA medical facilities without a PNS or PSCT program is to ensure that OEF/OIF/OND Servicemembers and Veterans are referred to appropriate polytrauma and TBI services.

b. **Responsibilities within PSC**

The OEF/OIF/OND Program Manager at VA medical facilities without a PNS or PSCT program (see Appendix B for PPOC locations) is responsible for:

(1) Ensuring all OEF/OIF/OND Servicemembers and Veterans with polytrauma and TBI are referred to the appropriate specialty care program for clinical care and case management;

(2) Ensuring all OEF/OIF/OND/ Servicemembers and Veterans with polytrauma and TBI in need of care management are assigned to a nurse or social worker case manager;

(3) Ensuring that the Lead Case Manager is jointly determined by the specialty care program and the OEF/OIF/OND/ Care Management team;

(4) Developing and maintaining an inventory of VA and non-VA sources for polytrauma and TBI services available within their catchment area, and making them available to patients, their families, and to other providers;

(5) Being familiar with the content of this Handbook and with the information about polytrauma and TBI available on the Web site at <http://www.polytrauma.va.gov/>; and

(6) Participating in PSC sponsored conference calls and other PSC sponsored activities within their VISNs.

30. CASE MANAGEMENT IN POLYTRAUMA SYSTEM OF CARE

a. **Overview**

(1) The PSC has a robust case management component whose role is to transition Veterans and Servicemembers seamlessly across levels of care and to coordinate resources to meet their medical and psychosocial needs. Polytrauma Case Managers are usually nurses and social workers. All Veterans and Servicemembers receiving services in a PSC program receive comprehensive case management services. The Polytrauma Case Manager serves to support the

individual's and family's health needs across sites and unique episodes of care within the PSC, and to ensure the patient receives the highest level of quality integrated services.

(2) Polytrauma Case Management is a specialized and highly skilled component of care management provided to Veterans and Servicemembers who require intensive support and monitoring due to complex medical, mental health or psychosocial factors. This requires frequent assessment, planning, advocacy, support, coordination of multiple services, and evaluation to meet the Veteran's complex needs. It may be short term or long term, based on clinical needs of the Veteran, family and caregiver. Case management is intended to maximize resource utilization and promote quality and Veteran-centered care while producing cost effective outcomes.

b. **Scope of Services**

Polytrauma Case Managers serve as Lead Case Managers for Veterans and Servicemembers with polytrauma and TBI receiving care in one of the PSC programs. They function as core members of the polytrauma IDTs.

(1) **Specialty Population for Case Management.** Specialty populations require intensive case management support and monitoring. Veterans and Servicemembers with polytrauma and TBI have multiple and complex care needs and, as such, qualify as specialty population for Case Management. Their problems interfere with life in a disabling manner, and are at high risk for psychosocial issues and health related problems. They require significant coordination of services across echelons of care, and across agencies of care, including DoD, VA, and non-VA entities.

(2) **Lead Case Manager.** At times, multiple case managers may be involved in the Veteran's or Servicemember's care. In such instances, a lead case manager must be identified as having primary responsibility for the medical, psychological, and psychosocial concerns of the Veteran. Polytrauma Case Managers serve as Lead Case Managers for Veterans and Servicemembers participating in rehabilitation care in one of the PSC programs. They are the clinicians who best understand the rehabilitation needs of the patients and can be effective as primary communicators with patients, family, caregivers, and the IDT providers.

(3) **Core IDT Member.** Polytrauma Case Managers are core members of the IDT at all levels of the PSC. Polytrauma case management requires well-coordinated and collaborative interdisciplinary efforts which are dependent upon effective communication and cooperation. The overarching goal is to evaluate, plan, implement, and coordinate options and services to meet the health care needs of Veterans and Servicemembers, as well as addressing the needs of their families.

c. **Responsibilities within PSC.** The Polytrauma Case Manager is responsible for:

(1) Contacting the Veteran and Servicemember prior to transfer for inpatient admission and the first outpatient appointment to answer any questions about upcoming rehabilitation procedures;

(2) Completing and documenting a comprehensive biopsychosocial care management assessment, updating the assessment as necessary based on clinical judgment, and developing a care management plan of care;

(3) Communicating and coordinating the care plan with the IDT providers, other involved case managers, and the Veteran, Servicemember, and their families. This includes regular communication with the OEF/OIF/OND Program Manager, and participation in OEF/OIF/OND Care Management team meetings and activities within the facility;

(4) Facilitating access to services and ensuring that communication with stakeholders, service providers, payer sources, and referral sources is maintained;

(5) Assisting to resolve any issues at the local level to include ensuring appointments are scheduled, authorizations are obtained, family resources secured, and any psychosocial issues are addressed (e.g., temporary lodging, home modifications, community resources, in-home services, etc.);

(6) Continually assessing the need for a change in care management services, and adjusting the level of intervention as appropriate based on the medical and psychosocial needs of the Veteran, Servicemember, and their family members;

(7) Referring Veterans and Servicemembers to IDT recommended programs and services, coordinating care and services according to the patient's IRCR Plan of Care, and monitoring implementation of that plan;

(8) Providing clinical services, such as individual, family, grief and adjustment counseling, coordination of family meetings, and offering supportive services for patients and families;

(9) Ensuring smooth transitions between components of the PSC, between VA and DoD, and between hospital and home environment;

(10) Assessing caregiver support needs and making appropriate referrals to the facility caregiver support coordinator;

(11) Collaborating with the IDT to develop plans for follow up care, including: medical, nursing, and therapy appointments; equipment and supplies; prosthetic and/or orthotic equipment; psychosocial needs; and, special instructions for ongoing care;

(12) Communicating the discharge plans and treatment recommendations verbally and in writing to the patient and family, the receiving treatment facilities, and/or appropriate VA/DoD stakeholders;

(13) Verifying that the recommendations are implemented; and

(14) Assessing, updating, and monitoring clinical outcomes and Veteran and family satisfaction.

d. Staffing

(1) All levels of PSC programs must ensure that Polytrauma Case Managers are available at staffing levels necessary to meet the needs of Veterans and Servicemembers with polytrauma and TBI.

(2) Polytrauma Case Managers must demonstrate specialized education and training in the care of patients with polytrauma and TBI by way of their educational degree or certification, clinical training, continuing education, and experience, as detailed in subparagraph 11c. Additional knowledge and skills required include:

(a) Knowledge to assess and treat OEF/OIF/OND Veterans. The Polytrauma Case Manager needs to have the skills and ability to complete psychosocial assessments for returning combat Veterans, including: detailed military history; history of polytrauma and treatment; and, mental health and emotional problems and treatment;

(b) Knowledge of OEF/OIF/OND benefits. The Polytrauma Case Manager needs to be familiar with benefits available for this special population of Veterans and needs to be able to assist them with application for benefits and advocate on their behalf. This would include but not be limited to: military; Traumatic Servicemembers' Group Life Insurance (TSGLI); VA; Vocational Rehabilitation; Social Security; and, the Americans with Disabilities Act;

(c) Knowledge of OEF/OIF/OND special issues including age-specific characteristics, family dynamics, and educational needs;

(d) Ability to coordinate care for OEF/OIF/OND Veterans across DoD and VA. Polytrauma Case Manager must have a thorough understanding of the PSC, and be familiar with military culture (language, ranks, acronyms, etc.), resources, and military medical processes (Medical Boards, MMSO, TRICARE);

(e) Knowledge of VA and community resources, including: transitional housing, transportation, home modifications, day treatment, support groups, adaptive equipment, and local, state and federal brain injury services;

(f) Ability to assimilate multiple discipline treatment goals into a meaningful care plan; and

(g) Ability to collaborate with other case managers within the VA and military healthcare.

e. Polytrauma Case Management Process**(1) Referral**

(a) All Veterans and Servicemembers receiving rehabilitation services in one of the PSC programs from acute rehabilitation, post-acute rehabilitation, transitional rehabilitation, outpatient rehabilitation services, to community reentry and vocational rehabilitation require referrals to a Polytrauma Case Manager.

(b) Veterans are identified by self-referral, caregiver, family member, the PACT Nurse Care Manager, other VA and non-VA clinicians and healthcare team members, or health informatics alert systems. The Veteran, Servicemember, or surrogate is asked to consent to case management services.

(2) **Assessment.** Following admission into a PSC program, the Polytrauma Case Manager meets with the patient and family and completes a comprehensive psychosocial assessment leading to the development of the plan of care. The assessment and planning process are conducted in collaboration with the patient and family. Results are documented in the medical record and communicated to the IDT. Re-assessment is conducted, as necessary, due to changes in patient and family medical, rehabilitation and psychosocial needs.

(3) **Treatment**

(a) **Plan of Care.** The Polytrauma Case Management Plan of Care is a comprehensive plan that includes a statement of problems/needs determined upon assessment; strategies to address the problems/needs; and measurable goals to demonstrate resolution based upon the problems/needs, timeframe, available resources, and the desires/motivation of the patient and family (CMSA, 2008, p.275).

(b) **Implementation of the Plan of Care.** Implementation of the IRCR Plan of Care is accomplished through coordination, collaboration and communication with the IDT (including VA and non-VA providers), the Veteran, and the family or caregiver.

(c) **Intensity of Case Management Services.** Intensity of case management services is dependent on the care setting (e.g., inpatient vs. outpatient rehabilitation), the patient's medical condition (e.g., severe vs. mild, and acute vs. chronic injuries), and complexity of psychosocial needs and environmental factors (e.g., strong family support system vs. weak, or no support system, availability of services in the community). The following 4 levels of intensity of Case Management services are identified in VHA Handbook 1010.01 *Care Management of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans, subparagraph 11j*:

1. Intensive Case Management – daily or weekly services. Polytrauma Case Management generally falls into the intensive and progressive categories;

2. Progressive Case Management – monthly services;

3. Supportive Case Management – quarterly services; and

4. Long-Term or Chronic Case Management – yearly services.

(d) **Monitoring and Re-evaluation of the Plan of Care.** Monitoring and re-evaluation of the plan of care are critical to ensure that the right care is provided, at the right time, in the right place, at the right cost, and is integrated and coordinated each and every time.

(4) **Transition of Polytrauma Case Management.** Polytrauma Case Managers have a crucial role in transition planning. They coordinate the handoff to the next level of care and case

management as the patient's rehabilitative goals change. Transition planning is an imperative part of rehabilitation planning in order to ensure the patient's timely, appropriate, and safe transition to the next level of care or setting, including securing the resources necessary for ongoing care.

(a) Transition of Polytrauma Case Management occurs under the following conditions:

1. Patients no longer require rehabilitation services and monitoring by the PSC team, but have ongoing medical and psychosocial needs. These patients will be transitioned to the appropriate clinical service for care and case management follow up, such as PACT, OEF/OIF/OND Care Management, Mental Health providers, Federal Recovery Coordinators (FRC), etc. The local VA care team will determine who assumes the case management responsibilities based upon the recommended focus of care.

2. Patients have ongoing rehabilitation needs to be addressed at a different PSC location. Their rehabilitation care and case management will be transitioned to the recommended level and location of the PSC.

3. Servicemembers have ongoing healthcare or rehabilitation needs to be addressed at a DoD facility. These patients' care and case management needs will be addressed at the location and level agreed upon by the Military Case Manager.

(b) Polytrauma Case Manager responsibilities during transfer include:

1. Providing a comprehensive updated assessment of the patient at the time of transition, and recommendations for continuation of care and rehabilitation as documented in the IRCR Plan of Care;

2. Notifying or confirming that the OEF/OIF/OND Program Manager is aware of the transfer of care of the patient to the local facility, and informing the patient and the family about the case management transfer;

3. Documenting in the medical record the name of the receiving case manager and the measures put in place to avoid any interruption in services;

4. Contacting the patient and family at least twice, or as often as necessary, in the first 2 weeks following the transfer to ensure that services are in place at the receiving facility;

5. Being available for consultations with the case manager at the receiving location regarding recommendations for services for the Veteran or Servicemember;

(c) Referring Servicemembers, National Guard members, and Reservists who require complex medical and rehabilitation care involving multiple transitions following discharge from a PRC or PTRP to the Federal Recovery Coordination Program (FRCP). Participation in the FRCP ensures that both short term and long term transition issues are appropriately addressed and that transition of care and benefits between VA and DoD occurs without gaps and delays.

(d) When Servicemembers are discharged from a PSC program to home, the Polytrauma Case Manager will notify the OEF/OIF/OND Program Manager at the facility in whose catchment area the Servicemember resides to enroll him or her at the local VA medical center.

(e) All severely injured Veterans who are transferred across PSC levels of care and locations must be referred to the FRCP to ensure long term coordination of care and availability of appropriate level of services.

(5) **Discharge From Polytrauma Case Management**

In order to discharge a Veteran from Polytrauma Case Management, the following criteria must be met:

(a) No outstanding care management issues;

(b) Completed care management treatment plan;

(c) Stable psychosocial environment;

(d) Concurrence by the OEF/OIF/OND Program Manager and Care Management Review Team;

(e) Discussion documented in clinical note in VA's electronic health record and in final CMTRA contact; and

(f) Inform treatment providers and include transition of care to the Patient Aligned Care Team.

(6) **Documentation.** The case manager must document in accordance with Joint Commission (JC) standards, the Commission on Accreditation of Rehabilitation Facilities (CARF) guidelines, accepted professional case management, social work and nursing standards of practice, and local facility policy. Documentation for OEF/OIF/OND seriously ill and injured Veterans will also occur in Care Management Tracking Record Application (CMTRA).

31. REPORTING REQUIREMENTS IN POLYTRUAMA SYSTEM OF CARE

a. **National PM&RS Program Office Reports.** Reports are submitted to the PM&RS Program Office through secure Share Point 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.

b. **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:

(1) **Treating Specialty Code 1N (Polytrauma Rehabilitation Unit).** Code 1N is used to designate specialty inpatient rehabilitation treatment provided at the PRCs. Polytrauma beds are separate 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 bed units. These programs must be CARF accredited.

(2) **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.

(3) **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 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.

(4) **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.

c. **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.

d. **Mayo Portland Adaptability Inventory-4 Participation Index (M2PI).** Outcomes of outpatient rehabilitation care in the PSC are monitored using the M2PI. Data is collected upon admission into and discharge from the PSC program, but the scale can also be utilized at other points in the course of treatment. IDTs must capture both the raw scores, and the standard T-scores on the M2PI. Local means of data capture and collection must be utilized until a national mechanism is in place for data entry. (See information about the Mayo Portland Adaptability Inventory at <http://tbims.org/combi/mpai/>).

32. DECISION SUPPORT SYSTEM IDENTIFIERS (CLINIC STOP CODES)

a. **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 (see Appendix H for a complete list of stop codes and their definitions):

- (1) 195 - PTRP Individual;
- (2) 196 - PTRP Group;
- (3) 197 – Polytrauma Individual;
- (4) 198 – Polytrauma Group;
- (5) 199 – Polytrauma Telephone; and
- (6) 240 – Physical Medicine and Rehabilitation Assistive Technology Clinic.

b. **Credit Stop Codes.** Credit stop codes are used in the secondary position to identify the clinical specialty of the provider associated with the outpatient care provided by designated PNS, PSCT, and PTRP. The following DSS IDs represent providers or disciplines on the core polytrauma teams (see Appendix I for a complete list and description of the Credit Stop Codes):

- (1) 201 – PM&RS Physician;
- (2) 202 – Recreation Therapy;
- (3) 204 – Speech Pathology;
- (4) 205 – Physical Therapy;
- (5) 206 – Occupational Therapy;
- (6) 213 – PM&RS Vocational Assistance;
- (7) 214 – Kinesiotherapy;
- (8) 217 – Blind Rehabilitation Outpatient Specialist;
- (9) 117 – Nursing;
- (10) 125 - Social Work Service;
- (11) 509 – Psychiatry – Individual;
- (12) 510 – Psychology Individual;
- (13) 538 - Psychological Testing;
- (14) 557 – Psychiatry – Group;
- (15) 558 – Psychology Group; and

(16) 160 – Clinical Pharmacy.

c. **TBI Coding in the International Classification of Diseases, 9th Edition (ICD-9-CM)**

(1) **TBI Codes.** VA has developed a list of accepted ICD-9-CM codes which are utilized to identify clinical activity associated with TBI. See Appendix J for a listing and definitions of ICD-9-CM codes typically associated with TBI.

(2) **TBI Severity.** Severity classification is based on patient presentation proximate to the time of injury. Specific coding guidance for representing severity of initial injury can be found in Appendix K.

(3) **Initial versus Subsequent Visits.** Providers treating a patient who has sustained a TBI must apply the injury code only once at the time of their initial encounter following the injury, regardless of when the injury took place. An initial encounter does not refer to the first time the patient is seen by each clinician for that particular injury, but rather the first time the patient is treated by any medical professional for the TBI. Clinical documentation must clearly indicate the encounter coded is the initial encounter for that particular injury. Encounters occurring following the initial visit related to the TBI need to be coded with the symptom code(s) which best represent the patient's chief complaint or symptom(s) in the primary position, followed by the appropriate late effect code as one of the secondary codes:

(a) 905.0 Late effect of intracranial injury with skull or facial fracture;

(b) 907.0 Late effect of intracranial injury without skull or facial fracture;

(c) An exception to this rule occurs when the patient is seen for inpatient or outpatient rehabilitation, in which case the v57.x series is always in the primary position, followed by the appropriate symptom and late effect code(s).

(4) **Personal History of TBI.** The V15.52 code is used when no other code is available to reflect a previous TBI despite the patient reporting a personal history of injury.

(5) **TBI Screening.** Clinical screening for a possible TBI needs to be captured using the V80.01 code, whether or not the screening is positive. Codes associated with TBI (either injury or late effect codes) must not be entered at the time of screening, as a positive TBI screen does not indicate a TBI diagnosis.

d. **TBI Coding in the International Classification of Diseases, 10th Edition (ICD-10-CM)**

VA has adopted the *International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM)* for diagnosis coding with its associated Official ICD-10-CM Guidelines for Coding and Reporting and the *International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)* for inpatient hospital procedure coding and its associated Official ICD-10-PCS Guidelines for Coding and Reporting. These code sets replace ICD-9-CM, Volumes 1 and 2, (diagnoses) and ICD-9-CM, Volume 3, (inpatient

procedure codes). The Current Procedure Terminology (CPT[®]) will continue to be used for outpatient procedure coding.

(1) **TBI Codes.** VA has developed a list of accepted ICD-10-CM codes which are utilized to identify clinical activity associated with TBI. See Appendix J for a listing and definitions of ICD-10-CM codes typically associated with TBI.

(2) **Coding TBI Severity.** Severity classification is based on patient presentation proximate to the time of injury. Specific coding guidance for representing severity of initial injury can be found in Appendix K.

(3) **Initial versus Subsequent Visits.** Providers treating a patient who has sustained a TBI must apply the injury code only once at the time of their initial encounter following the injury, regardless of when the injury took place. An initial encounter does not refer to the first time the patient is seen by each clinician for that particular injury, but rather the first time the patient is treated by any medical professional for the TBI. Clinical documentation must clearly indicate the encounter coded is the initial encounter for that particular injury. Subsequent encounters occurring following the initial visit related to the TBI need to be coded with the symptom code(s) which best represent the patient's chief complaint or symptom(s).

(4) **Coding TBI Symptoms.** The procedure for coding TBI symptoms changes radically under ICD-10-CM. The concept of late effect no longer exists. For cases involving intracranial injury (S06), the clinician also codes any associated open wound of the head (S01) or skull fracture (S02). The appropriate 7th character is added to each code from category S06:

(a) 7th character "A," initial encounter, is used while the patient is receiving active treatment for the condition. Examples of active treatment are: surgical treatment, emergency department encounter, and evaluation and treatment by a new physician;

(b) 7th character "D," subsequent encounter, is used for encounters after the patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase. Examples of subsequent care are: removal of external or internal fixation device, medication adjustment, other aftercare and follow up visits following treatment of the injury or condition;

(c) 7th character "S," sequela, is for use for complications or conditions that arise as a direct result of a condition, such as cognitive disorder. When using 7th character "S", it is necessary to use both the injury code that precipitated the sequela and the code for the sequela itself. The "S" is added only to the injury code, not the sequela code. The 7th character "S" identifies the injury responsible for the sequela. The specific type of sequela (e.g., scar) is sequenced first, followed by the injury code.

Coding example: Attention and concentration deficit associated with concussion

R41.840

S06.0x1S

Note the placeholder and the "S" extension

(5) **Personal History of TBI.** The Z87.820 code is used when no other code is available to reflect a previous TBI despite the patient reporting a personal history of injury.

(6) **TBI Screening.** Clinical screening for a possible TBI must be captured using the Z13.850 code, whether or not the screening is positive. Codes associated with TBI (either injury or late effect codes) must not be entered at the time of screening, as a positive TBI screen does not indicate a TBI diagnosis.

33. REFERENCES

a. Title 38 U.S.C. §§ 1703, 1710, 1710A, 1710B, 1710C, 1710D, 1710E, 1782, 8111, and 8153.

b. Commission on Accreditation of Rehabilitation Facilities (CARF)
<http://vaww.oqsv.med.va.gov/functions/integrity/accred/carf.aspx> (accessed October 31, 2012).
NOTE: This is an internal VA Web site and is not available to the public.

c. Malec, J. (2005). The Mayo-Portland Adaptability Inventory. *The Center for Outcome Measurement in Brain Injury*. <http://tbims.org/combi/mpai> (accessed October 31, 2012).

d. Powell, SK & Tahan, HA. *CMSA Core Curriculum for Case Management*. 2nd ed., Lippincott Williams & Wilkins, 2008.

e. VA/DoD Clinical Practice Guideline. Management of Concussion/mTBI, 2009.
http://www.healthquality.va.gov/management_of_concussion_mtbi.asp (accessed October 31, 2012).

f. Memorandum of Agreement between Department of Veterans Affairs and Department of Defense for Medical Treatment Provided to Active Duty Service Members with Spinal Cord Injury, Traumatic Brain Injury, Blindness or Polytraumatic Injuries
<http://vaww.dodcoordination.va.gov/docs/MOAMOUSpinalCordInjuryTraumaticBrainInjury2.pdf> (accessed October 31, 2012). *NOTE: This is an internal VA Web site and is not available to the public.*

g. VA Office of Construction and Facilities Management - Space Planning Criteria - Polytrauma Rehabilitation Center (PRC) 111. <http://www.cfm.va.gov/til/space.asp> (accessed October 31, 2012)

h. Vanderploeg, R & Cornis-Pop, M. (Eds.). *Veterans Health Initiative: Traumatic Brain Injury*. Independent Study Course, April 2010.

i. VA Polytrauma/TBI website. www.polytrauma.va.gov (accessed October 31, 2012).

j. Veterans Health Initiative: Traumatic Brain Injury Web Course.
<https://www.tms.va.gov/plateau/user/login.jsp>

k. VHA Handbook 1010.01, *Care Management of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans*. October 9, 2009.

l. VHA Handbook 1176.01, *Spinal Cord Injury and Disorders System of Care*, February 8, 2011

CLASSIFICATION OF TRAUMATIC BRAIN INJURY (TBI) SEVERITY*

Criteria	Mild	Moderate	Severe
Structural imaging	Normal	Normal <u>or</u> abnormal	Normal <u>or</u> abnormal
Loss of Consciousness (LOC)	0-30 min	Greater than (>)30 min and Less than (<) 24 hrs	> 24 hrs
Alteration of consciousness/ mental state (AOC)**	a moment up to 24 hrs	>24 hrs Severity based on other criteria	
Post-traumatic amnesia (PTA)	0-1 day	>1 and <7 days	> 7 days
Glasgow Coma Scale (best available score in first 24 hrs)	13-15	9-12	< 9

* VA-DoD Clinical Practice Guideline for Management of Concussion/mTBI, 2009

** Alteration of mental state must be immediately related to the trauma to the head. Typical symptoms include: looking and feeling dazed and uncertain of what is happening, confusion, difficulty thinking clearly or responding appropriately to mental status questions, and being unable to describe events immediately before or after the trauma event.

NOTE: A TBI resulting from an object passing through the skull into the brain, such as a bullet or fragments from an explosion, is called a penetrating brain injury. Penetrating brain injuries are classified as severe.

POLYTRAUMA SYSTEM OF CARE PROGRAM LOCATIONS AND DESIGNATION

VISN	Station	FACILITY	PRC	PNS	PSCT	PPOC
1	402	Togus			1	
	405	White River Jct			1	
	518	Bedford			1	
	523A4	VA Boston HCS-West Roxbury Div.		1		
	608	Manchester			1	
	631	Northampton			1	
	650	Providence			1	
	689	West Haven			1	
2	528	Western New York HCS - Buffalo			1	
	528A5	Canandaigua			1	
	528A6	Bath			1	
	528A7	Syracuse		1		
	528A8	Albany			1	
3	526	Bronx		1		
	561	New Jersey HCS			1	
	561A4	Lyons			1	
	620	Hudson Valley HCS			1	
	620A4	Castle Point Division-Hudson Valley H			1	
	630	New York Harbor HCS - NY Div.			1	
	630A4	New York Harbor HCS-Brooklyn			1	
	630A5	New York Harbor HCS-St. Albans			1	
	632	Northport			1	
4	460	Wilmington			1	
	503	James E. Van Zandt VA (Altoona)			1	
	529	Butler			1	
	540	Clarksburg				1
	542	Coatesville			1	
	562	Erie			1	
	595	Lebanon			1	
	642	Philadelphia		1		
	646	Pittsburgh HCS-Univ Dr			1	
	693	Wilkes Barre			1	
5	512	Baltimore			1	
	613	Martinsburg			1	
	688	Washington		1		
6	517	Beckley				1
	558	Durham			1	
	565	Fayetteville NC				1
	590	Hampton			1	
	637	Asheville				1

VISN	Station	FACILITY	PRC	PNS	PSCT	PPOC
	652	Richmond	1	1		
	658	Salem			1	
	659	W.G. (Bill) Hefner Salisbury VAMC			1	
7	508	Atlanta			1	
	509	Augusta		1		
	521	Birmingham			1	
	534	Charleston			1	
	544	Columbia SC			1	
	557	Dublin				1
	619A4	Tuskegee				1
	679	Tuscaloosa			1	
8	516	Bay Pines			1	
	546	Miami			1	
	548	W Palm Beach			1	
	573	Gainesville			1	
	672	San Juan		1		
	673	Tampa	1	1		
	675	Orlando			1	
9	581	Huntington			1	
	596A4	Lexington-Cooper Dr		1		
	603	Louisville			1	
	614	Memphis			1	
	621	Mountain Home			1	
	626	Middle Tennessee HCS - Nashville			1	
	626A4	Middle Tennessee HCS-Murfreesboro			1	
10	538	Chillicothe				1
	539	Cincinnati			1	
	541	Cleveland-Wade Park		1		
	552	Dayton			1	
	757	Columbus				1
11	506	Ann Arbor HCS			1	
	515	Battle Creek				1
	550	Illiana HCS (Danville)			1	
	553	Detroit (John D. Dingell)			1	
	583	Indianapolis		1		
	610	N. Indiana HCS-Marion				1
	655	Saginaw				1
12	537	Jesse Brown VAMC - Chicago HCS			1	
	556	JA Lovell Fed HCC - North Chicago			1	
	578	Hines		1		
	585	Iron Mountain MI				1
	607	Madison WI			1	

VISN	Station	FACILITY	PRC	PNS	PSCT	PPOC
	676	Tomah			1	
	695	Milwaukee WI			1	
15	589	Kansas City			1	
	589A4	Columbia MO				1
	589A5	Eastern Kansas HCS - Topeka Division				1
	589A7	Robert J. Dole VAM&ROC (Wichita)			1	
	657A0	St Louis-Jeff Bks.		1		
	657A4	Poplar Bluff				1
	657A5	Marion IL				1
16	502	Alexandria			1	
	520	Gulf Coast HCS - Biloxi			1	
	564	Fayetteville AR			1	
	580	Houston		1		
	586	G. V. Montgomery VAMC - Jackson			1	
	598	Central AR. Veterans HCS LR			1	
	623	Muskogee			1	
	629	SE Louisiana HCS - New Orleans				1
	635	Oklahoma City			1	
	667	Overton Brooks VAMC - Shreveport			1	
17	549	Dallas VAMC		1		
	671	San Antonio VAMC	1	1		
	671A4	Kerrville VAMC				1
	674	Temple VAMC			1	
	674A4	Waco VAMC				1
	740	NVAHC Valley Costal Bend				1
18	501	New Mexico HCS - Albuquerque			1	
	504	Amarillo HCS				1
	519	West Texas HCS - Big Spring				1
	644	Phoenix			1	
	649	Northern Arizona HCS - Prescott				1
	678	S. Arizona HCS - Tucson		1		
	756	El Paso				1
19	436	Montana HCS - Ft. Harrison			1	
	442	Cheyenne				1
	554	Eastern Colorado HCS - Denver		1		
	575	Grand Junction				1
	660	Salt Lake City HCS			1	
	666	Sheridan				1
20	463	Anchorage				1
	531	Boise			1	
	648	Portland			1	
	653	Roseburg HCS				1

VISN	Station	FACILITY	PRC	PNS	PSCT	PPOC
	663	Seattle		1		
	663A4	American Lake				1
	668	Spokane				1
	687	Walla Walla				1
	692	S. Oregon Rehabilitation - White City				1
21	459	Pacific Islands HCS (Honolulu)				1
	570	Fresno				1
	612A4	N. California HCS-Sacramento			1	
	640	Palo Alto-Palo Alto	1	1		
	654	Sierra Nevada HCS - Reno				1
	662	San Francisco			1	
	358	Manila				1
22	593	Southern Nevada HCS - Las Vegas				1
	600	Long Beach HCS			1	
	605	Loma Linda VAMC			1	
	664	San Diego HCS			1	
	691	Greater Los Angeles HCS		1		
23	437	Fargo VA HCS				1
	438	Sioux Falls			1	
	568	Black Hills HCS			1	
	618	Minneapolis VA HCS	1	1		
	636	Nebraska-Western Iowa HCS			1	
	636A6	Central Iowa			1	
	636A8	Iowa City			1	
	656	St Cloud			1	
		TOTAL	5	23	87	39

NOTE: Abbreviations used in Appendix B Chart:

VISN - Veterans Integrated Services Network

PRC - Polytrauma Rehabilitation Center

PNS - Polytrauma Network Site

PSCT - Polytrauma Support Clinic Team

PPOC - Polytrauma Point of Contact

REFERRAL GUIDELINES FOR POLYTRAUMA AND TRAUMATIC BRAIN INJURY

Polytrauma-Traumatic Brain Injury (TBI) Rehabilitation Services	PRC	PNS	PSCT	PPOC
Acute Comprehensive Interdisciplinary Inpatient Rehabilitation	X			
Emerging Consciousness Program	X			
Residential Polytrauma Transitional Rehabilitation Program	X			
Comprehensive Interdisciplinary Inpatient Rehabilitation	X	X		
Outpatient Interdisciplinary Rehabilitation		X	X	
Community Reintegration	X	X	X*	
Interdisciplinary Outpatient Rehabilitation	X	X	X	X*
Evaluation and management of emerging problems	X	X		
Management of stable problems		X	X	X*
Follow-up Specialty Care	X	X	X	
Case Management and Care Coordination	X	X	X	X
Acute Amputee Rehabilitation	X	X		
Amputation Rehabilitation	X	X	X*	X*
Mental Health Care	X	X	X	X*
Pain Management	X	X	X	X*
Driver Rehabilitation	X	X	X*	
Consultation	X	X		
Telerehabilitation	X	X	X*	X*

* Depending on local resources.

NOTE: Abbreviations used in Appendix C Chart:

PRC - Polytrauma Rehabilitation Center

PNS - Polytrauma Network Site

PSCT - Polytrauma Support Clinic Team

PPOC - Polytrauma Point of Contact

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

DISCIPLINE	Full-time Employee (FTE)
Rehabilitation Physician	1
Nurse Manager	1
Registered Nurse (2.0 must be Certified Rehabilitation Registered Nurse (CRRN))	11
Licensed Practical Nurse or Certified Nursing Assistant	8
Nurse Educator	1
Clinical Nurse Leader (CNL)**	1
Admission and Follow-up Nurse Case Manager	1
Social Worker	3
Speech-Language Pathologist	3
Pharmacist	0.5
Physical Therapist	3.5
Occupational Therapist	3.5
Recreation Therapist	2
Neuropsychologist	1
Counseling Psychologist	1
Family Therapist	1
Blind Rehabilitation Outpatient Specialist	1
Certified Prosthetist	1
Certified Driver Trainer	1
Program Administrator	1
Program Assistant	1

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

** The CNL is a mandated position for all patient care settings in all Department of Veterans Affairs medical centers by 2016 and the rapid implementation of this role at the PRCs is a high priority. Office of Nursing Service will assist sites, as needed, with the implementation.

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

DISCIPLINES	Full-time Employee (FTE)
Program Director	1
Program Assistant	1
Pharmacist	0.5
Physiatrist	.5
Psychiatrist	.5
Registered Nurse	1
Licensed Practical Nurse	5
Speech Language Pathologist	1
Occupational Therapist	2
Physical Therapist	.5
Recreation Therapist	2
Recreation Therapist Assistant	1
Neuropsychologist	1
Counseling Psychologist	1
Social Worker	1
Blind Rehabilitation Outpatient Specialist	.5

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

REQUIRED CORE STAFFING FOR POLYTRAUMA NETWORK SITES (PNS)*

DISCIPLINES	Full-time Employee (FTE)
Rehabilitation Physician	.5**
Registered Nurse	.5**
Social Worker	.5**
Speech-Language Pathologist	.5**
Physical Therapist	.5**
Occupational Therapist	.5**
Clinical Psychologist	.5**
Blind Rehabilitation Outpatient Specialist	.5**
Certified Prosthetist	.5**

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

** .5 FTE is required to be available to the PNS team, with flexibility allowed based on workload demand.

ADDITIONAL STAFF RECOMMENDED FOR PNS

DISCIPLINE	Full-time Employee (FTE)
Program Manager	*
Program Assistant	*
Health Coach/Clinical Educator	*
Therapeutic Recreation Specialist	*
Vocational Specialist	*
Other Disciplines based on local needs	*

*FTE determined by workload demand

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

DISCIPLINE	Full-time Employee (FTE)
Rehabilitation Physician	.5*
Registered Nurse	.5*
Social Worker	.5*
Speech-Language Pathologist	.5*
Physical Therapist	.5*
Occupational Therapist	.5*
Psychologist	.5*
Other Disciplines based on local needs	

* .5 FTE is recommended to be available to the PSCT team, with flexibility allowed based on workload demand.

DECISION SUPPORT SYSTEM (DSS) IDENTIFIERS (ID) - CLINIC STOP CODES

DSS ID Number	Primary (P), Secondary (S), or Either (E)	DSS ID Name	Definition
195	P	Polytrauma Transitional Rehabilitation Program - Individual	Records care provided in the Physical Medicine and Rehabilitation’s Polytrauma Transitional Rehabilitation (PTRP) Program. The PTRP focuses on integration into the community and independent living through a structured program focused on restoring home, community, leisure, psychosocial and vocational skills in a controlled therapeutic setting. Includes provider and support services.
196	P	Polytrauma Transitional Rehabilitation - Program Group	Records the encounter of a group of patients in the Physical Medicine and Rehabilitation’s PTRP Program. The PTRP focuses on integration into the community and independent living through a structured program focused on restoring home, community, leisure, psychosocial and vocational skills in a controlled therapeutic setting. Includes provider and support services.
197	P	Polytrauma/Traumatic Brain Injury (TBI) - Individual	Records patient visit for evaluation, management, and follow-up treatment of patients with polytraumatic or TBI provided by a physician and other appropriate health team members trained in the diagnostic aspects of TBI and polytrauma as well as the special care needs of the patient and their family caregivers. Should be paired with a secondary stop code to represent the type of provider/specialty associated with the clinic unless paired with a telehealth secondary code. Includes provider and support services.

DSS ID	Primary (P),	DSS ID Name	Definition
198	P	Polytrauma/TBI-Group	Records the encounter of a group of polytrauma or TBI patients for the purpose of receiving therapeutic treatment, education, information, and/or counseling. Use when services are provided to more than one patient in the same session. Should be paired with a secondary stop code to represent the type of provider/specialty associated with the clinic unless paired with a telehealth secondary code. Includes provider and support services.
199	P	Telephone Polytrauma/Traumatic Brain Injury (TBI)	Records patient consultation or medical care management, advice, and/or referral provided by telephone contact between a patient or patient's next-of-kin and/or the person(s) with whom the patient has a meaningful relationship by clinical and professional staff trained in the diagnostic aspects of TBI and polytrauma. Includes provider and support services.
240	E	Physical Medicine and Rehabilitation Assistive Technology Clinic	Records patient visit for evaluation, management, and follow-up treatment of patients in the focused area of assistive technology as provided by physician and other appropriate health team members trained in the diagnostic aspects and the special care needs of the patient and family caregivers. Assistive technology clinics must obtain Commission on Accreditation Rehabilitation Facilities accreditation under the Assistive Technology Supports and Services Standards. Specific interventions would include wheeled mobility & seating, adapted computer access, electronic aids to daily living, augmentative and alternative communication, electronic cognitive devices, and any other major medical equipment related to the areas above. Service providers in the Assistive Technology Clinics are encouraged to maintain special certification such as Assistive Technology Provider, and Seating and Mobility Specialist from the Rehabilitation Engineering Society of North America. Includes provider and support services.

DECISION SUPPORT SYSTEM (DSS) IDENTIFIERS (ID) – CREDIT STOP CODES

DSS ID Number	Primary (P), Secondary (S), or Either (E)	DSS ID Name	Definition
201	E	Physical Medicine and Rehabilitation Service (PM&RS)	Records patient visit to PM&RS for physician services. Psychiatrists are trained to diagnose, treat, and direct an interdisciplinary rehabilitation plan that provides the best possible patient outcomes. Includes provider and support services.
202	E	Recreation Therapy Service	Records patient visit for consultation and/or evaluation concerning potential benefits of recreational therapy and/or actual participation by an outpatient in a structured, supervised recreational activity. Includes provider and support services.
203	E	Audiology	Records patient visit for the purpose of consultation and/or evaluation of a hearing impairment. Includes provider and support services.
204	E	Speech Pathology	Records patient visit for the purpose of consultation, evaluation, and/or treatment for speech impediments. Includes provider and support services.
160	E	Clinical Pharmacy	Patient visit with a pharmacist for Medication Therapy Management - specialized education, instruction, and/or counseling regarding prescribed medications. Use in the primary position when the Clinical Pharmacy Specialist is the direct patient care provider. Use in the secondary position when the pharmacist is in a supportive role to a primary provider.
205	E	Physical Therapy	Records patient visit for the purpose of receiving treatment from a physical therapist. Includes the provider and support services.
206	E	Occupational Therapy	Records patient visit for the purpose of receiving treatment from an occupational therapist. Includes provider and support services.

DSS ID	Primary (P),	DSS ID Name	Definition
213	E	PM&RS Vocational Assistance	Records patient visit for vocational testing, assessment, guidance, counseling, or hands-on treatment provided by the PM&RS Vocational Rehabilitation Therapy staff. This is to include educational therapy and any other rehabilitation medicine vocational rehabilitation therapy not specifically described as PM&RS Compensated Work Therapy.
214	E	Kinesiotherapy (KT)	Records patient visit for therapy to enhance the strength, endurance, and mobility of individuals with functional limitations or those requiring extended physical conditioning based on the application of scientifically based exercise principles. Includes provider and support services.
217	E	Blind Rehab Outpatient Specialist (BROS)	Records outpatient visit to a BROS in their home environment or in the VA medical center outpatient area for pre- or post- Blind Rehabilitation Center evaluation and/or care, or for training vets unable to participate in inpatient programs.
117	S	Nursing	Includes assessment, education and treatment services provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) in nurse administered clinics. May be used with Primary Care or Specialty Care RN or LPN run clinics.
125	E	Social Work Service	Records individual patient visit with a social worker. When the work is completed as a portion of another specialty clinic, use that code in the primary position with Decision Support System (DSS) Identifier 125 in the credit position. Use DSS Identifier 125 as a primary only when the work is not completed as a part of another specialty service.
509	E	Psychiatry - Individual	Records patients visit for the purpose of evaluation, follow-up and treatment provided by a physician trained in mental, emotional and behavioral disorders. Use by psychiatrist only when care is not delivered in an interdisciplinary setting such as a Mental Health Clinic or Post-Traumatic Stress Disorder (PTSD) Clinical Team. Includes provider and support services.

DSS ID	Primary (P),	DSS ID Name	Definition
510	E	Psychology - Individual	Records patient visit for the purpose of evaluation, follow-up, and treatment provided by a psychologist. Use when the psychologist's care is not delivered in an interdisciplinary clinic setting such as a Mental Health Clinic or PTSD Clinical Team. Includes provider and support services.
538	E	Psychological Testing	Records the individual patient encounter for psychological and/or neuropsychological assessment, using psychometric instruments or tests interpreted by a psychologist.
557	E	Psychiatry-Group	Use by psychiatrist only when care is not delivered in an interdisciplinary setting such as a Mental Health Clinic or PTSD Clinical Team. Records group visits for the purpose of evaluation, follow-up and treatment provided by a physician trained in mental, emotional and behavioral disorders. Includes provider and support services.
558	E	Psychology-Group	Use when the psychologist's care is not delivered in an interdisciplinary clinic setting such as a Mental Health Clinic or PTSD Clinical Team. Records patients visit for the purpose of evaluation, follow-up, and treatment provided by a psychologist. Includes provider and support services.

ICD-9 AND ICD-10 CODES FOR TRAUMATIC BRAIN INJURY (TBI)

800-801, 803-804 & 850-854 Series Codes

Series Code	Description
800	Fractures of vault of skull – requires a fourth and fifth digit
801	Fractures of base of skull – requires a fourth and fifth digit
803	Other and unqualified skull fractures – requires a fourth and fifth digit
804	Multiple fractures involving skull or face with other bones– requires a fourth and fifth digit
850	Concussion– requires a fourth and fifth digit
851	Cerebral laceration– requires a fourth and fifth digit
853	Other and unspecified intracranial hemorrhages – requires a fourth and fifth digit
854	Intracranial injuries of other and unspecified nature – requires a fourth and fifth digit

799.2x Emotional / Behavioral Symptoms

ICD-9 Code	Symptom
799.21	Nervousness
799.22	Irritability
799.23	Impulsiveness
799.24	Emotional lability
799.25	Demoralization and apathy
799.29	Other signs and symptoms involving emotional state

799.5x Cognitive Symptoms

ICD-9 Code	Symptom
799.51	Attention and concentration deficit
799.52	Cognitive communication deficit
799.53	Visuospatial deficit
799.54	Psychomotor deficit
799.55	Frontal lobe and executive function deficit
799.59	Other signs and symptoms involving cognition

NOTE: Memory deficits will be coded as 780.93.

ICD-10-CM CODES FOR TBI

S02, S06, and S07 Series Codes

Series Code	Description
S02.0	Fractures of vault of skull—requires 7 th character
S02.1	Fractures of base of skull—requires 7 th character
S02.8	Fractures of other specified skull and facial bones—requires 7 th character
S02.9	Fractures of unspecified skull and facial bones—requires 7 th character
S06.0	Concussion—requires 7 th character
S06.1	Traumatic cerebral edema—requires 7 th character
S06.2	Diffuse traumatic brain injury—requires 7 th character
S06.3	Focal traumatic brain injury—requires 7 th character
S06.4	Epidural hemorrhage—requires 7 th character
S06.5	Traumatic subdural hemorrhage—requires 7 th character
S06.6	Traumatic subarachnoid hemorrhage—requires 7 th character
S06.8	Other specified intracranial injuries—requires 7 th character
S06.9	Unspecified intracranial injury—requires 7 th character
S07.0	Crushing injury of the head—requires 7 th character

R40 Somnolence, Stupor, and Coma

ICD-10 Code	Symptom
R40.0	Somnolence
R40.1	Stupor
R40.2	Coma—requires 7 th character

R41 Other Signs and Symptoms of Cognitive Function and Awareness

ICD-10 Code	Symptom
R41.0	Disorientation, unspecified
R41.1	Anterograde amnesia
R41.2	Retrograde amnesia
R41.3	Other amnesia
R41.4	Neurologic neglect syndrome

R41.84 Other Cognitive Deficit

ICD-10 Code	Symptom
R41.840	Attention and concentration deficit
R41.841	Cognitive communication deficit
R41.842	Visuospatial deficit
R41.843	Psychomotor deficit
R41.844	Frontal lobe and executive function deficit
R41.89	Other symptoms and signs involving cognitive functions and awareness

NOTE: Memory deficits will be coded as R41.1, R41.2, or R41.3.

R45 Symptoms and Signs Involving Emotional State

ICD-10 Code	Symptom
R45.0	Nervousness
R45.1	Restlessness and agitation
R45.2	Unhappiness
R45.3	Demoralization and apathy
R45.4	Irritability and anger
R45.5	Hostility
R45.6	Violent behavior
R45.8	Other symptoms and signs involving emotional state

ICD-9 AND ICD-10 MODIFIERS FOR TRAUMATIC BRAIN INJURY (TBI) SEVERITY

800-801, 803, 804 & 851-854 Series Fifth Digit Modifiers

Series Modifiers	Description
0	Unspecified state of consciousness
1	No LOC
2	Brief LOC (< 1 hour)
3	Moderate LOC (1-24 hours)
4	Prolonged (> 24 hours) LOC and return to pre-existing conscious level
5	Prolonged (>24 hours) LOC without return to pre-existing conscious level
6	Unspecified LOC
9	Concussion, unspecified

ICD-9 MODIFIERS FOR CONCUSSION SEVERITY

850 Series Modifiers

Series Modifiers	Description
850	No LOC
850.1	Brief LOC (< 1 hour)
850.11	LOC of 30 minutes or less
850.12	LOC from 31 to 59 minutes
850.2	Moderate LOC (1-24 hours)
850.3	Prolonged (>24 hrs.) LOC and return to pre-existing conscious level
850.4	Prolonged (>24 hrs) LOC, without return to pre-existing conscious level
850.5	LOC of unspecified duration
850.9	Concussion, unspecified

ICD-10 7th CHARACTERS FOR TBI

S02 Series 7th Characters

7th digit	Description
A	Initial encounter for closed fracture
B	Initial encounter for open fracture
D	Subsequent encounter for fracture with routine healing
G	Subsequent encounter for fracture with delayed healing
K	Subsequent encounter for fracture with nonunion
S	Sequela

S06 and S07 Series 7th Characters

7th digit	Description
A	Initial encounter
B	Subsequent encounter
S	Sequela

ICD-10 SEVERITY CLASSIFICATION FOR INTRACRANIAL INJURY

S06.0, S06.1, S06.2, S06.3, S06.4, S06.5, S06.6, S06.8 Series

ICD-10 Code	Description
S06.-X0	No LOC
S06.-X1	LOC of 30 minutes or less
S06.-X2	LOC from 31 to 59 minutes
S06.-X3	LOC from 1 hour to 5 hours 50 minutes
S06.-X4	LOC of 6 hours to 24 hours
S06.-X5	LOC greater than 24 hours with return to pre-existing conscious level
S06.-X6	LOC greater than 24 hours without return to pre-existing conscious level with patient surviving
S06.-X7	LOC of any duration with death due to brain injury prior to regaining consciousness
S06.0X8	LOC of any duration with death due to other cause prior to regaining consciousness
S06.0X9	LOC of unspecified duration