

**PHYSICAL MEDICINE AND REHABILITATION
INDIVIDUALIZED REHABILITATION AND COMMUNITY REINTEGRATION
CARE PLAN**

- 1. PURPOSE.** This Veterans Health Administration (VHA) Handbook defines the procedures for development and implementation of the Individualized Rehabilitation and Community Reintegration Care Plan for Veterans and military Servicemembers who receive inpatient or outpatient rehabilitative care for functional deficits or needs related to Traumatic Brain Injury (TBI) and polytrauma.
- 2. SUMMARY OF CONTENTS.** This new Handbook describes the processes for development and implementation of Individualized Rehabilitation and Community Integration Care Plans and the responsibilities of Department of Veterans Affairs (VA) staff members in the process.
- 3. RELATED ISSUES.** VHA Directive 1172 to be published.
- 4. RESPONSIBLE OFFICE.** The Chief Consultant, Rehabilitation Services, is responsible for the contents of this VHA Handbook. Questions may be referred to the Physical Medicine and Rehabilitation Service (PM&RS) National Program Director at 202-461-7444. Facsimile transmissions may be sent to 202-495-5473.
- 5. RECERTIFICATION.** This VHA Handbook is scheduled for recertification on or before the last working day of May 2015.

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Under Secretary for Health

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1. PURPOSE: This Veterans Health Administration (VHA) Handbook defines the procedures for the development and implementation of the Individualized Rehabilitation and Community Reintegration Care Plan for Veterans and military Servicemembers who receive inpatient or outpatient rehabilitative care for functional deficits or needs related to Traumatic Brain Injury (TBI) and polytrauma.

2. BACKGROUND

One of the biggest challenges for VHA in recent years has been meeting the complex treatment needs of the severely injured service members from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). These conflicts have dramatically changed the nature of combat-related injuries because of new enemy tactics such as improvised explosive devices (IED), advancements in body armor that protect vital organs but leave extremities vulnerable, and improvements in battlefield medicine that increase survival of severely wounded soldiers. Polytrauma is a new word in the medical lexicon that is now being used to describe the multiple injuries to physical regions or organ systems, one of which may be life threatening, which results in physical, cognitive, psychological, or psychosocial impairments and functional disability. With polytrauma, TBI frequently occurs in combination with other disabling conditions such as, amputation, auditory and visual impairments, spinal cord injury (SCI), Post-Traumatic Stress Disorder (PTSD), and other medical and mental health problems. Due to the severity and complexity of their injuries, Servicemembers and Veterans with TBI or polytrauma require an extraordinary level of coordination and integration of clinical and other support services.

3. AUTHORITY: The National Defense Authorization Act of Fiscal Year 2008 amended Subchapter II of Chapter 17 of Title 38, United States Code (U.S.C.). It requires that VHA develop an Individualized Rehabilitation and Community Reintegration Care Plan for Veterans and members of the Armed Services with TBI.

4. DEFINITIONS

a. **Community Reintegration.** Community reintegration refers to the resumption of age, gender, and culturally appropriate roles in the family, community and workplace. Community reintegration needs to emphasize a multidisciplinary approach, which also includes peers and family, in the attempt to close the gap between treatment activities and functional competence in the individual's natural environment. The primary focus of community reintegration needs to be on what the individual with TBI or polytrauma must achieve in order to return to home, community, work, or school. Ongoing assessment of progress and modification of goals is critical to the success of any community reintegration program.

b. **Continuum of Rehabilitation Care.** Treatment and rehabilitation of individuals with TBI or polytrauma can encompass services from the onset of injury throughout a person's life. By necessity, options must be available to accommodate the diverse needs of individuals with TBI or polytrauma. It is important to recognize that appropriate treatment and rehabilitation varies from individual to individual and that programs and treatments change, as a person's needs change. The scope of rehabilitation services available in the Polytrauma System of Care (PSC) includes: acute, subacute, and long-term inpatient rehabilitation; emerging consciousness program; transitional residential rehabilitation; outpatient services; and day rehabilitation programs.

c. **Interdisciplinary Team (IDT).** An IDT is characterized by a number of disciplines functioning as a coherent unit in the assessment, planning, and implementation of a person's care plan. Constituency of the IDT for the individual patient is determined by his or her rehabilitation and medical needs. To avoid fragmented care, continuous communication, collaboration, and coordination among the team members is critical.

d. **Polytrauma.** Polytrauma is defined as two or more injuries 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. TBI frequently occurs as part of the polytrauma spectrum in combination with other disabling conditions, such as amputations, burns, pain, fractures, auditory and visual impairments, PTSD, and other mental health conditions. When present, injury to the brain is often the impairment that dictates the course of rehabilitation due to the nature of the cognitive, emotional, and behavioral deficits related to TBI.

e. **Polytrauma and TBI Rehabilitation Centers (PRC).** The PRC serves as a regional referral center for acute medical and rehabilitation care. PRCs are located at the VA medical centers in Minneapolis, MN; Palo Alto, CA; Richmond, VA; and Tampa, FL. *NOTE: A fifth PRC has been designated at the San Antonio medical center and is in the design phase.*

f. **Polytrauma Network Sites (PNS).** The PNS provides key components of post-acute rehabilitation care for individuals with polytrauma and TBI including, but not limited to, inpatient and outpatient rehabilitation and day programs. A PNS is located in each of VA's 21 Veterans Integrated Service Networks (VISNs) and San Juan.

g. **Polytrauma Support Clinic Teams (PSCT).** The PSCT provides interdisciplinary outpatient rehabilitation services for Veterans and active duty service members with mild or stable functional deficits from brain injury and polytrauma

h. **Polytrauma Point of Contact (PPOC).** The PPOC is knowledgeable about the PSC and ensures that patients with TBI or polytrauma are referred to a VA, private sector facility, or program capable of providing the level of rehabilitation services required for their condition.

NOTE: Sites designated with a PRC, PNS, and PSCT maintain dedicated rehabilitation IDTs, led by a rehabilitation physician. Members of the IDT have additional training in the specialized rehabilitation needs of individuals with polytrauma and TBI.

i. **Traumatic Brain Injury (TBI).** TBI is defined as traumatically induced structural injury or physiological disruption of brain function as a result of an external force. Injuries can be penetrating or closed, and the latter can be mild, moderate, or severe. The TBI severity level is determined by using the following measurements at the time of the injury: Glasgow Coma Scale (GCS) score, length of loss of consciousness (LOC), and length of post-traumatic amnesia (PTA).

5. SCOPE

The VHA PSC provides an integrated and coordinated continuum of services for eligible Veterans and military personnel with TBI or polytrauma. This system of care either provides for, or formally links with key components of care that address the lifelong needs of individuals with impairments resulting from TBI or polytrauma. Such services include, but are not limited to: inpatient rehabilitation, outpatient rehabilitation, transitional rehabilitation, day programs, and community re-entry programs. The PSC also manages the ongoing and emerging rehabilitation and psychosocial needs of Veterans with polytrauma and TBI. This includes ongoing follow up and treatment, case management, coordination of services, monitoring the implementation of the treatment plan, overseeing the quality and intensity of VA and non-VA services, and providing education and support for patients and caregivers. The tiered PSC integrates specialized rehabilitation services at regional centers, VISNs, and local VA medical centers.

6. DEFINING THE INDIVIDUALIZED REHABILITATION/COMMUNITY REINTEGRATION CARE PLAN

a. **Contents of the Plan.** Each plan needs to include:

(1) Goals for improving the physical, cognitive, and vocational functioning of the individual and designed to maximize the independence and reintegration of the individual into the community. Goals need to be attainable and measurable.

(2) Access to all appropriate rehabilitative components of the continuum of care, and where appropriate, to long-term care services.

(3) A description of specific rehabilitative treatments and other services to achieve the rehabilitation goals, including the type, frequency, duration, and location of such treatments and services.

(4) The name of the Case Manager designated to oversee implementation of the plan. The PSC Case Manager must have specific expertise in the care required by the individual for whom the Case Manager is designated. This expertise may be acquired through experience, education or training.

(5) Dates on which the effectiveness of the plan is reviewed.

b. **Comprehensive Assessment**

(1) Each plan is based on a comprehensive assessment that addresses:

(a) The physical, cognitive, vocational, neuropsychological, and social impairments of the individual;

(b) Homelessness, mental illness, and substance use disorders; and

(c) The family education and family support needs of the individual after discharge from inpatient care, at the commencement of, and during the receipt of outpatient services.

(2) The assessment is completed by a team of individuals with expertise in TBI that is led by a rehabilitation physician. The team is comprised from any of the following disciplines:

(a) Assistive Technologist or Rehabilitation Engineer;

(b) Audiologist;

(c) Blind Rehabilitation Specialist;

(d) Dietitian;

(e) Driver Rehabilitation Specialist;

(f) Educational Therapist;

(g) Kinesiotherapist;

(h) Low Vision Rehabilitation Optometrist;

(i) Neurologist;

(j) Neuro-ophthalmologist;

(k) Neuropsychologist;

(l) Nueropsychiatrist;

(m) Occupational Therapist;

(n) Ophthalmologist;

(o) Optometrist;

(p) Orthotist or Prosthetist;

(q) Otolaryngology Physician;

(r) Physical Therapist;

- (s) Psychiatrist;
- (t) Psychologist;
- (u) Recreation Therapist;
- (v) Rehabilitation Nurse;
- (w) Social Worker; and
- (x) Speech Language Pathologist.

c. The IDT for each individual patient is determined by the patient's rehabilitation and medical needs under the direction of the rehabilitation physician in collaboration with the patient and, as warranted, the patient's family. All members of the IDT participate in goal setting and treatment planning, and contribute their specialized expertise to the development of the Individualized Rehabilitation and Community Reintegration Care Plan.

c. **Participation and Collaboration**

(1) The individual, and the family or legal guardian of such individual, participate and collaborate in the development of the Individualized Rehabilitation and Community Reintegration Care Plan to the maximum extent practicable.

(2) When developing the rehabilitation care plan, the IDT needs to coordinate goals and plans with mental health providers and other medical services as indicated by the clinical needs of the Veteran.

(3) A state protection and advocacy agency may collaborate in the development of the care plan when the individual, or the family or guardian of an incapacitated individual covered by the plan, requests such collaboration.

(4) In the case of a plan required for a member of the Armed Forces who is serving on active duty, the IDT needs to collaborate with the individual's Department of Defense (DOD) command in the development of the plan.

(5) When exploring the development of appropriate vocational rehabilitation objectives, the IDT needs to coordinate goals, plans and services with other VA programs such as Therapeutic and Supported Employment Services, VHA's Office of Mental Services and the Vocational Rehabilitation and Employment (VR&E) Divisions at VA Regional Offices. **NOTE:** *VR&E services are administered by the Veterans Benefits Administration (VBA).*

d. **Communication of the Plan.** The Rehabilitation and Community Reintegration Care Plan must be documented in the patient's electronic medical record using VHA's national template. **NOTE:** *See Attachment A.* Typically the plan is reviewed with the patient and family by the Case Manager and a copy is provided to the patient as well as others involved in the care, as appropriate, e.g., DOD, and VR&E.

7. RESPONSIBILITIES OF THE CHIEF CONSULTANT, REHABILITATION SERVICES

The Chief Consultant, Rehabilitation Services, has overall responsibility for the contents of this VHA Handbook.

8. RESPONSIBILITIES OF THE PM&RS NATIONAL PROGRAM DIRECTOR

The PM&RS National Program Director is responsible for:

a. Developing national policy and procedures for development and implementation of an Individualized Rehabilitation and Community Reintegration Care Plan for Veterans and members of the Armed Forces recovering from TBI or polytrauma and receiving inpatient or outpatient rehabilitative hospital care or medical services;

b. Providing consultation and guidance to VISNs and VA medical facilities for the implementation of this Handbook.

9. RESPONSIBILITIES OF VISN AND FACILITY DIRECTORS

The VISN and Facility Directors are responsible for:

a. Ensuring that the rehabilitation plan of care is developed and managed by an interdisciplinary rehabilitation team with expertise in TBI, e.g., one of the components of the PSC: PRC, PNS, or PSCT.

b. Ensuring access to all appropriate rehabilitative components of the PSC; and

c. Monitoring implementation of the Individualized Rehabilitation and Community Reintegration Care Plan template by:

(1) Certifying the template has been implemented at each VA medical facility, and

(2) Providing a quarterly utilization report through the Office of the Deputy Under Secretary for Health for Operations and Management to the PM&RS national program office.

10. RESPONSIBILITIES OF VISN CHIEF INFORMATION OFFICER (CIO)

The VISN CIO is responsible for ensuring that all medical facilities install the patches containing the VA TBI/Polytrauma Individualized Rehabilitation and Community Reintegration Care Plan template. The patches can be referenced as PXR*2*15 and TIU*1*246. Both patches were made available March 17, 2009, with an installation to occur no later than March 31, 2009.

11. RESPONSIBILITIES OF REHABILITATION PHYSICIAN

The rehabilitation physician is responsible for:

- a. Completing a clinical assessment;
- b. Consulting with rehabilitation and other specialists as needed;
- c. Participating in the staffing of the patient;
- d. Ensuring that the care plan is comprehensive and reflects input from the patient and family; and
- e. Determining the dates on which the effectiveness of the care plan will be reviewed.

12. RESPONSIBILITIES OF THE POLYTRAUMA TBI INTERDISCIPLINARY TEAM (IDT)

The Polytrauma TBI IDT is responsible for:

- a. Performing comprehensive interdisciplinary assessments;
- b. Developing the Individualized Rehabilitation and Community Reintegration Care Plan that includes input from all IDT members;
- c. Collaborating with the patient and family in the development of the care plan; and
- d. Documenting the care plan in the patient's electronic medical record.

13. RESPONSIBILITIES OF THE POLYTRAUMA-TBI CASE MANAGER

The Polytrauma-TBI Case Manager is responsible for:

- a. Reviewing the care plan with the patient (if this does not occur in an IDT patient family conference), and providing a copy to the patient and family within 24 hours of completion of the plan.
- b. Monitoring implementation of the treatment plan and facilitating coordination of services.
- c. Communicating with the patient, on a regular basis, to assess satisfaction and effectiveness of the plan.
- d. Collaborating with other programs and agencies, as appropriate, for the patient's needs, e.g., OEF-OIF Care Management, Federal Recovery Coordinator, relevant military Service Command; VR&E Services, state vocational rehabilitation programs, and state protection and advocacy agencies.

14. REFERENCES

National Defense Authorization Act 2008, Title XVII, Section 1710C

ATTACHMENT A

**SAMPLE CHECKLIST FOR POLYTRAUMA-TBI
INDIVIDUALIZED REHABILITATION/REINTEGRATION PLAN OF CARE**

1. Plan of Care:

- Initial
- Interim
- Discharge

2. Current Military Status:

- Active Duty:

- Veteran

3. Transition: (Use free text to include information on medical board process)

4. Brief history of injuries: (Date, where, how, injuries sustained)

5. Current problems:

6. Patient and Family Goals:

7. Summary of IDT evaluations: (List disciplines involved)

8. Consults requested and/or follow-up on consults:

9. Interdisciplinary Treatment Goals:

10. Rehabilitation and Reintegration Plan: (Treatments, frequency, duration, location, discharge/transition)

11. Date of IDT conference with patient and family to review plan:

12. Written copy provided: (Yes or No)

13. Family education and support needs:

14. Current location/living arrangements:

15. Current Vocational Status: (Select one and detail status in free text area)

- Unemployed
- Employed
- Student
- Volunteer

___ Homemaker

16. Vocational Rehabilitation Plan (VBA, State, relevant military Service Command)
17. Physician responsible for managing the treatment plan: (Name and contact information)
18. Polytrauma-TBI Case Manager responsible for monitoring implementation: (Name and contact information)
19. Military Case Manager: (Name and contact information)
20. Plan has been communicated to military: (Yes or No)
21. Other care coordination information: (Transition Patient Advocate, Federal Recovery Coordinator)
22. Date care plan is to be reviewed: