

**Outpatient Brain Injury Rehabilitation Program
Physical Medicine and Rehabilitation
Minneapolis VA Health Care System**

Mission Statement

The mission of the Minneapolis VA Health Care System (MVAHCS) Outpatient Brain Injury Rehabilitation Program (OBIRP) is to enhance, preserve and restore the quality of life of the person served through the use of rehabilitation services.

Vision Statement

Medical treatment is not complete until the person served is restored to the optimum attainable level of independence and social participation in a home community of his or her choice. Furthermore, rehabilitation is best when provided by an interdisciplinary team that includes our service provider experts as well as the person served, his or her support system, and any other rehabilitation and medical consultants as needed.

Overview

The OBIRP is located within the Physical Medicine and Rehabilitation (PM&R) Service and provides a full array of outpatient rehabilitation services (**See Table 1**) for individuals needing rehabilitation services following traumatic or non-traumatically acquired brain injury. Services are provided by a roster of trained, licensed, and/or credentialed rehabilitation professionals. Services are provided to all eligible Veterans and Active Duty Service Members (ADSM) who meet criteria for admission.

Low Vision Rehabilitation	Rehabilitation Nursing and Nurse case management
Occupational Therapy (includes Driving assessment and training)	Rehabilitation Psychology and Neuropsychology
Pharmacy, including PharmD onsite consultation	Social Work
Physiatry	Speech-Language Pathology
Physical Therapy	Vocational Rehabilitation and counseling
Prosthetics/Orthotics	Other Consultative Services - Audiology, ENT, Orthopedics, Neurology, Neurosurgery, Nutrition, Ophthalmology and Neuro-ophthalmology, Plastic Surgery, etc.
Psychiatry	
Recreation Therapy	
Rehabilitation Engineering	

Table 1: Interdisciplinary team members and array of services provided

RELATIONSHIP WITH OTHER OUTPATIENT PM&R PROGRAMS AND CLINICS

PM&R OBIRP shares staff, services, resources, and infrastructure with the TBI Wellness Clinic and the Polytrauma Multidisciplinary Rehab Service (MDRS.). Highlights of these three outpatient PM&R services are displayed in **Table 2**. These three services

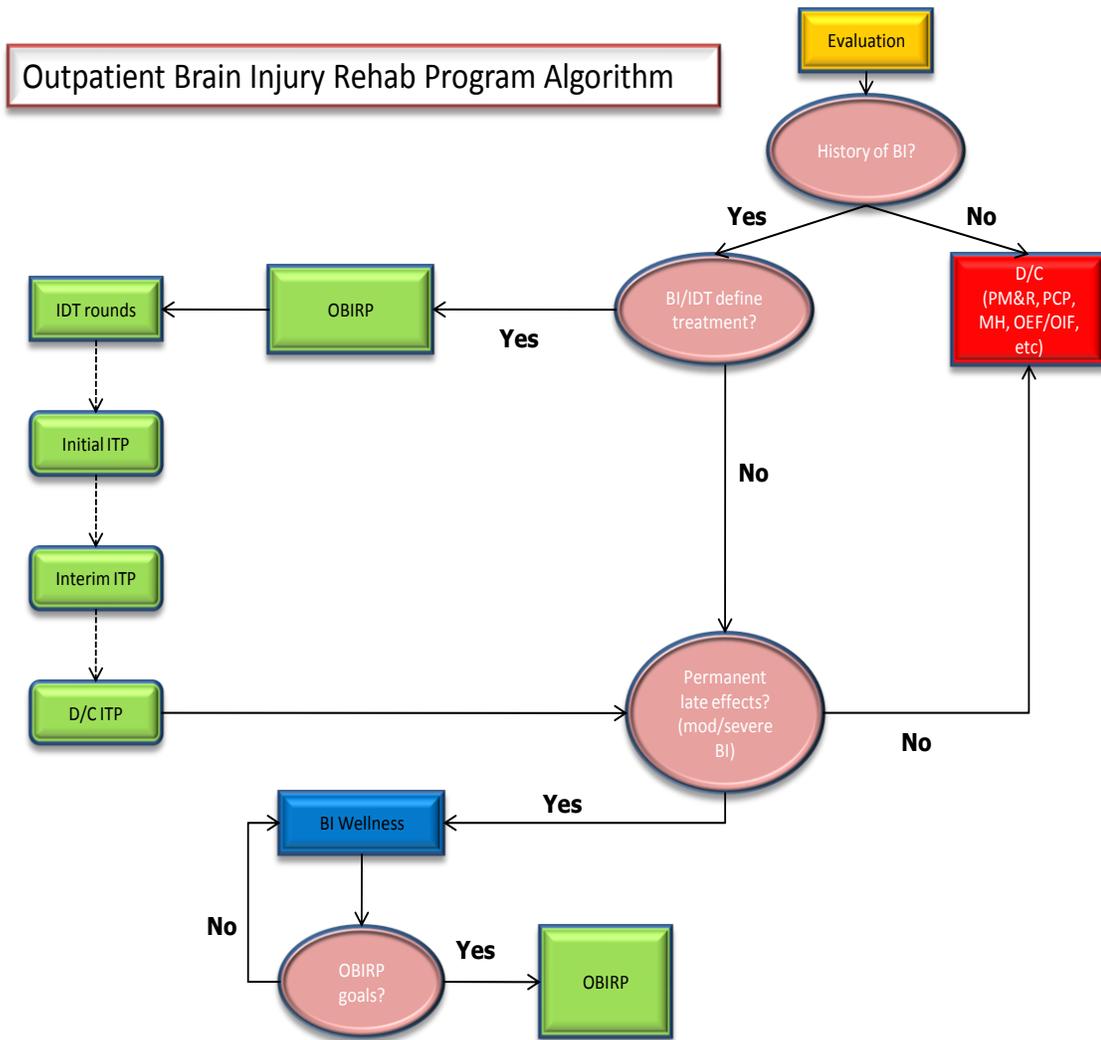
differ in terms of patient diagnosis, case management model, and/or singular or collective pursuit of participant-centered goals (i.e. interdisciplinary vs. multidisciplinary focus), but do not differ in quality of care provided to participants, including the delivery of services or goods (e.g. prosthetic/orthotic supplies.)

Participant flow between OBIRP and TBI Wellness clinic:

Length of enrollment in the OBIRP is finite and based on successful pursuit of specific patient-centered goals. Individuals who have completed their OBIRP interdisciplinary care plan but with ongoing case management needs or targeted medical and/or therapeutic needs are enrolled in the TBI Wellness Clinic. Readmission to the OBIRP is possible if needs change or if renewed interdisciplinary care is appropriate. Participants or individuals who do not meet admission criteria for OBIRP but have scattered needs may also be enrolled in the TBI Wellness Clinic. Their admission to the OBIRP is always possible at a later date if their needs change and admission criteria are met. Flow between the OBIRP and the TBI Wellness Clinic is displayed in **Figure 1**.

	OBIRP: Interdisciplinary Rehab	TBI Wellness Clinic	Multidisciplinary Rehab
Brain Injury (BI) present at onset of services	Yes with unequivocal BI Rehab needs	Yes, but may be remote/chronic.	No
Veteran status	Veteran or ADSM	Veteran or ADSM	Veteran or ADSM
Length of Enrollment	Finite depending on successful pursuit of personal goals.	Open-ended.	Finite. May be assessment only. Length of intervention, if provided, is based on successful pursuit of personal goals.
Possible discharge destination	TBI Wellness clinic or complete separation	OBIRP or complete separation	Complete separation. Probable transfer of care to non-PM&R services
Re-enrollment possible	Yes, if needs change. May transfer from TBI Wellness clinic	Yes, if needs change. May transfer from OBIRP.	Yes, if re-consulted and needs have changed that warrant new onset of services.
Delivery of Care	Interdisciplinary Rehab evaluation and treatment	1 or more service providers via multidisciplinary delivery	1 or more service providers via multidisciplinary delivery
Probable source of case management	BI case management from PM&R service (Social work and/or R.N.)	PM&R case management (Social work and/or R.N.)	OEF/OIF case management staff.

Table 2: Outpatient PM&R programs that share staff, resources, and infrastructure.



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Figure 1: Flow between OBIRP and TBI Wellness Clinic¹

¹ Outpatient TBI multidisciplinary services (i.e. TBI Wellness Clinic) and services for outpatients without TBI diagnosis are not further described in this document.

Scope of the Program

PARAMETERS OF THE OBIRP SCOPE OF SERVICES:

Characteristics of populations served: Clients are adult², male or female, Veteran or ADSM's who have sustained brain injury and who benefit from interdisciplinary rehabilitation services. ADSM's enrolled in the OBIRP are frequently returnees from Operation Enduring Freedom or Operation Iraqi Freedom (OEF/OIF). Clients may present with additional polytrauma injuries or conditions requiring further, specialized rehabilitation service.

Settings: Rehabilitation services are provided in PM&R clinic areas but may also occur throughout the hospital campus or in the local community. Services may be provided in the community via fee-for-service payment to non-MVAHCS facilities if necessitated by distance from the medical center or when deemed appropriate by the interdisciplinary team to address client goals.

Days and Hours of Service: Rehabilitation services are typically provided Monday through Friday during normal business hours. On an intermittent basis, therapy services may be provided after these hours or on weekends (e.g. cognitive therapy groups, recreation therapy outings). Social work case management services for the OBIRP are also provided Monday through Friday during normal business hours. 24/7 on-call emergency case management coverage is also available.

Frequency of services: Delivered services are based on specific rehabilitation needs of persons served. For Fiscal Year (FY) 2010³, the average amount of interdisciplinary services provided by the OBIRP to enrolled clients was 20.2 hours.

Payer sources: Veterans receiving care are covered through the VHA Service Connection system. ADSM's receiving care are covered under a Memorandum of Agreement with their military medical insurance (i.e. Tricare).

Fees: Co-payments for hospital services are calculated per individual Means Tests and subsequent Service Connection and, as such, may vary between persons served. Case managers provide information on expected fees via the written Rehab Disclosure Statement provided near the time of enrollment plus are available on request to arrange conversations between persons served and MVAHCS Business Office representatives. These conversations can be arranged. Such conversations can be arranged before, during, or after program enrollment.

Referral Sources: Referrals for admission are accepted from sources within MVAHCS, from other VA Medical Centers, the Department of Defense (DoD), and from non-VA community providers.

² All clients receiving MVAHCS PM&R services are operationally defined as adult regardless of actual, chronologic age.

³ Fiscal year 2010 is defined as October 1, 2009 to September 30, 2010.

Specific services offered: The OBIRP, in combination with other services in MVAHCS, provide all necessary therapeutic, medical, surgical services required by persons served. For highly specialized services not available at MVAHCS, arrangements are made in the community through fee-for-service arrangements.

Portions of the continuum served: The OBIRP provides outpatient, post-acute rehabilitation services for clients who do not require services from our Comprehensive Integrated Inpatient Program (CIIRP) or services from our residential program (Polytrauma Transitional Rehab Program (PTRP)). Clients enter the OBIRP via transfer after discharge from the CIIRP or PTRP or via direct referrals/consults if they have not received inpatient rehabilitation. When an individual transfers care within the PM&R BI continuum, communication and coordination are provided by the assigned case manager and discipline specific providers. This communication and coordination takes place at inpatient discharge meetings, via departmental electronic communication, via team meetings, and via direct provider contact.

Services for families/support services of the person served: Case management assistance, including outreach to family members, is provided by PM&R Social Work and Nursing staff and from the OEF/OIF case management program. Families of ADSM may also receive case management aid from the Active Duty military liaisons stationed at MVAHCS. Supportive counseling is available through Rehab Psychology. Day care services for children are available on site and can be offered on an as-needed basis with funds provided by MVAHCS Voluntary Services. Lodging may be available for extenuating circumstances as coordinated through the case managers.

If family needs arise that cannot be met by MVAHCS services, referrals are made to community agencies. Once appropriate consent is obtained, education regarding client involvement in interdisciplinary sessions may be given to family members via direct education, telephone conference calls, or other means of communication.

PARAMETERS FOR PERSONS SERVED BY THE OBIRP:

Age: For FY 2010, the average age of enrolled participants was 42.7 months (range 23-79 years.)

Activity limitations: Persons served by the OBIRP have limitations ranging from complete physical and/or cognitive dependence on caregivers, to independence in physical cares but needing mild assistance from others, to independence with use of using adaptive devices. In some instances, clients are without activity limitations.

Behavioral and/or psychological status: A person's behavioral and/or psychological status is assessed at the time of admission by review of the medical record, psychological assessments, and/or social work psychosocial evaluations. Persons with psychological or behavior challenges who are able to participate in and benefit from rehabilitation services are provided behavioral and psychological support and/or treatment through the

rehabilitation team, including physician, Rehabilitation Psychology, and other Mental Health consultants.

Persons with psychological or behavior issues which pose a danger to themselves or others, or which prevent their participation in the rehabilitation program are beyond the scope of the OBIRP. These individuals are referred to MVAHCS Mental Health services until a time when they are able to participate in OBIRP programming.

Cultural needs: Participants are viewed as unique individuals and the treatment plans are created to support cultural, religious, gender, age, and interest differences.

Impairments: Enrolled individuals may present with a broad range of changes in body structures or functions, including but not limited to brain injury. Outpatient rehabilitation services are generally directed toward treatment of impairments or limitations of new onset, though persons with chronic impairments from brain injury are eligible for admission or re-admission to the program if new intervention is thought to be beneficial.

Intended discharge/transition environments: Depending on individual progress over the course of intervention, participants may be discharged without follow-up or they may be enrolled in the TBI Wellness Clinic (see **Figure 1**) for sporadic follow-up, including one or more therapeutic relationships via the clinic's multidisciplinary model.

Medical acuity: OBIRP participants do not have acute medical needs. With post-acute status, they need only intermittent outpatient physician intervention and intermittent rehabilitation nursing services. Case management services as provided by social work and nurse case management may be delivered more often.

Medical stability: Participant must be medically stable enough to participate in their planned rehabilitation program. Participants who are medically unstable are transferred to either another medical service or, if appropriate, the CIIRP until they can more actively participate in outpatient programming. The OBIRP and CIIRP, in combination with the broad hospital based services available at the MVAHCS, provide all necessary medical and surgical services required by persons served. For highly specialized services not available at the VA, arrangements are made in the community via a fee-for-service model.

Participation restrictions: Participation restrictions vary widely between participants. Some live independently and are fully engaged in their home communities of choice while others are fully dependent on others. As needed, directed rehabilitation services are delivered to maximize community integration and participation.

Criteria and Process Descriptions

REASONS FOR REFERRAL

1. Need for a comprehensive rehabilitation evaluation after brain injury that exceeds the scope of the Comprehensive TBI evaluation protocol mandated by VHA⁴.
2. Need for comprehensive, interdisciplinary rehabilitation evaluation and treatment after brain injury
3. Need to improve activity and participation skills and independence after brain injury.
4. Need for aid in adapting to residual loss of independence after brain injury, including caregiver training and education.
5. Need for other brain injury related services requiring interdisciplinary care, including pain management by physical or behavioral methods.

REFERRAL SOURCES AND POINTS OF ENTRY

1. Referrals for admission to the OBIRP are accepted from:
 - a. Within MVAHCS PM&R. This may include referrals for re-admission to the OBIRP upon significant status change.
 - b. Within MVAHCS
 - c. From other VAMC's in VISN 23.
 - d. From hospitals and facilities outside of VHA (e.g. private sector facilities.)
 - e. Department of Defense (DoD.)
 - f. From other sources (e.g. advocacy organizations, etc.)
2. Referrals for persons with brain injury not identified via VHA Directive 20101-012 (Footnote 4) are received by direct consultation either through inter/intra-facility electronic consultation or direct phone referral to the program point of contact.

ADMISSION CRITERIA

1. History of acquired brain injury as determined during the initial physician evaluation with associated rehabilitation goals that are best addressed by the interdisciplinary rehabilitation team.
2. Ability to successfully participate in interdisciplinary rehabilitation services, in an outpatient setting.
3. Absence of behaviors posing immediate safety threat to self or others.
4. Participant demonstrates ready ability to engage with the interdisciplinary team and shows potential for successful outcomes.

ADMISSION PROCESS

Each person's rehabilitation program is based on an interdisciplinary assessment of individual medical problem and rehabilitation needs/goals as well as their strengths, resources, interests, and preferences. This individualized program is reviewed and modified over the span of treatment as necessary. The participant, family and others appointed by the person served are integral members of the rehabilitation team.

⁴ VHA Directive 20102-012 (2009.)

If the assessment reveals that the person did not sustain a brain injury or does not demonstrate interdisciplinary rehabilitation goals or needs, the referral is closed and the person is not admitted to the OBIRP. In these instances the person is provided an explanation of denial and is referred to other rehabilitation or medical services to meet needs identified during intake.

Key points of the Admission Process:

1. **Physician Evaluation:** The physician evaluation is a comprehensive assessment for brain injury and related rehabilitation needs. The initial physician documentation includes an *Interim Plan of Care* for those who are appropriate for admission to the OBIRP.
 - a. *Interim Plan of care:* The interim plan of care includes initial participant goals and triggers interdisciplinary team members' consultations. This document is shared with the person served and his/her family during the initial physician evaluation.
2. **Team Communication:** Discussion of the *Interim Plan of Care* is communicated with the treatment team during weekly interdisciplinary rounds. This discussion includes factors influencing care for the person served, including accessibility to services (scheduling constraints, etc.).
3. **Lodger status:** If travel restrictions or distance require it, an individual may be scheduled for a 3-5 day outpatient lodger stay for a compressed evaluation and treatment regimen. For these situations, referrals undergo chart review and pre-evaluation telephone screening with case management staff to boost the efficiency of the shortened intervention time.
 - a. Accommodations are provided through a stay on the CIIRP unit, the PTRP unit, the Minneapolis Fisher house, or a near-by hotel depending on availability and/or level of independence.

INTERVENTION AND/OR TREATMENT PROCESS

An interdisciplinary assessment is triggered by the *Interim Plan of Care*. The duration of the interdisciplinary assessment varies from several days to weeks depending on the scheduling preferences of the person served. Typically these evaluations are completed within 14 days of a participant's desired start date. If the person participates as an outpatient lodger, the interdisciplinary assessment and a short burst of diagnostic treatment occurs within 3-5 days.

Key points of the Treatment process:

1. **Discipline Specific Evaluations:** Disciplines are consulted based on the needs and goals of the person served. Discipline-specific assessments are carried out within the scope of practice of each discipline.
 - a. Participating disciplines may include, but are not limited to those listed in Table 1.
 - b. Information for discipline specific assessments is culled from:
 - Discipline specific evaluation tools or examination techniques.
 - Documentation from referral sources, including records of previous care or response to previous intervention.

- Input from the person served and his/her family.
 - c. Evaluations are documented per each discipline's policy.
 - d. Consultations to other providers within MVAHCS are initiated as needed.
2. Interdisciplinary Treatment Plans (ITP):
- a. *Initial ITP*: Once discipline specific evaluations are completed, the interdisciplinary team completes a full *ITP*. The goals of the person served are discussed and incorporated into the plan. The completed *ITP* is shared with the person served and his/her family during subsequent physician visits or discipline specific visits. Interdisciplinary treatment is provided as described in the PM&R Interdisciplinary Care Policy⁵ and discipline-specific scopes of practice.
 - b. *Interim ITP*, including Re -evaluations: *Interim ITP* reports are written during interdisciplinary rounds to document changes in status, including progress made on goals. The timing of the reports varies for participants based on individualized goals, progress toward those goals, and frequency of appointments. *Interim ITP*'s also document updates on active problems, additional consultations required, and any changes in rehabilitation plans.
 - Disposition Planning: When discharge criteria are nearly met, discharge planning is discussed in interdisciplinary team rounds. Content of these conversations are documented in the *Interim ITP* stemming from that meeting.
 - c. *Discharge ITP* and Discharge Reports: Once discharge criteria are met, arrangements for discharge and recommendations for follow-up are made in collaboration with the person served and other stakeholders and are documented in a formal Interdisciplinary Discharge Reports. All arrangements and follow-up recommendations are communicated by the assigned social work case manager. Discharge reports are also written by each discipline working with the participant at the time of discharge.

DISCHARGE CRITERIA

Participants are discharged from the OBIRP when either of the following occur:

1. Interdisciplinary goals are met
2. The participant is no longer making progress toward their identified goals or is unable to actively engage in programming.

DISCHARGE PROCESS

Key points of the Discharge Process

1. To facilitate discharge plans, an interdisciplinary team meeting occurs and a Discharge ITP is completed. All discharge planning is done in a coordinated fashion with interdisciplinary team members to insure that the person served is discharged to a situation that maximally addresses his/her current level of function and continued needs. Available resources are considered.
2. Discharge arrangements from the program are coordinated by the assigned case manager. The decision to discharge is made in collaboration with the person

⁵ MVAHCS PM&R policy "Interdisciplinary Care for the Outpatient Rehabilitation Program" (2008).

- served, the family, and the referral source or other stakeholders as appropriate (e.g. DoD).
3. Appropriate follow-up medical services, based on the needs of the person served, are arranged either at the MVAHCS or in the person's home community via the assigned case manager.
 4. Program discharge plans are summarized in the discharge documentation as well as in discipline specific Discharge Reports. Discharge plans are communicated to participants and stakeholders via case manager and other discipline specific providers. Continuity of care is arranged by the assigned case manager and the physician in collaboration with the team.

OBIRP PROGRAM EVALUATION

Program evaluation occurs on a monthly basis via the OBIRP Rehabilitation Standards Workgroup.

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