PHYSICAL MEDICINE AND REHABILITATION SERVICE (PM&RS) PROCEDURES

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) Handbook describes policies and procedures for the mission, purpose, organization, provision of rehabilitative care, business practices, performance improvement strategies, and other pertinent topics regarding physical medicine and rehabilitation programs and services.

2. SUMMARY OF CONTENTS: This VHA Handbook provides a description of the procedure for a comprehensive continuum of health care and rehabilitation for Veterans. Changes in VHA procedures described in this Handbook reflect innovations and efforts to systematize the rehabilitative continuum of care within VHA. This Handbook establishes principles in planning and administering Physical Medicine and Rehabilitation Service (PM&RS) programs regarding components, purpose, scope, and procedures.

3. RELATED ISSUES: VHA Handbook 1170.02 and VHA Handbook 1172.01.

4. RESPONSIBLE OFFICE: The Director, Physical Medicine and Rehabilitation Program, Rehabilitation and Prosthetic Services (10P4R), is responsible for the contents of this VHA Handbook. Questions may be referred to 202-461-7444.


6. RECERTIFICATION: This VHA Handbook is scheduled for recertification on or before the last working day of May, 2019.

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Under Secretary for Health

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## PHYSICAL MEDICINE AND REHABILITATION SERVICE (PM&RS) PROCEDURES

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PHYSICAL MEDICINE AND REHABILITATION SERVICE PROCEDURES (PM&RS)

1. PURPOSE: This Veterans Health Administration (VHA) Handbook describes the procedures relating to Physical Medicine and Rehabilitation Service (PM&RS) Procedures and assists facility leadership in establishing, maintaining, and improving programs in PM&RS by establishing principles in planning, administering, and improving care provided to Veterans with disabilities, and describes an approach that integrates rehabilitative service procedures across the full spectrum of VHA health care services. The changes in VHA procedures described in this Handbook reflect innovations and efforts to systematize the provision of rehabilitative care within VHA. AUTHORITY: 38 United States Code (U.S.C.) 7301(b).

2. BACKGROUND:

   a. VHA is committed to providing specialized treatment and comprehensive rehabilitation care to Veterans with impairments, functional limitations, and/or disabilities. During World War II, United States (U.S.) military health care professionals pioneered an interdisciplinary team approach to assess and manage complex disabilities associated with battlefield injuries. This approach has remained central to effective rehabilitation. Recent trends in health care have emphasized the importance of comprehensive rehabilitation for individuals with disabilities. There has been significant reorganization of the PM&RS organization and leadership structures across the Department of Veterans Affairs (VA). Recent VHA-based outcomes research has further clarified the attributes of effective teams and the influence of organizational culture on these teams.

   b. As a result of this reorganization, Veterans Integrated Service Networks (VISNs) assumed the primary day-to-day responsibility for health care delivery, regional budgetary control, performance oversight, and local organizational development. The focus of VA Central Office became centered on policy development, Congressional reporting, outcomes development and assessment, and administrative oversight. Additionally, there were shifts in emphasis from inpatient to ambulatory care and from service-focused to patient-focused teams. Changes were also made to improve health care quality and increase patient satisfaction.

   c. Since the reorganization changed many PM&RS programs from the standard model of service chief and therapy sections, each PM&RS Program is now organized uniquely and differently to best meet the needs of Veteran patients at each VA medical facility. Veterans may have their rehabilitation provided in a variety of environments across the continuum of care, from acute inpatient hospitalization, through a spectrum of inpatient and outpatient rehabilitation care settings, including VA Community Living Centers (CLC), the home, and the community. The provision of rehabilitation services is determined by the Veteran’s rehabilitative needs rather than by where the services are delivered or under what title.

   d. To ensure that Veterans receive rehabilitation care in a program appropriate to their needs, performance measures or supporting indicators may be developed that require compliance by individual programs. The latest performance and supporting measure information, along with the technical manuals are available at the Office of Performance Measurement website. NOTE: This is an internal VA website that is not available to the public.
3. MISSION:

   a. **The Three-fold Mission of PM&RS is:**

      (1) To emphasize comprehensive rehabilitation of the Veteran across a full continuum of care. Utilizing an interdisciplinary approach, PM&RS aims to prevent, manage, or limit impairments and disabilities of individual patients, while improving the patient’s functional abilities, independence, and quality of life. The standard of care must be directly comparable to the current state-of-the-art care available in the academic and private sectors of health care. The quality and appropriateness of services offered is ensured throughout PM&RS by an ongoing process of monitoring and feedback.

      (2) Commitment to the education and training of rehabilitation professionals necessary to discharge all required rehabilitation functions in order to support patient care at a high level of competence. PM&RS cooperates with all appropriate educational offices at VA Central Office, VISN sites, and local VA medical facilities in the identification and provision of training activities to meet the needs of all rehabilitation personnel.

      (3) To support the Office of Research and Development (ORD), particularly the Rehabilitation Research and Development (RR&D) Section, in promoting clinical and basic scientific research directed toward the advancement of the art and the science of medical rehabilitation and engineering technology.

   b. Each VA medical facility must develop an individual mission based on the health care needs of the Veterans in its region and on the fundamental principles of PM&RS. These principles include: a patient-centered holistic approach, interdisciplinary team management, and restoration or compensation of, or for, physical, cognitive, behavioral, and psychosocial function.

   c. The goal of PM&RS is to be recognized as the model of excellence in the delivery of integrated medical rehabilitative services for Veterans, the Veterans’ families, and other VA stakeholders.

4. SCOPE:

   a. PM&RS is a direct service provider, as well as a supportive and consultative service that provides management of disorders that alters functional status. This treating specialty emphasizes the evaluation, restoration, and optimization of function through physical modalities, therapeutic exercise and interventions, adaptive equipment, modification of the environment, education and consultation, and assistive devices in order to prepare for the Veteran’s optimum independence, PM&RS utilizes diagnosis, treatment, and prevention methodologies.

   b. The population served by PM&RS ranges from young adult to geriatric, with a wide spectrum of neurological, orthopedic, medical, psychiatric, and surgical conditions, including special populations with stroke, spinal cord injury (spinal cord injury and disorder (SCI/D)) that are not served by the SCI/D System of Care in accordance with VHA Directive 1176, Spinal Cord Injury and Disorders System of Care, and VHA Handbook 1176.01, Spinal Cord Injury and Disorders (SCI/D) System of Care, dementia, brain dysfunction or traumatic brain injury (TBI),
and amputation. PM&RS is committed to providing specialized treatment and quality rehabilitation care across the full continuum of care to all Veterans with disabilities.

c. The organizational structure of PM&RS varies between VA medical facilities. Core rehabilitation services typically include: physiatry, physical therapy (PT), occupational therapy (OT), kinesiotherapy (KT), recreation therapy (RT), speech language pathology (SLP) and vocational rehabilitation specialists; however, these disciplines may not be available at all VA medical facilities.

d. Eligible Veterans and other eligible participants are to have access to the appropriate level of rehabilitative services, across the continuum of care, including contractual arrangements, based on their individually-assessed need. Providers must monitor the quality of the services and treatment programs through the analysis of individual and aggregate clinical outcomes. **NOTE:** The phrase “or other eligible participant” includes active duty Servicemembers with an injury or illness who need rehabilitation services to facilitate their recovery and rehabilitation.

e. Patients throughout the continuum of care may demonstrate a need for rehabilitation services to improve their functional status. Referrals to rehabilitation services originate from multiple sources throughout the continuum of care. Regardless of the origin of the rehabilitation referral, once a consult to a rehabilitation program is initiated, the Veteran must be screened for an appropriate rehabilitation treatment plan of care based on the Veteran’s rehabilitation needs.

5. PHYSICAL MEDICINE AND REHABILITATION SERVICE LEADERSHIP:

a. **VA Central Office.** The PM&R Program Office is within Rehabilitation and Prosthetic Services, which is organizationally aligned within VHA Office of Patient Care Services. Rehabilitation and Prosthetic Services includes Audiology and Speech Pathology Service, Blind Rehabilitation Service, Chiropractic Service, PM&RS, Prosthetic and Sensory Aids Service, and Recreation Therapy Service.

b. **National.** The PM&RS Program Office is led by the National Director of PM&RS.

c. **Veterans Integrated Service Network.** Some VISNs have been organized into service lines and have a VISN service-line leader for PM&RS. Others are aligned under the VISN Chief Medical Officer (CMO).

d. **Facility.** Local leadership is varied. Larger PM&RS programs, especially those with rehabilitation bed units, are led by a physiatrist, who may also be a service chief, service line Director, or other similar position. In smaller VA medical facilities, PM&R leadership may be provided by a non-physician, such as a PM&R Manager or Supervisory Therapist. In some VA medical facilities, PM&RS is within a larger leadership entity, such as: Geriatrics and Extended Care, Rehabilitation, and Community Care; etc.

6. PHYSICAL MEDICINE AND REHABILITATION SERVICE FIELD ADVISORY BOARD: The PM&RS Field Advisory Board (FAB) provides technical and administrative advice and assistance to the National Director and National PM&RS Program Office on national rehabilitation issues. **NOTE:** Additional field advisory, committees, councils, and work groups
may be established, as needed, to augment the primary PM&RS FAB, and provide further advice and assistance to the National PM&RS Program Office.

a. The Chair of the PM&RS FAB is selected from the existing board members and formalizes recommendations to the National PM&RS Director. National PM&RS Program Office staff members participate in Board meeting activities as necessary.

b. The PM&RS FAB consists of at least two representatives each for: rehabilitation physicians, kinesiotherapists, occupational therapists, and physical therapists. These representatives are recommended by the program that they are representing, and are approved by the National PM&RS Director. Each representative serves one 3-year term.

c. Terms of appointment are staggered to ensure continuity on the Board. Optional one term extensions may be granted by the National PM&RS Director based upon the status of current assignments or other program needs. The PM&RS FAB may include appropriate associate members from other sections of the Rehabilitation and Prosthetics Services and the Office of Patient Care Services, as needed, for those disciplines that are often included within PM&RS. **NOTE:** At this time those liaison representatives include: RT, rehabilitation nursing, SLP, and chiropractic care.

7. RESPONSIBILITIES:

a. **Medical Facility Director.** The medical facility Director is responsible for:

1. Creating and maintaining the mission for the rehabilitation programs within the facility, based on the fundamental principles in paragraph 3b of this Handbook.

2. Having final authority over, and responsibility for, the accountability of the program within the organizational structure.

3. Ensuring continual compliance with accreditation standards.

4. Removing, where such removal is readily achievable, architectural, attitudinal, communication, employment, and other barriers to people with disabilities.

5. Collaborating with the operational leadership of the rehabilitation program.

6. Supporting public information efforts designed to inform various groups about the benefits of rehabilitation and supporting rehabilitation in-service and educational programs.

7. Contacting the National Director of PM&RS prior to the implementation of any proposed organizational changes in a rehabilitation bed unit. **NOTE:** For additional information see VHA Handbook 1000.01, Inpatient Bed Change Program and Procedures at: http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2355. This is an internal VA web site that is not available to the public.

8. Collaborating with local PM&RS manager and Human Resources Management, to determine the most appropriate supervision and leadership of therapy disciplines. In larger programs, it is appropriate for each therapy discipline to have a therapy supervisor or leader. In
facilities that have service line organization, therapies may be supervised by a program or clinical manager.

(9) Ensuring that PM&RS is well represented on medical facility-wide committees in order to promote the needs of disabled Veterans.

b. **Facility Physical Medicine and Rehabilitation Service Chief or Service Line Manager.** The facility Chief, PM&RS or Service-Line Manager is responsible for:

(1) Having a working knowledge of the principles of rehabilitation.

(2) Being accessible and available to personnel and involved in the operations of the rehabilitation programs. This is accomplished through an “open-door policy,” as well as regular formal and informal meetings with program staff. Staff is to be made aware of the availability of such communication channels and the opportunity to give input regarding the operations of the programs.

(3) Ensuring excellence in performance in all aspects of:

(a) Financial management and reporting;

(b) Resource utilization;

(c) Accomplishment of strategic plans;

(d) Management of programmatic outcomes;

(e) Communication of pertinent issues; and

(f) Gathering input from all levels of personnel for decision making.

(4) Establishing a “lead” or “senior” therapist in those instances when a therapy discipline is not supervised by a person credentialed in that therapy discipline. This lead or senior therapist must be the subject matter expert for that discipline in areas such as: recruitment, performance evaluation, training, competencies, scope of practice, and other professional discipline issues.

(5) Recommending to executive leadership projected staffing needs, equipment and supply management, and other operational aspects of administering and managing a program. Any such recommendations are based on information and data PM&RS has collected and analyzed.

(6) Ensuring continual compliance with accreditation standards.

(7) Removing, where such removal is readily achievable, architectural, attitudinal, communication, employment, and other barriers to people with disabilities through meetings with various levels of personnel.

(8) Supporting public information efforts designed to inform various groups regarding the benefits of rehabilitation, and presenting rehabilitation in-services and educational programs. This involvement consists of activities such as participating or presenting at meetings of groups
involved in rehabilitation, including local community events that promote and publicize the value of rehabilitation and educating all levels of the organization regarding the value of rehabilitation.

(9) Ensuring the provision of appropriate PM&RS orientation to Veterans and the Veteran’s family members or caregivers. A uniform method of orientation for new patients admitted to the inpatient rehabilitation unit must be developed. All Veterans admitted to the inpatient rehabilitation unit must be adequately oriented along with the Veteran’s family members or caregivers to the program and the facility. \textit{NOTE: It is recommended that a rehabilitation orientation packet be given to each Veteran upon admission.}

(10) Managing information and performance improvement (see paragraph 18). This includes establishing policy on how the program obtains and uses patient outcome data and information to continually improve the quality of care to patients and their families.

(11) Overseeing the care rendered by rehabilitation specialists, as defined in facility-level policy and in accordance with VA compliance regulations. There are Standards for all Hybrid Title 38 professions which include: PT, OT, KT, Physical Therapy Assistant (PTA), and Occupational Therapy Assistant (OTA). These standards must be considered when hiring or promoting a professional in each of these occupations.

(12) Maintaining regular contact with them and disseminating information from the PM&R program office to all local rehabilitation personnel at their facility.

c. \textbf{Interdisciplinary Rehabilitation Team}. The responsibilities of the interdisciplinary rehabilitation team include:

(1) \textbf{Assessment Process and Documentation}. A thorough initial assessment is performed by all members of the interdisciplinary rehabilitation team. This assessment gathers pathophysiological, functional, cognitive, communicative, behavioral and emotional, pharmacological, physical, and social data from qualified individuals regarding each Veteran’s goals, impairments, activity limitations, participation restrictions, discharge environment, and need for care. This data is analyzed to:

(a) Create the information necessary to decide the approach and timeframes to meet the patient's rehabilitation care needs; and

(b) Enable decisions establishing the patient's interdisciplinary plan of care. Evaluation and treatment are initiated according to the timeframe established in the medical facility’s PM&RS policies and procedures.

(2) \textbf{Interdisciplinary Plan of Care}.

(a) The interdisciplinary plan of care is utilized by the rehabilitation team as a method of compiling the assessment information of the interdisciplinary team (IDT) members into a single custom plan of care for the Veteran. The plan of care represents the overall direction that the IDT is working towards assisting the Veteran to achieve improvements in independence, function, and quality of life. \textit{NOTE: An interdisciplinary plan of care can be used for both inpatients and outpatients.}
(b) Each member of the IDT administers discipline-specific evaluations based on the individual medical and surgical diagnoses, impairments, and sequelae of the patient. These evaluations assist the IDT to establish the projected achievable goals and timelines for rehabilitation. The physiatrist or physician with extensive rehabilitation experience provides oversight to the interdisciplinary rehabilitation plan of care. The interdisciplinary plan and any changes to the plan, made by the IDT or the Veteran are communicated in the electronic medical record to the interdisciplinary team. The physician designates a point of contact (POC) to communicate the IDT plan to the Veteran.

(c) The interdisciplinary plan of care is a participant-centered, coordinated, and collaborative plan based on active involvement of the patient, family, and rehabilitation team members or other support system participants identified by the patient and IDT. The plan synthesizes information gathered from the Veteran, the Veteran’s family, and discipline-specific evaluations, allowing for the completion of a functional impairment list, identified interventions, and expected short-term, long-term, and discharge goals. Based on input from the Veteran and the overall IDT assessment, the strengths, abilities, needs, and preferences of the patient or CLC resident are identified and noted in the plan of care. The interdisciplinary plan must include measurable goals, discharge planning, and patient education. The IDT determines the frequency of treatment and the estimated length of stay at admission, which are reviewed with the Veteran. The interdisciplinary plan of care is not intended to replace discipline-specific treatment plans or notes. **NOTE:** For more information see VHA Handbook 1172.04, Physical Medicine and Rehabilitation Individualized Rehabilitation and Community Reintegration Care Plan, at: http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2229. This is an internal VA Web site that is not available to the public.

(d) Regular and frequent assessments must be performed on a discipline-specific and interdisciplinary basis, including a revision of program goals and areas of identified need, as required by the patient’s or CLC resident’s condition. This includes specific and detailed information regarding the progress of the individual as determined by the re-evaluations of each consulted discipline to ensure that appropriate adjustments are made to the plan of care, and facilitate discharge planning. The results of re-evaluations are documented in the medical record and communicated to the team and the Veteran during the IDT meeting. Assessment and re-assessment timeframes are determined within local medical facility policy.

(e) All team members are required to complete a discharge summary relevant to their discipline’s scope of practice. The combined discharge summaries must detail the medical, physical, functional, cognitive, psychological, and psychosocial status of the Veteran at the time of discharge. The summary must include medications, activity restrictions, adaptive equipment provided, and progress towards rehabilitation goals. Additional discharge information addresses the discharge living setting, written instructions provided to the patient, CLC resident, caregivers, any community contacts, and future appointments to assist with the Veteran’s transition back into the community.

(f) For outpatient rehabilitation, the interdisciplinary plan of care and IDT meetings guide the clinical process for patients with functional rehabilitation goals requiring intervention from two or more rehabilitation professionals, if applicable. Outpatient rehabilitation IDTs are led by a board-certified or board-eligible attending physiatrist, physician with extensive rehabilitation
experience, service or care-line manager, resident physician (if on the team), or Rehabilitation Case Manager. Outpatient rehabilitation IDTs provide individualized, coordinated, and outcome-focused outpatient services, including rehabilitation services, therapy services, education, and psychological treatment and support to patients who live in the IDT's local service area.

(3) Treatment Interventions.

(a) Provision of rehabilitation services and interventions is determined by a rehabilitation IDT with oversight by a board certified or board eligible attending physiatrist, physician with extensive rehabilitation experience, service or care-line manager, resident physician (if on the team), or Rehabilitation Case Manager. Treatment interventions are an integration of medical, psychosocial, and functional interventions.

(b) Veterans receiving comprehensive inpatient rehabilitation on a unit accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) receive services from the IDT, depending on the Veterans’ assessed need. Rehabilitation care plans are communicated to the entire rehabilitation IDT, facilitated by the Rehabilitation Case Manager, and implemented on a continuous basis, 24-hours a-day, 7-days a-week.

(4) Reassessment and Monitoring of Progress.

(a) The progress of each Veteran is reviewed regularly with regard to:

1. The response to the rehabilitation interventions as outlined in the interdisciplinary plan of care;

2. Changes in the Veteran’s condition;

3. Choices for alternative interventions; and

4. Progress towards meeting the rehabilitation goals.

(b) The discharge plan is reviewed and adjusted as necessary.

(c) The notes from meetings need to address the progress made and specify any new or modified interventions needed prior to discharge.

(5) Documentation. Progress reports are entered into the Veteran’s electronic medical record to reflect the patient’s condition and progress towards the rehabilitation goals. Documentation frequency must meet the standard set in the medical facility’s PM&RS policies and procedures, which must be in accordance with the accrediting agency requirements for the medical facility. **NOTE:** For more information, visit the VHA Chief Business Office Web site at [http://vaww1.va.gov/cbo/](http://vaww1.va.gov/cbo/). This is an internal VA Web site that is not available to the public.

(6) Veteran and Family Education. The Veteran and the Veteran's family are provided with appropriate education and training to increase their knowledge of the Veteran's condition and treatment needs, and to learn skills and behaviors that promote recovery and improve function. Assessment of learning needs, abilities, and readiness to learn is done by each member
of the rehabilitation team and documented in discipline-specific progress notes. **NOTE:**

*Documentation of Veteran education may be documented by discipline-specific progress notes.*

Types of instruction include:

(a) Rehabilitation techniques to facilitate adaptation to, or functional independence in, the environment;

(b) Access to available community resources;

(c) Safe and effective use of medical equipment, when applicable; and

(d) Safe and effective use of medication in accordance with legal requirements and the Veteran’s needs.

(7) **Therapeutic Apartment Stay or Therapeutic Home Pass.** The therapeutic apartment stay or home pass is designed to help patients, CLC residents, and their families evaluate the application of skills acquired in the inpatient rehabilitation program to their own setting. Information obtained as a result of an apartment stay or a home pass, needs to be incorporated into the patient’s treatment plan to maximize the patient's independence at home.

(8) **Family Conferences.** For the purpose of this Handbook, the family is defined as those persons living with the Veteran. In cases where the Veteran is living alone, family includes people identified by the Veteran to be contacted in case of emergency. The Veteran determines who is considered family, and who is appropriate to participate in the family conference, unless the Veteran lacks the mental capacity to make this determination. Family may include significant others, spouse, domestic partner, friend, children, siblings, or other blood relatives. A court appointed guardian may also be considered appropriate to participate in the family conference.

(a) Family conferences are held at a frequency necessary to maintain good communication. They usually occur near the time of admission and before discharge. In the family conference, information is exchanged with the family and the Veteran to reach an understanding of the rehabilitation plan. Additionally, education is provided regarding the Veteran’s current status, progress, limitations, and prognosis. Questions are also answered and effective discharge plans are confirmed.

(b) After the completion of the family conference, a progress note is written by a designated IDT member outlining the purpose of the conference, the participants, and the outcome.

(9) **Discharge.** Written discharge criteria are established by the VA medical facility PM&RS and approved by the Chief of Staff or other executive bodies of the VA medical facility.

(a) Discharge planning begins on the first day of admission (or prior to admission for patients seen on rehabilitation consult) and discharge action plans are reviewed during IDT meetings.

(b) The estimated date of discharge and discharge action plans are set during the initial assessment.
(c) If discharge to the home setting is contemplated, appropriate arrangements to transition care to the outpatient primary care team must be initiated, with development of a care plan that builds upon rehabilitation progress in the inpatient setting.

(10) Follow-up and After Care. Follow-up or after care is accomplished by planning and coordinating the care, treatment, and rehabilitation deemed necessary after the Veteran is discharged from the inpatient program.

(a) Follow-up care is planned while the Veteran is an inpatient, and it is documented in the discharge summary.

(b) Prior to discharge, the Social Worker designated for the rehabilitation team works with the Veteran and Veteran’s family to resolve issues regarding housing, residential care, financial support, home care, and any other issues to ensure continued recovery or maintenance after discharge.

(c) Follow-up care and treatment by the designated rehabilitation IDT members must be provided, as indicated within the discharge summary.

d. The Veteran and the Veteran’s Family. The Veteran and the Veteran's family are responsible for:

(1) Providing information regarding personal goals and needs relative to the Veteran’s rehabilitation.

(2) Cooperating with the IDT, as well as, participating in the development of therapeutic goals within the IDT plan of care for the Veteran.

e. Physical Medicine and Rehabilitation Inpatient Team. Rehabilitation care is always patient or resident centered. All rehabilitation team members are responsible for documenting in their assessment the extent of the Veteran’s involvement in goal setting and the assessment process. All interventions by providers include education and training of Veterans, the Veteran’s family members, and caregivers. The IDT specializes in the management of the complex needs of patients and CLC residents who would benefit from comprehensive and intensive rehabilitation services. Composition of the IDT is determined by the needs and goals of the patient or CLC resident. The patient, resident and their family, or other support system is an integral part of the IDT. The Veteran is a crucial member of the team, and the Veteran's goals are at the center of the rehabilitation process (see Appendix C). Disciplines represented on the rehabilitation IDT may include, but are not limited to: rehabilitation case manager; physiatrist or physician with extensive rehabilitation experience; speech language pathologist; social worker; physical therapist; occupational therapist; kinesiotherapist; recreation and creative arts therapist; psychologist; rehabilitation nurse; and clinical pharmacist.

f. Rehabilitation Case Manager. The Rehabilitation Case Manager is responsible for:

(1) Ensuring continuity of care by coordinating the admission process between referral sources and the inpatient team.
(2) Promoting systems to ensure continuous rehabilitation efforts 24 hours a day, 7 days a week.

(3) Monitoring and facilitating the implementation of the care plan.

(4) Facilitating communication between the inpatient team and home or outpatient programs to foster continuing rehabilitation care.

(5) Ensuring the Veteran is an active participant in developing goals, establishing therapeutic interventions, and planning discharge.

(6) Facilitating communication between the Veteran and other members of the team (see the American Case Management Association website at www.acmaweb.org or the Case Management Society of America website at www.cmsa.org for additional information on case management).

g. **Physiatrist or Physician with Extensive Rehabilitation Experience.** The Physiatrist or Physician with extensive rehabilitation experience is responsible for:

   (1) Providing specialized medical assessment and interventions for injuries and disease processes that have resulted in the need for rehabilitation and in specialized musculoskeletal, neurological, and functional examination;

   (2) Assessing the Veteran’s needs as a whole;

   (3) Developing treatment strategies with input from specific rehabilitation team members;

   (4) Requesting consults, as needed;

   (5) Coordinating implementation of the rehabilitation services;

   (6) Routinely assessing the Veteran's progress;

   (7) Contributing towards discharge planning; and

   (8) Completing an admission history and physical examination that meets the current standards of the medical facility. The admission history and physical, in addition to those elements required by the VA medical facility, contains a functional history and examination, other medical conditions that impact rehabilitation, and the physiatrist's impression regarding prognosis for the rehabilitation goals (see the American Academy of Physical Medicine and Rehabilitation website at http://www.aapmr.org/ for additional information on physical medicine and rehabilitation).

h. **Speech Language Pathologist.** The Speech Language Pathologist is responsible for:

   (1) Providing evaluation, treatment, and management of speech, language, voice, fluency, cognitive, communication, and swallowing disorders.
(2) Determining, after an initial evaluation and the results of the diagnostic battery are available, the most effective treating modalities for each Veteran.

(3) Providing direct patient or CLC resident care.

(4) Communicating information about the Veteran's abilities and disabilities to other members of the team.

(5) Working with the Veteran’s family members and other caregivers to develop effective communication strategies to use with the Veteran (see the American Speech-Language-Hearing Association website at www.asha.org for additional information on speech-language hearing).

i. **Social Worker.** The Social Worker designated for the rehabilitation team is responsible for:

   (1) Providing psychosocial assessment and intervention, which includes: next-of-kin information; identification of social support systems; current living situations and alternative options; financial and employment status; and needs for discharge.

   (2) Providing counseling for the Veteran, caregiver, and the Veteran’s family in understanding the:

      (a) Nature and level of disability;

      (b) Adjustment to the disability;

      (c) Goals for rehabilitation;

      (d) Plans for discharge; and

      (e) Community reintegration.

   (3) Reviewing the orientation packet with the Veteran to ensure that the Veteran received and understood the information, and requesting, if appropriate, language interpreters for the individual Veteran to assist in communicating this information.

   (4) Documenting the orientation session with the Veteran in the Veteran's electronic medical record.

   (5) Assisting the Veteran in completing an Advance Directive (see VHA Handbook 1004.02 Advance Care Planning and Management of Advance Directives).

   (6) Serving as the POC on the interdisciplinary team assisting the Veteran, caregiver, and the Veteran’s family in coordinating community resources (see the National Association of Social Workers website at http://socialworkers.org/ for additional information on social workers).

j. **Physical Therapist.** The Physical Therapist is responsible for providing:
(1) Evaluation in muscle strength, balance and coordination, joint flexibility, physical endurance, locomotion and transfer mobility, and pain.

(2) Specific assessment techniques that include, but are not limited to: manual muscle tests; gait analysis; range of motion; and neurological examination.

(3) Common interventions that include, but are not limited to: therapeutic exercises, manual intervention, neuromuscular re-education, resistive muscle strengthening, gait training, and use of prostheses and orthoses; recommendations for specialized equipment; use of modalities such as transcutaneous electrical nerve stimulator (otherwise known as TENS), functional muscle stimulation, ultrasound; and patient, caregiver, and family education (see the American Physical Therapy Association website at www.apta.org for more information on physical therapy).

k. Occupational Therapist. The Occupational Therapist is responsible for providing:

(1) Evaluation and treatment in areas that support participation of clients in their everyday life occupations.

(2) Specific evaluations involving an analysis of occupational performance in the areas of: activities of daily living (ADLs); instrumental activities of daily living (IADLs) education; work; play; leisure; and social participation. These evaluations include evaluations of performance patterns, (habits, routines, and roles), body structure, body functions (e.g. neuromuscular, sensory, visual, perceptual, and cognitive), performance skills (motor, process, and communication, and interaction skills), and context and activity demands.

(3) Common treatment interventions, which include, but are not limited to:

(a) Training in self-care, home management, and community or work reintegration to enhance safety and performance.

(b) Specialized training in the use of assistive technology, adaptive devices, and orthotic and prosthetic devices.

(c) Therapeutic use of self, purposeful activities, and modalities to address remediation, or compensation of physical, cognitive, neuromuscular, sensory functions, and behavioral skills (see the American Occupational Therapy Association, Inc. website at www.aota.org for additional information on occupational therapy).

l. Kinesiotherapist. The Kinesiotherapist is responsible for:

(1) Providing evidence-based exercise techniques adapted to enhance the strength, endurance, and mobility of individuals with functional limitations or those requiring extended physical conditioning.

(2) Determining; in collaboration with the Veteran, the appropriate evaluation tools and interventions necessary to establish a goal-specific treatment plan.
(3) Ensuring, when appropriate, specific assessment techniques, which include, but are not limited to: musculoskeletal; neurological; ergonomic; biomechanical; psychosocial; and task-specific functional tests and measures.

(4) Ensuring, when appropriate, common interventions, which may include: therapeutic exercises; gait training; gait treatment; assessment of use of assistive devices; neuromuscular re-education; and strategies to educate the Veteran, the Veteran’s family, and caregiver on techniques to enhance neuromusculoskeletal, psychomotor, and psychosocial wellbeing (see the American Kinesiotherapy Association website at www.akta.org for more information on kinesiotherapy).

m. Recreation and Creative Arts Therapist. The Recreation and Creative Arts Therapist is responsible for:

(1) Direct-care interdisciplinary service with a mission to improve and enrich bio-psycho-social functioning through active therapy or meaningful therapeutic activities to maintain and improve functional independence and life quality. The intended outcome of the service is independence in life activities based upon the patient’s or resident’s needs and goals.

(2) Treatment outcomes, which are met through the professional skills of therapists, specialists, and assistants through a four-step process of assessment, planning, intervention, activity implementation, and evaluation of services delivered.

(3) Recreation therapy services that include patient-centered care, best practices, education, technology, and research. Recreation and creative arts therapies provide an activity-based patient-centered service that integrates function, quality, and meaning to one's life (see the American Therapeutic Recreation Association website at http://www.atra-online.com for additional information on therapeutic recreation).

n. Psychologist. The psychologist provides assessments of cognitive, behavioral, and emotional status, and is responsible for:

(1) Identification of cognitive weaknesses for possible remediation;

(2) Identification of pre-disability coping styles in order to maximize coping strategies and to avoid difficulties in the rehabilitation process;

(3) Assessment and description of brain-behavior relationships in terms of higher cortical functioning;

(4) Evaluation to assist the Veteran with adjustment issues regarding disability and chronic illness;

(5) Psychosocial interventions to promote adjustment and optimal functioning;

(6) Psychotherapy, including evidence-based psychological treatments, to address more significant mental health problems; and
(7) Communicating information regarding the Veteran's learning abilities to other members of the IDT and the identification of strategies for the team to approach the treatment plan (see the American Psychological Association website at http://www.apa.org/ for additional information on psychology).

   o. **Rehabilitation Nurse.** The Rehabilitation Nurse is responsible for providing initial assessments and treatment in:

      (1) Sleep and wake patterns;
      (2) Bowel and bladder functioning;
      (3) Skin condition;
      (4) Pain management;
      (5) Nutritional status;
      (6) Current ADL status;
      (7) Cognitive and perceptual deficits;
      (8) Safety issues including assessing fall risks;
      (9) Contributing factors to the diagnosis (hypertension, etc.); and
      (10) Veteran’s, caregiver’s, or the Veteran's family learning needs (see the Association of Rehabilitation Nurses website at http://www.rehabnurse.org/ for additional information on rehabilitation nursing).

   p. **Clinical Pharmacist.**

      (1) The Clinical Pharmacist is a professional health care team member that is recommended as a member of the core team based on CARF requirements for medication use reviews and their role as the medication expert.

      (a) The Clinical Pharmacist has expertise in evaluating the medication management needs of the Veteran to minimize adverse drug events and optimize medication use to facilitate achievement of individual patient goals for recovery.

      (b) In addition, Clinical Pharmacists (or Clinical Pharmacy Specialists), as mid-level providers, may manage comprehensive medication needs of the Veteran by initiating, titrating, and discontinuing medications (as clinically indicated) and thereby assist the clinical team. A Clinical Pharmacist can assist with the use of medications to relieve inflammation, pain, anxiety, and numerous other conditions, depending on their area of specialty, recognized in their individual scope of practice.
(2) The Clinical Pharmacist is responsible for the following activities:

   (a) Performing initial medication use evaluation upon admission to the program, to include
       assessment of present and past medication history, reviewing drug regimens for potential
       interactions, incompatibilities, redundant or unnecessary medications and history of allergy,
       intolerances and adverse drug reactions;

   (b) Participating in team meetings to discuss overall goals of therapy and assists in
       addressing the ongoing medication management needs of the Veteran;

   (c) Collaborating and development pharmacotherapy treatment plans that take into account
       the overall treatment goals of the IDT and are tailored to the Veteran’s needs;

   (d) Providing assessment of medication adherence with the Veteran’s IDT treatment plan;

   (e) Providing assistance with self-medication use, based on individual patient needs; and

   (f) Incorporating the Veteran’s, caregiver’s, or the Veteran’s family learning preferences
       when providing education regarding medications and compliance with prescribed drug regimen.

8. ANCILLARY SERVICES: Services that are not always part of the Rehabilitation IDT, but
   may be consulted based on the patient’s or CLC resident’s needs include but are not limited to:

   a. Aquatic Therapy;

   b. Audiology;

   c. Blind Rehabilitation;

   d. Cardiac Rehabilitation;

   e. Cardiothoracic Surgery;

   f. Chiropractic Services;

   g. Dentistry or Oral and Maxillofacial Surgery;

   h. Dialysis;

   i. Driver Training;

   j. Endocrinology;

   k. Gastroenterology;

   l. General Medicine;

   m. General Surgery;

   n. Geriatric Medicine;
o. Gynecology;
p. Infectious Diseases;
q. Internal Medicine;
r. Neurology;
s. Neuro-ophthalmology;
t. Neuropsychology;
u. Neurosurgery;
v. Orthopedic Surgery;
w. Otolaryngology;
x. Pain Management;
y. Plastic Surgery;
z. Podiatry;
 aa. Psychiatry;
 bb. Psychological Services, including Evidence-Based Psychotherapy;
 cc. Pulmonary;
 dd. Prosthetics;
 ee. Radiology;
 ff. Rehabilitation Psychology;
 gg. Rheumatology;
 hh. SCI/D System of Care;
 ii. Urology;
 jj. Vascular Surgery;
 kk. Women’s Health; and
 ll. Wound and Ostomy.
9. CONTINUUM OF REHABILITATION CARE:

a. Rehabilitation occurs across a continuum at various levels of intensity and in different care settings. Veterans may have their rehabilitation provided in a variety of environments from acute inpatient hospitalization through a spectrum of inpatient and outpatient rehabilitation care settings, including CLCs and within the home, if medically appropriate. Regardless of the location, any designated inpatient rehabilitation unit must earn and maintain CARF Accreditation. **NOTE:** There is a waiver for smaller bed units, if approved by the National PM&RS Program Director.

b. The continuum of rehabilitation services is determined by the Veteran's rehabilitative needs and not by the program's location or designation. After a patient or CLC resident is identified as needing rehabilitation services, a designated and qualified rehabilitation specialist screens the patient or CLC resident. This person is called the Rehabilitation Point of Contact (RPOC).

c. **Core Levels of Care.** Core levels of care in the rehabilitation continuum include:

   (1) **Acute Medical Rehabilitation Consultative Services.** Hospitalized patients experiencing the onset of illness or injury may benefit from one or more rehabilitation therapies to assist in regaining physical and functional abilities. This is typically initiated by a consult to PM&RS.

      (a) An appropriate credentialed and privileged provider may initiate this consult to a physical medicine physician for a comprehensive medical assessment or to manage a specific condition, such as Polytrauma, TBI or amputation care, or to perform or recommend various modalities and therapy treatments. In most VA medical facilities, Licensed Independent Providers (LIP), Nurse Practitioners (NP) and Physician Assistants (PA) are able to initiate consults and make referrals for specific therapies such as OT, PT, KT, and RT specialists, if their approved Scope of Practice at the medical facility permits.

      (b) Specifically, PAs and NPs may provide and coordinate comprehensive PM&RS patient care services when authorized by an approved Scope of Practice. The Scope of Practice ensures that PAs practice medicine as agents of their supervising physicians with defined levels of autonomy.

         1. PAs and NPs may order PM&RS consults and other specialty consults for assigned patients as the Scope of Practice permits.

         2. These services are provided in central therapy clinics, satellite clinics, and at the bedside or in another environment (home, group home, assisted living facility, etc.) depending upon the needs of the patient.

   (2) **Comprehensive Integrated Inpatient Rehabilitation Program (CIIRP) i.e., Inpatient Rehabilitation Bed Services.**

      (a) CIIRP provides a patient-centered, coordinated, intensive program of multiple services delivered by an IDT that may include, but is not limited to: a rehabilitation physician, rehabilitation nursing, rehabilitation case management, OT, PT, SPT, KT, RT, social work, and
psychology. The IDT supports and reinforces each patient’s individual plan of care 24 hours a day, 7 days a week (see VHA Handbook 1170.01, Accreditation of Veterans Health Administration Rehabilitation Programs).

(b) CIIRP must meet high standards of care and earn accreditation from CARF. Regardless of the location, if an inpatient bed section’s function is designated as comprehensive inpatient rehabilitation it must be accredited by CARF.

(c) The rehabilitation environment of care requires that rehabilitation beds are co-located in the same designated area, and that treatment areas provide opportunities for patients to interact with each other as part of the rehabilitation process. The physical location of inpatient rehabilitation beds varies. Rehabilitation bed units may be in their own designated area or may be located adjacent to acute medical services, such as neurology and general medicine. Rehabilitation beds may also be located in a designated area of the CLC.

(d) The focus of the CIIRP is on meaningful functional improvement and successful community re-entry. Goals are identified in mobility, activities of daily living (ADL), instrumental activities of daily living (IADL), productive activity, and preparation for home and community. The treatment program has a specific timeframe and is goal-oriented with a focus on practical life-skills training. Treatment interventions are individualized and cost-effective, incorporating the Veteran, the Veteran’s family, and caregiver education and preparation for the Veteran’s transition back into the community. Patients usually remain in the CIIRP until goals are met, maximal functional improvement is achieved or it is determined that the needs of the patient would be better served within another continuum.

(e) Each CIIRP program has admission criteria and an admission screening process. This level of care is appropriate for patients with one or more conditions requiring treatment by a rehabilitation team, at a level of intensity that can be provided more effectively and efficiently within an inpatient rehabilitation program. Patients are admitted from various sources, including the same facility, another VA medical facility, military treatment facilities (MTF), community medical facilities, and home. **NOTE: Most programs offer short-stay evaluations, as needed, to determine ongoing care needs.**

(f) The Rehabilitation Continuum of Care Chart of Recommendations describes programming for specific rehabilitation services across the continuum of care. The Rehabilitation Continuum of Care Algorithm provides a decision tree for determining the most appropriate level of rehabilitation services for a patient with identified rehabilitation needs (see Appendix A).

(3) **Outpatient Medical Rehabilitation.**

(a) Outpatient rehabilitation must be considered when a patient has functional limitations requiring skilled intervention by rehabilitation therapists, but inpatient medical care is not necessary. The expectation is that the patient’s condition will improve in a reasonable and generally predictable period of time or the services must be necessary for establishing a safe and effective environment. Outpatient services may be provided in the outpatient therapy department, the community, or the home. A plan of care must be developed in conjunction with
the patient's medical team proving primary care, either in the community or through the VA Patient-Aligned Care Team (PACT).

(b) An outpatient medical rehabilitation program is a patient-centered, individualized, coordinated program that has focused outcomes and is directed at optimizing the function of the patient. An assessment process initiates the individualized treatment approach for each patient. The rehabilitation program provides consultative, diagnostic, preventative, and therapeutic services.

(c) Referrals for outpatient rehabilitation services are generated by various sources, e.g., primary care; medical subspecialties such as orthopedics, rheumatology, and neurology; inpatient attending physicians; non-VA community providers; etc. Procedures for directing and managing referrals are established by the individual VA medical facility and may include specific service agreements that outline appropriate referral patterns between disciplines.

(d) Following an initial assessment, the patient may be scheduled for outpatient treatment at an established frequency and for an established duration, if the criteria for treatment are met. Generally, the patient’s medical condition must allow for safe participation in the therapy program, but the patient must also be willing to participate. There is also a reasonable expectation that improvement can be attained from the therapeutic intervention and that the patient is willing and able to participate in a rehabilitation program. When a response to treatment is not predictable, a trial of therapy may be recommended.

(e) Many PM&RS programs provide all, or portions of, condition-specific, structured, outpatient programs, such as cardiac rehabilitation, weight management (e.g., MOVE! Weight Management Program for Veterans), and low-back programs that are offered to a group of patients over a specified timeframe.

(f) During the course of outpatient care, rehabilitation specialists may determine that additional services are needed, such as psychological, psychiatric, psychopharmacological, or other medical subspecialty consultation; for example, clinical pharmacology to consult on medication options for care or social work, etc. Each facility must have a process to request additional services.

(4) **Transitional Rehabilitation.** Transitional rehabilitation is for Veterans and active duty Servicemembers with Polytrauma or TBI who have physical, cognitive, or behavioral difficulties that persist after the acute phase of rehabilitation and prevent such Veterans and Servicemembers from effectively re-integrating into the community or returning to duty. Transitional rehabilitation offers a progressive return to independent living through a structured program focused on restoring home, community, leisure, psychosocial, and vocational skills in a controlled, therapeutic setting. Services provided typically include:

(a) Group therapies;

(b) Individual therapies;

(c) Case management and care coordination;

(d) Medical care;
(e) Vocational rehabilitation services;

(f) Discharge planning; and

(g) Follow-up. (See VHA Handbook 1172.02, Physical Medicine and Rehabilitation Service Transitional Rehabilitation Bed Section, at: http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2244). **NOTE:** This is an internal VA Web site that is not available to the public.)

(5) **CLC.** Rehabilitation services provided in a CLC setting can vary in the intensity of services provided based on the needs of the resident and are indicated by Treating Specialty Code 64 designated for short-stay PM&RS Bed Sections. PM&R National Program Office and Geriatric and Extended Care National Program Office have collaborated to describe rehabilitation provided on CLC units.

(6) **Home and Community Care.** Rehabilitation services may be provided as part of a home care program. Therapists providing services in the home setting must have specialized training to meet The Joint Commission Homecare Standards and Durable Medical Equipment (DME) Home Care Standards.

(7) **Telerehabilitation.** Telerehabilitation services can be used to increase access to specialty rehabilitation care on an outpatient basis. These services allow the provider to be located at a tertiary VA medical facility while the patient is at a Community-based Outpatient Clinic or at home. Veterans with disabilities, especially in rural areas, can greatly benefit from telerehabilitation. Many of these Veterans have mobility issues and/or socioeconomic factors that affect their ability to receive needed care. The results are that this population often have decreased access to care and possibly decreased quality of care. For Veterans with disabilities that need long-term follow-up, such as stroke or TBI, telerehabilitation offers the option for clinicians to enhance services that can be offered, thereby assisting in increased functional gains and social re-integration.

10. **REFERRAL AS ACCESS TO CARE:**

   a. **Referral to Consultation Service.** Veterans must be referred for PM&RS by means of a consult in the patient’s or CLC resident’s electronic medical record. The medical facility’s PM&R policies and procedures specify method, mode, and content of the referral. The consult document is to be completed with as much specificity as possible. **NOTE:** Service agreements between disciplines may be used to specify content within a referral for rehabilitation services.

   b. **Referral to Inpatient Rehabilitation Services.** Inpatient rehabilitation services may be provided in various venues within the medical facility. Services provided are determined by the patient’s or CLC resident’s assessed functional impairments. Services may be provided in a CIIRP (see paragraph 9c(2)) or in a CLC. All referrals for admission for inpatient rehabilitation services are to be evaluated by a RPOC who determines the necessary level of service (see paragraph 9 and Appendix B). In the case of CIIRP, a designated person such as a nurse manager, case manager, physician, or social worker needs to be designated as a rehabilitation admissions coordinator to coordinate the admission with the referral source, the Veteran, caregiver, the Veteran’s family, and the rehabilitation IDT. **NOTE:** Written admission criteria
established by the PM&RS must be approved by the Chief of Staff or other medical facility executives.

(1) Transfers from Within the Facility.

(a) A Veteran referred for consideration of admission to the CIIRP must have a consult completed by the referring service to the rehabilitation admitting physician, provider or designee.

(b) The rehabilitation admitting physician or designee has final authority to accept or deny requests for inpatient transfers.

(c) Referrals for a Veteran for admission to the CLC must follow the procedures established by the CLC and Geriatrics and Extended Care (see VHA Handbook 1142.01, Criteria and Standards for VA Community Living Centers (CLC)).

(d) A discharge summary must be available upon admission to the CIIRP.

(2) Admissions from Outside the Facility.

(a) Eligibility for VA health care must be determined by the VA medical facility admission process.

(b) The rehabilitation admitting physician, or designee, has final authority to accept or deny admissions.

c. **Referral for Outpatient Services.** Veterans are referred to outpatient PM&RS physician clinics or specific therapy clinics by means of a consult in the patient’s electronic medical record from an approved credentialed and privileged provider with an approved Scope of Practice. The medical facility’s PM&RS policies and procedures must specify method, mode, and content of the referral. The consult document must be completed with as much specificity as possible. **NOTE:** Service agreements between disciplines may be used to specify the content within a referral for rehabilitation services. Also, within certain practice settings, patients may have direct access to physical therapy services without a physician’s consult in accordance with state laws and local memoranda; see the American Physical Therapy Association website for language regarding direct access at: [http://www.apta.org](http://www.apta.org).

11. CLINICAL INDICATIONS FOR PARTICIPATION AND DISCHARGE FROM THE INPATIENT REHABILITATION CONTINUUM OF CARE: The following indications for participation and discharge from inpatient rehabilitation apply to all levels of the continuum of care. **NOTE:** Individual programs may have additional admission and discharge criteria as well.

a. **Clinical Indications for Inpatient Rehabilitation Continuum of Care.** The following are clinical indications for inpatient Rehabilitation Continuum of Care:

(1) Onset of an injury or a medical or surgical event within the past 90 days resulting in the need for rehabilitation, unless complicating factors exist (i.e., the Veteran’s medical instability has precluded participation in rehabilitation and has shown improvement, referral was delayed due to administrative issues, or the Veteran’s condition has changed from baseline);
(2) The event has resulted in an impairment of functional performance relative to baseline;

(3) The Veteran has specific functional improvement goals within a projected timeframe;

(4) The Veteran has the ability to actively and safely participate in the rehabilitation program;

(5) The Veteran agrees to participate in rehabilitation; and

(6) The discharge setting is either to the pre-hospital living setting or to alternative living options that have been identified, which have the necessary support systems. Discharge is addressed with the Veteran, the Veteran’s family or caregiver, as appropriate, prior to admission to the program.

b. **Discharge Criteria for Inpatient Rehabilitation Continuum of Care.** The discharge criteria for inpatient Rehabilitation Continuum of Care are:

(1) Treatment goals have been achieved;

(2) Care needs require transition to a higher or lower level of care than offered by the program;

(3) The Veteran is no longer making progress towards goals and no new goals have been identified;

(4) The Veteran requests discharge from the program;

(5) Documented patient non-adherence to program services by the Veteran, which indicates that continued participation is either not safe or not an appropriate approach to care; or

(6) The Veteran is unable to actively and safely participate in the rehabilitation program.

**NOTE:** Although sometimes challenging, persons with dementia or other cognitive impairment should not be excluded from receiving rehabilitation because of the dementia or cognitive impairment. Innovative rehabilitation approaches and techniques need to be used to assess these patients’ potential for improved function.

12. **POLYTRAUMA SYSTEM OF CARE (PSC) TRAUMATIC BRAIN INJURY (TBI):**

a. The PSC was developed to meet the rehabilitation needs of a new generation of Veterans with injuries from current combat operations in Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn. Use of weapons, such as improvised explosive devices in non-conventional war settings, is resulting in combat wounded Veterans with severe and multiple injuries. Improved body armor and new strategies for casualty care have increased the survival rate of those who are seriously injured.

b. The term “Polytrauma” is defined as two or more injuries sustained in the same incident that affect multiple body parts or organ systems that result in physical, cognitive, psychosocial, or psychological impairments, and functional disabilities. TBI frequently occurs as part of the polytrauma spectrum in combination with other disabling conditions, such as: amputation;
auditory and visual impairments; burns; nerve injuries; soft tissue injuries; fractures; post-traumatic stress disorder (PTSD); and other mental health conditions. Due to the severity and complexity of their injuries, Servicemembers and Veterans with polytrauma require an extraordinary level of coordination and integration of clinical and other specialty services (see: VHA Handbook 1172.01 Polytrauma System of Care at: http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2875 for detailed information). NOTE: This is an internal VA Web site that is not available to the public.

c. PSC is an integrated system of specialized interdisciplinary programs designed to meet the complex medical, psychological, rehabilitation, and prosthetic needs of Veterans with polytrauma. This is a tiered system of care that includes four components: Polytrauma Rehabilitation Centers (PRC); Polytrauma Network Sites (PNS); Polytrauma Support Clinic Teams (PSCT); and Polytrauma Point of Contacts (PPOC).

13. AMPUTATION SYSTEM OF CARE PROGRAM: The Amputation System of Care provides specialized expertise in amputation rehabilitation incorporating the latest practice in medical rehabilitation management, rehabilitation therapies, and technological advances in prosthetic componentry.

a. Amputation System of Care Model. The Amputation System of Care model is designed to provide graded levels of expertise and accessibility, and is comprised of four distinct components of care: Regional Amputation Centers; Polytrauma-Amputation Network Sites; Amputation Clinic Teams; and Amputation POC (see VHA Handbook 1172.03, Amputation System of Care at http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2774 for detailed information). NOTE: This is an internal VA Web site that is not available to the public. As geographic access to services increases, the level of specialty support services may decrease. This model contributes to enhancements of the current system and is available to all Veterans.

(1) Regional Amputation Centers. The Regional Amputation Centers provide the highest level of specialized expertise in clinical care and technology and provides rehabilitation to patients with the most complicated symptoms.

(2) Polytrauma-Amputation Network Sites. The Polytrauma-Amputation Network Sites provide a full range of clinical and ancillary services to Veterans within the local VISN catchment area.

(3) Amputation Clinic Teams. Amputation Clinic Teams are located at sites with limited inpatient and prosthetic capabilities, but have a core Amputation Care Team to provide regular follow-up and to address ongoing care needs of Veterans with amputations.

(4) Amputation Point of Contact. The Amputation POC is an individual specifically identified by all other facilities to act as the POC for consultation, assessment, and referral of a Veteran to a facility capable of providing the level of services required.

b. Prevention of Amputation in Veterans Everywhere Program.

(1) VA’s Prevention of Amputation in Veterans Everywhere (PAVE) Program, formerly known as Preservation Amputation Care and Treatment, was established in 1993 to meet the
changing needs of an aging Veteran population in which amputations are due to neuropathic and vascular conditions, with fewer traumatic amputations. It represents a model of care developed to prevent or delay amputation through proactive early identification of patients, such as those facing secondary complications due to diabetes who are at risk of limb loss. Presently, VA is faced with increasing numbers of Servicemembers with traumatic amputations as they transition from the military and seek continued medical care at VA medical facilities as Veterans. The PAVE Program is also inclusive of the needs of these Veterans, ensuring that they receive optimal medical and compassionate patient-centered care.

(2) The PAVE Program provides a model of care for those patients “at-risk” for amputation and for those who have already suffered an amputation. Utilizing a Team Coordinator, the program incorporates interdisciplinary management of care utilizing available resources that include: primary care; infectious disease; diabetes teams; nurses; podiatrists; vascular surgeons; rehabilitation physicians; therapists (physical, occupational, recreational, etc.); social workers; mental health care workers; and prosthetic and orthotic personnel. The PAVE Program tracks every patient with an amputation, or those at risk of limb loss, from day of entry into the VA health care system, through all appropriate care levels (see VHA Directive 2012-020, Prevention of Amputation in Veterans Everywhere (PAVE) Program for detailed information at http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2778). NOTE: This is an internal VA Web site that is not available to the public.

14. DRIVER REHABILITATION PROGRAM:

a. Section 3903 of 38 U.S.C. requires VA to provide opportunities for driver education and training for certain military personnel and all eligible Veterans with disabilities. The VA Driver Rehabilitation Program is designed to provide professional evaluation and instruction for eligible Veterans and Servicemembers in the safe, competent utilization of special add-on equipment, and the mastery of specific skills to effectively and independently drive a motor vehicle in accordance with state Department of Motor Vehicles regulations.

b. Evaluation and assessment are provided to eligible Veterans having a variety of impairments due to physical, neurological, and psychiatric disorders or diseases associated with aging that limit their ability to drive, and that are amenable to intervention. NOTE: An ocular health and visual functioning evaluation is recommended as well. The program provides assistance in the selection of an appropriate vehicle and equipment for the Veteran with disabilities; thereby increasing mobility and allowing the individual the opportunity to independently enter the mainstream of society (see VHA Handbook 1173.16, Driver Rehabilitation for Veterans with Disabilities Program at: http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2148 for additional information). NOTE: This is an internal VA web site that is not available to the public.

15. SCOPES OF PRACTICE FOR THERAPISTS: Rehabilitation therapists are responsible, within the limits of their academic preparation and approved scope of practice, for the independent performance of their profession.

a. Scopes of practice are written and approved under the provision of the local VA medical facility policies.
b. A scope of practice is based on:

(1) Professional standards of practice;

(2) Documented education and training;

(3) Specific experience in the delivery of patient care; and

(4) Licensure, certification, or registration, when applicable, for rehabilitation disciplines.

16. STAFF EDUCATION AND AFFILIATION PROGRAM:

a. **Medical Residency Program.** Residency programs in PM&RS established in VA medical facilities follow resident supervision guidance established within VHA Handbook 1400.01, Resident Supervision. VA medical facilities sponsoring a PM&RS Residency Training Program must have a CIIIP (see paragraph 9c(2)) with diagnostic capabilities as required by the American Board of Physical Medicine and Rehabilitation. No new PM&RS VA-sponsored residency programs may be initiated by a facility; hence, all new PM&RS programs must have an affiliated sponsor of the accredited program. Resident supervision and graduated responsibilities must follow VHA regulations (see VHA Handbook 1400.01) and Accreditation Council for Graduate Medical Education (ACGME) guidelines (see [http://www.acgme.org/adspublic/](http://www.acgme.org/adspublic/)) or guidelines of the American Osteopathic Association (AOA) (see [http://www.osteopathic.org/inside-aoa/accreditation/Pages/default.aspx](http://www.osteopathic.org/inside-aoa/accreditation/Pages/default.aspx)). VA PM&RS Programs may serve as a participating site for a PM&RS Residency Training Program sponsored by an academic affiliate, if they are approved by the PM&RS Residency Review Committee (RRC). **NOTE:** For additional information regarding establishing a new or managing an existing PM&RS affiliation, see VA Office of Academic Affiliations at [http://vaww.va.gov/oaa/GME_default.asp](http://vaww.va.gov/oaa/GME_default.asp). This is an internal VA website that is not available to the public.

b. **Associated Health Trainee Program.** The Office of Academic Affiliations (OAA) allocates positions and funding for trainee support of occupational therapy and physical therapy (see [http://vaww.va.gov/oaa/AHE_default.asp](http://vaww.va.gov/oaa/AHE_default.asp)). **NOTE:** This is an internal VA Web site that is not available to the public. Annually, the PM&RS Program Office forwards information from OAA regarding the availability of positions and funding for occupational and physical therapy traineeships. Requests must be coordinated locally, usually through the Designated Education Officer (DEO), often known as the Associate Chief of Staff (ACOS) for Education. The PM&RS Program Office develops criteria for standards of excellence for clinical training sites and uses those criteria in recommending positions and funding to OAA.

c. **Affiliation Agreements.** Clinical training in PM&RS therapies may be provided at selected VA medical facilities through affiliation relationships in accordance with OAA guidelines. Officials at the sponsoring educational institution and VA medical facility must co-sign an Affiliation Agreement in order to establish a training program at such medical facility. The office of the ACOS for Education or DEO will assist in ensuring that appropriate procedures are followed in establishing an affiliation agreement (see [http://www4.va.gov/oaa/agreements.asp](http://www4.va.gov/oaa/agreements.asp) for further information on affiliation agreements). OAA must approve all affiliation agreements with a school of medicine or any affiliation agreement...
which deviates from the standard, approved templates provided on OAA’s website. In addition to an affiliation agreement, a program letter of agreement (PLA) is required for affiliations with schools of medicine.

d. **Staff Training and Development.** Continuing education is expected of every PM&RS employee. Mandatory training requirements are posted at [http://vaww.ees.lrn.va.gov/Training/mandatory/](http://vaww.ees.lrn.va.gov/Training/mandatory/). **NOTE:** This is an internal VA website that is not available to the public. Within the local PM&RS, continuing education needs must be assessed annually, and a staff training and development plan prepared for each employee. PM&RS educational activities may be administered by the Employee Education System (EES), educational institutions, PM&RS in-services, grand rounds, etc.

17. **STAFF AWARDS AND RECOGNITION:**

a. Special "Advancement for Performance" awards are approved at the facility level.

b. Special "Advancement for Achievement" awards can give some employees up to a five-step increase, but must go to the Professional Standards Board for review and recommendation of the step increase (see VA Handbook 5017/6 for both advancement for performance and achievement, at: [http://www1.va.gov/vapubs/viewPublication.asp?Pub_ID=354&FType=2f](http://www1.va.gov/vapubs/viewPublication.asp?Pub_ID=354&FType=2f) for more detailed information).

18. **MANAGEMENT OF INFORMATION AND PERFORMANCE IMPROVEMENT:**

PM&RS programs are committed to continually improving their organizations and service delivery to the persons served. PM&RS programs provide the Veteran, and other interested stakeholders, with ongoing information about the actual performance of the program, and the program’s ability to achieve optimal outcomes for the persons served through the program’s services. Information is collected and used to manage and improve service delivery. Each PM&RS program must establish policy on how the program obtains and uses patient outcome data and information to continually improve the quality of care to patients and their families. This process is based on the philosophy and practice of performance improvement, which is a part of the daily work practices of all PM&RS staff.

a. **Information Gathering.** Each PM&RS program, regardless of size or complexity, must establish a system for collecting and analyzing data and information in order to measure and analyze outcomes. The leadership at each local VA medical facility determines the appropriate customer service tool to be utilized to correspond with the organizational process improvement protocol within that facility. If any surveys or focus groups are deemed necessary, it is the decision of local VA medical facility leadership. This process must adhere to the following guidelines:

   (1) The information gathered must be relevant to the mission of the PM&RS Program, to the VA medical facility or health care system, the VISN, and to the needs of the stakeholders.

   (2) This outcome information is used throughout the performance improvement planning activities for the rehabilitation care program, and is shared with consumers, team members, management and quality management officials, and others, as appropriate.
(3) The information shared with stakeholders accurately reflects the performance of the program and considers the requests and input of stakeholders.

(4) Each VA medical facility must determine if the information collection is subject to the Paperwork Reduction Act of 1995, Title 5 Code of Federal Regulation 1320. **NOTE:** For more information and guidelines for data collection see VA Handbook and Directive 6309, Collections of Information.

b. **Strategic Planning.** A mission, vision, and core values for the PM&RS Program must be developed or reaffirmed prior to the development of information and performance planning. This defines the direction of the program. Once the mission, vision, and core values are established, then strategic planning can be initiated. Strategic Planning determines, through collection and analysis of information, how the program can attain its mission and vision. **NOTE:** This strategic plan must be re-evaluated annually (see VA Strategic Plan at: [http://www1.va.gov/OP3/docs/StrategicPlanning/VA_2010_2014_Strategic_Plan.pdf](http://www1.va.gov/OP3/docs/StrategicPlanning/VA_2010_2014_Strategic_Plan.pdf)). The strategic planning process includes the following aspects:

1. Retrospective review of the program including its successes and challenges;
2. Analysis of the program’s strengths, weaknesses, opportunities, and threats;
3. Collection of information and input from a variety of stakeholders or customers to determine program development needed to meet future needs and expectations;
4. Establishment of goals and the identification of objectives;
5. Marketing and sharing the strategic plan widely with all stakeholders;
6. Implementation and monitoring the plan; and
7. Making needed modifications to the strategic plan.

c. **Performance Improvement.** Performance improvement (PI) is a continuous process and may be organized under a number of system titles such as quality improvement (QI), continuous quality improvement (CQI), etc. The data derived from the achieved outcomes, the efficiency of the organization, and satisfaction with health services delivery from various perspectives (e.g., patients, other stakeholders) provides an assessment of how effectively the organization improves the life of the Veteran.

1. A PI Plan for a PM&RS program is required to evaluate and improve processes and services in achieving desirable outcomes; this must be completed as a service-level policy memorandum. At a minimum, this plan includes: purpose of the plan; detailing how information is to be obtained; explanation of how the information is to be used and shared with stakeholders; the QI or PI model being used (e.g., Plan-Do-Study-Act (PDSA) model); and roles and responsibilities of PM&RS leadership, managers, and staff. **NOTE:** It is recommended that an interdisciplinary group be involved, such as a designated team or committee.

2. Performance activities, outcomes, and improvements must be regularly reported to all stakeholders, including Veterans, PM&RS staff, facility leadership, referral sources, Veteran
Service Organizations (VSO), and other identified stakeholders. It must be reported in a format that is easily understandable to all parties receiving the information.

d. **Clinical Practice Guidelines.** Clinical Practice Guidelines (CPG) can be useful when developing performance improvement to decrease variability of care across the system. The guidelines are designed to be adapted to individual facility needs and resources. CPG can be used to determine the best interventions and steps of care for patients to optimize health care utilization, and achieve the best outcomes. **NOTE:** Guideline recommendations must facilitate, not replace, clinical judgment. See [http://www.healthquality.va.gov/](http://www.healthquality.va.gov/) for more information and a list of specific CPGs applicable to Veteran and Servicemember patient populations.

19. **ACCREDITING ENTITIES:**

   a. **Commission on Accreditation for Rehabilitation Facilities.** CARF provides an international, independent, peer review system of accreditation that is widely-recognized by federal agencies, forty state governments, major insurers, and leading professional groups in rehabilitation, as well as, consumer and advocacy organizations throughout the U.S. and in other countries. Established in 1966, CARF serves as the pre-eminent accreditation body that sets standards and promotes the delivery of quality rehabilitation services for people with disabilities.

      (1) The standards developed by CARF are consumer-focused, field-driven, state-of-the-art national and international standards for rehabilitation. They have been developed in the areas of medical rehabilitation, aging services, behavioral health, and employment and community services. CARF standards are applicable to both inpatient and outpatient settings, and a variety of specialized programs. Consequently, CARF standards directly address many of the populations and services that are important to VHA.

      (2) The positive outcomes of rehabilitative care have been shown to increase when this care is provided in a dedicated unit with coordinated, interdisciplinary evaluation and services. Although rehabilitation care may be delivered in a variety of settings, the interdisciplinary focus, including dedicated staff and appropriate case management, must not be compromised. No institution is exempt from the need for external oversight. Consequently, CARF accreditation ensures that VHA meets community standards for accountability in rehabilitation care (see Commission on Accreditation of Rehabilitation Facilities (CARF) website at [http://vaww.oqsv.med.va.gov/functions/integrity/accred/carf.aspx](http://vaww.oqsv.med.va.gov/functions/integrity/accred/carf.aspx) for more detailed information).

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

   b. **The Joint Commission.** The Joint Commission accreditation is nationally-recognized as a symbol of quality and is considered one of VHA’s major external quality reviews. Maintaining The Joint Commission accreditation for all VA medical facilities is consistent with one of VHA’s goals to “Provide Excellence in Healthcare Value.” The Joint Commission accreditation confers recognition that healthcare organizations meet certain standards of quality and safety, and are compliant with health care quality standards of payers, both public (e.g., Medicare) and commercial. ACGME requires that healthcare organizations sponsoring or participating in Graduate Medical Education (GME) programs be accredited by The Joint Commission or by another recognized body with reasonably-equivalent standards (see The Joint Commission website at [http://vaww.archive.oqp.med.va.gov/oqp_services/accreditation/accreditation.asp](http://vaww.archive.oqp.med.va.gov/oqp_services/accreditation/accreditation.asp) for
more detailed information). **NOTE:** This is an internal VA Web site that is not available to the public. All VA health care facilities are currently accredited by The Joint Commission.

20. HEALTH, SAFETY, SPACE, AND EQUIPMENT: Current health, safety, and sanitation VHA Directives must be adhered to in PM&RS, as they pertain to space, personnel, fabricated articles, equipment, supplies, and utilities. Ongoing staff training in these areas must be provided. Procedures for emergencies (e.g., disaster, fire, hazardous material, etc.) must be developed, by local VA medical facility PM&RS service chief, supervisors, and/or administrative officer, in writing and communicated to all staff and volunteers within PM&RS. Special attention must be given to policies and procedures that address:

a. **Patient Incidents.** Patient or CLC resident incidents must be identified and promptly reported according to facility published policy.

b. **Infection Control Program.** Infection control programs are instituted in PM&RS in compliance with the facility’s infection control committee, and current Centers for Disease Control and Prevention (CDC) guidelines.

c. **Safety Practices.** Local policies must be developed regarding safety and maintenance of all PM&RS equipment, and for patient participation in PM&RS-sponsored off-station recreational outings and community trips.

d. **Emergency Preparedness.** All PM&RS staff must be trained and knowledgeable about what to do in the event of an emergency. Emergencies include fire, cardiac arrest, behavioral and medical emergency, natural disasters, bomb threats, power failures, etc.

e. **Risk Prevention.** All incidents, accidents, safety hazards, and risk issues must be identified and presented to the supervisor by any PM&RS staff member. Local VA medical facility policy is to be followed to determine if there is a problem, or an opportunity to improve care, and to determine if further action is necessary to reduce risk.

f. **Consolidated Memorandum Receipt.** All Consolidated Memorandum Receipt (CMR) listed equipment used in PM&RS is on a preventative maintenance program, calibrated as necessary, and, when applicable, in compliance with Occupational Safety and Health Administration standards. Documentation of the calibrations must be maintained by the facility PM&RS administration and with environmental management.

g. **Hazardous Items.** Hazardous equipment and supplies used in PM&RS must be used only in accordance with written safety and storage regulations that conform to both the VA Handbook 0062, Environmental Compliance Management, and the guidelines established by local VA medical center policy. Material Safety Data Sheets (MSDS) are available according to local policy.

h. **Space.** PM&RS areas and facilities are to be used primarily for the benefit of Veterans participating in a PM&RS program. With the recommendation of the PM&RS leadership and authorization of the VA medical facility Director; equipment, supplies, and space may be used by VA and non-VA individuals or organizations, provided this does not interfere with patient
care and meets safety, security, and liability criteria (see the national planning criteria for PM&RS at http://www.cfm.va.gov/til/space.asp).

21. RESEARCH: PM&RS promotes rehabilitation research activities, and appropriately applies research findings to the clinical setting.

   a. PM&RS staff is encouraged to initiate research activities directed towards producing relevant, reliable data and information in all Veteran rehabilitation facilities.

   b. PM&RS research is always conducted under the auspices of the local Research Service subject to pertinent regulations and guidelines.

   c. PM&RS research, including the preparation and publication of professional papers, is accomplished with policies and procedures prescribed by ORD (see http://vaww.research.va.gov/). NOTE: This is an internal VA Web site that is not available to the public.

22. BUSINESS PRACTICES: PM&RS has a continuous collaborative relationship with Fiscal Service, Medical Care Collections Fund (MCCF), and the Compliance Office in order to maintain the highest ethical standards across all business practices and operations. Because of the dynamic health care environment, PM&RS must maintain compliance with standards of accrediting and regulatory organizations, including, but not limited to, CARF and The Joint Commission and recommends compliance with third party payer documentation requirements.

23. FINANCIAL PLANNING AND BUDGETING:

   a. Information Gathering. PM&RS leaders at all levels use information to effectively manage the financial aspects of PM&RS operations. The process of financial planning and budgeting considers data and information of various aspects including:

      (1) Customer and employee needs and expectations;

      (2) National, VISN, and local initiatives or directives;

      (3) Outcome data; and

      (4) Strategic planning.

   b. Budgeting, Costing, and Internal Controls. Each PM&RS program is responsible for preparing budget forecasts for operational needs, including clinical service and office supplies, equipment, human resources, and staff education, etc., in accordance with current fiscal guidance. NOTE: PM&RS requests these resources by following the local medical facility’s established policies and procedures.

   c. Fund Control Points. PM&RS is responsible for one or more fund control points (FCP). Fiscal Service assigns funds according to service’s budget request into these FCPs. PM&RS leaders at each facility are responsible for controlling cost ceiling amounts apportioned to their respective control points.
d. **Purchasing.** When appropriate, facilities with PM&RS programs may have one or more purchase cardholders who purchase supplies using a Government credit card. Cardholders must comply with all acquisition, Federal, VA, and local regulations.

### 24. COSTING, BILLING, AND REVENUE:

a. **Decision Support System (DSS).** DSS is a cost accounting system that integrates expenses and workload, simulates business scenarios, and monitors patient treatment patterns. DSS supports comparisons between facilities for assessing treatment protocols and resources consumed during treatment, including production unit (department) group costs. DSS provides the link between expenses, workload, and patient utilization. By linking the costs associated with patient utilization and attaching the information to patient episodes of care, managers can analyze patterns of health care delivery, monitor performance measures, and consider cost efficiency when managing workload and controlling medical care costs. In order for DSS efficiency reports to be accurate, PM&RS Managers must submit and continuously monitor labor maps for employees’ respective DSS units. The process of mapping involves submission of accurate distribution of staff time devoted to clinical and administrative functions. Additionally, different products or services for clinics need to be established based on national recommendations. Together, the labor mapping and products combine to provide costing information either along patient or clinical lines.

b. **Workload and Productivity.** Workload data can be captured through various mechanisms, including Appointment Management, Event Capture, and Encounter systems. These systems can be used for both inpatient and outpatient settings, and can be accessed through the CPRS.

1. Data entered for inpatient and outpatient workload are stored in the local Veterans Health Information and Technology Architecture (VistA) system, and transferred to the Austin Information Technology Center to also be stored in the National Patient Care Database. Informational reports can be accessed locally through VistA, and nationally through the VHA Support Service Center (VSSC) website at [http://vssc.med.va.gov](http://vssc.med.va.gov). **NOTE:** This is an internal VA website not available to the public.

2. DSS measures the effectiveness of department resources. Specified time is the total number of minutes it should take to accomplish the total department workload, according to the labor Relative Value Units (RVU) (labor minutes used per procedure or test). It is calculated by multiplying product volumes (number of procedures or test) by variable labor RVUs. This number is divided by 60 to convert minutes to hours. Specified time is also expressed as Full-Time Equivalent employees.

3. In the CLC, minutes and service dates are entered by the rehabilitation therapist in Section O of the Minimum Data Set. (see VHA Handbook 1142.03, Requirements for Use of the Resident Assessment Instrument (RAI) Minimum Data Set (MDS), and VHA Directive 2012-016, Documentation of Kinesiotherapy Services in Department of Veterans Affairs Community Living Centers in the Resident Assessment Instrument Minimum Data Set.

4. Department productivity is calculated by dividing specified hours by actual worked hours, but DSS states acceptable ranges of work productivity are from 70 to 110 percent based
on volume of procedures entered for workload compared to the number of duty hours worked. 

**NOTE:** Local management is encouraged to review productivity of clinicians but realize that there are complexities in patient diagnosis and treatment needs that will cause significant variations. This level of information currently can be extracted only through DSS Product level reports. See DSS reference at: [http://vaww.dss.med.va.gov](http://vaww.dss.med.va.gov). This is an internal VA website that is not available to the public.

c. **Billing and Coding.** PM&RS supports appropriate billing and coding through compliance with national, VISN, and local policies for documenting and completing data capture for inpatient and outpatient services. PM&RS staff utilizes the most recent edition of the International Classification of Diseases-Clinical Modifications (otherwise known as ICD-CM) current procedural terminology (otherwise known as CPT) associated with Rehabilitation Services within electronic encounter forms. PM&RS collaborates with VA Office of Information & Technology (OI&T) to ensure that technology is available in CPRS, VistA, electronic templates, etc. (see [http://vaww1.va.gov/cbo/](http://vaww1.va.gov/cbo/)). **NOTE:** This is an internal VA Web site that is not available to the public.

d. **Compliance.** PM&RS must ensure compliance with accurate coding and documentation of diagnostic and procedural data in order to maintain delivery of the highest-ethical standards of care. To achieve this PM&RS maintains a workforce educated in compliance issues, and ensures adherence to National, VISN, and local policies regarding compliance.

e. **Veterans Equitable Resource Allocation (VERA).** VERA is a patient classification system that divides patients and CLC residents into two care classes, complex and basic, based primarily on individual or multiple diagnostic codes. Some of the complex classification groups represent diagnostic categories typically served by PM&RS including stroke, amputation and TBI. PM&RS provides accurate documentation and coding to ensure that patients are placed in the appropriate care class, as this may affect the VISN budget (see the Veterans Equitable Resource Allocation (VERA) Information website at [http://vaww.arc.med.va.gov/](http://vaww.arc.med.va.gov/) for more detailed information). **NOTE:** This is an internal VA website that is not available to the public.

25. **MARKETING:** Marketing is used to heighten awareness and communicate the services available in PM&RS, and can be accomplished by many different methods. Examples include:

a. Open House;

b. Grand Rounds;

c. In-services to employees and service organizations;

d. Participation in community activities (e.g., health fairs and school programs); and

e. Celebration of National Discipline Recognition Events (e.g., National PT, OT, KT, RT, and Rehabilitation Week or Month).

26. **COMMUNICATION:** There are various mechanisms for national communication, such as national conference calls, national email groups, PM&RS SharePoint, national conferences, and the national Web sites. There are designated VISN PM&RS POCs or Leads, and some have
VISN Rehabilitation Councils that provide interaction between facilities and staff. Additionally, the PM&RS FAB provides a field perspective to VA Central Office.

27. REFERENCES:

   a. VA Handbook 5017/6, Employee Recognition and Awards.

   b. VHA Handbook 1000.01, Inpatient Bed Change Program and Procedures.

   c. VHA Handbook 1142.01, Criteria and Standards for VA Community Living Centers (CLC).

   d. VHA Handbook 1170.01, Accreditation of Veterans Health Administration Rehabilitation Programs.

   e. VHA Handbook 1172.01, Polytrauma System of Care.

   f. VHA Handbook 1172.02, Physical Medicine and Rehabilitation Service Transitional Rehabilitation Bed Section.

   g. VHA Handbook 1172.03, Amputation System of Care.

   h. VHA Handbook 1172.04, Physical Medicine and Rehabilitation Individualized Rehabilitation and Community Reintegration Care Plan.


   j. VHA Handbook 1176.01, Spinal Cord Injury and Disorders (SCI/D) System of Care.

   k. VHA Handbook 1173.16, Driver Rehabilitation for Veterans with Disabilities Program.

   l. VHA Handbook 1400.01, Resident Supervision.

   m. VHA Handbook 1120.01, MOVE! Weight Management Program for Veterans (MOVE!).

   n. VA Directive and Handbook 6309, Collections of Information.

   o. VA Handbook 0062, Environmental Compliance Management.


   q. VHA Directive 2012-016, Documentation of Kinesiotherapy Services in Department of Veterans Affairs Community Living Centers in the Resident Assessment Instrument Minimum Data Set.
THE REHABILITATION CONTINUUM OF CARE ALGORITHM

Rehabilitation Continuum of Care

- Patient is referred with a need for rehabilitation services.
- Designated and qualified rehabilitation continuum of care specialists screen the patient.
- Does the patient need comprehensive inpatient rehabilitation?
  - NO: Recommend appropriate placement in rehabilitation continuum.
  - YES: Supportive
    - Outpatient In-Home

- Is there a Commission on CARF accredited rehab unit?
  - NO: Is there a CARF accredited unit within the VISH that is feasible?
    - NO: Is there a CLC offering rehabilitation?
      - NO: Monitor patient to assess if rehab goals are met
      - YES: Admit to the CLC treatment specialty code 64
    - YES: Admit to the CARF accredited unit (treatment specialty code 26 or 64)
  - YES: Admit to nearest CARF accredited unit within VISH

CARF – Commission on Accreditation of Rehabilitation Facilities
CLC – Community Living Centers
VISH – Veterans Integrated Service Network
<table>
<thead>
<tr>
<th>Levels of Care</th>
<th>High Intensity</th>
<th>Mod Intensity</th>
<th>Low Intensity</th>
<th>Supportive</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient</strong></td>
<td>Physical Medicine and Rehabilitation (PM&amp;R)</td>
<td>PM&amp;R Geriatric and Extended Care (GEC)</td>
<td>PM&amp;R GEC</td>
<td>GEC Restorative Nursing</td>
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<tr>
<td><strong>Outpatient</strong></td>
<td>Ordering Provider</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Responsible Provider</strong></td>
<td>Yes, direct</td>
<td>Yes, direct or consultative</td>
<td>Yes, consultative</td>
<td>As clinically indicated</td>
</tr>
<tr>
<td><strong>MD or Licensed Practitioner Visits</strong></td>
<td>Daily</td>
<td>Weekly</td>
<td>Monthly</td>
<td>Every 30 days</td>
</tr>
<tr>
<td><strong>Rehabilitation Team</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Consultative</td>
<td>Consultative</td>
</tr>
<tr>
<td><strong>Presence of Certified Rehabilitation Registered Nurse (CRRN) or Nurse with Rehabilitation Experience</strong></td>
<td>Yes, direct</td>
<td>Yes, direct or consultative</td>
<td>Yes, consultative</td>
<td>As clinically indicated</td>
</tr>
<tr>
<td><strong>Expected Length of Stay (LOS)</strong></td>
<td>Short Stay: Determined by the FRG Classification Typically &lt;30 days</td>
<td>Short Stay: Determined by the FRG Classification Typically &lt;30 days</td>
<td>Short Stay: Determined by the FRG Classification Typically &lt;90 days</td>
<td>Benchmark Diagnosis. May be &gt;90 days. Rehab Involvement: Limited</td>
</tr>
<tr>
<td><strong>Functional Independence Measurement (FIM)/Resource Utilization Group (RUG)/Function Related Group (FRG)</strong></td>
<td>9.4 hrs. (7.0 Minimum)</td>
<td>7.0 hrs. (4.8 Minimum)</td>
<td>4.8 hrs. (4.1 Minimum)</td>
<td>4.1 hrs. (3.9 Minimum)</td>
</tr>
<tr>
<td><strong>Nursing Hours Per Patient Day</strong></td>
<td>Restorative Nursing (Nsg) plus rehab therapies &gt; 2 Nsg. Activities</td>
<td>Restorative Nsg. 6 days a week, 15 min a day, &gt; 2 Nsg. Activities</td>
<td>Not Applicable</td>
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<tr>
<td><strong>Restorative Care</strong></td>
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<td><strong>Therapy Disciplines</strong></td>
<td>Minimum of 2</td>
<td>Minimum of 2</td>
<td>Minimum of 1</td>
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<tr>
<td><strong>Therapy HPPD</strong></td>
<td>Minimum of 3</td>
<td>Minimum of 2</td>
<td>Minimum of 1</td>
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### Levels of Care

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<th>Therapy Days per Week</th>
<th>Inpatient</th>
<th>Outpatient</th>
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<tr>
<td>High Intensity</td>
<td>Minimum of 5</td>
<td>As clinically indicated</td>
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<tr>
<td>Mod Intensity</td>
<td>Minimum of 5</td>
<td>As clinically indicated</td>
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<tr>
<td>Low Intensity</td>
<td>Minimum of 3</td>
<td>As clinically indicated</td>
</tr>
<tr>
<td>Supportive</td>
<td>As clinically indicated</td>
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<tr>
<th>Accreditation Requirements</th>
<th>Inpatient</th>
<th>Outpatient</th>
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<tr>
<td>Commission on Accreditation of Rehabilitation Facilities (CARF) and The Joint Commission (TJC)</td>
<td>CARF and TJC</td>
<td>Long Term Care (LTC) and TJC</td>
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<td>CARF and/or TJC</td>
<td>Outpatient CARF</td>
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<tr>
<td>Long Term Care (LTC) and TJC</td>
<td>Outpatient Homecare or TJC</td>
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<tr>
<th>Beds in Designated Area</th>
<th>Inpatient</th>
<th>Outpatient</th>
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<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Not Required</td>
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<th>Discharge Destination</th>
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<td>Community</td>
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<td>FIM</td>
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<td>Determined by Program</td>
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<td>Per Departmental Policies</td>
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<th>Outpatient</th>
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<td>Per Departmental Policies</td>
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THE PHYSICAL MEDICINE AND REHABILITATION (PM&R) INPATIENT TEAM

Rehabilitation care is always patient centered. The Veteran is a crucial member of the team whose goals should be at the center of the rehabilitation process as illustrated in the diagram below.

Consultants to the Rehabilitation Team:  
(see paragraph 8 for complete list)

Audiologist  
Blind Rehabilitation Staff  
Chaplain  
Dietitian  
Optometrist  
Podiatrist  
Prosthetist or Orthotist  
Respiratory Therapist  
Medical, Surgical, Psychiatric Specialists  
Wound Care Specialist  
Peer Support Groups  
Educator  
Women’s Veteran Program Manager or Women’s Health Team Case Manager
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<th>Veterans Integrated Service Network (VISN)</th>
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<td>VA Central Iowa – Des Moines</td>
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   NOTE: This is an internal VA website and not available to the public.

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