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RESCISSIONS

The following material is rescinded:

Circulars

10-89-101

CHAPTER 2. SPINAL CORD INJURY (SCI) TREATMENT ISSUES

2.01 PURPOSE

This chapter addresses a variety of situations in which SCI patients may find themselves and the explanation of administrative procedures.

2.02 EMERGENCY CARE OF SCI VETERANS

a. Patients with SCI requiring immediate surgical intervention should receive care in a Department of Veterans Affairs (VA) medical center with a designated SCI Center. If urgency requires that treatment be provided at a non-SCI Center, the Chief of the nearest SCI Center will be advised of this fact as soon as possible (ASAP). Such patients will be retained only until they can be safely transferred to a VA medical center with an SCI Center.

b. Chiefs, SCI Service, shall be notified by the respective SCI Coordinator, of all admissions of SCI veterans to non-SCI medical centers.

c. All SCI veterans who are to be admitted to a VA medical center with an SCI Center shall be admitted to the SCI Center, or shall be transferred to the SCI Center ASAP, or within 24 hours of admission unless the Chief, SCI Center, does not find it feasible to accept the patient. In such a case, the patient will continue to receive treatment at the VA medical center pending future action by the SCI Center.

d. SCI veterans in any intensive care setting shall remain there until properly discharged to the SCI Service by the physician-in-charge.

e. The SCI veteran, while in intensive care, shall be seen by the patient's primary SCI physician and an SCI nurse on a daily basis, at a minimum. They shall enter daily progress notes on the patient's record and interact with the intensive care unit (ICU) staff.

f. After having undergone surgery, SCI veterans shall be returned to the SCI ward within 24 hours after leaving the recovery room, except in extenuating circumstances. In these cases, the patient's primary SCI staff physician and nurse shall visit the patient daily and document their findings in the progress notes.

2.03 MEDICAL COVERAGE DURING NON-DUTY HOURS

A copy of VA Pamphlet, "VA Guidelines for the Care and Treatment of SCI Patients," shall be made available to all non-SCI physicians and nurses covering SCI during weekend, holiday, evening and night (W.H.E.N.) hours. These guidelines were prepared to assist the health professional who does not have specific skills in the handling of emergencies likely to occur in SCI veterans.

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a. An SCI physician will be on-call at all times for assistance and consultation.

b. Non-SCI staff must have undergone training in SCI emergencies prior to assuming on-call duties.

#### 2.04 ADMISSION OF SCI VETERANS

a. The Chief, SCI Service, shall ensure that admission of SCI veterans is accomplished in an expeditious manner. If an eligible SCI veteran from their catchment area cannot be accepted for admission at the time of the application for hospitalization to a SCI

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center, the Chief of that SCI Center will be responsible for making arrangements for care at another SCI Center having available beds. The Chief, SCI Service, will be responsible for communicating these arrangements to the patient or the patient's representative, and for seeing that the quality of patient care is not compromised. Although a veteran may apply to any SCI Center, emphasis will be placed upon addressing the SCI veteran's needs in the immediate SCI catchment area. Other factors such as the urgency of the patient's medical need, available resources, eligibility, and entitlement priorities will be considered in addressing the needs of other SCI applicants.

b. The SCI centers were developed primarily to care for veterans with trauma to the spinal cord resulting in neurologic deficit.

(1) The SCI veteran will be assigned to a primary SCI physician responsible for the care of the SCI veteran in its entirety. This responsibility will remain intact as long as the patient receives care at the facility. This "holistic" patient approach promotes continuity and quality care. It is strongly suggested this primary physician-patient relationship will extend to the therapeutic areas of SCI Home Care and SCI outpatient care.

(2) Generally, there are a wide array of medical conditions associated with the care of a spinal cord injured person that the primary SCI physician is able to address successfully without the need for specialty consultation from outside the SCI Service.

(a) In those relatively rare instances where the patient's condition requires care in areas of medicine, surgery, or psychiatry where consultation is required, a request for consultation should be ordered by the SCI physician.

(b) The consult should clearly indicate whether the primary SCI physician is seeking an advisory consultation, or a consultation in which treatment by the consultant is requested. Treatment for the patient should be limited to "that particular medical or surgical issue" in the consultant's specialty. NOTE: The SCI physician still retains the primary responsibility for the whole patient.

(c) Upon examination, the consultant may accept responsibility for the patient's treatment for that particular portion of care, or decline to accept the patient, in either case the medical record will be properly documented to accurately reflect the course of treatment afforded the patient. When that particular issue of care is resolved, the consultant again so states in the record and the patient again becomes the sole responsibility of the primary SCI medical doctor (M.D.).

(4) If the complexity and acuity of the SCI veteran's care becomes so great as to warrant physical transfer to a specialty ward outside the SCI Service, the patient's primary SCI physician will retain shared patient responsibility

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in that the primary SCI physician will make sure the prescribed treatment is proper for an SCI veteran.

(a) This requires the primary SCI physician to visit the patient on a daily basis.

(b) When the medical crises has been resolved, the patient will be transferred back to the SCI Service where the SCI physician will again assume the primary care role.

c. The diagnostic categories of patients who should have access to the SCI centers include:

- (1) Traumatic lesions of the spinal cord, resulting in neurologic deficits.

- (2) Intraspinal, nonmalignant neoplasms, resulting in neurologic deficit.
- (3) Vascular insults to the spinal cord or cauda equina of thromboembolic, hemorrhagic or ischemic nature, producing neurologic deficit.
- (4) Inflammatory disease of the spine, spinal cord or cauda equina resulting in nonprogressive neurologic deficit.
- (5) Demyelinating disease limited to the spinal cord and of a stable nature.
- (6) When appropriate, traumatic lesions of the spinal column without neurologic deficit but which carry a high risk of SCI when expertise on the SCI Service in the care and handling of the patient could prevent neurological deficit.

d. Exceptions

(1) Although similar in appearance to SCI, veterans diagnosed with the pathologic entities listed should not be admitted to SCI centers NOTE: This is due either to the progressive nature of the disease or the limited rehabilitation potential of patients stricken with it):

(a) Quadriparesis or paraparesis due to intracranial disease with or without a brain syndrome.

(b) Intraspinal, intra- or extra-medullary malignancy of a primary or secondary origin.

(c) Conversion hysteria manifested as paraplegia or quadriplegia.

(d) Demyelinating disease in acute active relapse and/or with extensive intracranial deficit.

(2) Because the SCI centers have expertise and equipment to handle pressure sores, they are often urged to take non-SCI veterans for the management of decubitus ulcers. The admission of these cases to SCI centers is inappropriate except in rare circumstances, and then on a very limited and temporary basis, and should be accomplished at the discretion of the Chief, SCI Service.

2.05 ADMISSION OF ACUTE NON-VETERAN SCI PATIENTS

a. The following VA policies has been developed for the admission of non-veterans other than active duty military personnel. NOTE: This does not apply to VA SCI services furnished under a sharing agreement.

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(1) Admission must be considered necessary for humanitarian emergency reasons because appropriate specialized facilities are not available in the area.

(2) Request for admission should be made to the nearest Chief, SCI Service, within 72 hours post-injury. The Chief, SCI Service or Acting Chief, SCI Service, will approve requests for admissions of acute non-veteran SCI patients.

(3) Admission should be accomplished within 1-week post-injury and prior to any major surgery to the spinal column.

(4) Management at a VA SCI Center will make a critical difference in the patient's outcome.

(5) The cost of VA care, including prosthetic/orthotic devices and the cost of transportation to and from the SCI center, will not be borne by VA. Charges for SCI services will be according to M-1, Part I, Chapter 15, or the cost accounting and/or billing methodology currently in use.

(6) Length of stay in a VA SCI Center will be limited to a maximum of 3 months. The VA medical center Director may authorize extension of hospitalization, if necessary. Every effort will be made to stabilize the patient and transfer the patient to non-VA health care facilities.

(7) Those applicants who are not yet hospitalized and in need of emergency care (where the absence of immediate care would be life threatening to the patient) will be given the highest priority for treatment and consideration for admission if warranted and feasible.

(8) The quality of care made available to eligible veterans will not be diminished, and acceptance of eligible veterans will not be delayed as a result of the hospitalization of a non-veteran.

#### 2.06 ADMISSION OF ACTIVE DUTY PERSONNEL

a. A memorandum of understanding between VA and the Department of Defense (DOD) has been approved with the objective of providing the most expeditious and best possible care for active duty military personnel who sustain spinal cord injuries.

b. Under this agreement, DOD agrees that:

(1) A military medical treatment facility (MMTF) with an SCI veteran will notify the Armed Services Medical Regulating Office (ASMRO) of a patient needing care.

(2) ASMRO will report to the MMTF which VA SCI Center will receive the SCI veteran in transfer.

(3) The medical and administrative personnel of the MMTF will establish immediate phone contact with their counterparts at the designated VA medical center to discuss and make specific arrangements. The referring hospital will ordinarily determine that the patient will receive a discharge from active military service which will not bar the member from medical benefits, and will be subject to provisions of Veterans Health Administration (VHA) manual M-1, Part I, Chapter 4.

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(4) The general goal will be to effect arrangements within 3 days (4 days from overseas) and should not exceed 12 days. The ability to complete medical review board processing will not be a prerequisite for this transfer.

(5) When the patient is ready for transfer, arrangements will be effected immediately.

(6) The Surgeon General's Office of the appropriate military service will provide necessary assistance to VA medical centers in preparing VA medical review boards.

(7) If possible, active duty patients arriving from overseas will go directly to a VA medical center without passing through a transit military hospital.

c. Under the memorandum of understanding, VA agrees that it will:

- (1) Accept any patient as soon as transfer can be arranged.
- (2) Provide ASMRO with a current and regularly updated list of SCI treatment centers which are designated to receive active duty SCI veterans.
- (3) Initiate medical board proceedings as requested by the appropriate military Surgeon General's Office.
- (4) Coordinate with community hospitals so that VA-eligible, DOD SCI veterans who are ready for transfer to another hospital are transported directly from a community hospital to a VA facility.

d. Certain VA medical centers are currently designated as capable of providing the sophisticated care and intensive rehabilitation required by recently-injured military service personnel. These centers are designated in Appendix 1A.

e. Active duty patients with spinal cord injuries should be referred to the designated SCI Center closest to the patient's home at the time of induction, or the home to which the veteran plans to return, subject to availability of beds. If the patient's condition requires, transfer to the closest VA SCI Center will be arranged. If the SCI Center is unable to accept the patient, for example, because of nonavailability of beds, that SCI Center will find the patient a bed rather than let the referring facility do the search. NOTE: The Director, Spinal Cord Injury Programs (117F), VA Central Office, 810 Vermont Avenue, NW, Washington, DC, 20420, will assist, if necessary.

#### 2.07 PATIENT TRANSFERS, DISCHARGES, AND FOLLOW-UP

a. It is the responsibility of the VA medical center first contacted for admission to proceed with arrangements for transfer to the nearest appropriate SCI Center. The Directors of VA medical centers without SCI centers will ensure the expeditious transfer of patients. The SCI Coordinator at a non-SCI center VA medical center is responsible for initiating referrals to the SCI Center and coordinating arrangements for transfer. The patient's primary physician will be responsible for consulting with the Chief, SCI Service, regarding immediate medical management and transfer.

b. Follow-up care will be scheduled for all discharged SCI veteran-patients and provided by the SCI Center outpatient clinic or an SCI outpatient support clinic.

(1) Patients will be scheduled for an annual checkup at the SCI Center's outpatient clinic. An SCI outpatient support clinic may perform the annual examinations if they have the proper resources and equipment available to do

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so. Results of this evaluation will be forwarded to the Chief of the lead SCI Center.

(2) If the veteran receives medical follow-up at an SCI Center yet resides closer to another VA medical center, the SCI social worker will facilitate forwarding a copy of the closing social work and medical discharge summary to the respective SCI Coordinator. This should make the non-SCI medical center aware of an SCI veteran living in their primary service area (PSA). The SCI social worker and the SCI Coordinator will keep each other advised of subsequent admissions and other SCI veteran-related activities.

(3) When an SCI veteran needs referral to a VA medical center near the veteran's home, the SCI social worker will send a referral (medical summary, comprehensive

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social work assessment, and closing summary) to the SCI Coordinator for follow-up. This referral will include the specific services requested, a diagnostic workup and/or treatment as indicated.

c. SCI veterans should not be discharged until all attainable rehabilitation goals for their hospitalization have been achieved. Exceptions would be when:

(1) The patient chooses to terminate the hospitalization against medical advice, or

(2) In the judgment of the patient and SCI treatment team, a period of convalescence at home would enhance and speed the patient's rehabilitation. NOTE: Family members and others in the support network should understand SCI care procedures, use of prosthetics and the prevention of complications.

#### 2.08 LONG-TERM SCI CARE

a. Long-term SCI care must be provided for SCI veterans unable to attain or maintain a community level of adjustment. This care will be provided at one of the SCI centers with designated long-term beds or in a VA nursing home care unit. Out-placement efforts should continue on all long-term patients when appropriate.

b. No SCI veteran shall be discharged to a nursing home solely because of the patient's SCI condition. Nursing homes (VA or community) are not synonymous with VA long-term SCI care environments, and patients should not be discharged to a nursing home unless the patient's general medical condition and social circumstances necessitate such placement.

c. In recognition of the special needs and increased costs involved in the care of ventilator dependent patients, VA and community resources should be creatively utilized.

d. Aging veterans will be provided quality care by VA. As the aging have special needs (in particular: supplies, quality of life concerns, and a less restrictive and supportive living environment), there will be sufficient planning to ensure these needs are met.

#### 2.09 FEMALE SCI VETERANS

a. VA will provide quality care to female SCI veterans.

b. In planning for service delivery, the special needs of the female SCI veterans will be met. In particular, provisions will be made for:

(1) Privacy,

(2) Appropriate supplies,

(3) Apparel, and

(4) Access to gynecological services.

#### 2.10 PREVENTIVE SCI MEDICINE AND THE ANNUAL PHYSICAL

A most important function of SCI care is the prevention of complications of SCI. Yearly physicals are the cornerstone of the preventive medical mission.

a. Yearly physical exams should be performed at SCI centers or appropriately equipped SCI outpatient support clinics.

b. For the purpose of health maintenance and detection/prevention of SCI-related complications, the examination shall consist of no less than:

- (1) Medical history - physical exam to include:
  - (a) Sensory and motor level reflex functions,
  - (b) Skeletal changes,
  - (c) ADL function changes (use of Functional Independence Measure (FIM) recommended),
  - (d) Skin integrity,
  - (e) Cardiovascular assessment (cardiac risk evaluation),
  - (f) Pulmonary function,
  - (g) Digital rectal examination, and
  - (h) Stool for occult blood.
- (2) Dental evaluation;
- (3) Psychosocial assessment (including vocational rehabilitation potential/readiness and sexuality);
- (4) Rehabilitation-functional evaluation (changes due to aging included);
- (5) Chest x-ray as indicated;
- (6) Tonometry (when over age 35);
- (7) Electrocardiogram (EKG), when indicated;
- (8) Complete Blood Count (CBC) chemical profile (including lipids) - UA C/S, to include acid phosphatase/prostatic specific antigen (for patients over age 40);
- (9) Urinary tract evaluation (function and morphology):
  - (a) Creatinine clearance;
  - (b) Urinary cytology;

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- (c) Renal sonogram;
- (d) Computerized renal scan;
- (e) Intravenous Pyelogram (IVP), when indicated;
- (f) Cystoscopy with biopsy, when indicated, especially in patients with indwelling catheters; and

- (g) Urodynamics evaluation every 3 years, or more frequently if indicated.
- (10) Abdominal sonogram (gall bladder and aorta);
- (11) Rectosigmoidoscopy (over age 40)/colonoscopy when indicated;
- (12) Health promotion such as:
  - (a) Immunization (pneumovax (once), influenza);
  - (b) Anti-smoking information;
  - (c) Substance abuse screening and counseling; and
  - (d) Purified Protein Derivative (PPD).
- (13) Dietary and nutritional assessment;
- (14) Female SCI veterans, to include a:
  - (a) Pelvic exam,
  - (b) Pap smear,
  - (c) Breast exam, and
  - (d) Mammogram.

c. Letters to patients containing a summarization of their yearly physical results and the necessary follow-up care are certainly a most welcome and beneficial undertaking that will help the patients along for the coming year.

#### 2.11 SEXUALITY AND/OR FERTILITY COUNSELING

Prior to the projected discharge date, SCI veterans will be offered the opportunity to undergo sexuality and fertility counseling by means of a formal urological and psychological consultation. The spouse or significant other should be involved in the process.

#### 2.12 INFECTION CONTROL

In coordination with VA medical center Infection Control Program, all SCI Services must develop and implement an effective SCI infection control policy, paying particular attention to SCI veterans with antibiotic-resistant bacteria. The standard operating procedures (SOP) of each SCI Center or unit shall contain a section on infection control.