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Chapter 4

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4.01 TREATMENT PLAN RESPONSIBILITY

a. A qualified physician will be responsible for supervising the provision of medical services to individual patients and for meeting the general public health needs of the domiciliary community.

b. Coordination of professional services and evaluation procedures will be accomplished through the inter-disciplinary team. Individual patient care plans will be developed by the treatment teams. Care plans will include: reason for admission, treatment goals (short- and long-range) and an appropriate plan for discharge. Each patient will participate in the development of their treatment and discharge plan.

4.02 INTERDISCIPLINARY SERVICES

a. Treatment programs in the Domiciliary Care Program are comprehensive, structured, and individualized; they are the product of an interdisciplinary treatment planning process. The Domiciliary Care Program offers the following services to meet participants needs:

(1) **Medical services** include initial evaluation, prescription of treatment, medication review, ongoing clinical management and consultation with patient's key therapists.

(2) **Nursing services** include comprehensive health assessment; ongoing monitoring of the progress of participants; preventive health care; health counseling and education of patients, families, and other staff; and coordination of patient care.

(3) **Social Work Service** provides a comprehensive psychosocial assessment which will be used for treatment and discharge planning purposes. Emphasis is placed on the development of a plan that will promote the veteran's optimal use of the

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domiciliary experience and return to community living. The social worker functions as a casemanager, linking the patient with family or support system and the community health and social services network.

(4) **Psychological services** provide a comprehensive psychological and vocational assessment on all domiciliary patients.

(5) **Nutrition services** include nutritional counseling and education.

(6) **Therapeutic recreational activities** planned to meet the physical and social needs of the participants, are an integral part of the individual's treatment program.

(7) **Rehabilitation treatment services** provided on an individual and/or group basis by professional and paraprofessional personnel, include but are not limited to occupational therapy, speech therapy, physical therapy, kinesiotherapy, vocational rehabilitation services and compensated work therapy.

b.
Domiciliary program staffing will be multi-dimensional, sometimes transcending traditional discipline oriented boundaries.

4.03 SERVICE DELIVERY PROCESS

(1) **Outreach.** Efforts will be made to reach the homeless and resource deficient veterans where they congregate. This includes emergency community shelters, street

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corners, and soup kitchens. In addition, self-referral and hospital referral will be encouraged through effective information dissemination.

(2) **Admission Assessment and Treatment Plan Development.** The health status of the veteran will be evaluated and the clinical needs ascertained. Appropriate clinically-oriented treatment and discharge plans will be developed and implemented with the patient as an active participant. Treatment and discharge plans will be based upon information gained through comprehensive interdisciplinary patient assessment. This process will be initiated within 3 work days and be completed within 2 weeks.

(3) **On-going Assessment.** Frequent patient progress evaluation must be continuous and must be recorded to ensure continued appropriateness of planned clinical interventions and therapeutic goals and objectives.

(4) **Discharge Planning and Outplacement.** The discharge planning process begins with the initial assessment. Efforts must be made to ensure continuity in the provision of appropriate clinical services once the patient leaves the treatment program. In addition, adequate living arrangements must be made and potential employment possibilities explored. Outplacement possibilities include transfer from shorter term biopsychosocial rehabilitation to long-term health maintenance domiciliary care, return to independent living or referral to community-based care programs. Specific considerations of State Veterans Homes and Community Residential Care Programs as alternative placements are encouraged when continued structure is deemed most therapeutic for the veteran after receiving maximum therapeutic benefit from domiciliary care.

(5) **Aftercare and Monitoring.** Once the veteran has returned to the community, steps must be taken to ensure that plans for ongoing treatment through VA and non-VA programs will not be disrupted. It is expected that outreach and treatment team personnel will, as needed, develop strategies to monitor patients adjustment to community living after discharge from the homeless program. Aftercare/monitoring activities will be recorded in the patient's treatment file.

4.04 CLINICAL CARE PROGRAMS

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a. Domiciliary care utilizes a broad range of clinical care services and programs to address the needs of veterans. This care is provided by:

(1) Domiciliary based programs specifically tailored to the needs of the domiciliary patient, and

(2) The full scope of hospital based programs and services provided to the domiciliary patient on an outpatient basis.

b. Domiciliary Care Programs typically include sobriety maintenance, vocational assessment and counseling, work restoration, head trauma rehabilitation, and AIDS/HIV disease support services and psychiatric rehabilitation services.

c. Domiciliaries may develop innovative domiciliary-based programs designed to meet specialized needs of some patient population subgroups, i.e., lithotripsy patients, oncology patients, and patients requiring institutional support during periods of pre-hospitalization, evaluation and assessment as well as post-hospital treatment and rehabilitation.

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d. DCHV (Domiciliary Care for Homeless Veteran) Program

(1) General

(a) In response to the increasing number of homeless veterans, the Domiciliary Care Program has developed the DCHV Program to address the complex needs of the homeless veteran. The DCHV provides:

1. Community outreach and referral,
2. Admission screening and assessment,
3. Medical and psychiatric treatment (including substance abuse treatment) and social-vocational rehabilitation, and
4. Post-discharge community support.

(b) The goal of the program is clinical, social and vocational rehabilitation directed toward the earliest possible return of functional independence and health for each veteran treated. This process, for as many veterans as possible, will facilitate independent or semi-independent reintegration into community-based living.

(2) Program Highlights

(a) Innovation, creativity and originality are encouraged in program development and implementation. Programmatic flexibility is encouraged to successfully address the unique needs of individual patients.

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(b) Clinically appropriate services are provided primarily through the use of existing domiciliary and hospital based delivery systems. Case management by appropriate interdisciplinary treatment team members is initiated to ensure a comprehensive continuity of clinical care.

(c) Using the interdisciplinary treatment team and case manager model, each patient's treatment will be individualized.

(d) Care may include, but is not limited to, clinical interventions, patient education, basic living skills, vocational assessment/counseling, social skills, work restoration and community re-entry skills.

(3) Therapeutic Community

Necessary treatment can often best be provided in the therapeutic community milieu which has evolved in the domiciliary setting. Emphasis is placed on personal responsibility, improved self-esteem through accomplishment and a problem-solving attitude. An effective therapeutic community environment provides the springboard from which more specific treatments can be administered. It also provides patients opportunities to increase their overall sense of self-worth and self-confidence.

4.05 VOCATIONAL INITIATIVES

a. Vocational strengths and deficits will be identified by the interdisciplinary treatment team with referral to the most appropriate rehabilitative treatment providers.

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b. Such rehabilitation may include, but is not limited to:

- (1) Vocational assessment testing and counseling,
- (2) Incentive therapy program,
- (3) Compensation work therapy program,
- (4) Live in/work out program, and
- (5) Referral to community-based job resources.

c. Vocational assessment and rehabilitation will be directed toward restoration of vocational readiness to support return to independent or semi-independent community reintegration.

d. Return to full community living will be expected of patients participating in live-in/work-out activities as soon as they have acquired adequate resources for such transition. Treatment team will monitor and document patient's progress.

e. Patients participating in live-in/work-out programs will be required to maintain their own living area, account daily for their presence, and keep required medical appointments. They will be excused, as appropriate, from other scheduled domiciliary activities.

4.06 ADMISSION EVALUATION

a. An admission history and complete physical examination will be completed on each patient. Requests for special examinations, tests, and laboratory

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procedures will be initiated within 48 hours of admission. This examination will include:

- (1) General physical examination and special examinations as may be indicated.
- (2) An electrocardiogram will be done when clinically indicated.
- (3) Blood serological tests for syphilis, complete blood count and appropriate blood chemistries and urinalysis.
- (4) Oral examination by a dentist.
- (5) Other examinations as may be indicated such as, but not limited to; hearing, glaucoma, podiatry, and physical tolerance testing.

b. When patients from a VA medical center are discharged to a VA domiciliary or returning from ASIH status, the domiciliary will be provided discharge summaries and other information needed to assure continuity of care.

c. For those patients whose disabilities are primarily psychosocial, the referring health care facility should forward a current summary including all relevant medical and psychosocial information to assist in the determination of suitability for admission. This information will be reviewed by the DSC.

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4.07 MEDICAL CARE

There will be vigorous efforts to prevent the onset of preventable diseases and disabilities associated with infections and chronic diseases as well as the aging process through initiation of activities such as AIDS/HIV disease education and counseling, immunization, weight control, education against addictive habits, early cancer detection, glaucoma testing, hearing tests, exercise, leisure education, early detection and prompt treatment of clinical disorders.

a. Annual Medical Examinations

(1) Each patient will have an annual comprehensive medical and dental examination. The report of examination will include a statement of medical need for continuance of domiciliary care. A complete physical examination with necessary clinical laboratory tests will be a part of the comprehensive medical examination. If the patient has had such a medical examination in the interim since admission (such as during a period of hospitalization) the annual examination will be performed within 1 year of that last examination.

(2) Notification of determination of medical ineligibility for continued domiciliary care as a result of such a medical examination must be made to the Chief, Domiciliary Care Program, as early as possible and no later than 5 working days.

(3) Chest X-rays will be obtained in accordance with accepted medical practice.

(4) TB skin tests will be performed annually.

b. Chest X-ray will be obtained when clinically indicated. If indicated, a sputum examination for active tuberculosis also will be completed. An intercutaneous administration of 5 units of PPD (purified protein derivative)

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tuberculin (Mantoux test) should be administered. One week later, a second PPD should be done if the first one was negative to rule out a booster effect in subsequent positive tuberculin tests. Reference should be made to MMWR 5-18-90, Vol. 39, No. RR-8. A positive test can now be defined from 5mm of induration to 15mm induration depending on many variables.

4.08

INFECTION CONTROL

Each domiciliary care program will establish and maintain an infection control program in accordance with procedures outlined by the Committee on Hospital Infections. The Domiciliary Care Program will implement a comprehensive infection control prevention program to adequately address patient care needs.

a. **Immunization Program.** Each domiciliary will establish and maintain an active immunization program and followup system in accordance with accepted medical practice. All immunizations must be appropriately recorded in the patient's clinical record.

b. **Tuberculosis Control**

(1) The Chief of Staff is directly responsible for maintaining an effective tuberculosis control program for patients.

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(2) All new admissions will be administered a two step PPD with at least two controlled skin tests placed within 1 week of admission. PPD testing will be administered annually in a one step procedure after initial testing.

(3) All new PPD's should be evaluated for active tuberculosis. All skin tests should be appropriately recorded in millimeters induration in the patient's clinical record.

(4) Domiciliary staff working with a patient population known to be at risk for tuberculosis should consider participation in a program of regular testing.

(5) Patients with a history of tuberculosis which was not adequately treated with chemotherapy must have a chest X-ray annually. Those who have not received adequate chemotherapy should be considered for therapy according to current American Thoracic Society recommendations. Persons with a history of tuberculosis who have received appropriate chemotherapy will be treated the same as the rest of the population regarding chest X-rays.

(6) When tuberculosis is suspected, the patient will be immediately transferred to the medical center for further examination and treatment. Concurrently, patients and staff who are known to have been exposed will be examined for infection in accordance with M-2, Part IV, "Medical Service." Any symptoms suggestive of tuberculosis will receive prompt attention.

4.09

MEDICAL CONSIDERATIONS FOR DISCHARGES

a. Administrative provisions for discharge of patients is contained in M-1, part I, chapter 13, and M-1, part I, chapter 4, paragraph 4.22.

b. Prior to discharge of patient, the need for physical examination will be determined by the treating physician. If the physician recommends continued

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domiciliary care, the patient will be so advised and the physician's decision will be recorded in the health record. If the patient leaves against the physician's advice, the provisions for irregular discharge in M-1, part I, chapter 13, will apply.

c. Irregular discharges may be initiated by the Chief, Domiciliary Care Program, in consultation with the treatment team, for patients who refuse to cooperate with medical rehabilitative programs and procedures, or for patients who persist in obtaining medical services and medication from non-VA sources. All such recommended discharges must be cleared by a physician as not endangering the patient's health.

4.10

ADDITIONAL PROFESSIONAL SERVICES

a. Services including but not limited to the following list will ensure that care is provided domiciliary patients in accordance with programs designed as appropriate and necessary for domiciliary care which has a primary emphasis on treatment, rehabilitation and return to community living. Programs will also be provided for patients who require supportive maintenance care in an institutional setting, but who do not require hospitalization or skilled nursing care.

(1) Audiology and Speech Pathology Service

(2) Blind Rehabilitation Service

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(3) Building Management Service

(4) Chaplain Service

(5) Dental Service

(6) Dietetic Service

(7) Laboratory Service

(8) Library Service

(10) Nursing Service

(11) Optometry Service

(12) Pharmacy Service

(13) Podiatry Service

(14) Prosthetics Service

(15) Psychiatry Service

(16) Psychology Service

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(17) Recreation Service

(18) Rehabilitation Medicine Service

(19) Social Work Service

(20) Voluntary Service

b. Sufficient qualified staff (as determined by centrally approved program standards and criteria) will be assigned to ensure appropriate access to treatment programs in the domiciliary necessary to provide quality care for patients.

4.11 RESEARCH INITIATIVES

a. Domiciliary care personnel are encouraged to submit innovative research proposals through their local R&D (Research and Development) offices. Additional information may be obtained by contacting Medical Research Service, VA Central Office (142A).

b. Research focused on aging has been designated by the R&D as a special emphasis area. In addition, aging research foci have been developed by each GRECC (Geriatric Research, Education and Clinical Center).

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