

March 31, 2011

PHYSICAL MEDICINE AND REHABILITATION OUTCOMES FOR ACUTE STROKE, TRAUMATIC BRAIN INJURY, AND LOWER-EXTREMITY AMPUTATION PATIENTS

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides policy regarding the recording and tracking of medical rehabilitation outcomes for acute stroke patients, and the special patient populations of traumatic brain injury (TBI) and lower-extremity amputations.

2. BACKGROUND

a. Public Law 104-262, Section 104, The Eligibility Reform Act, established the requirement that VHA maintain its capacity to provide for the specialized treatment and rehabilitative needs of selected patient populations, including amputations and TBI. Initially, the two major capacity categories addressed by the Department of Veterans Affairs (VA) for these two impairment groups were resources as measured by dollars, and reasonable access as measured by timeliness. Beginning in Fiscal Year (FY) 1999, VHA was challenged with implementing indicators of workload and outcomes (functional and quality) in lieu of resources as its measures of capacity for these special emphasis populations.

b. In FY 1999, the Patient Treatment File (PTF) indicated a total of 12,542 patients were treated with either a principal diagnosis of stroke or a principal stroke diagnosis associated with a secondary diagnosis. Medical rehabilitation outcomes were reported for only 1,412 patients who were treated in a rehabilitation bed setting. This represents only 11 percent of the acute stroke patients admitted to the VA health care system. The Uniform Data System for Medical Rehabilitation (UDSMR) reports that stroke patients comprise approximately 30 percent of the admissions to rehabilitation beds in both VHA and the private sector. Little attention has been given to tracking and reporting outcomes on those patients treated outside the traditional rehabilitation bed setting. Stroke and TBI patients are both classified within the Complex Care Funding Group as defined by the Veterans Equitable Resource Allocations (VERA) 2010 Handbook.

c. The Physical Medicine and Rehabilitation (PM&RS) Program Office (117C) has been tracking medical rehabilitation outcomes of all patients discharged from inpatient medical rehabilitation bed units under a national contract with UDSMR since 1993. In 2007, UDSMR began providing reports detailing inpatient rehabilitation outcomes for VHA continuum facilities as well. Today, PM&RS continues to have the capability of tracking rehabilitation outcomes across the full continuum of care, including both acute inpatient units and Community Living Centers (CLC), through the Functional Status and Outcomes Database (FSOD) for Rehabilitation located at the Austin Information and Technology Center (AITC). Established in FY 1997 through a cooperative effort (between the PM&RS Program Office, AITC, and UDSMR), FSOD utilizes VA Functional Independence Measure (FIM) software (also referred to as FIMware) for

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data entry. Information regarding rehabilitation outcomes across the full continuum of care is transferred electronically to the UDSMR each quarter for preparation of individual facility reports. Since incorporation of FSOD at the AITC, outcomes data may now be tracked on any selected impairment group without regard to the bed unit or setting in which rehabilitative care is provided. FSOD provides the flexibility for tracking rehabilitation outcomes across the full continuum of care for the stroke, amputation, and TBI populations. It also provides a resource from which data can be extracted to measure the Department's performance in meeting its capacity and other monitors related to the provision of rehabilitation services.

d. In FY 2003, VHA initiated a performance measure that captured the percent of applicable inpatients with FIM to assess the need for rehabilitation intervention for inpatients with stroke, amputation or TBI. Evidence of this initial assessment was determined through FIM score entry into FSOD. This report has continued to be monitored through the Office of Quality and Performance as either a performance measure or supporting indicator report since FY 2003. In FY 2009, 78 percent of all inpatients with stroke, amputation, or TBI had an initial functional assessment utilizing the FIM tool to determine further rehabilitation needs.

e. In FY 2006, a supporting indicator was introduced that measured admissions to a rehabilitation bed unit for targeted patients with stroke, amputation or traumatic brain injury utilizing FSOD data entries. While no benchmark has been established in VA or the private sector, percentages are available on a quarterly basis for facilities to consider in their strategic planning.

3. POLICY: It is VHA policy that all VA medical centers with inpatient or CLC beds must have connectivity to FSOD for Rehabilitation at the AITC, and must use FSOD to measure and track the rehabilitation outcomes on all acute stroke, lower-extremity amputations, and TBI patients admitted to a VA inpatient unit.

4. ACTION

a. **VHA PM&RS Program Office.** The VHA PM&RS Program Office is responsible for:

(1) Training in the local use and management of FSOD.

(2) Assigning a level of access to FSOD in collaboration with the AITC staff. Requests for access are to be directed to the PM&RS Office by calling (717) 272-6621 extension 4401 or (414) 384-2000 extension 41104.

(3) Validating the data and reporting the performance measurement results in collaboration with the Offices of Performance and Quality Service (10Q) and Policy and Planning (105).

b. **Facility Director.** The facility Director is responsible for ensuring that:

(1) The FSOD is utilized to enter and track rehabilitation outcomes of all cases of acute stroke, and patients with lower-extremity amputation and TBI admitted to a VA inpatient unit.

(2) The local Information Resources Management Office provides the necessary technical support for FSOD applications, e.g., connectivity, and software downloads in collaboration with the Austin Service Desk at the AITC. **NOTE:** *The Austin Service Desk telephone number is (512) 326-6780.*

(3) Appropriate staff are credentialed in the administration of the FIM assessment tool required by the UDSMR Offices in Buffalo, NY, and the PM&RS Program Office at VA Central Office.

(4) A FIM Credentialing Coordinator is designated to monitor the process and liaison with UDSMR.

(5) At least one person is designated to coordinate administration of the FIM software, data entry into the FSOD, and management of the facility's data. This designee is the primary liaison to the PM&RS Program Office for monitoring and tracking outcomes. **NOTE:** *It is recommended that the designee be a rehabilitation manager, clinician, TBI case manager, Preservation Amputation Care and Treatment (PACT) Coordinator, or quality management person actively involved in rehabilitation care management.*

5. REFERENCES: None.

6. RESPONSIBILITY: The Director, Physical Medicine and Rehabilitation Service (117C), is responsible for contents of this Directive. Questions are referred to (202) 461-7444.

7. RESCISSION: VHA Directive 2005-032, dated August 8, 2005, is rescinded. This VHA Directive expires March 31, 2016.

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