



Department of Veterans Affairs Office of Inspector General

Combined Assessment Program Summary Report

Evaluation of Polytrauma Care in Veterans Health Administration Facilities

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections completed an evaluation of polytrauma care in Veterans Health Administration (VHA) facilities. The purpose of the evaluation was to determine whether VHA facilities complied with selected requirements related to screening, evaluation, and coordination of care for patients affected by polytrauma.

Inspectors evaluated polytrauma care at 57 facilities during reviews conducted from October 1, 2011, through September 30, 2012. Fifty-four facilities had Combined Assessment Program reviews that included 2 Level I sites, 6 Level II sites, 36 Level III sites, and 10 Level IV sites. We made separate visits to the remaining three Level I sites. We identified five areas where VHA facilities needed to improve compliance.

We recommended that the Under Secretary for Health ensures that:

- VHA performs a detailed analysis of workload and resource use to determine whether there is continued need for the numbers of sites at the current levels and whether changes in the requirements for dedicated polytrauma resources are needed.
- Level IV sites performing comprehensive traumatic brain injury evaluations have approved alternate plans.
- Clinicians consistently complete traumatic brain injury evaluations within 30 days of positive screens.
- The case management process meets requirements.
- Staff caring for polytrauma patients have the documented competencies required for caring for these patients.



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Under Secretary for Health (10)

SUBJECT: Combined Assessment Program Summary Report – Evaluation of Polytrauma Care in Veterans Health Administration Facilities

Purpose

The VA Office of Inspector General Office of Healthcare Inspections evaluated polytrauma care in Veterans Health Administration (VHA) facilities. The purpose of the evaluation was to determine whether VHA facilities met selected requirements related to screening, evaluation, and coordination of care for patients affected by polytrauma.

Background

Polytrauma is defined as two or more injuries sustained in the same incident that affect multiple body parts or organ systems and result in physical, cognitive, psychological, or psychosocial impairments and functional disabilities.¹ Traumatic brain injury (TBI) frequently occurs as part of the polytrauma spectrum. In 2005, VHA was directed to designate cooperative centers for clinical care, consultation, research, and educational activities on complex TBI and polytrauma associated combat injuries. Additionally, VHA must ensure that returning war veterans with lasting injuries have the best medicine and integrative holistic therapies available.

VHA established a four-tiered Polytrauma System of Care with components for each level of care.² The four levels are:

- Polytrauma Rehabilitation Centers – Level I: Five sites provide acute medical care and acute and transitional rehabilitation care (Minneapolis, MN; Palo Alto, CA; Richmond, VA; San Antonio, TX; and Tampa, FL). These sites provide both inpatient and outpatient care. Level I sites serve as regional referral centers for acute medical and rehabilitation care and as hubs for research and education related to polytrauma and TBI. In addition, each site is required to have inpatient

¹ VHA Directive 2009-028, *Polytrauma-Traumatic Brain Injury (TBI) System of Care*, June 9, 2009.

² VHA Directive 2009-028.

beds, a specialized program for severely injured patients who regained consciousness after a period of unconsciousness or coma, outpatient programs, and residential transitional rehabilitation programs.

- Polytrauma Network Sites – Level II: There is one Polytrauma Network Site located within each of the 22 Veterans Integrated Service Networks (VISNs). These sites provide inpatient and outpatient post-acute rehabilitation care and have day treatment programs and interdisciplinary teams that help with community re-integration.
- Polytrauma Support Clinic Teams – Level III: These 87 sites, located within each VISN, provide only outpatient care for veterans and active duty service members with mild or stable functional deficits.
- Polytrauma Points of Contact – Level IV: These 39 sites are expected to screen patients and then refer those with positive screens to pre-approved specialists for evaluation. Level IV sites are generally smaller and more rural than the other three levels' sites. They have a point-of-contact who ensures that patients with polytrauma and TBI are referred to a program capable of providing rehabilitation services by an interdisciplinary team. Usually Level IV sites refer to the nearest Level I site, the Level II site within their VISN, or one of the Level III sites within their VISN.

VHA requires all veterans who served in Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn to be screened for TBI when they present to the VA for medical treatment.³ When patients screen positive for TBI, providers are required to refer them for further evaluation. The evaluation must be completed by a Level I, II, or III team within the Polytrauma System of Care. If the facility is a Level IV site, the evaluation can be performed by a pre-approved specialist with the appropriate background and skills, such as a neurologist, who has had training in the evaluation protocol.

In our review, we found that most VHA providers informed patients of TBI screening results and appropriately submitted TBI assessment consults for comprehensive evaluations or documented patients' refusal. When patients failed to appear for evaluation appointments, staff made sufficient attempts to reschedule. Training regarding accessing community resources, addressing polytrauma symptoms, and identifying polytrauma restrictions/precautions was offered to families.

³ VHA Directive 2010-012, *Screening and Evaluation of Possible Traumatic Brain Injury in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans*, March 8, 2010.

Scope and Methodology

Inspectors evaluated polytrauma care at 57 facilities during reviews conducted from October 1, 2011, through September 30, 2012. Fifty-four facilities had Combined Assessment Program (CAP) reviews that included 2 Level I sites, 6 Level II sites, 36 Level III sites, and 10 Level IV sites. We made separate visits to the remaining three Level I sites. The 54 CAP facilities were a stratified random sample of all VHA facilities and represented a mix of size, affiliation, geographic location, and VISNs. We generated an individual report for the 54 CAP facilities. For this report, we analyzed and summarized the data from the individual facility CAP reviews and the three Level I reviews.

We reviewed facility policies, patients' electronic health records (EHRs) (574 for screening and 444 for evaluations; 52 inpatient stays and 449 outpatients), and 433 staff training records. Additionally, we conversed with staff and inspected the Level I dedicated inpatient units. The patient sample within each facility was not a probability sample, and thus does not represent the entire patient population of that facility. Therefore, the summary results presented in this report are not generalizable to the entire VHA.

Inspectors conducted the reviews in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

Issue 1: Workload and Staffing

VHA provided guidelines to facilities defining the minimum numbers of clinicians required to screen, evaluate, and treat patients with polytrauma diagnoses.⁴ The tables below show selected workload numbers for the 57 facilities included in our review.

	Level I (5 sites)	Level II (6 sites)	Level III (36 sites)	Level IV (10 sites)
Total number of OEF/OIF veterans screened for TBI				
Fiscal year (FY) 2011	2,711–11,110	165–6,816	0–13,196	177–2,888
FY 2012	3,375–7,107	1,479–7,964	616–8,921	679–5,926

Level I	Number of inpatient polytrauma admissions FY 2012 (unique patients)	Average length of stay FY 2012 (in days)
Minneapolis, MN	23	43.26
Palo Alto, CA	14	53.13
Richmond, VA	23	49.83
San Antonio, TX	16	39.29
Tampa, FL	47	49.21

Level I Staffing FY 2012*						
Site	Rehabilitation Physicians		Rehabilitation Nurses		Social Workers	
	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
Required minimum staffing:	1.5	0.5	12	0.5	4	0.5
San Antonio, TX	4	4	22	1	2.33	1.0
Tampa, FL	2	1	23.6	2	3	3
Minneapolis, MN	1.5	1.3	16.0	2.0	3.0	2.0
Palo Alto, CA	2	2	34	9	4	5
Richmond, VA	1	1	8	0	4	1

* Self-reported in May 2013.

⁴ VHA Directive 2009-028.

A. Workload and Staffing:

Level I – The workload numbers on the previous page indicate wide differences in the number of patients screened and admitted. Workload among the five sites appears uneven. The resources expected to be dedicated to polytrauma inpatient care at Level I sites is extensive, and it may not be necessary to have five Level I sites to serve the decreasing target population.

Level II – These sites had no admissions in FYs 2011 or 2012, and some did not have any inpatient beds dedicated to polytrauma as required. They generally either used beds in regular rehabilitation units or transferred patients to the closest VHA facility with rehabilitation beds. VHA requires that when polytrauma patients are admitted for inpatient care, the polytrauma team will develop and manage the plan of care.⁵ With so few polytrauma admissions, staff may not develop the expertise to treat polytrauma inpatients, and resources expected to be dedicated to inpatient polytrauma care may be better used elsewhere.

Level III – These sites varied widely in how many patients they evaluated and treated, and some did not have the workload to support fully functioning interdisciplinary polytrauma teams. Some sites did not have interdisciplinary teams and did not use specialists to complete the comprehensive evaluation. Additionally, the volume of patients did not appear to support the required staffing levels. The resources allocated for these sites may be better used elsewhere.

Level IV – Some Level IV sites attempted to do more than VHA expected, and often staff without appropriate expertise performed comprehensive TBI evaluations. Eight of the 10 Level IV sites reviewed provided comprehensive TBI evaluations onsite rather than referring patients to the nearest referral site. While facilities may request approval of an alternate plan, none of these eight sites had submitted a request.

As military operations wind down, fewer veterans are presenting for evaluation, with a resultant decrease in polytrauma workload. Facility Physical Medicine and Rehabilitation (PM&R) Services are responsible for the treatment of polytrauma patients as well as patients undergoing rehabilitation for other reasons. We noted that many facilities' PM&R Service did not use dedicated providers to address polytrauma patients' unique needs. It appears that facilities reacted to the decreased polytrauma demands by transitioning away from the earlier model of specially trained rehabilitation physicians leading dedicated polytrauma rehabilitation teams. Instead, we consistently observed that polytrauma patients were treated by generalist PM&R interdisciplinary teams. Further, we found that some sites did not have all the required team members and that the full-time employee equivalent was sometimes divided among many staff rather than

⁵ VHA Directive 2009-028.

assigned to a single individual (i.e., a 0.5 full-time employee equivalent was divided among several therapists).

We recommended that VHA perform a detailed analysis of workload and resource use to determine whether there is continued need for the numbers of sites at the current levels and whether changes in the requirements for dedicated polytrauma resources are needed. We also recommended that VHA ensure that Level IV sites performing comprehensive TBI evaluations have approved alternate plans.

B. Rehabilitation Nurses:

Nursing care in a rehabilitation setting focuses on assisting individuals with impairments resulting from injuries, illness, or chronic disease in reaching their optimal level of health and function. Rehabilitation nurses have expertise in the care of conditions such as amputation, brain injury, and visual impairment.⁶ Although rehabilitation nurse services were provided at Level I sites, 3 Level II sites and 15 Level III sites did not provide these services. During our onsite reviews, some facilities told us they had difficulty attracting rehabilitation nurse applicants. We discussed these reported difficulties with VHA during our review, and subsequently, VHA published an updated handbook that eliminated the requirement for rehabilitation nurses at Level II and III facilities.⁷

Issue 2: Timeliness of Comprehensive TBI Evaluations

VHA requires clinicians to perform and document comprehensive evaluations within 30 days of positive TBI screens or document patients’ refusal.⁸ We found that 94 (21 percent) of 444 evaluations were not completed within 30 days of positive screens. These 94 evaluations break down by level as follows:

	Total	Level I	Level II	Level III	Level IV
Total	444	41	45	282	76
Evaluations not completed within 30 days of positive screen	94 (21%)	16 (39%)	11 (24%)	52 (18%)	15 (20%)

We recommended that VHA ensure clinicians consistently complete TBI evaluations within 30 days of positive screens and that compliance is monitored.

⁶ VHA Handbook 1172.1, *Polytrauma Rehabilitation Procedures*, September 22, 2005.

⁷ VHA Handbook 1172.1, *Polytrauma System of Care*, March 20, 2013.

⁸ VHA Directive 2010-012.

Issue 3: Case Management

VHA requires that case managers be assigned to patients who screen positive for TBI and provide coordination throughout the course of treatment, including communication at specific points and treatment planning.^{9,10,11} We found that:

- For 21 percent (103/487) of patients, case managers were not assigned to the patients at the time of comprehensive evaluation. The table below shows the breakdown by level.

	Total	Level I	Level II	Level III	Level IV
Total	487	46	57	311	73
Case managers not assigned to patients at the time of evaluation	103 (21%)	10 (22%)	5 (9%)	50 (16%)	38 (52%)

- For the 52 inpatients whose EHRs we reviewed:
 - Social workers did not contact patients/families prior to or on the day of admission for 18 patients (35 percent) and daily during the stay for 39 patients (75 percent). In addition, they did not complete psychosocial assessments for 7 patients (13 percent) or care plans for 8 patients (15 percent) and did not coordinate discharge plans for 15 patients (29 percent).
 - Discharge plans did not include all required items, including medical and nursing needs, equipment and supplies, and discharge instructions (range 7–27 patients; 13–52 percent).
 - When discharged to another facility or the military, there was no documentation that the discharge plan accompanied the patient for 77 percent (20/26).
 - There was no documentation that discharge instructions were given to the patient/caregiver for 43 percent (20/47).
 - Interdisciplinary team members relevant to the patients’ care were not involved in care planning (range 3–29 patients; 7–59 percent), the VHA care planning template was not used for 9 patients (17 percent), and there was no documentation that care plans were shared with 19 patients/families (37 percent).

⁹ VHA Directive 2012-008, *Social Work Case Management in a VA Polytrauma Rehabilitation Centers*, February 14, 2012.

¹⁰ VHA Handbook 1010.01, *Care Management of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans*, October 9, 2009.

¹¹ VHA Handbook 1172.04, *Physical Medicine and Rehabilitation Individualized Rehabilitation and Community Reintegration Care Plan*, May 3, 2010.

- For the 449 outpatients whose EHRs we reviewed, care plans were not created for 66 of 449 patients (15 percent) and did not include skills to maximize independence for 45 of 319 patients (14 percent) or vocational rehabilitation for 50 of 272 patients (18 percent) for whom they were indicated. There was no documentation that care plans were shared with 84 of 383 patients/families (22 percent).

Current social work and case manager staffing levels appeared adequate to support patient case management. However, social workers and case managers told us they were not always notified when patients were evaluated and scheduled for therapy related to polytrauma injuries. Documentation of interactions at required intervals was lacking at many sites.

We recommended that VHA ensures the case management process meets requirements and that compliance is monitored.

Issue 4: Staff Training and Competencies

VHA requires that employees involved in polytrauma care receive appropriate training and are competent to provide care to this special population.¹² During our review, we asked facilities to detail the expected training requirements for their polytrauma staff. We found the following:

- Polytrauma System of Care orientation was not completed for employees hired within the 12 months prior to our visits for 32 percent (24/76) of applicable staff.
- When required by facilities, specialty certification was not current for 46 percent (32/69) of applicable staff, and functional independence measurement¹³ certification was not completed for 12 percent (19/156) of applicable staff.

We recommended that VHA ensures that facilities consistently document that staff caring for polytrauma patients have the documented competencies required for caring for polytrauma patients and that compliance is monitored.

Conclusions

We noted that few patients presented for new polytrauma care. It appeared that much of the care provided was for continuing needs related to polytrauma injuries rather than for acute needs. Many of the Level III and IV sites relied on general PM&R Service staff to

¹² VHA Handbook 1172.1.

¹³ The functional independence measurement assesses the degree of disability and is particularly useful for judging the extent of recovery from serious injury. It has five grades, ranging from 0 (fully independent) to 4 (completely dependent).

provide the polytrauma care needed. Although patients received rehabilitation care in these settings, it was not always from an interdisciplinary team with the polytrauma training VHA has expected.

We found opportunities for improvement in the areas of resource dedication, timeliness of comprehensive evaluations, provision of comprehensive evaluations at approved sites, comprehensive case management, and staff training.

Recommendations

Recommendation 1. We recommended that the Under Secretary for Health ensures that VHA performs a detailed analysis of workload and resource use to determine whether there is continued need for the numbers of sites at the current levels and whether changes in the requirements for dedicated polytrauma resources are needed.

Recommendation 2. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that Level IV sites performing comprehensive TBI evaluations have approved alternate plans.

Recommendation 3. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that clinicians consistently complete TBI evaluations within 30 days of positive screens and that compliance is monitored.

Recommendation 4. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that the case management process meets requirements and that compliance is monitored.

Recommendation 5. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that staff caring for polytrauma patients have the documented competencies required for caring for polytrauma patients and that compliance is monitored.

Comments

The Under Secretary for Health concurred with the findings and recommendations. The implementation plan is acceptable, and we will follow up until all actions are completed.



JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Under Secretary for Health Comments

**Department of
Veterans Affairs**

Memorandum

Date: August 8, 2013

From: Under Secretary for Health (10)

Subject: **OIG Draft Report, Combined Assessment Program Summary Report – Evaluation of Polytrauma Care in Veterans Health Administration Facilities (VAIQ 7380502)**

To: Assistant Inspector General for Healthcare Inspections (54)

1. I have reviewed the draft report and concur with the report's recommendations. Attached are corrective action plans.
2. Should you have additional questions, please contact Karen Rasmussen, M.D., Acting Director, Management Review Service, at (202) 461-6643, or by e-mail at karen.rasmussen@va.gov.



Robert A. Petzel, M.D.

Attachment

VHA Action Plan

OIG Draft Report, CAP Summary Report – Evaluation of Polytrauma Care in Veterans Health Administration Facilities (VAIQ 7380502)

Date of Draft Report: July 10, 2013

Recommendations/ Actions	Status	Completion Date
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OIG Recommendations

Recommendation 1. We recommended that the Under Secretary for Health ensures that VHA performs a detailed analysis of workload and resource use to determine whether there is continued need for the numbers of sites at the current levels and whether changes in the requirements for dedicated polytrauma resources are needed.

Concur

The VHA Polytrauma System of Care (PSC) was designed to improve access to specialized rehabilitation services for Veterans and Servicemembers with polytrauma and traumatic brain injury (TBI) by facilitating delivery of care closer to home and providing case management services to assist patients in transitioning back to community living. Successful activation of the PSC relies on judicious utilization of resources while assuring access to interdisciplinary teams of specialized rehabilitation providers across the system. Detailed analysis of workload and resource utilization is monitored locally and nationally with the assistance of reports available through the VHA Support Service Center (VSSC) and supports the enduring commitment to provide services and care coordination across the rehabilitation continuum. The Physical Medicine and Rehabilitation Services (PM&R) Program Office uses this information to manage requests from facilities to change the designation of their polytrauma programs, e.g., from Polytrauma Point of Contact to Polytrauma Support Clinic Team, and to monitor rehabilitation staffing levels. Since 2012, PM&R has processed four requests for changes in polytrauma program designation and has utilized a web-based application to track staffing levels and composition of the polytrauma teams across the PSC. Additionally, the revised VHA Handbook 1172.01, dated March 20, 2013, describes changes in team staffing models to allow for more flexibility in the disciplines represented and the percentage of effort assigned.

PM&R will continue to monitor inpatient and outpatient workload and staffing throughout the PSC to assure appropriate resource utilization. Existing staffing models and programming will be modified, as appropriate, to assure the availability of specialty care in the traditional clinical settings, as well as support the expansion of specialty TBI and polytrauma services, as necessary.

Actions:

- PM&R will monitor inpatient and outpatient workload throughout the PSC and will report data to the field through the office of the Deputy Under Secretary for Health for Operations and Management (DUSHOM).

Timeline for completion October 31, 2013

- PM&R will aggregate updated information regarding staffing levels and composition of the polytrauma teams throughout the PSC and will provide an analysis of the findings to the Committee on Care of Veterans with Traumatic Brain Injury.

Timeline for completion April 30, 2014

This action plan is complete when VHA provides documentation of:

- The first workload report that is provided to the field.
- Briefing of the analysis to the Committee on Care of Veterans with Traumatic Brain Injury.

Recommendation 2. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that Level IV sites performing comprehensive TBI evaluations have approved alternate plans.

Concur

VHA Directive 2010-012, *Screening and Evaluation of Possible Traumatic Brain Injury in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans*, addresses the TBI Screening and Evaluation process for OEF/OIF/Operation New Dawn (OND) deployment-related injuries. “Given the expertise required to establish a diagnosis of TBI and implement appropriate treatment, the (TBI evaluation) protocol must be completed by Level II Polytrauma Network Sites (PNS) or Level III Polytrauma Support Clinic Teams (PSCT) existing within the VHA Polytrauma System of Care.” If there is no Level II PNS or Level III PSCT at the medical center, “the medical center has the option of determining an

alternate plan and team that meets the intent of this Directive. This may include having the evaluation completed by a specialist with an appropriate background and skills, such as a psychiatrist, neurologist, or neuropsychiatrist who has also had training in the evaluation protocol and in directing an interdisciplinary rehabilitation treatment team. Alternate plans are to be reviewed with the Veterans Integrated Service Network (VISN) Chief Medical Officer and the National Director of Physical Medicine and Rehabilitation.”

Since the Polytrauma OIG Combined Assessment Program review, many sites have submitted Alternate Plans that were discussed with and approved by PM&R. To date, all but 6 of the 38 PPOC sites have an approved alternate plan in place. PM&R will contact Polytrauma Points of Contact (PPOC) sites that do not have an approved plan and request that they submit an alternate plan for TBI Evaluation. PM&R will monitor submission of plans until 100 percent compliance is documented.

Actions:

- PM&R will monitor submission of alternate plans for the remaining 6 PPOC sites until 100% compliance with VHA Directive 2010-012 is documented.

Timeline for completion January 31, 2014

This action plan is complete when VHA provides documentation of 100 percent compliance with policy requirements for Alternative Plans.

Recommendation 3. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that clinicians consistently complete TBI evaluations within 30 days of positive screens and that compliance is monitored.

Concur

VHA Directive 2010-012 addresses the TBI Screening and Evaluation process for OEF/OIF/OND deployment related injuries and states that, “the patient with possible TBI is seen for the Comprehensive TBI Evaluation (CTBIE) within 30 days of the initial positive screen regardless of the facility or specialty team responsible for completing the evaluation.”

PM&R continues to collaborate with Primary Care and the VHA Support Service Center (VSSC) to make web-based reports available for local compliance and monitoring of performance on the TBI screening and evaluation process, and releases reports through the office of the DUSHOM

to local facilities at least quarterly. PM&R will continue to provide training to the field regarding the management of patients who may have suffered a TBI and assist VISN and facility staff in properly utilizing existing reports to monitor compliance, completion rates, and implement performance improvement plans.

Actions:

- PM&R will provide education on existing online reports detailing the TBI screening and evaluation process that will assist facilities in monitoring their clinical activity. The training will be provided via Lync meeting during the quarterly PSC call which involves all PSC teams.

Timeline for completion September 30, 2013

- VSSC TBI Screening and Evaluation reports are updated on a monthly basis and available to the field through online reports. PM&R will collaborate with the office of the DUSHOM to notify underperforming sites and develop corrective action plans. The first report is by October 31, 2013, and quarterly thereafter.

Timeline for completion January 30, 2014

This action plan is complete when VHA provides documentation of:

- Education provided to the field.
- Two quarterly reports demonstrating improvement of performance at underperforming sites.

Recommendation 4. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that the case management process meets requirements and that compliance is monitored.

Concur

VHA Handbook 1172.04, *Physical Medicine Rehabilitation and Community Reintegration Care Plan*, defines the procedures for the development and implementation of the Individualized Rehabilitation and Community Reintegration (IRCR) Care Plan for Veterans and military Servicemembers who receive inpatient or outpatient rehabilitative care for deficits related to TBI and polytrauma. The Handbook provides clear direction that outlines the responsibilities for polytrauma/TBI case managers. This includes monitoring, implementation, documentation of the treatment plan, coordination of services, and ongoing collaboration with other VHA case management programs. VHA Directive 2012-008, *Social Work Case*

Management in VA Polytrauma Rehabilitation Centers, provides policy on social work case management in Polytrauma Rehabilitation Centers (PRC). This Directive defines frequency of case management follow-up and documentation requirements.

Actions:

- PM&R will provide education on the case management responsibilities for the development and communication of the IRCR Care Plan. Training will be provided via Lync meeting during national Polytrauma Case Management calls.

Timeline for completion November 15, 2013

- PM&R will monitor PRC case management documentation and patient follow-up requirements via presentations during quarterly PRC calls through presentations by each of the five PRC sites. These presentations will identify challenges and processes for improvement in an open and transparent forum.

Timeline for completion January 31, 2014

- PM&R will monitor implementation of the IRCR Care Plan template through Polytrauma Network Site (PNS) presentations. PNS teams from each VISN will report outcomes during monthly PNS conference calls. These presentations will identify challenges and processes for improvement in an open and transparent forum. A presentation by three sites per month will be completed.

Timeline for completion June 30, 2014

This action plan is complete when VHA provides documentation of:

- Education provided to the field.
- Presentations made during monthly PNS calls and quarterly PRC calls.

Recommendation 5. We recommended that the Under Secretary for Health, in conjunction with VISN and facility senior managers, ensures that staff caring for polytrauma patients have the documented competencies required for caring for polytrauma patients and that compliance is monitored.

Concur

VHA Handbook 1172.01, *Polytrauma System of Care*, dated March 20, 2013, updates the educational requirements of the now rescinded

VHA Handbook 1172.1, *Polytrauma Rehabilitation Procedures*, dated September 22, 2005, by shifting the emphasis on provider competencies in the specialized areas of TBI and polytrauma rehabilitation. Since 2005, PM&R organized 18 national conferences on TBI and polytrauma related topics with more than 10,000 participants; developed a mandatory TBI Continuing Education Course with a web based version in 2010 and 2011, and presented satellite broadcasts about TBI and polytrauma topics on the VA Content Distribution Network. Given the multitude of learning options now available to TBI and polytrauma providers, VHA Handbook 1172.01, dated March 20, 2013 requires that specialized training and experience be demonstrated through competencies in the areas of TBI and polytrauma rehabilitation. These can be reflected in one or more of the following: job position functional statement or position description, certifications, continuing education record, professional competencies, orientation training, and scope or standards of practice. PM&R will collaborate with VISN offices to ensure they understand their responsibilities as related to monitoring competencies of staff assigned to polytrauma teams.

Actions:

- PM&R will develop a sample polytrauma/TBI competencies checklist and will disseminate to the PSC Leadership to provide guidance for monitoring specialized skills and knowledge of TBI and polytrauma providers.

Timeline for completion September 30, 2013

- The Office of the DUSHOM will require an attestation from VISNs all polytrauma/TBI staff have completed the checklist verifying competencies.

Timeline for completion April 30, 2014

This action plan is complete when VHA provides documentation of:

- Dissemination of the sample Polytrauma/TBI competencies checklist.
- VISN attestations of completion of the competency checklists by all polytrauma/TBI staff.

OIG Contact and Staff Acknowledgments

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