

CONTENTS

CHAPTER 8. SPINAL CORD INJURY (SCI) HOME CARE SERVICES

PARAGRAPH	PAGE
8.01 Policy .....	8-1
8.02 Definition .....	8-1
8.03 Eligibility .....	8-2
8.04 Fee Basis Home Care Services .....	8-2
8.05 SCI-HC .....	8-2
8.06 Categories of Care .....	8-3
8.07 Program Instructions .....	8-3
8.08 SCI-HC Responsibilities of Chief, SCI Service .....	8-6
8.09 SCI-HC Staff .....	8-6
8.10 Quality Improvement .....	8-11
8.11 Reports .....	8-11

CHAPTER 8. SPINAL CORD INJURY (SCI) HOME CARE SERVICES

8.01 POLICY

a. All SCI centers will provide follow-up through SCI Home Care (SCI-HC) Programs consisting of an interdisciplinary team under the professional supervision of the Chief, SCI Service.

b. Patients who are placed in community nursing homes shall be seen and followed by SCI-HC staff as circumstances dictate; coordination of services with program officials should occur as appropriate. Patients placed outside a 100-mile radius of the SCI Center will be referred to the appropriate medical center and SCI Coordinator for follow-up.

8.02 DEFINITION

a. The program is designed to assist newly injured patients and their families in their adjustment when released from the hospital to community. This program also offers a variety of services to other patients in order to sustain them in the community and will be an integral part of the SCI Service. Services provided include, but are not limited to, the following:

- (1) Prevention of complications through observation of areas of vulnerability, education, and eventual referral to the SCI Coordinator;
- (2) Home evaluation;
- (3) Medical management and care;
- (4) Psychosocial support;
- (5) Referrals to community agencies;
- (6) Nutritional counseling;
- (7) Direct nursing care;
- (8) Assessment of equipment needs;
- (9) Education and support to patients, families and caregivers;
- (10) Leisure counseling and training;
- (11) Support for vocational follow-up;
- (12) Establishment of a therapeutic regimen in the home; and
- (13) Training and assistance in activities of daily living.

M-2, Part XXIV  
Chapter 8

January 27, 1994

b. All newly injured patients, especially high quadriplegic and ventilator-dependent, should be referred for follow-up when residing within a 100-mile radius and greater distances at the discretion of the Chief, SCI Service. Other patients should be referred to the closest Department of Veterans Affairs (VA) Hospital Based Home Care (HBHC) and SCI Coordinator when it is determined that follow-up care from a team will help sustain them in the community.

c. A number of resources (community, State and Federal), are available and designed to assist the spinal cord injured veteran in reintegration into community life, relocation and rehabilitation. The emphasis is on the transition from inpatient hospitalization to sustained community living.

#### 8.03 ELIGIBILITY

SCI veterans who do not require inpatient care and are eligible for services under 38 Code of Federal Regulations (CFR) 17.60 (a) through (i). The priorities for care listed in M-1, Part 1, Chapter 17, Section IX, will be used for admission to the SCI-HC Program.

#### 8.04 FEE-BASIS HOME CARE SERVICES

a. Because of the possibility of medical complications, bowel and bladder care for certain spinal cord-injured veterans is considered supportive medical services. If the veteran is eligible for fee-basis outpatient medical services under 38 United States Code (U.S.C.) Section 17.50(b), the clinic of jurisdiction or medical center may authorize such care under the fee-basis program to enable the veteran to reside in the veteran's community.

b. The provisions of M-1, Part I, Chapters 18 and 30, are applicable to SCI veterans requiring home care services. A relative (by blood or marriage) of a veteran in the fee-basis program should not be excluded from treating the veteran for a fee, as long as professional requirements are met. Family members trained by VA to provide special care to certain veterans (such as those trained in the SCI Home Care Program or the SCI Program) should not be paid for their services. When bowel and bladder care cannot be procured through a Visiting Nurse Association (VNA) or other skilled licensed provider, a family member may receive reimbursement for provision of this care when the following conditions are met:

(1) The family member has been trained and certified by a SCI Center as being competent to provide bowel and bladder care.

(2) Reimbursement will not exceed the hourly rate paid to nursing assistants employed by VA at a VA facility.

c. In no instance should fee-basis bowel and bladder care be authorized for a veteran who has been rehabilitated and is able to perform this function unassisted.

#### 8.05 SCI-HC

a. The SCI-HC Program provides a critical link in the continuum of care for SCI veterans, especially in the area of wellness and prevention, by means of an interdisciplinary team. The SCI-HC Program renders important medical,

M-2, Part XXIV  
Chapter 8

January 27, 1994

rehabilitation, and preventive psychosocial services determined necessary to sustain the SCI veteran in the community.

b. Upon admission to the SCI-HC Program, the team prepares a treatment/rehabilitation/prevention plan in collaboration with the patient and family/caregiver.

c. In general, participation in the SCI-HC Program is limited to 1 year after discharge from initial rehabilitation.

M-2, Part XXIV  
Chapter 8

January 27, 1994

d. All SCI veterans who do not require inpatient care are eligible. Before admission, the patient and the caregiver must be evaluated and educated to ensure successful participation on the basis of the patient's physical and psychosocial status.

e. Discharge from the program may be based on established criteria.

f. All SCI veterans in the SCI-HC Program are eligible for readmission to the SCI Center if medically indicated.

g. The consolidated health record is used for documentation. The SCI-HC participates in the service based SCI Quality Improvement (QI) Program and reports all inappropriate discharges to the QI Coordinator.

h. Special training is necessary for patients and caregivers in home safety, infection control, and response to emergency situations.

#### 8.06 CATEGORIES OF CARE

Patients admitted to the SCI Home Care Program generally fall into three categories which are as follows:

(1) Intensive. Patients will receive no less than one or more visits per week by any discipline. Patients in this category require frequent visits due to the scope of problems and/or severity of concerns. Examples of patients in this category include: the newly injured following initial discharge from the medical center and adjustment to community living; those experiencing acute problems, i.e., new diagnosis of diabetes or hypertension; any patient with specific changes in the home and/or health environment, i.e., breakdown in community support system, change in attendant, equipment.

(2) Maintenance. Patients will be visited no less than one visit every 2 to 3 weeks by any discipline. Patients in this category include: patients in need of regular lab work, patients in need of functional rehabilitation evaluations, patients requiring regular nutritional counseling, or those in need of family caregiver support.

(3) Preventive. Each patient will be visited no less than quarterly by any discipline. This category of patients has no ongoing major problems, but needs periodic monitoring for support, assessment, and prevention of problems. Patients in this category include individuals:

(a) Identified as at risk for recurrence of problems;

(b) With a history of high recidivism who may benefit from ongoing monitoring to avoid hospitalization; or

(c) In special programs, i.e., lifeline, where monitoring is necessary.

January 27, 1994

M-2, Part XXIV  
Chapter 8

M-2, Part XXIV  
Chapter 8

January 27, 1994

8.07 PROGRAM INSTRUCTIONS

a. Admissions Criteria

(1) Those patients identified as priority for the services offered by SCI-  
HC include:

(a) All new injuries; and

M-2, Part XXIV  
Chapter 8

January 27, 1994

(b) Old injuries with multiple health and psychosocial problems, and those new to the VA medical center with problems in need of follow-up.

(2) The patient will meet the following criteria:

(1) Patient requires professional care, which, if not provided, would result in hospitalization, and recurring travel to a VA medical center for outpatient care is neither feasible nor advisable.

(2) Patient will respond better to care in the home setting than at the health care facility.

(3) The home environment is physically suitable or adaptable for the daily care to be provided at home. The patient's medical problems can be managed or coordinated by the SCI-HC team.

(4) The patient and members of the family (or others) are assisted in developing the proposed plan for care, have given an informed consent to be part of the program, and are in agreement with treatment plans.

(5) Patient's home should be within 100 mile radius or 2 hours' driving time from the medical center.

b. Discharge Criteria

(1) The patient has reached the goals identified in the care plan and no longer needs SCI-HC intervention.

(2) The patient is readmitted to the medical center for more than 10 working days.

(3) The patient and/or family requests termination.

(4) Refusal of veteran, family, and/or significant other to cooperate with the SCI-HC Program team will result in discharge from the program. This will be discussed with the veteran, family and/or significant other prior to the final decision and documented in the record. The veteran will be notified in person and in writing.

NOTE: An SCI Home Care representative should sit in on Discharge Planning meetings of patients admitted for initial rehabilitation and other patients, if requested.

c. Readmissions

(1) All patients enrolled in SCI-HC can be readmitted to the medical center at any time if medically indicated.

(2) Respite care is recognized as an important consideration for families and caregivers and may be arranged as beds are available.

(3) The SCI-HC physician is responsible for coordinating transfers to other clinical units or medical centers with the receiving physician.

d. Patient Care Plan and Delivery of Services

(1) Upon admission to the program, a plan of care will be developed with the patient and family by the SCI-HC team. Specific goals of treatment and target dates for accomplishment will be established.

(2) The frequency of home visits will be determined by the individual needs of each patient, and progress notes will be written by each team member after every home visit.

(3) The care plan will be reviewed and updated by the entire team no less than every 60 days and determination made regarding need for continuance on the program.

e. Length of Stay. There is an expectation that new injuries will be enrolled in the SCI-HC Program for no more than 1 year. The focus of services should be geared toward independent community functioning. Justification of extension beyond 1 year must be approved by Chief, SCI Service. All patients should be reevaluated within a minimum of every 90 days regarding the need for continuation of the program.

f. Medical Records Documentation.

(1) The Chief, SCI Service, is responsible for ensuring that documentation is completed by the treatment team.

(2) The Consolidated Health Record (CHR) will meet VA and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requirements and standards to include:

- (a) A comprehensive assessment (patient/family/home situation);
- (b) An interdisciplinary treatment plan;
- (c) Progress notes after each home visit;
- (d) Documentation of treatment plan review;
- (e) Discharge plans; and
- (f) Discharge summary.

g. Emergency Situations, Safety, and Infection Control. As a part of the admissions process and on an ongoing basis as needed, patients and caregivers are provided education and training in home safety, infection control, and handling emergency situations.

(1) Patients should be given written information regarding procedures of handling emergencies during the program's normal duty hours, as well as after hours. Plans should be developed to ensure continuing and appropriate care in the event of an emergency that would result in the interruption of patient services.

M-2, Part XXIV  
Chapter 8

January 27, 1994

(2) Patients are provided education regarding basic home safety, the safe and appropriate use of medical equipment, and the identification, handling and disposal of wastes in a safe and sanitary manner.

(3) The program should have infection control procedures that address personal hygiene, isolation precautions, aseptic procedures, staff health, transmitted infections, and appropriate cleaning and sterilization of equipment. All staff, patients, and caregivers should be instructed regarding their responsibilities in the infection control program.

(4) A system should be developed to report and document all accidents, injuries, safety hazards, and infections.

#### 8.08 SCI-HC RESPONSIBILITIES OF CHIEF, SCI SERVICE

The SCI-HC Program is the overall clinical and administrative responsibility of the Chief, SCI Service. The Chief, SCI Service, is responsible for implementing all aspects of care of nonhospitalized SCI veterans including home care and independent living. The responsibilities of the Chief, SCI Service, are to:

- a. Maintain overall responsibility for SCI-HC with SCI Service.
- b. Ensure that a written policy and procedure manual is developed to comply with all applicable VA Central Office and JCAHO standards and requirements. It will be reviewed at least annually and updated as necessary.
- c. Select coordinator of SCI-HC Program in conjunction with respective service chief.
- d. Delegate administrative responsibility for SCI-HC to Program Coordinator.
- e. Assign the physician in charge of SCI-HC team members.
- f. Provide input in the performance evaluation of all SCI-HC team members.
- g. Provide liaison with other service.

#### 8.09 SCI-HC STAFF

a. The SCI-HC team should be interdisciplinary. Recommended team composition includes:

- (1) Coordinator,
- (2) Physician,
- (3) Nursing personnel,
- (4) Social worker,
- (5) Rehabilitation therapist,
- (6) Psychologist,
- (7) Dietitian,
- (8) Secretary, and

(9) Other team members considered appropriate on a local level, e.g., physician's assistant and recreation therapist. NOTE: The availability of a clinical pharmacist on the consultation basis is also recommended.

b. The coordinator will be selected by the Chief, SCI Service, with the concurrence of the respective service chiefs. Other staff members will be selected/assigned by their respective service chiefs with the concurrence of the Chief, SCI Service, in consultation

with the SCI-HC Coordinator. All staff will remain on the full-time employee (FTE) ceiling of their respective services for administrative and professional supervision, but will be programmatically accountable to the Chief, SCI Service.

c. Team Responsibilities. All team members are expected to:

- (1) Participate in the selection of patients for the program.
- (2) Participate in team meetings, both administrative and clinical.
- (3) Document in the CHR according to agency policy.
- (4) Provide input in the QI process.
- (5) Conduct, arrange home visits and/or home evaluations as appropriate.
- (6) Share new developments pertaining to patient/caregiver/home situation with other team members.
- (7) Participate in inpatient discharge planning activities which may include rounds, team meetings, etc.
- (8) Evaluate safety and emergency preparedness in the home.
- (9) Participate in discharge planning from the program.
- (10) Report program needs, problems or concerns to the coordinator.
- (11) Maintain clinical privileges.
- (12) Participate in orientation of new staff to SCI, as well as ongoing staff development/continuing education activities for the SCI-HC Program.
- (13) Comply with professional standards and guidelines of their respective disciplines.

d. Individual responsibilities of team members are as follows:

- (1) SCI-HC Coordinator. The SCI coordinator:
  - (a) Provides administrative direction to the program interpreting national SCI-HC, local VA medical center policy, and JCAHO guidelines to the SCI-HC team and the facility.
  - (b) Is responsible for developing and implementing local policies and procedures.

(c) Coordinates the provision of services and administrative functions of the program.

(d) Facilitates appropriate referrals to the program.

(e) Monitors and controls program operation expenditures and advises Chief, SCI Service, on budgetary requirements.

(f) Coordinates and participates with selecting officials in the filling of SCI-HC personnel vacancies and arranges orientation of new SCI-HC staff.

- (g) Prepares and maintains program reports and statistics.
- (h) Evaluates program effectiveness.
- (i) Provides input into the Performance Appraisals of team members and forwards input through the Chief, SCI Service.
- (j) Designates an Acting Coordinator and SCI-HC QI representative.
- (k) Ensures appropriate documentation in the CHR according to agency policy.
- (l) Routinely supervises the SCI-HC clerk and/or typists.
- (m) Maintains appropriate records for reporting purposes.
- (2) SCI-HC Social Worker. The SCI-HC social worker:
  - (a) Provides a comprehensive assessment of patient, caregivers, and family members, and develops a psychosocial treatment plan appropriate to individual needs and family life style.
  - (b) Provides individual/group counseling to patient, caregiver, and other family members as indicated.
  - (c) Coordinates discharge planning from SCI-HC and referrals to community agencies.
- (3) SCI Physician. In order to encourage continuity of care, the primary SCI physician of each patient will:
  - (a) Assess and review the patient's physical condition prior to medical center discharge.
  - (b) Make initial home visit and follow-up visits as needed.
  - (c) Provide medical direction to the program. Evaluate medical needs, supervise and support the treatment goals for their patient(s).
  - (d) Write the orders for treatment, diet, drugs, supplies, equipment, diagnostic tests and consultation requests.
  - (e) Review clinical record of the physician's patient(s) at least every 60 days to ensure patient progress toward achieving goals. Special attention will be given to the monitoring of prescribed medications.
  - (f) Ensure appropriate physician coverage when absent.

M-2, Part XXIV  
Chapter 8

January 27, 1994

(g) Responsible for coordinating transfers to other clinical units or medical centers with the receiving physician.

(4) SCI-HC Registered Nurse (R.N.). The SCI-HC R.N.:

(a) Performs an admission assessment of patient, family and home, identifies nursing needs and initiates patient care plan.

(b) Provides direct nursing care in the home within the scope of the program.

(c) Provides health teaching and supervision to the caregiver and the patient.

(d) Plans and implements rehabilitative and restorative nursing measures.

(e) Provides and supervises venisection and intravenous (IV) therapy and documents same.

(f) Evaluates the effectiveness of the nursing care and patient care plan.

(g) Supervises nursing personnel and coordinates nursing care activities.

(h) Provides nursing liaison services between patient, medical center staff, and community agencies.

(5) SCI-HC Psychologist. The SCI-HC psychologist:

(a) Provides psychological evaluations of patients as appropriate.

(b) Provides assessment of caregivers and family members' ability to sustain patient care at home.

(c) Develops a psychological treatment/rehabilitation plan for patient and caregiver appropriate to individual needs and family life style based on a comprehensive psychological.

(d) Provides vocational assessment counseling and on-the-job training placement to appropriate patients.

(e) Provides individual/group counseling to patient, caregiver, and other family members as indicated, to assist them in coping with the psychological stress of illness and disability.

(6) SCI-HC Licensed Practical Nurse (LPN)/Home Care Technician (HCT)

(a) Takes and records vital signs and changes dressings so that maximum patient hygiene is achieved.

(b) Monitors prescribed medications under supervision of an R.N.

(c) Observes patient for objective evidence of physical regression or psychological condition, and documents information about pain, edema, dyspnea, depression, and other systems of anxiety or depression.

(d) If privileged, may provide other nursing care under the supervision of the R.N., e.g., catheter care, tracheostomy care, ostomy care, venisection care, bowel care, and dressing changes.

M-2, Part XXIV  
Chapter 8

January 27, 1994

(e) Reinforces, demonstrates and instructs patients and caregivers in procedures to achieve better health and greater independence including use of therapeutic or rehabilitation devices.

(7) SCI-HC Rehabilitation Medicine Service (RMS) Therapist (Occupational therapy (OT), Physical therapy (PT), or Kinesotherapy (KT)). The SCI-HC RMS therapist:

(a) Conducts an evaluation of the patient's functional ability for home placement and makes recommendations for structural alterations, environmental controls and adaptive medical equipment.

(b) Assesses the patient's goals, living skills and physical abilities, patient needs, caregiver's capabilities, and home environment. Develops and implements a treatment plan from the assessment.

(c) Demonstrates and reinforces rehabilitation measures, e.g., exercise, proper positioning, range of motion, activities of daily living, transfers, etc., in order to assure optimum level of functioning.

(8) SCI-HC Dietitian. The SCI-HC dietitian:

(a) Assesses and monitors the nutritional status of the patient.

(b) Assesses the capability of the caregiver and home resources to support the patient's nutritional care at home and provide liaison to community resources.

(c) Prepares a nutritional care plan to meet the needs of the patient and caregiver at home providing advice in menu planning, food storage, and preparation for patient's special dietary needs.

(d) Counsels patient and caregiver on normal nutrition and prescribed diet modification utilizing educational materials.

(9) SCI-HC Pharmacist (Consultant). The SCI-HC consultant pharmacist:

(a) Monitors and reviews medications on a regular basis.

(b) Provides education to patients, caregivers, and staff on medication, supplies and procedures.

(c) Provides liaison between SCI-HC team and pharmacy.

(10) SCI-HC Clerk and/or Typist. The SCI-HC clerk or typist:

(a) Performs principal clerical, secretarial and administrative services, e.g., arranges travel, admission, clinic appointments, etc., directly related to the program.

(b) Reviews and maintains the patient's CHR in the SCI-HC office. Transcribes diagnostic and therapeutic orders from the doctor's orders to the appropriate medical record forms and requests.

(e) Maintains program records and files as directed by the coordinator, prepares all program correspondence, and maintains minutes of meetings.

(d) Prepares outpatient routing and statistical activity record and accurately tabulates visit totals, then abstracts data for preparation of required reports.

(e) Serves as receptionist for the program; notifies staff of calls and determines priorities of requests as directed by Program Coordinator.

(11) SCI-HC Recreation Therapist. The SCI-HC recreation therapist:

(a) Assesses and monitors the patient's:

1. Leisure,
2. Social and recreational abilities,
3. Deficiencies,
4. Interests,
5. Barriers,
6. Life experiences,
7. Needs, and
8. Potential.

(b) Provides treatment services designed to improve social, emotional, cognitive, and physical functional behaviors as necessary prerequisites to future leisure/social involvement.

(c) Establishes leisure education designed to help the patient acquire the knowledge, skills, and attitudes needed for:

1. Independent leisure,
2. Social involvement,
3. Adjustment in the community,
4. Decision-making ability, and
5. Appropriate use of free time. NOTE: The recreation therapist(s) monitors the extent to which goals are achieved relative to the use of leisure time and the acquisition of socialization skills.

#### 8.10 QUALITY IMPROVEMENT (QI)

SCI-HC QI is an integral component of the SCI Service Quality Assurance Program. An ongoing and continuous evaluation of the program is conducted to ensure the quality and appropriateness of care provided to patients. The team identifies important aspects of care and monitors areas of service delivery which are identified as high-risk, high-volume, or problem-prone. A systematic plan is developed for collecting and analyzing data, taking corrective action, and reporting results. The quality assurance plan should comply with VA Central Office and local JCAHO, and be evaluated on an annual basis. The results are reported through the SCI-QI Program to the medical

January 27, 1994

M-2, Part XXIV  
Chapter 8

M-2, Part XXIV  
Chapter 8

January 27, 1994

center Quality Assurance Program. SCI Home Care staff shall actively participate in the SCI Service QI Program and have a representative sit on the SCI-QI Committee.

#### 8.11 REPORTS

The SCI-HC Program will submit reports to VA Central Office as requested.