

POLYTRAUMA REHABILITATION PROCEDURES

1. REASON FOR ISSUE. This Veterans Health Administration (VHA) Handbook describes the procedures for the Polytrauma Rehabilitation Program and defines Polytrauma Rehabilitation Centers (PRC) in the provision of comprehensive interdisciplinary rehabilitation, medical care, and coordination of care.

2. SUMMARY OF CHANGES. This is a new Handbook defining the parameters of the Polytrauma Rehabilitation Program.

3. RELATED ISSUES. None.

4. RESPONSIBLE OFFICE: The Office of Patient Care Services, the Chief Consultant, Rehabilitation Strategic Healthcare Group (117) is responsible for the contents of this VHA Handbook. Questions may be referred to the Director, Physical Medicine and Rehabilitation Services at 612-725-2044.

5. RECISSIONS. None.

6. RECERTIFICATION. This VHA Handbook is scheduled for recertification on or before the last working day of September 2010.

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POLYTRAUMA REHABILITATION PROCEDURES

1. PURPOSE

This Veterans Health Administration (VHA) Handbook describes the procedures for the Polytrauma Rehabilitation Program and defines Polytrauma Rehabilitation Centers (PRC) in the provision of comprehensive interdisciplinary rehabilitation, medical care, and coordination of care for the severely wounded with multiple complex injuries.

2. BACKGROUND

a. Recent combat has resulted in new patterns of polytraumatic injuries and disability requiring specialized intensive rehabilitation processes and coordination of care throughout the course of recovery and rehabilitation. While serving in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), military service members are sustaining multiple severe injuries as a result of explosions and blasts. Improvised explosive devices, blasts, landmines, and fragments account for 65 percent of combat injuries (see subpar. 17a). Congress recognized this newly emerging pattern of military injuries with the passage of Public Law 108-422, Section 302, and Public Law 108-447.

b. Of these injured military personnel, 60 percent have some degree of traumatic brain injury (TBI) (see <http://www.dvbic.org/>). Operating under a national Memorandum of Agreement (MoA) with the Department of Defense (DOD), the four current Department of Veterans Affairs (VA) TBI Lead Centers have provided rehabilitation care to the majority of the severely combat injured requiring inpatient rehabilitation. Consequently, they have developed the necessary expertise to provide the coordinated interdisciplinary care required. This experience has demonstrated that treatment of brain injury sequelae needs to occur before, or in conjunction with, rehabilitation of other disabling conditions.

c. Recognizing the specialized clinical care needs of individuals sustaining multiple severe injuries, VA has established four PRCs. The PRC mission is to provide comprehensive inpatient rehabilitation services for individuals with complex physical, cognitive, and mental health sequelae of severe and disabling trauma and provide support to their families. Intensive case management is essential to coordinate the complex components of care for polytrauma patients and their families. Coordination of rehabilitation services must occur seamlessly as the patient moves from acute hospitalization through acute rehabilitation and ultimately back to the patient's home community.

d. The Secretary of Veterans Affairs designated four PRCs, co-located with TBI Lead Centers, at VA Medical Centers in Richmond, VA; Tampa, FL; Minneapolis, MN; and Palo Alto, CA (see App. A). It is VHA policy that the PRCs provide a full-range of care for all patients eligible for VA care, who have sustained varied patterns of severe and disabling injuries including, but not limited to: TBI, amputation, visual and hearing impairment, spinal cord injury (SCI), musculoskeletal injuries, wounds, and psychological trauma.

3. DEFINITIONS

a. **Admission and Follow-up Clinical Case Management.** The PRCs provide clinical case management of referrals prior to admission and follow-up case management for the ongoing rehabilitation plan of care after discharge. Individuals assigned to this function, the clinical case managers, require knowledge and clinical reasoning skills necessary to review the medical status of the patient, identify all of the current medical problems, evaluate the acuity level, assess factors surrounding readiness for inpatient rehabilitation, and monitor the patient's status until transferred. The clinical case manager makes recommendations for alternative care settings when appropriate. Following discharge from a PRC, the clinical case manager proactively follows the patient to monitor medical and functional problems, coordinates the ongoing rehabilitation plan of care and services, advocates for the patient's medical treatment needs, and assesses clinical outcomes and satisfaction. ***NOTE:** A Certified Rehabilitation Registered Nurse (CRRN) who possesses the critical clinical expertise and the knowledge of rehabilitation practice can best perform these functions.*

b. **Clinical and/or Counseling Psychologist.** The clinical and/or counseling psychologist must have expertise and experience in rehabilitation psychology. Rehabilitation psychologists provide clinical and counseling services assisting individuals in coping with, and adjusting to, chronic or traumatic injuries or illnesses that may result in a wide variety of physical, sensory, neurocognitive, emotional, and/or developmental disabilities. These include, but are not limited to: SCI, brain injury, stroke, amputation, and medical conditions such as chronic pain, psychiatric disability, substance abuse, impairments in sensory functioning, burns and/or disfigurement, deafness and hearing loss, blindness and vision loss, and other physical, mental, and/or emotional impairments with the potential to limit functioning and participation in life activities. These services include assessing and addressing neurocognitive status, moods and/or emotions, desired level of independence and/or interdependence, mobility and freedom of movement, self-esteem and self-determination, subjective view of capabilities, quality of life, and satisfaction with achievements in specific areas such as work, social relationships, and being able to go where one wishes beyond the mere physical capability to do so. Given the high likelihood of acute stress reactions and post-traumatic stress disorder (PTSD) following polytrauma from combat injuries, this clinical and/or counseling psychologist must have expertise in the assessment and treatment of these conditions.

c. **Clinical Spiritual Care.** The "spiritual dimension" of patient care refers to values, beliefs, and sources of meaning that enable the person to overcome adversity of the moment and look ahead with hope toward recovery and healing of the whole person (holistic care). VHA Handbook 5338.3 describes the roles and functions of VHA Chaplains, which includes the assessment of the patient's spiritual resources, their efficacy for coping, and appropriate pastoral care interventions.

d. **Comprehensive Integrated Inpatient Rehabilitation.** Comprehensive Integrated Inpatient Rehabilitation is "a program of coordinated and integrated medical and rehabilitation services that is provided 24-hours per day and endorses the active participation and choice of persons served throughout the entire program. The persons served, in collaboration with the interdisciplinary team members, identify and address their medical and rehabilitation needs. The individual needs of the persons served drive the appropriate use of the rehabilitation continuum

of care, the establishment of predicted outcomes; the provision of care, the composition of the interdisciplinary team, and discharge to the community of choice. An integrated, interdisciplinary team approach is reflected throughout all activities” (see subpar.17g).

e. **Interdisciplinary Team (IDT).** An interdisciplinary team is characterized by a variety of disciplines working together as a team in the assessment, planning, and implementation of a person’s care plan. To avoid fragmented care, continuous communication, collaboration, and coordination is critical. IDT functions as a unit, cooperating among disciplines to achieve maximum patient and family outcomes (see subpar. 17e).

f. **Neuropsychologist.** A clinical neuropsychologist is a clinical or counseling psychologist with training and expertise in the applied science of brain-behavior relationships. Clinical neuropsychologists use this knowledge in the assessment, diagnosis, treatment, and/or rehabilitation of patients across the lifespan with neurological, medical, neurodevelopmental, and psychiatric conditions, as well as other cognitive and learning disorders. The clinical neuropsychologist uses psychological, neurological, cognitive, behavioral, and physiological principles, techniques, and tests to evaluate patients' neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning. Clinical neuropsychologists are doctoral-level psychology independent practitioners of diagnostic and intervention services. *NOTE: The American Psychological Association recognizes the specialty of clinical neuropsychology.*

g. **Nurse Case Management.** CRRNs or Certified Case Managers provide a number of important services including an in-depth assessment of functional status, acuity level and prognosis, and the need for specific services and resources including the level of rehabilitation. In collaboration with the rehabilitation team, they set long- and short-term goals. The case manager may also make recommendations for alternative care settings when appropriate. Following discharge, nurse case managers may continue to monitor medical care and the ongoing rehabilitation plan of care and services (see subpar. 17b).

h. **Pain Management.** Pain is a multidimensional phenomenon usually associated with injury or disease and involving the experiences of pain and suffering, and is commonly associated with disability and emotional distress. Effective pain management requires a comprehensive assessment that considers multiple biomedical, psychological, interpersonal, and spiritual factors; the development of an individually tailored plan for care; ongoing reassessment of the effectiveness of pain interventions; and patient and family education. Particular challenges are associated with assessment and management of pain in the cognitively-impaired veteran, and with efforts to balance optimal pain management with rehabilitation goals. Consultation with a range of specialists with expertise in the management of specific pain conditions may routinely be necessary.

i. **Polytrauma.** Polytrauma is defined as two or more injuries to physical regions or organ systems, one of which may be life threatening, resulting in physical, cognitive, psychological, or psychosocial impairments and functional disability. TBI frequently occurs in polytrauma in combination with other disabling conditions such as amputation, auditory and visual impairments, SCI, PTSD, and other mental health conditions. Injury to the brain is the

impairment that primarily guides the course of the rehabilitation in patients admitted to the PRC's.

j. **Rancho Los Amigos Levels of Cognitive Function.** The Rancho Los Amigos Levels of Cognitive Function Scale is a descriptive instrument that characterizes a patient's level of functional cognition. It describes typical stages of recovery following moderate to severe brain injury. The scale ranges from a lower level of no response to an upper level of purposeful and appropriate behavior (see subpar. 17d).

k. **Rehabilitation Nurses.** The PRCs provide rehabilitation nursing services for patients and their families. Nursing care in a rehabilitation setting focuses on assisting individuals with impairments resulting from injuries, illness, or chronic disease reach their optimal level of health and function. Rehabilitation nurses have additional expertise in the sequelae and rehabilitation care of conditions such as amputation, brain injury, neuromuscular conditions, orthopedic conditions, stroke, visual impairment, etc. As integral members of the patient's IDT, rehabilitation nursing integrates the rehabilitation plan of care 24-hours a day, 7-days a week (24/7). Rehabilitation nurses are also involved in educating the patient and caregivers to facilitate optimal transition to the next level of care (see subpar. 17b).

l. **Social Work Case Management.** In collaboration with the clinical case management described, PRCs must provide social work case management services for all patients and their families. Social work case management differs from clinical case management in that the social work case manager addresses the psychosocial needs of the patient, advocates for the patient and family, provides supportive services for the family and caregivers, and addresses home and community environment issues. A social work case manager conducts a comprehensive psychosocial assessment, which includes review of cultural issues, patient support systems, family and caregiver support systems, financial and vocational status, and the living situation. In partnership with the clinical case manager, patient, and family, the social work case manager develops treatment and discharge plans and provides ongoing case management services including post-discharge services. The social work case manager may also provide clinical services, such as individual and family counseling and grief counseling. The social work case manager contacts the patient and/or family prior to transfer to answer questions they may have and to assist with the transition. Social work case management services continue through the rehabilitation process and post-discharge services providing assistance with transitions to a DOD military treatment facility (MTF), or other VHA facility, or to the home and community.

m. **VA-DOD Seamless Transition Social Work Liaison.** The VA-DOD social work liaisons are assigned to the major MTFs receiving service members returning from combat. The primary role of the VA-DOD liaisons is to ensure the transfer of health care, both inpatient and outpatient, from the MTF to the appropriate VA facility. They provide education to the MTFs about the specialized care and rehabilitation services available at the PRCs. They also support the PRCs by reinforcing the need to have all polytrauma patients screened by a PRC to ensure that the optimal care setting is identified.

4. SCOPE

a. **Mission.** The PRC mission is to provide comprehensive inpatient rehabilitation services for individuals with complex physical, cognitive, and mental health sequelae of severe and disabling trauma, to provide medical and surgical support for ongoing and/or new conditions, and to provide support to their families. Intensive clinical and social work case management services are essential to coordinate the complex components of care for polytrauma patients and their families. Coordination of rehabilitation services must occur seamlessly as the patient moves from acute hospitalization through acute rehabilitation and ultimately back to the patient's home community. Transition to the home community may include a transfer from a PRC to a less acute facility.

b. **Scope of Services.** PRCs provide specific inpatient, transitional, and outpatient rehabilitation tailored to individual patterns of impairment sustained in the trauma as well as management of associated conditions through consultation with other specialties, as necessary. These programs include, but are not limited to:

(1) **Comprehensive Interdisciplinary Inpatient Evaluations.** The PRCs offer short-term admissions to inpatient rehabilitation for comprehensive interdisciplinary evaluations for patients with varying levels of acuity and severity. A patient at any level on the Rancho Los Amigos Level of Cognitive Function Scale may be appropriate for admission. These evaluations help determine the range and types of services needed to manage the full scope of medical, rehabilitation, and psychosocial sequelae resulting from combat injury and the most appropriate setting in which to deliver those services. Members of the IDT administer a variety of assessment instruments and then meet as a group to integrate results and recommendations. Suggestions for optimal care settings vary depending upon the extent and severity of injury, family and institutional support, and availability of services in the community.

(2) **Acute Comprehensive Interdisciplinary Inpatient Rehabilitation.** Acute comprehensive interdisciplinary inpatient rehabilitation is a highly-specialized level of care designed to treat patients as soon as they are sufficiently medically stable to tolerate initial rehabilitation programming. The primary emphasis is to provide intensive interdisciplinary rehabilitation services in the early months after the injury. The focus of acute rehabilitation is on cognitive, physical, emotional, and behavioral improvement. Goals include: increased cognition, self-awareness, functional communication, mobility, psychosocial skills, activities of daily living, productive activity, and preparation for home and community. The treatment program is goal-oriented with a focus on practical life-skills training, individualized and cost-effective treatment, and patient and family education, support, and preparation. Patients remain in acute rehabilitation until goals are met or maximal improvement is realized.

(3) **Transitional Community Re-entry.** Patients at high-levels of cognitive function who have progressed beyond the need for basic rehabilitation interventions may be admitted for high-level cognitive rehabilitation, advanced gait training, advanced prosthetic training, vocational evaluation, evaluation for return to school, and other transitional or community re-entry programming.

(4) **Outpatient Interdisciplinary Rehabilitation.** The PRCs provide individualized, coordinated, and outcome focused outpatient services including medical support, therapy services, education, and psychosocial treatment and support to patients who live in their local service areas.

(5) **Reevaluations.** Reevaluations at a PRC are available as needed. These interdisciplinary reevaluations of polytrauma patients are an important component of the continuum of care for patients sustaining severe injury and disabling impairments. In some instances, use of telerehabilitation technology may be appropriate.

(6) **Ongoing Case Management and Follow-up.** Ongoing clinical and social work case management services are provided to patients requiring continued rehabilitation services. These services involve acting as the point of contact for emerging medical, psychosocial, or rehabilitation problems; managing the continuum of care; care coordination; acting as patient and family advocate; and assessing clinical outcomes and satisfaction. The assigned clinical and social work case managers make proactive regular and routine contacts with the patient and family as long as active treatment goals remain.

(7) **Consultation.** The PRCs serve as consultants to the VA system, the military health care system, and non-VA care providers. Their staff reviews patient records, provides recommendations for care, assists with identifying an appropriate care setting, and provides continued support as needed. Consultation through telerehabilitation is also available.

5. CLASSIFICATION OF POLYTRAUMA SEQUELAE

a. Combat injuries are often the result of a blast. Blasts cause injuries through multiple mechanisms. Severe blasts can result in total body disruptions and death to those closest to the blast site or they can result in burns and inhalation injuries. Blast injuries typically are divided into four categories: primary, secondary, tertiary, and quaternary or miscellaneous injuries.

(1) **Primary Blast Injuries.** Primary blast injuries are caused by overpressure to gas-containing organ systems, with most frequent injury to the lung, bowel, and inner ear (tympanic membrane rupture). These exposures may result in traumatic limb or partial limb amputation.

(2) **Secondary Blast Injuries.** Secondary blast injuries occur via fragments and other missiles, which can cause head injuries and soft tissue trauma.

(3) **Tertiary Blast Injuries.** Tertiary blast injuries result from displacement of the whole body by combined pressure loads (shock wave and dynamic overpressure).

(4) **Miscellaneous Blast-related Injuries.** These are miscellaneous blast-related injuries such as burns and crush injuries from collapsed structures and displaced heavy objects. Soft tissue injuries, fractures, and amputations are common.

b. Animal models of blast injury have demonstrated damaged brain tissue and consequent cognitive deficits. Indeed, the limited data available suggests that brain injuries are a common occurrence from blast injuries and often go undiagnosed and untreated as attention is focused on

more “visible” injuries. A significant number of casualties sustain emotional shock and may develop PTSD. Individuals may sustain multiple injuries from one or more of these mechanisms. Explosions can produce unique patterns of injury seldom seen outside combat.

Source: Centers for Disease Control and Prevention (CDC) Classification of Blast Injuries

System or organ	Injury or condition
Auditory or vestibular	Tympanic membrane rupture, ossicular disruption, cochlear damage, foreign body, hearing loss, distorted hearing, tinnitus, earache, dizziness, sensitivity to noise.
Eye, orbit, face	Perforated globe, foreign body, air embolism, fractures.
Respiratory	Blast lung, hemothorax, pneumothorax, pulmonary contusion and hemorrhage, atrioventricular fistula (source of air embolism), airway epithelial damage, aspiration pneumonitis, sepsis.
Digestive	Bowel perforation, hemorrhage, ruptured liver or spleen, mesenteric ischemia from air embolism, sepsis, peritoneal irritation, rectal bleeding.
Circulatory	Cardiac contusion, myocardial infarction from air embolism, shock, vasovagal hypotension, peripheral vascular injury, air embolism-induced injury.
Central nervous system	Concussion, closed or open brain injury, petechial hemorrhage, edema, stroke, small blood vessel rupture, spinal cord injury, air embolism-induced injury, hypoxia or anoxia, diffuse axonal injury .
Renal and/or urinary tract	Renal contusion, laceration, acute renal failure due to rhabdomyolysis, hypotension, hypovolemia.
Extremity	Traumatic amputation, fractures, crush injuries, burns, cuts, lacerations, infections, acute arterial occlusion, air embolism-induced injury.
Soft tissue	Crush injuries, burns, infections, slow healing wounds.
Emotional or psychological	Acute stress reactions, PTSD, survivor guilt, post-concussion syndrome, depression, generalized anxiety disorder.
Pain	Acute pain from wounds, crush injuries, or traumatic amputations; chronic pain syndromes.

c. Understanding blast injury as a common mechanism-of-injury for polytrauma patients helps guide assessments beyond the most obvious physical problem. Understanding common associated injuries guides a more comprehensive evaluation and care plan process to prevent more disabling conditions from arising in the future. Such a mechanism-of-injury-based approach to evaluation and treatment is more proactive and efficient and, ultimately, cost effective.

6. POLYTRAUMA REHABILITATION CENTERS

a. **PRC Referral Areas.** The four PRCs utilize the referral areas established for the TBI Lead Centers. The military is accustomed to this existing pattern for making referrals. Individuals with polytrauma are referred to the PRC based on the location of their family and/or intended discharge location (see App. A).

b. **Accreditation and Certification**

(1) Rehabilitation programs are accredited by the Rehabilitation Accreditation Commission (CARF) in Comprehensive Integrated Inpatient Rehabilitation and Brain Injury Rehabilitation.

NOTE: Per VHA policy, facilities with SCI Centers, Blind Rehabilitation Centers, or other rehabilitation programs are CARF-accredited.

(2) Prosthetists and/or Orthotists are board-certified by the American Board for Certification in Orthotics and Prosthetics, Inc. (ABC), or the Board for Orthotist or Prosthetist Certification (BOC).

(3) Prosthetic and Orthotic Laboratories are accredited by ABC or BOC.

(4) Blind Rehabilitation Outpatient Specialists are certified in orientation and mobility.

(5) Assigned nursing staff includes CRRNs.

c. **Staffing**

(1) **Core Staff.** Each PRC must ensure that the appropriate disciplines are available and at sufficient levels to meet the individual needs of patients with polytrauma. Due to the specialized expertise necessary to manage this type of patient, staff needs to be dedicated and non-rotating.

Recommended Core Staffing Levels Per Six Beds:

Discipline	FTE
Rehabilitation Physician	.5
Registered Nurse (1.0 must be CRRN)	5.5
Licensed Practical Nurse and/or Certified Nursing Assistant	4.0
Nurse Manager	.5
Admission and Follow-up Clinical Case Manager	.5
Social Worker Case Manager	1.0
Speech-Language Pathologist	1.0
Physical Therapist	1.0
Occupational Therapist	1.0
Recreation Therapist	.5
Counseling Psychologist	.5
Neuropsychologist	.5
Social Worker	.5

(2) **Core Staff Education and Competencies**

(a) Medical and rehabilitation professionals provide services consistent with: state practice acts, licensure requirements, registration requirements, certification requirements, requirements of their educational degrees, professional training to maintain established competency levels, on-the-job training requirements, and professional standards of practice.

(b) All PRCs need to have an ongoing educational program that addresses the needs of all health care professional staff involved in polytrauma care. Areas that need to be included are:

1. Age-appropriate interventions;
2. Amputation care;
3. Assistive technology;
4. Auditory impairment;
5. Blast injuries;
6. Blind rehabilitation system of care;
7. Changes in sexuality due to altered physical and cognitive function;
8. Family needs and psychosocial support, including psychological support for the impact of trauma on the family;
9. Managing emergence from minimal responsiveness;
10. Managing inappropriate sexual behaviors;
11. Managing the family under stress or in crisis;
12. Pain management;
13. PTSD;
14. Prosthetic equipment and appropriate selection;
15. Psychological issues surrounding change in body image;
16. Psychological issues surrounding change in vocation;
17. Rehabilitation nursing;
18. Techniques for managing agitation;
19. Techniques for managing the patient in or emerging from post-traumatic amnesia;
20. TBI sequelae; and
21. Visual impairment and rehabilitation techniques.

(c) PRC staff need to serve as education and/or training resources in their areas of expertise for other health care providers in the medical center, trainees, staff from other VA facilities, and health care personnel from non-VA facilities, as appropriate.

(3) **Dedicated Consultative Specialists.** Consults to the appropriate medical specialists must be made based on the acuity and complexity of the patient's polytrauma sequelae. Staff from these consultative services must be available 24/7 to respond to urgent requests or emergent needs. The clinical specialties considered integral to the PRC are:

- (a) Audiology,
- (b) Blind Rehabilitation,
- (c) Clinical Chaplaincy,
- (d) Clinical Nutrition,
- (e) Clinical Pharmacy,
- (f) Dentistry and/or Oral and Maxillofacial Surgery,
- (g) Driver Training,
- (h) Gastroenterology,
- (i) General Medicine,
- (j) General Surgery,
- (k) Infectious Diseases,
- (l) Kinesiotherapy,
- (m) Neurology,
- (n) Neuro-ophthalmology,
- (o) Neurosurgery,
- (p) Optometry,
- (q) Orthopedic Surgery,
- (r) Orthotics,
- (s) Otolaryngology,

- (t) Pain Management,
- (u) Plastic Surgery,
- (v) Prosthetics,
- (w) Psychiatry,
- (x) PTSD Team,
- (y) Pulmonology,
- (z) Radiology,
- (aa) Urology, and
- (bb) Vocational Rehabilitation.

(4) **Other Consultative Specialists.** Additional specialty services that may be required include, but are not limited to:

- (a) Cardiothoracic Surgery,
- (b) Dialysis,
- (c) Podiatry, and
- (d) Vascular Surgery.

d. **Facility and Environment of Care**

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

- (a) Agitation and confusion;
- (b) Chemical use, abuse, and dependency;
- (c) Elopement risks;
- (d) Equipment risks;
- (e) Handicap accessibility;
- (f) Physical hazards;
- (g) Physically aggressive behaviors;

(h) Self-injurious behaviors; and

(i) Suicidal ideation.

(2) Space Requirements

(a) Bed Unit. PRCs' inpatient beds are located in a designated area and are contiguous to each other or to other inpatient rehabilitation beds.

(b) Rehabilitation Clinics. Clinical treatment areas are available to appropriately meet the rehabilitation plan of care.

(c) Distraction Free Areas. Private treatment area(s) are available for evaluation and treatment when privacy and/or distraction-free space are needed.

(d) Multipurpose Room. Space for group (patient and/or family) therapies is available for psychosocial support, therapeutic recreation, cognitive rehabilitation, independent living skills training, and education.

(e) Day room. A rest and relaxation area is available for families that promote interaction with the patient in a relaxed therapeutic setting.

(f) Prosthetic and Orthotic Laboratory. Space is available for fabrication and fitting of prosthetic and orthotic devices.

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

(a) Computer-aided Design and/or Computer-aided Manufacturing (CAD/CAM);

(b) Specialized beds, wheelchairs, and other seating devices;

(c) Gait and balance evaluation equipment;

(d) Recreation materials for patient and family that are age-appropriate;

(e) Specialized equipment associated with a Prosthetic and Orthotic Laboratory; and

(f) Specialized patient lifts and transfer equipment.

7. ADMISSION CRITERIA

Individuals sustaining polytrauma have received acute medical care for the conditions associated with the initial injury and are in the recovery phase. Due to the medical complexity of these patients, PRCs must be prepared to admit individuals who may have a higher level of

medical acuity and require interdisciplinary management by various medical specialists. The general admission criteria to the PRC include:

- a. The individual with polytrauma is an eligible veteran or an active duty military service member; and
- b. The individual has sustained multiple physical, cognitive, and/or emotional impairments secondary to trauma; and
- c. The individual has the potential to benefit from inpatient rehabilitation; or
- d. The individual has the potential to benefit from a transitional community re-entry program; or
- e. The individual requires an initial comprehensive rehabilitation evaluation and care plan.

8. REFERRAL

a. VA has a longstanding national MoA with DOD to provide specialized care to service members with SCI, TBI, and those requiring blind rehabilitation. This MoA establishes each agency's responsibilities concerning the transfer of active duty personnel to a VA facility designated as a Center for SCI, TBI, or Blind Rehabilitation. Under this MoA, there are special reimbursement rates and billing submission procedures. **NOTE:** *The majority of polytrauma patients being admitted to the PRCs have TBI as a primary diagnosis.*

b. It is recommended that all patients experiencing a polytraumatic injury be referred to a VA PRC. The PRC team has specialized expertise to determine the most appropriate setting for care. If the patient does not require admission to a PRC, the team can assist with coordination of care at the most appropriate facility. Referral to a PRC also ensures that the patient and family are integrated into the VA system of care with the appropriate rehabilitation services. **NOTE:** *The SCI Chief for the applicable region needs to be contacted by the PRC admissions clinical case manager to consult on the transfer of patients with a diagnosis of TBI and SCI.*

c. Referrals to the PRC must be given the highest priority and the screening process needs to be expedited to ensure that there are no delays in transferring a patient to the Center. The PRC must accept admissions on a 24/7 basis. To establish the medical needs and acuity of the patient, there is a need to review medical documentation, consult with the referring treatment provider, and coordinate a plan for transfer.

d. Referral of service members with polytrauma to a PRC is initiated by DOD, typically by the MTF social worker or case manager, or other DOD representative. Where assigned, the VA-DOD liaison social worker is actively involved in the referral process, facilitating communications, information exchange, transition of care, and family support. The PRC's admissions clinical case manager coordinates the referral and screening process for the accepting VA PRC. **NOTE:** *For those referral sources that do not have VA-DOD liaisons, admission screening is to be coordinated between the PRC admission clinical case manager and the MTF.*

e. The MTF is expected to provide the PRC admission clinical case manager with information necessary to medically screen the patient and manage the transition of care. Where assigned, the VA-DOD liaison social worker obtains and ensures that the PRC receives the following:

(1) Names and contact information for the service member's attending physician and case manager and/or social worker.

(2) Medical record information. Of particular importance are the medical history, hospital course, procedures, diagnostic studies, radiological reports, laboratory reports, microbiology reports, medications, and any precautions or restrictions.

(3) Reports of progress in therapies.

(4) Documentation related to guardianship, powers of attorney, capacity for decision-making or other legal documents.

(5) The service member's military command information including the point of contact (POC), location, and phone number.

(6) Information on the military duty status of the service member, e.g., Physical Evaluation Board (PEB), Medical Evaluation Board (MEB).

(7) The psychosocial history, family support needs, advance directives, and other supplementary documentation.

f. The PRC admission clinical case manager identifies all the current medical problems, assesses acuity level, and factors surrounding readiness for inpatient rehabilitation. The admission clinical case manager reviews all clinical information with the Physical Medicine and Rehabilitation Service (PM&RS) attending physician on the PRC. **NOTE:** *The PRC admission clinical case manager must ensure that the VA-DOD Seamless Transition Liaison and the PRC OIF POC or OEF POC are aware of the referral.* When a transfer to a PRC is planned, the admission clinical case manager must:

(1) Monitor the patient's medical and rehabilitation status until transfer occurs and update the PM&RS attending physician at the PRC.

(2) Contact the service member's family to begin orientation and transition to the PRC. Orientation information includes the PRC rehabilitation philosophy, facilities, typical day, therapies available, team members, average length of stay, and any additional information requested by the family.

(3) Provide the MTF with the name and pager number of the PRC PM&RS attending physician.

(4) Involve the PRC social work case manager to ensure identification of psychosocial support needs of the patient and family, particularly regarding transportation, lodging, childcare, etc.

(5) Apprise the IDT of the planned admission, documenting pre-admission screening information in the medical record.

(6) Obtain authorization for transfer to the PRC from the Military Medical Support Office (MMSO), if not done by the MTF or VA-DOD social work liaison.

(7) Coordinate with the MTF regarding logistics and transportation for the active duty service member and family.

g. The VA-DOD social work liaison continues to be involved in the transition process by:

(1) Contacting the PRC's OIF POC or OEF POC for administrative tracking purposes;

(2) Providing the patient and family with VA-developed information materials describing the polytrauma program and the facility to which the patient has been accepted;

(3) Facilitating communications between the MTF, the patient's family, and the PRC during the transition process;

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

(5) Ensuring that the PRC has all of the required medical and administrative information to transfer care of the service member; and

(6) Being available to assist with any transition issues.

h. When assessment of the referral identifies a more appropriate treatment setting, the admission clinical case manager, in consultation with the PM&RS attending physician at the PRC, makes recommendations as to the most appropriate care setting, and assists the MTF and VA-DOD social work liaison with locating this setting. This may be another service within the PRC's medical center, e.g., medicine, surgery, extended care, or another facility.

i. The PRC Medical Director, or PM&RS staff physician designee, is responsible for:

(1) Screening the patient in collaboration with appropriate medical specialties and identifying the most appropriate admitting bed service, e.g., PRC, surgery, medicine, and psychiatry;

(2) Responding to the referral promptly, preferably the same day received;

(3) Personal communication with the responsible physician at the referring facility, as needed, to determine current patient status, readiness for transfer, and setting required at transfer; and

(4) Arranging for admission or transfer to an acute medical, surgical, or psychiatric unit when warranted by the patient's condition.

9. THE INTERDISCIPLINARY TEAM (IDT)

Dedicated IDTs participate in the assessment, planning, and implementation of the plan of care. Assignment of PRC core staff to an IDT is a regular rather than a rotating duty. Close interaction and integration among professionals from different disciplines ensure that individuals with polytrauma receive optimal care. An IDT serves each patient admitted to a PRC. The membership of the team is determined by assessing the individual's rehabilitation needs, predicted outcomes, and medical needs.

a. Core IDT Membership

(1) **Patient and Family.** The patient, as appropriate, and the patient's family, or other support system, must be included in all phases of the rehabilitation process. Their input is essential to the development of an individualized plan of care and establishing goals that are relevant to their needs. "The person at the focus of planning, and those who love the person, are the primary authorities on the person's life direction" (see subpar.17a).

(2) **Rehabilitation Core Disciplines.** Each rehabilitation professional has specialized skills and knowledge based upon education, clinical training, and experience. To address the complex needs of individuals with polytrauma, the core rehabilitation disciplines require additional training in specific treatment areas. This includes, but is not limited to: neurorehabilitation, cognitive rehabilitation, state-of-the-art prosthetics, and visual rehabilitation. The core IDT is responsible for the major portion of the rehabilitation program and includes as members:

- (a) Admission and follow-up clinical case manager,
- (b) Attending PRC PM&RS physician,
- (c) CRRN,
- (d) Clinical neuropsychologist,
- (e) Counseling psychologist,
- (f) Occupational therapist,
- (g) Physical therapist,
- (h) Recreation therapist,
- (i) Rehabilitation nursing staff,
- (j) Social work case manager, and

(k) Speech language pathologist.

b. **Core IDT Responsibilities.** The responsibilities of the Core IDT are to:

(1) Perform a full interdisciplinary assessment.

(2) Establish a coordinated and integrated interdisciplinary plan of care that includes all required disciplines and reflects the goals of the patient and family.

(3) Document the interdisciplinary care plan. The social work case manager must review this plan with the patient and/or family within 24 hours of completion. *NOTE: It may be beneficial to provide a copy of this plan to the family.*

(4) Collaborate with the patient and family when making decisions regarding the plan of care.

(5) Ensure that all individuals involved in the care of the patient and family are aware of the plan of care, including adjustments to the plan as goals are met and new goals are established.

(6) Identify issues related to the patient and/or family, such as individual family stressors and establish a plan to address these issues and communicate such to all appropriate staff.

(7) Identify the characteristics of the intended discharge environment and develop a discharge plan.

(8) Identify the skill sets necessary to be successful in the next environment for the patient, family, support systems, and other potential caregivers.

(9) Conduct IDT meetings as often as needed to monitor progress and update the treatment plan to reflect progress and new goals.

c. **VA Polytrauma Dedicated Consultative Services.** Individuals with polytrauma may have ongoing medical issues that require the expertise of other medical specialties. Attending staff from these consultative services must be available 24/7 to respond to urgent requests or emergent needs. Depending on the needs of the patient, the consultant may need to participate as an active member of the PRC team. The consultants need to have specialized expertise in polytrauma sequelae, e.g., a mental health consultant with expertise in managing and differentiating problems associated with TBI, PTSD, or substance abuse. *NOTE: The clinical specialties that are identified as essential to the PRC are identified in subparagraph 6c.*

d. **Referring Medical Facility.** The PRC staff needs to maintain regular communications with the MTF or other facility that referred the patient, particularly when the patient is in DOD's PEB process or when there are unresolved medical problems. This ensures that both agencies are aware of the status of the patient should questions arise from family members as well as internal and external stakeholders. *NOTE: Weekly communication is recommended.*

10. EVALUATIONS

Evaluation is a systematic, ongoing process. Evaluations include assessment of medical, physical, cognitive, psychological, functional, and psychosocial conditions.

a. **Initial Evaluations.** Each member of the IDT has discipline-specific evaluations to administer based on the individual patient's impairments and sequelae. These evaluations assist the IDT to establish the overall projected-achievable goals and timelines for rehabilitation. The results of the evaluations must be completed and documented within the following timeframes:

(1) The admission history and physical, initial assessment, problem list, and treatment plan must be completed on the day of admission. The PM&RS attending physician on the PRC must staff the patient with the admitting clinician within 24 hours of admission;

(2) The nursing assessment must be completed on the day of admission and there needs to be a continuation or reassessment of that completed by the admissions clinical case manager;

(3) The core interdisciplinary evaluations must be initiated upon admission, or the first day of regular scheduling following admission;

(4) Non-emergent consultations must be responded to within 48 hours of the order;

(5) The social work case manager must complete a comprehensive psychosocial assessment, including patient and/or family expectations and goals, within 24 hours of admission or the first day of regular scheduling following admission; and

(6) Results of consults, diagnostics, and other evaluations must be communicated to the patient and/or family within 24 hours following completion.

b. **Reevaluations.** Reevaluations need to occur as clinical conditions necessitate, but not less often than weekly. Closely monitoring all identified problem areas, including medical, physical, functional, cognitive, and psychological, ensures that appropriate adjustments are made to the plan of care. The results of reevaluations are documented in the medical record and communicated to the team during the weekly IDT meeting.

c. **Discharge Summaries and Evaluations.** A discharge summary is required of all team members. It includes the medical, functional, and psychosocial status of the patient at the time of discharge, medications, progress, goals achieved, activity restrictions, adaptive equipment, discharge setting, family and other support systems, education provided, continued care needs, and follow-up services arranged as appropriate to each discipline.

11. INTERDISCIPLINARY TREATMENT PLAN

a. Interdisciplinary treatment plans are a collaborative effort based on active involvement of the patient, family, and discipline-specific assessments of each patient.

- b. Treatment plans are intended to be dynamic rather than static documents. They change in response to the patient's condition and progress toward goals.
- c. The PM&RS attending physician at the PRC conveys to the team, and documents, the medical plan of care. This plan describes the current medical issues, treatments, procedures ordered, restrictions and precautions, and any other information relevant to the patient's medical care.
- d. Each member of the IDT is responsible for recommending patient-specific interventions as a result of their assessments.
- e. The IDT's plan is reviewed during weekly team rounds. At this time the IDT reviews progress toward treatment goals, identifies new goals, time frames, treatment interventions, and revises the plan of care accordingly.
- f. The social work case manager is available to communicate with the patient and family on a daily basis to solicit feedback and bring any concerns to the IDT.
- g. The social work case manager must provide the patient and family with updates on progress and adjustments to the plan of care in a timely fashion, and must document all patient and family interactions in the medical record.

12. TREATMENT

a. **Medical Treatment.** The PRC PM&RS attending physician is responsible for managing the medical treatment of patients with polytrauma and ensuring that all appropriate medical specialists are consulted and are active participants in the medical care of the patient. Due to the severity and complexity of polytrauma, the attending physician needs to be alert to the possibility of rapidly changing conditions and seek consultation services as appropriate.

(1) The PRC PM&RS attending physician, or staff physician designee, must make daily rounds on weekdays and as needed per patient's condition. House staff provides care on weekends with PM&RS staff physician input as needed.

(2) Consultative service providers are expected to be actively involved in care according to the acuity of the patient, until the reason for the consultation is resolved. Consultative service providers may participate in bedside rounds with the PM&RS attending physician or the IDT. Their assessments and recommendations must be documented in the medical record in a timely fashion.

(3) If the acuity of the polytrauma patient warrants physical transfer to another bed section, the rehabilitation plan of care must be continued within the medical limits of the patient and the PRC PM&RS attending physician continues to be actively involved in the care of the patient. The PM&RS attending physician, or resident, must visit the patient regularly and keep the family informed of the patient's status.

(4) The PM&RS attending physician must be accessible to the patient and family, and provide the family with a means to maintain contact.

(5) Polytrauma medical sequelae may include: agitation and aggressive behavior, amputation, burns, contractures, deep vein thrombosis and pulmonary embolus, dental injuries, depression and other mood disorders, fractures, often complex gastrointestinal complications and feeding tubes, headache, hearing impairment, heterotopic ossification, hydrocephalus, infection, nerve injuries, pain, peripheral and central vestibular disorders, PTSD, seizures, soft tissue damage, spasticity, SCI, visual impairment, and wounds.

b. **Rehabilitation Treatment**

(1) Patients with polytrauma are involved in various therapies according to their individual needs. Therapy services are integrated with the interdisciplinary plan of care and established goals. Rehabilitation treatment and procedures may include, but are not limited to:

- (a) Activities of daily living,
- (b) Architectural barriers,
- (c) Assistive technology,
- (d) Augmentative communication,
- (e) Cognitive rehabilitation,
- (f) Communication,
- (g) Community reintegration,
- (h) Driving,
- (i) Durable medical equipment,
- (j) Gait training,
- (k) Instrumental activities of daily living,
- (l) Mobility,
- (m) Neurobehavioral management,
- (n) Neuromuscular balance and coordination,
- (o) Oculomotor rehabilitation,
- (p) Orthotics,

(q) Physical performance and conditioning,

(r) Prosthetic fitting and training,

(s) Psychosocial skills,

(t) Sexuality,

(u) Swallowing,

(v) Vestibular rehabilitation,

(w) Visual motor and perceptual skills, and

(x) Wheelchair prescription and training.

(2) Co-treatment is promoted to meet the individualized needs of the polytrauma patient.

(3) Family involvement needs to be encouraged in all phases of the rehabilitation process.

(4) Age appropriate goals, activities, and materials are incorporated into the rehabilitation treatment plan.

(5) Treatment plans are implemented 24/7 through the collaboration of therapy, nursing, and medical staff.

(6) Treatment is provided according to needs and goals of the patient and family.

13. PATIENT AND FAMILY EDUCATION

a. Patients, their families, and significant others, need to receive appropriate education and training to increase their knowledge of the patients' illnesses or disabilities and treatment needs, and to learn the skills and behaviors that promote recovery and maximize function.

b. All rehabilitation personnel are responsible for providing education to patients and their families as appropriate to their specific disciplines and documenting the education when provided. All staff need to continually assess and document the patient and family's educational needs and readiness to learn so that educational efforts will be appropriate and effective.

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

d. Education may include, but is not limited to, instructions in:

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

(2) Accessing available community resources;

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

(4) The safe and effective use of medication;

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

(6) Restrictions and precautions, e.g., driving, alcohol, physical activity level;

(7) Behavior management techniques; and

(8) How to handle emergencies.

e. All education provided must be based upon, and appropriate to, the assessed needs, educational level, cultural background, and readiness to learn of the patient, family member, or significant other to whom it is offered.

14. FAMILY SUPPORT

Families of polytrauma patients have unique psychosocial needs due to the etiology of their family member's catastrophic injuries, the severity of the injuries, and the possible long-term impairments. The PRCs are responsible for ensuring that patients and their families receive all necessary support services to minimize stress during the hospital stay.

a. Each polytrauma patient and family has a designated social work case manager who has the responsibility for ensuring that their psychosocial needs are identified and addressed. These responsibilities include, but are not limited to:

(1) Ensuring that the patient and family have received an orientation to the PRC. This includes providing orientation information; written materials; a tour of the facility, bed unit, and therapy clinics; what to expect; and introductions to members of the IDT. **NOTE:** *This orientation should occur on the day of admission or the first day of regular scheduling following admission.*

(2) Assessing patient and family psychosocial support needs, documenting the assessment and plan in the medical record, and providing psychosocial interventions;

(3) Establishing a regular schedule for communication that meets the needs of the family, and providing the family with information on how to contact the social work case manager, or the on-call designee, during and after business hours, including a phone or pager number;

(4) Documenting the content of communications with family in the medical record;

(5) Facilitating involvement of the family and advocating for the family's needs and interests throughout the rehabilitation process;

(6) Providing the family with updates on progress and adjustments to the plan of care in a timely fashion;

(7) Providing the referring MTF and local military health care provider and duty station, as appropriate, with updates on progress; and

(8) Working closely with Voluntary Service and Chaplain Service to ensure availability of resources to meet the immediate needs of the family.

b. Through the social work case manager, PRCs involve VA and community programs and services to support polytrauma patients and their families. This includes:

(1) Ensuring that representatives from Chaplain Service and Readjustment Counseling Service are available to patients and families soon after admission and as needed; and

(2) Collaborating with Voluntary Service and Chaplain Service, who in turn work with local Veterans Service Organizations and community faith-based groups to provide supportive services, including safe and convenient lodging, transportation to and from the medical center, food, personal items, childcare, recreational opportunities, and other services as identified.

15. DISCHARGE PLANNING

Discharge planning is a process, not a single event. It is that part of the continuity of care process, which prepares the patient for the next level of care and assists the patient in making necessary arrangements for that transition. Creating a partnership with the patient and family is essential to an effective discharge plan.

a. **Pre-Discharge Procedures.** Discharge planning is the responsibility of the IDT. The clinical case manager and social work case manager ensure that the process is coordinated and all issues are addressed. This includes:

(1) Providing the family or caregiver with a notebook or folder to keep discharge information, e.g., resources, tip sheets, names and phone numbers, equipment requests, restrictions, and medications.

(2) Providing the family or caregiver with information and resources related to the intended discharge location that can be explored during the inpatient phase.

(3) Identifying any limitations of the family or caregiver, e.g., physical and emotional that may impact the discharge plan.

(4) Providing the patient and family with a therapeutic pass to practice skills learned in therapy. **NOTE:** *The IDT needs to provide specific goals and objectives for this experience.*

(5) Providing ample time in therapy sessions, early in the rehabilitation process, for the family or caregiver to become comfortable and skilled with the patient's ongoing care needs.
NOTE: Videotapes of complex techniques provide the patient and family additional support at home.

(6) Providing the family or caregiver with techniques on minimizing stress.

(7) Identifying medical and rehabilitation needs that require ongoing follow-up after discharge from the PRC.

(8) Assessing the intended discharge location for access, barriers, safety, required durable medical equipment, and other relevant characteristics.

b. **Discharge Procedures.** Discharge recommendations and other appropriate discharge records must be provided to patient and family in writing. All medical restrictions must be clearly documented and, at a minimum, a 30-day supply of medication and supplies are provided.

(1) Upon request, the PRC provides recommendations associated with the patient's ability to return to duty or other specific needs, e.g., 2-weeks' convalescent leave followed by light duty to include work hardening and close supervision to monitor accuracy of work; no lifting over 30 lbs.

(2) Upon request, the PRC provides clinical information to military medical boards.

c. **Social Work Case Manager.** To ensure a smooth transition from the PRC, the social work case manager is responsible for:

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

(2) Providing the patient or family with phone numbers for VA and military POCs to assist with any ongoing administrative issues.

(3) Providing the discharge recommendations to the appropriate entities, which may include, but is not limited to the: referring MTF, local VA responsible for following the patient, TRICARE, military medical holding company, military command, military case manager, and Seamless Transition Liaison.

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

(5) Notifying the patient's home VA facility's OIF POC or OEF POC of the planned discharge.

(6) Coordinating patient travel through the air evacuation office, to include contacting the MMSO and Global Patient Movement Requirement Center. **NOTE:** *PRC medical staff must assess the need for a medical or non-medical attendant to travel with the patient.*

(7) Arranging or coordinating ongoing services and treatment.

(8) Forwarding legal documents, such as guardianship or powers of attorney to appropriate POCs.

(9) Confirming that appropriate applications for special programs have been generated, e.g., Vocational Rehabilitation and Employment Service or Education Service in the Veterans Benefits Administration.

16. FOLLOW-UP CLINICAL CASE MANAGEMENT AND CARE COORDINATION

a. Individual case management is a distinct and customized approach to managing care for a beneficiary whose needs are usually multiple, complex, and costly. When individuals are diagnosed with a severe impairment, their physical, emotional, and psychosocial responses vary significantly. Because health care circumstances differ, a more tailored and customized approach to coordinating care is required. These beneficiaries must have care plans unique to their needs and often require extensive monitoring and care coordination.

b. Ongoing clinical and social work case management are provided to patients requiring continued rehabilitation services. This involves acting as POC for emerging medical, psychosocial, or rehabilitation problems; managing the continuum of care; care coordination; acting as patient and family advocate; and assessing clinical outcomes and satisfaction.

c. The clinical or social work case manager, as assigned, makes regular and routine contact with the patient and family as long as active treatment needs remain, to include:

(1) Establishing regular communications with the patient and family. Initially this needs to occur at least weekly and then based on the needs and requests of the patient and family.

(2) Assessing and monitoring the patient's integration back to the home environment.

(3) Monitoring implementation of the discharge plan and facilitating access to recommended services as needed.

(4) Monitoring ongoing medical, functional, and psychosocial issues.

(5) Assessing clinical outcomes and satisfaction.

(6) Assessing and monitoring support systems and family dynamics.

(7) Following up with ongoing military and/or VA administrative issues and facilitating resolution when possible.

(8) Proactively monitoring for identification of new issues.

d. If there are new issues or a change in the patient's condition, the clinical case manager must report these to the PM&RS attending physician on the PRC immediately. For urgent issues, the clinical case manager must advise the patient or family to seek care immediately at a community hospital or their local VA medical center. For non-emergency issues, the PRC provides consultation and assists with obtaining appropriate services.

17. REFERENCES

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**REFERRAL AREA FOR POLYTRAUMA REHABILITATION CENTERS (PRCS)
AND TRAUMATIC BRAIN INJURY (TBI) LEAD CENTERS**

Polytrauma Rehabilitation Center	Referral Area
McGuire Veterans Affairs Medical Center Physical Medicine and Rehabilitation Services 1201 Broad Rock Blvd. Richmond, Virginia 23249	Maine, Massachusetts, Rhode Island, Connecticut, Vermont, New Hampshire, New York, Pennsylvania, Delaware, Maryland, District of Columbia, Virginia, West Virginia, and North Carolina.
James A. Haley Veterans Affairs Medical Center Physical Medicine and Rehabilitation Services 13000 Bruce B. Downs Blvd. Tampa, Florida 33612	Tennessee, Kentucky, South Carolina, Georgia, Alabama, Florida, Puerto Rico, Arkansas, Louisiana, Mississippi, and Texas.
Minneapolis Veterans Affairs Medical Center Physical Medicine and Rehabilitation Services One Veterans Drive Minneapolis, MN 55417	Ohio, Michigan, Indiana, Illinois, Wisconsin, South Dakota, North Dakota, Minnesota, Oklahoma, Iowa, Nebraska, Kansas, and Missouri
Palo Alto HealthCare System Physical Medicine and Rehabilitation Services 3801 Miranda Avenue Palo Alto, California 94304	New Mexico, Arizona, Wyoming, Colorado, Montana, Utah, Nevada, Idaho, Oregon, Washington, Alaska, California, and Hawaii