

SPINAL CORD INJURY AND DISORDERS SYSTEM OF CARE PROCEDURES

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) Handbook describes procedures regarding the Spinal Cord Injury and Disorders (SCI&D) System of Care. **NOTE:** *This Handbook is for veterans with SCI&D defined in paragraph 6.*

2. SUMMARY OF MAJOR CHANGES: This VHA Handbook provides a description of a system of care for provision of a comprehensive continuum of health care and rehabilitation for veterans with SCI&D as defined in paragraph 6.

a. Changes in VHA procedures reflect innovations and efforts to systematize the SCI&D “Hub and Spokes” continuum of care within VHA.

b. Principles are established in planning and administering this SCI&D System of Care regarding the components, purpose, scope, and procedures.

3. RELATED ISSUES: VHA Directive 1176.

4. RESPONSIBLE OFFICE: The Chief Consultant, SCI&D Strategic Healthcare Group (SHG), is responsible for the contents of this VHA Handbook. Questions may be referred to the Chief Consultant, SCI&D SHG at 206-768-5401. Facsimile transmissions may be sent to 206-768-5258.

5. RECISSIONS: VHA Handbook 1176.1, Spinal Cord Injury and Disorders System of Care Procedures, dated May 21, 2002, is rescinded.

6. RECERTIFICATION: This VHA Handbook is scheduled for recertification on or before the last working day of May 2010.

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DISTRIBUTION: CO: E-mailed 5/3/05
FLD: VISN, MA, DO, OC, OCRO, and 200 – E-mailed 5/3/05

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SPINAL CORD INJURY AND DISORDERS SYSTEM OF CARE PROCEDURES

1. PURPOSE AND AUTHORITY

This Veterans Health Administration (VHA) Handbook describes procedures regarding the Spinal Cord Injury and Disorders (SCI&D) System of Care. **NOTE:** *This Handbook is for veterans with SCI&D defined in paragraph 6.* The authority is Title 38, United States Code (U.S.C.), Section § 7301, Subparagraph B.

2. BACKGROUND

Recent trends in health care have emphasized the importance of a comprehensive continuum of health care and rehabilitation for individuals with spinal cord injury (SCI). Changes in VHA procedures described in this Handbook reflect innovations and efforts to systematize the SCI&D “Hub and Spokes” continuum of care within VHA. This system of care is extensive within VHA and staffs, with varying levels of SCI&D expertise, are available at all Department of Veterans Affairs (VA) medical centers.

3. SCOPE

a. **Mission.** VHA’s SCI&D System of Care’s mission is to support, promote, and maintain the health, independence, quality of life, and productivity of individuals with SCI&D throughout their lives. This is accomplished through:

- (1) The efficient delivery of rehabilitation;
- (2) Sustaining and medical and/or surgical care;
- (3) Patient and/or family education;
- (4) Psychological, social, and vocational care;
- (5) Research;
- (6) Education; and

(7) Professional training in the continuum of care for persons with SCI&D. **NOTE:** *Quality of care is monitored through multiple mechanisms (see subpar. 9g).*

b. **Lifelong Continuum of Care.** VHA’s SCI&D System of Care provides an integrated and coordinated lifelong continuum of services for eligible veterans with SCI. This system of care either provides, or formally links with, key components of care that address the lifelong needs of individuals with SCI, including, but not limited to: emergency care, medical and/or

surgical stabilization, rehabilitation, primary care, preventive care, specialty sustaining care, surgical care, outpatient care, home care, and long-term care (see par. 6h).

4. NATIONAL SYSTEM OF SCI&D CARE

This SCI&D system of care consists of an integrated network of care based on a hub and spokes model. Comprehensive interdisciplinary specialty and primary care is located at designated SCI Centers (hubs). Locally accessible primary care is provided at other VA facilities (spokes) within specified referral areas (see App. A). These long-standing designated catchment areas are generally used for the transfer of veterans from a local VA or community hospital to the SCI Center for care. However, in the interest of preserving continuity of care, veterans with an existing relationship and treatment history at an SCI Center that is outside the designated catchment area will have their preferences respected by the referring and accepting facilities in accordance with VA travel regulations. All VA medical centers have responsibility for the provision of basic medical care, primary care, and emergent medical care for veterans with SCI&D. **NOTE:** *Appendix B provides a visual depiction of the hub and spokes model.*

a. **Under Secretary for Health.** Any proposed change to the SCI&D system of care requires the approval of the Under Secretary for Health, including, but not limited to changes in: mission, staffing, bed level, reduction of clinical services, reorganization, and clinical staff. The Chief Consultant, SCI&D, provides national program leadership for SCI&D health care and rehabilitation services.

b. **Chief Consultant, SCI&D Strategic Healthcare Group (SHG).** The Chief Consultant, SCI&D SHG, reviews proposed changes with the Chief Patient Care Services Officer (11), Deputy Under Secretary for Health for Operations and Management (10N), Deputy Under Secretary for Health (10A), and relevant others. The Chief Consultant, SCI&D then forwards a recommendation to the Under Secretary for Health. **NOTE:** *The Paralyzed Veterans of America (PVA) and United Spinal Association (USA) are given the opportunity to comment on significant changes.*

c. **Veterans Integrated Services Network (VISN) Director.** The VISN Director, or designee, provides a critical juncture in implementation and support of a national SCI “Hub and Spokes” system of care balancing needs for local responsiveness, and timely and full access, with national consistency and coordination. VISN Director is responsible for:

(1) Facilitating smooth and efficient transfers for care between VA facilities per referral guidelines provided in subparagraph 8f,

(2) Ensuring appropriate basic medical care, primary care, and emergent medical care for the SCI&D population,

(3) Supporting all components and services in the SCI&D system and continuum of care described in this Handbook,

(4) Providing and facilitating necessary communication, resources, and quality improvement efforts to maintain expertise and quality services in the SCI Primary Care Teams, SCI Outpatient Clinics, and SCI Centers,

(5) Facilitating travel and access to SCI Center services within the designated SCI catchment area, in accordance with M1-Part 1, Chapter 25,

(6) Ensuring proposed changes to the SCI system of care are appropriately reviewed and approved by the Deputy Under Secretary for Health for Operations and Management (10N), Chief Patient Care Services Officer (11), SCI&D SHG Chief Consultant (11S), and Deputy Under Secretary for Health (10A) before forwarding to the Under Secretary for Health for approval, and

(7) Facilitating education of VHA health care providers about the SCI system of care and SCI health care issues.

d. **Communication.** The structural elements of the system of care are linked by ongoing communication among providers to form an integrated network of care, meeting the needs of individuals with SCI&D. Communication between providers at SCI Centers and non-SCI Center facilities must take place upon admission, clinical need, transfer, or discharge of any patient. The SCI coordinator must notify the Chief, SCI Service, or designee, of admissions and discharges to non-SCI Center facilities using the SCD Registry's automated alert system or other appropriate mechanism. The Chief, SCI Service, or designee, must notify the SCI Coordinator of discharges from the SCI Center, using the SCD Registry's automated alert system or other appropriate mechanism.

e. **Acute Rehabilitation and Complex Specialty Care.** All acute rehabilitation and complex specialty care must take place at SCI Centers. Primary care services, or short-duration hospitalization, at non-SCI Centers may decrease the necessity of patient transfers. Referral guidelines recommend the conditions for treatment by each element of the hub and spokes system (subpar. 9f).

f. **Use of Clinical Practice Guidelines.** Clinical practice guidelines, as developed by the Consortium for Spinal Cord Medicine (CSCM) and other appropriate bodies, need to be used in the care of patients to the extent supported by current medical evidence and state of the art practice. The Chief, SCI Service, is responsible for incorporating clinical practice guidelines within the appropriate medical care settings.

g. **Spinal Cord Dysfunction (SCD) Registry.** The veteran population served is tracked for clinical, administrative, and outcome purposes by the SCD Registry minimal data set. The national data set, located at the Austin Automation Center (AAC), Austin, TX, includes, at a minimum, all items contained in the local SCD Registry. Through the registration of veterans within the SCI hub and spokes system, this tool provides a database linked to other Veterans Health Information System and Technology Architecture (VistA) files, allowing providers to track veterans admitted and discharged within the medical center, and to review utilization of laboratory, pharmacy, inpatient, and outpatient resources. The local SCD Registry is also used to

capture clinical aspects of care and outcome measures. Data is entered by the SCI Coordinator at non-SCI Center facilities and by personnel designated by the Chief, SCI at the SCI Centers.

(1) The data that is entered includes:

(a) Registration status.

(b) SCI network.

(c) Highest level of injury.

(d) VA medical center where most primary care is received. **NOTE:** *The “Hub” site needs to be listed as “annual rehab VA or “Additional Care Received at VA” to enable automatic alerts.*

(e) VA medical center where comprehensive preventive health evaluation is received.

(f) Etiology.

(g) Date of onset.

(h) American Spinal Cord Injury Association (ASIA) impairment and classification scale.

(i) Comprehensive preventive health evaluation offered.

(j) Comprehensive preventive health evaluation received.

(k) The primary care provider.

(l) Appropriate outcome information.

(2) The Registry is structured so that data is entered on a local level and transferred to a national database. The SCD Registry data set has multiple purposes; i.e., clinical, administrative, and research.

(3) SCI coordinators, and others using the Registry at each medical center, need to be provided the opportunity to receive training and ongoing education on the SCD Registry.

5. SCI SYSTEM OF CARE CONTINUUM

a. Emergency Care of Veterans with SCI&D

(1) Veterans with SCI requiring emergent, or immediate medical attention, in a non-SCI setting must be evaluated by staff trained in the Medical Care of Persons with SCI Module in the Veterans Health Initiative (VHI), available at <http://vaww.sites.lrn.va.gov/vhi/sci/index.cfm>, or with appropriate equivalent experience. Once this evaluation is completed, the patient’s medical condition is to be discussed with a consulting SCI physician if there are unresolved acute

processes and/or when consultation is deemed urgent. The SCI Coordinator needs to routinely run the SCD Registry report to identify patients seen in the urgent care setting for SCI clinician review. Patients with SCI requiring surgical intervention need to receive care in a VA medical center with a designated SCI Center. If urgency requires that treatment be provided at a non-SCI Center or community hospital, the Chief of the nearest SCI Center must be advised of this fact as soon as possible. Typically, such patients are retained only until they can safely be transferred to a VA medical center with an SCI Center. Veterans treated in emergency rooms or acute care centers in an SCI Center facility are to be discussed with a consulting SCI physician if there are unresolved acute processes and/or when consultation is deemed urgent. Staff in the SCI Centers and non-SCI Center facilities, are expected to use the tools available within the Computerized Patient Record System (CPRS) (or the SCD Registry) to review patient care for unscheduled visits and follow-up care needs.

(2) **Referrals Received from the Community to a VA without an SCI Center.** Referrals received from the community to a VA facility without an SCI Center are handled as a transfer of care from the local VA facility for purposes of veteran convenience and travel arrangements. However, the veteran is admitted directly to the SCI Center. Referrals received from the community direct to an SCI Center are to be handled as a direct admission, and, if the veteran desires, follow-up care is subsequently coordinated with the local VA medical center. **NOTE:** *Transportation for scheduled appointments and transfers to SCI Centers must be in accordance with M-1, Part-1, Chapter 25.04, 25.05 c., and 25.09.*

b. **Medical and Surgical Stabilization of New Injuries.** Medical, surgical, and interdisciplinary services are concerned with restoring anatomic and physiological equilibrium while managing the medical and physiological sequelae of SCI and other diseases or injuries. Stabilization of the injury is an attempt to prevent additional impairments while focusing on prevention of complications. The site of this care is the SCI Center. **NOTE:** *VHA provides back-up support to Department of Defense (DOD) in case of emergency.*

c. **Rehabilitation.** Rehabilitation is the process of providing comprehensive services deemed appropriate to the needs of persons with disabilities in a coordinated manner, in an integrated program designed to achieve objectives of improved health, welfare, and realization of the person's maximum physical, social, psychological, and vocational potential for useful and productive activity.

(1) Rehabilitation services are necessary for a person with a disability to:

(a) Achieve the person's maximum potential for personal, psychological, social, and economic adjustment; and

(b) Move beyond the services available in the person's usual daily experience.

(2) Rehabilitation continues as long as the person makes significant and observable improvement. Rehabilitation programs consist of coordinated and integrated services with the following broad elements: evaluation, treatment, education, and training. An interdisciplinary team provides these services to the individuals and their families.

- (3) Rehabilitation programs are designed to:
- (a) Promote outcomes that minimize and/or prevent impairments,
 - (b) Reduce activity restrictions, and
 - (c) Lessen limitations on meaningful social role participation.

NOTE: Rehabilitation services are provided at the SCI Centers.

d. **Primary Care.** Primary care is basic or general health care provided at all VA medical center facilities. Usually this contact is for common illnesses and health maintenance. What may be a relatively minor symptom or problem in the person without SCI may herald a grave and even life-threatening problem for the individual with SCI. The primary health care provider assumes ongoing responsibility for health maintenance and treatment for illness, including consultation with specialists.

e. **SCI Comprehensive Preventive Health Evaluation.** SCI Comprehensive Preventive Health Evaluations focus on the prevention or early identification of complications related to SCI. Comprehensive preventive health evaluation must be performed at SCI Centers, or at those SCI support clinics approved by the Chief Consultant, SCI&D to provide this service. The scope of the evaluation is comprehensive and includes elements of preventive health care defined for the general veteran population, provided there are no contraindications for so doing. *NOTE: Such elements are described in the modified VHA prevention index and chronic disease care index and are not listed here due to their periodic revision based on current concepts of health care.* The SCI Comprehensive Preventive Health Evaluation includes elements specific to the prevention of common sequelae and complications of SCI (subpar. 8a).

f. **Sustaining Medical and Surgical Care.** Sustaining care is the treatment for the spectrum of conditions that can arise after acute stabilization and initial rehabilitation.

g. **Respite Care.** Respite care is recognized as an important consideration for families and caregivers of physically dependent veterans. Each veteran using attendant care is offered respite care on the SCI unit in a VA medical center having an SCI Center, unless a veteran requests its provision in another setting. The duration of any respite care admission, absent complicating medical factors, will not exceed 14 days. However, the total of all respite care for a veteran in a year, absent complicating medical factors, is not to exceed 30 days.

h. **Long-term Care**

(1) VHA's SCI&D system of care is required to provide and maintain access to a full continuum of care for SCI&D patients, including long-term care; the mission of certain SCI Centers emphasizes the provision of long-term care; however, other facilities may also provide long-term care for persons with SCI. The goal of long-term care is to assist the veteran with SCI to attain or maintain a community level of adjustment and maximal independence despite the loss of functional ability due to the aging process, loss of a primary caregiver, or medical

complications. No veteran with SCI is to be discharged to a nursing home solely because of the patient's SCI.

(2) The continuum of extended care services for veterans with SCI is a mix of services designed to meet eligibility requirements, individual need, personal preference (choice), and to promote independent community living whenever possible. Options include: care at a designated VA SCI long-term care facility, VA nursing home care units, home care services, homemaker and/or home health aid services, adult day health care, contract home health care, home-based primary care, SCI home care (SCI-HC), community residential care, sub-acute intermediate care, Geriatric Evaluation and Management (GEM), Geriatric Research and Education Clinical Center (GRECC), assisted living, State or VA homes, domiciliary care, and respite care, as resources allow. *NOTE: The preceding list is not all-inclusive.*

(3) Patients are not to be discharged to a nursing home unless the patient's general health, status, and social circumstances necessitate such placement.

(4) The aging person with SCI&D has special needs (e.g., supplies, quality of life concerns, and desires for less restrictive and supportive living environments); such needs are to be incorporated into the patient's treatment plan.

(5) When it is appropriate for the veteran to be discharged to a nursing home, based on achievement of maximum hospital benefit, consultation with the veteran, the veteran's guardian, the appointed veteran advocate and/or family member (at the request of the veteran or guardian), and the SCI physician takes place. All other placement alternatives need to be considered before making such a decision.

(6) The VA or community nursing home needs to be as close as possible to the veteran's selected domicile or home and close to the veteran's social support; unless, a brief stay at another location is indicated for specialized health care needs or timeliness of placement.

(7) The nursing home must be a functionally accessible facility for the veteran and be in accordance with current Americans with Disabilities Act Accessibility Guidelines (ADAAG). In discharge planning, the SCI team needs to make every reasonable effort, by assurances and report, that essential equipment (e.g., lifts, bowel-care chairs, gurneys, etc.) is appropriately maintained and configured for the veteran.

(8) The nursing home must provide and negotiate for an appropriate and full-range of support and rehabilitative services as needed by the veteran. Clinical negotiations must be used to meet the individual needs of veterans with SCI.

(9) The nursing home must conform to all required State and Federal regulations.

(10) The nursing home referral is to include a summary of the interdisciplinary team's recommendations on the specific services and resources that the veteran requires to maintain functional status, achieve maximal independence, reduce social role limitation, and enhance quality of life.

(11) During the pre-placement planning process, the review of the needs and expected outcomes of the person with SCI is to be compared to the expertise that can be provided by the nursing home. Before the prospective nursing home placement, a site visit by members of the SCI team with appropriate clinical qualifications may be made to verify that the nursing home provides the level of care needed by the individual.

(12) SCI personnel are to maintain a pro-active educational approach to the care of veterans with SCI in nursing homes. Appropriate educational activities may include offering educational brochures, training sessions, and consultative visits.

(13) The placement plan must include the designated SCI health care provider who is the point-of-health-care-contact for nursing home personnel. Within the parameters of the nursing home's policies regarding credentialing and privileging, recommendations of SCI specific care and expected outcomes are to be monitored. Reports of contact or progress notes are to be included in the veteran's VA medical record. The SCI provider serves as a specialty resource on a regular recurring basis with the frequency of contact based on the veteran's clinical condition, preferably at least monthly.

(14) Veterans who develop urgent medical conditions need to be transferred to an appropriate medical facility per application of the referral guidelines (sub. 8).

(15) The designated SCI Center needs to continue to offer comprehensive preventive health evaluations, acute care, and follow-up care as needed.

i. **Mental Health Services.** Mental health services are coordinated throughout the SCI hub and spokes system of care. Attention to safety, confidentiality, privacy, and advocacy in removing communication, attitudinal, and access barriers is essential. Annual evaluations include psychological, social, and vocational assessment including vocational rehabilitation potential and/or readiness, social role participation, sexuality, quality of life, behavioral and mental health status, chemical dependency and/or use, living environment, and attendant training needs.

j. **SCI-Home Care (SCI-HC).** SCI-HC supports the transition and medical needs of patients to the home setting. The SCI-HC Program renders important medical, rehabilitation, and preventive services determined necessary to sustain the SCI veteran in the community. SCI-HC consists of interdisciplinary services as an integral part of the SCI outpatient services under the clinical and administrative responsibility of the Chief, SCI Service (see subpar. 9f).

k. **Home-Based Primary Care (HBPC) Services at Non-SCI Centers.** The HBPC program is an appropriate referral source at non-SCI centers for eligible veterans. The training of the caregiver in maintaining the veteran in the community is an important service HBPC can furnish. Encouragement to work with this population may be fostered by periodic contacts by the SCI Coordinator with the HBPC Coordinator. Follow-up, coordination, and referral by the SCI Coordinator with the HBPC Coordinator for special procedures beyond the capacity of the HBPC team are important factors for successful home placement. *NOTE: Consideration is given to the developed treatment plan and objectives in consultation with the SCI Coordinator.*

1. SCI Center Peer Counseling Services, Programs, and Referrals

(1) The SCI Center provides or links with other peer counseling services and programs through referrals to Veterans Service Organizations (VSOs), community-based peer counseling programs, etc. VA or community-based peer counseling programs assist the person with SCI&D and that person's family in adjusting to: new onset disability; understand coping with the rehabilitation process; develop new social skills and relationships; and transition to community living. Peer counselors serve as role models by sharing experiences and practical suggestions regarding living with a disability, listening to the concerns of the individual, and responding in such a way as to facilitate the rehabilitation process and enhance quality of life.

(2) The coordinator for peer counseling services, programs, or referrals must be an SCI social worker. When the SCI Center provides peer counseling services rather than establishing links or referrals with other peer counseling services and programs, the coordinator recruits, screens, and trains persons to:

(a) Serve as peer counselors;

(b) Identify appropriate veterans for participation;

(c) Monitor the involvement of peer counselors;

(d) Serve as the liaison between peer counselors, community peer counselors, and Voluntary Service; and

(e) Communicate issues and/or problems to the Chief, SCI Service.

(3) It has been demonstrated that peer counseling is an effective approach in helping SCI veterans adapt to their injuries. Many times talking with "someone who has been there" offers the veteran some insight and practical suggestions in dealing with a variety of problems. It is important to use good role models (e.g., persons who are employed, involved in meaningful and productive daily routines, involved in successful interpersonal relationships, and who have a generally constructive lifestyle). **NOTE:** *Referrals to community support groups (such as VSOs, Able-Disabled) are also a viable option.*

m. **Independent Living Programs (ILPs).** ILPs are an important link in the transition of the SCI veteran from the medical center to community life. ILPs are designed to promote life in the least restrictive community environment possible, based on a choice of acceptable alternatives that minimize the person's reliance on others. The Chief, SCI Service appoints the ILP Coordinator. The Coordinator involves members of the interdisciplinary team as needed. It is important that all interdisciplinary SCI team members, as well as the ILP Coordinator, serve as advocates for the SCI population by educating and advising agencies in the community on the unmet needs of veterans with SCI&D. The ILP coordinator ensures that SCI veterans receive education in attendant management skills.

n. **Home Improvement and Structural Alterations (HISA) Grants and Home Evaluations**

(1) The need for structural modification of the veteran's home and appropriateness of medical equipment for use in the home is to be evaluated by a rehabilitation therapist and prosthetic representative. Whenever possible, an on-site evaluation is recommended. Referrals to the facility's HISA Committee, Prosthetic Service, or Rehabilitation Medicine Service for assistance are to be made when the veteran has a medical need for home modifications or equipment (see VHA Handbook 1173.14).

(2) An evaluation of home accessibility is to be conducted before the discharge of an individual with a new SCI, and for other patients, as indicated. Individuals with knowledge and training in home evaluations complete the evaluation. *NOTE: Arrangements with staff at non-SCI center medical facilities may be indicated to accomplish home evaluations and transition planning.*

o. **Fee Basis Services**

(1) Bowel and bladder care for certain veterans with SCI are considered supportive medical services due to the possibility of medical complications. The clinic of jurisdiction, or medical center, authorizes such care under the fee-basis program to eligible veterans dependent upon others for their bowel and bladder care while residing in their community.

(2) Provisions of M-1, Part I, Chapter 18, are applicable to SCI veterans requiring home-care services. Adverse determinations of entitlement are not to be made without considering recommendations from the nearest SCI Center. When bowel and bladder care is not desired or cannot be procured through a skilled licensed provider, any individual employed by the veteran as a home health attendant, when trained and certified as competent by VHA personnel, may receive reimbursement for provision of this care. A relative (by blood or marriage) of a veteran in the fee basis program is not to be excluded from treating the veteran for a fee, as long as professional and/or training requirements are met. Reimbursement does not exceed the hourly rate paid to nursing assistants employed at a VA facility. Reimbursement is to be consistent with the hourly rate set by the local or state guideline in which the SCI veteran resides. In no instance shall fee-basis bowel and bladder care be authorized for a veteran who can perform this function unassisted. Bowel and bladder care at VA expense may be authorized for all veterans based on clinical need, including those receiving Aid and Attendance benefits.

p. **Sexuality and/or Fertility Counseling.** Veterans with SCI must be offered the opportunity to undergo sexuality and fertility counseling by means of formal urological and psychological consultation. The spouse, or significant other, may be invited to be involved in the process at the discretion of the veteran.

6. POPULATION SERVED AND ADMITTING PROCESS

a. **SCI&D.** VHA's SCI&D system of care provides a full-range of care for all eligible veterans who have sustained injury of the spinal cord or a generally stable neurologic impairment of the spinal cord.

b. **Stable and Non-progressive Spinal Cord Neurological Deficits.** The diagnostic etiologies of patients with stable and generally non-progressive neurologic deficit of the spinal cord, or cauda equina, who need to receive care through the SCI&D program include:

(1) Traumatic lesions of the spinal cord.

(2) Intraspinial, nonmalignant neoplasms. *NOTE: Intraspinial, intra- or extra-medullary malignancy of a primary or secondary nature may be accepted on a case-by-case basis for initial rehabilitation with follow-up consultation to the patient's non-SCI primary provider.*

(3) Vascular insults of a thromboembolic, hemorrhagic, or ischemic nature.

(4) Inflammatory disease of the spine, spinal cord, or cauda equina resulting in nonprogressive neurological 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. *NOTE: These carry a high risk of SCI and may be served when expertise of the SCI Service could prevent neurological deficit.*

c. **Exceptions and Qualifiers**

(1) Although similar in appearance to SCI, veterans diagnosed with the pathologic entities listed as follows, are not to be admitted to SCI Centers.

(a) Quadriplegia or paraplegia due to intracranial disease with or without a brain syndrome.

(b) Conversion disorder and/or hysteria manifested as paraplegia or quadriplegia.

(c) Demyelinating disease in active relapse and/or with extensive intracranial deficit that would be more appropriately admitted to the Neurology Service. *NOTE: Treatment services and programs for the Multiple Sclerosis (MS) population are the primary responsibility of the National Director of Neurology. However, the delivery of MS services is appropriately shared by Neurology Service, Rehabilitation Medicine Service, and SCI Service, according to the patient's identified needs and the professional expertise available in each of these three programs.*

(2) The admission of non-SCI veterans to the SCI Centers is inappropriate except in rare circumstances; i.e., on a very limited and temporary basis, and this exception must have the approval of the Chief, SCI Service.

(3) When the SCI staff has particular, specialized knowledge (e.g., training in bowel care regimen, wound care, etc.) that is needed to provide quality care to patients with any of the

conditions listed as an exception under subparagraph 6c, the SCI staff may provide consultation to the treating physician. **NOTE:** *The decision to provide consultation is at the discretion of the Chief, SCI Service.*

d. **Admission of Veterans with SCI&D**

(1) The Chief, SCI Service, or designee, is responsible for the admission of eligible SCI veterans. Admissions must be predicated on mission, scope of services, evaluation, and/or determination of diagnostic etiology (see subpars. 6a, 6b, and 6c) and the medical and functional requirements of the patient. **NOTE:** *Non-SCI utilization criteria are not to be used.*

(2) It is the responsibility of the VA medical center first contacted for admission to proceed with arrangements for transferring the veteran to the nearest appropriate SCI Center. When the first VA medical center contacted does not have an SCI Center, arrangements must be made by the contacted VA to transfer the patient directly to an accepting SCI Center. Admission to the local VA may take place, but it is not a prerequisite for coordinating arrangements for the veteran's admission to the SCI Center.

(3) The SCI Coordinator, or referring physician, must provide a patient history and physical examination note, pertinent progress notes, and physician-dictated interim or discharge summary, for review by the SCI Center considering the patient for transfer.

(4) Agreement on the transfer and/or admission date must be coordinated by the SCI admitting physician and referring SCI Coordinator, or by the SCI admitting physician and the community provider. **NOTE:** *The logistics and timing of the transfer are assessed based upon physician-to-physician contact.*

(5) Activation of available SCI beds not currently staffed will be facilitated to accommodate admissions if the census and referrals to the SCI Center exceed the required staffed bed numbers. If an eligible SCI veteran from the catchment area is in need of acute and/or sustaining SCI care and cannot be accepted for admission at the SCI center to which the veteran is normally referred, the Chief of that SCI Center is responsible for:

- (a) Making arrangements for care at another SCI Center.
- (b) Communicating these arrangements to the patient or the patient's representative.
- (c) Consultation with the patient's attending physician during the interim.

(6) Although a veteran may apply to any SCI Center, emphasis is placed upon addressing the SCI veteran's needs within the SCI catchment area. However, in the interests of preserving continuity of care, veterans with an existing relationship and treatment history at an SCI Center that is outside the designated catchment area will continue to be provided care at that facility. **NOTE:** *Other factors are considered in addressing the needs of SCI applicants, such as the urgency of the patient's medical need, the availability of resources, eligibility, and entitlement priorities.*

(7) Veterans with acute onset SCI are transferred immediately to an SCI Center. SCI veterans admitted to any VA medical center are to be transferred to the SCI Center within 72 hours for acute medical and/or surgical conditions and non-self-limiting conditions per referral guidelines (sub. 8). The SCI Coordinator at facilities without an SCI Center must communicate with the SCI Chief as frequently as the patient's status indicates. Such patients with acute care needs must be evaluated by personnel from the SCI Support Clinic or SCI Primary Care Team on a daily basis.

(8) Patients in a VA facility with an SCI Center must be admitted directly to the SCI Center unless the Chief, SCI Service approves admission to an alternate unit. Patients are to be located on the SCI unit unless there is a need for intensive care unit, nursing home care unit, or an exceptional clinical circumstance (which must be approved by the Chief, SCI Service). Any veteran with SCI&D not on the SCI unit must be evaluated daily by an SCI physician and SCI nurse; they must document the daily assessments and the appropriate clinical recommendations.

(9) The special needs of female SCI patients must be met through provisions for privacy (private rooms or shared with other females), appropriate supplies, apparel, and access to appropriate health care services.

e. **Admission of Active Duty Military Personnel**

(1) A Memorandum of Understanding between VA and DOD [“Memorandum of Understanding between the Department of Veterans Affairs and the Department of Defense: Referral of Active Duty Military Personnel who Sustain Spinal Cord Injury to Veterans Affairs Medical Facilities for Acute Rehabilitation and Healthcare Services”] is in effect. The objective is to provide the highest quality care for active duty military personnel who sustain SCI.

(2) Under this Memorandum of Understanding, DOD agrees that:

(a) A Military Treatment Facility (MTF) which has an active duty person with SCI must notify the Global Patient Movement Requirement Center (GPMRC) of a patient needing care.

(b) GPMRC must report to the MTF which VA SCI Center will receive the active duty person in transfer.

(c) The medical and administrative personnel of the MTF must establish immediate contact with their counterparts at the designated VA medical center to discuss and make specific arrangements. The referring hospital ordinarily determines that the patient is to receive a discharge from active military service which will not bar the member from medical benefits, and is subject to provisions of Title 38 Code of Federal Regulations (CFR) Part 17.

(d) The general goal is to effect arrangements preferably within 3 days (4 days from overseas) whenever patient's medical condition permits and not exceeding 12 days. The ability to complete medical review board processing is not a prerequisite for this transfer. Criteria for transfer before spinal stabilization surgery requires:

1. Attention to airway and adequate oxygenation;
2. Treatment of hemorrhage, no evidence of active bleeding;
3. Adequate fluid replacement;
4. Maintenance of systolic blood pressures (>90 mm mercury hydrargyrum (Hg));
5. Foley catheter placement when appropriate with adequate urine output;
6. Use of a nasogastric tube, if paralytic ileus develops;
7. Maintenance of spinal alignment by immobilization of the spine or adequate stabilization to prevent further neurologic injury (traction, tongs and traction, halo-vest, hard cervical collar, body jacket, etc.); and

8. Approval by the SCI Center Chief in consultation with either the neurosurgical or orthopedic spine surgery team.

(e) Patients are not to be transferred if there is:

1. Deteriorating neurologic function;
2. An inability to stabilize the spine, especially if the neurologic injury is incomplete;
3. Brady arrhythmias;
4. An inability to maintain systolic blood pressure >90 mm Hg;
5. Acute respiratory failure; or
6. New onset of fever, infection, and/or change in medical status (e.g., deteriorating physiological status).

(f) When the patient is ready for transfer, arrangements are to be effected immediately.

(g) The Surgeon General, or designee, of the appropriate military service provides the necessary assistance to VA medical centers in preparing and transmittal of medical review boards.

(h) If possible, active duty patients arriving from overseas are to go directly to a VA medical center without passing through a transit military hospital. **NOTE:** *If this does not occur, it needs to be noted and tracked as an exception in the Quality Improvement (QI) plan of the SCI center. Trends need to be evaluated.*

(3) Under the Memorandum of Understanding, VA agrees that it will:

(a) Accept any patient who meets diagnostic etiology criteria within the timeframe of 3 to 4 days whenever patient's medical condition permits, and not to exceed 12 days.

(b) Provide GPMRC with a current and regularly updated list of SCI treatment centers designated to receive active duty SCI patients.

(c) Initiate medical board proceedings as requested by the appropriate military Surgeon General's Office.

(d) Coordinate with community hospitals so that VA-eligible, DOD SCI patients who are ready for transfer to another hospital are transported directly from a community hospital to a VA facility.

(4) Certain VA medical centers are currently designated as capable of providing the sophisticated care and intensive rehabilitation required by recently injured military service personnel. *NOTE: These centers are designated in Appendix C.*

(5) Active duty patients with SCI need to be referred to the designated SCI Center closest to the patient's home at the time of induction, or the home to which the patient plans to return, or a location selected by the active duty member, guardian, conservator, or designee, subject to availability of beds. If the patient's condition requires, transfer to the closest VA SCI Center must be arranged. If the SCI Center is unable to accept the patient, that SCI Center must find the patient an appropriate SCI Center rather than having the referring facility conduct the search. *NOTE: The Chief Consultant, SCI&D SHG (11S), VHA Central Office, 810 Vermont Avenue, NW, Washington, DC, 20420, will assist when necessary.*

f. **Admission of Non-veteran SCI Patients.** The following has been developed for the admission of non-veterans, other than active duty military personnel, and is consistent with the contracting authorities listed in M-1, Part I, Chapter 15. *NOTE: This does not apply to VA SCI services furnished under a pre-approved sharing agreement.*

(1) Admission must be considered necessary for humanitarian emergency reasons because appropriate specialized facilities are not available in the area. Patients must meet the admission criteria as outlined in subparagraphs 6a, 6b, and 6c.

(2) Requests for admission are to be made to the nearest Chief, SCI Service, as soon as possible, post-injury. The Chief, SCI Service approves requests for admission of acute non-veteran SCI patients. Admission is to be accomplished within 1 week post-injury and before the beginning of acute rehabilitation.

(3) Management at a VA SCI Center makes a critical difference in the person's outcome.

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

(5) Length of stay in a VA SCI Center is limited to a maximum of 3 months. The VA medical center Director may authorize an extension of the hospitalization, if medically necessary and if requested by the third party payer. Every effort must be made to rehabilitate the patient for discharge to the community, or other appropriate non-VA resource.

(6) 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) are to be given the highest priority for treatment and consideration for admission.

(7) The quality of care available to eligible veterans on the SCI Unit must not be diminished; and the admission of eligible veterans must not be delayed because of the hospitalization of a non-veteran.

7. HEALTH CARE MANAGEMENT ISSUES THROUGHOUT THE CONTINUUM OF CARE

a. SCI Comprehensive Preventive Health Evaluations

(1) Critical functions of SCI care include health promotion, prevention, early identification, and treatment of complications related to lifestyle, aging, and living with a SCI. Annual comprehensive preventive health evaluations must be offered at SCI Centers by a multidisciplinary team trained in SCI care; or at those SCI Support Clinics that have demonstrated appropriate multidisciplinary team resources to provide these services and that are approved by the corresponding SCI Chief and Chief Consultant, SCI&D SHG.

(2) The scope of the evaluation is comprehensive and includes elements of preventive health and primary care defined for the general veteran. *NOTE: Such elements are addressed by VHA and are not listed here due to their periodic revision.* As standards of care are developed or modified, they will be implemented in the SCI&D system of care in the same manner as in other VA primary care sites. Health promotion and preventive health care are described in, but are not limited to, the modified VHA Chronic Disease Care and Prevention Care Index, the VHA Health Promotion and Disease Prevention Program, VHA Clinical Practice Guidelines, and VHA Performance Measures.

(3) The SCI specific evaluation includes the following elements.

(a) Medical History and Physical Examination. Medical history and physical examination must minimally include evaluation of allergies, medications, integumentary, cardiovascular, pulmonary, gastrointestinal, endocrine, genitourinary, musculoskeletal, and neurologic systems.

(b) Risk Factors. The integumentary system undergoes many anatomical and physiologic changes after SCI resulting in increased risk for pressure ulcers. All persons with altered sensation must have comprehensive assessment of risk factors, review of prevention strategies, and thorough inspection of skin.

(c) Cardiovascular Screening. Cardiovascular screening is particularly important in the SCI&D population since persons with spinal cord injury may have increased risk factors for

cardiovascular disease (e.g., low HDL level) and coronary artery disease may not manifest with chest pain due to sensory impairment in individuals with neurological level of injury above the neurologic level of T2.

1. Cardiovascular risk factor assessment should include hypertension screening with annual blood pressure measurement. A fasting lipoprotein profile should be obtained once every 5 years or more frequently, if indicated. If the testing opportunity is non-fasting, only values for total cholesterol and HDL cholesterol will be usable. Those with borderline or abnormal values warrant more frequent testing and should be counseled and treated in accordance with VA national guidelines.

2. An electrocardiogram should be obtained in all individuals with spinal cord injury age 35 years and older. Electrocardiogram is also mandatory for all symptomatic individuals realizing that symptoms may be subtle in those patients with a neurologic level of T2 and above. Cardiac ischemia may not result in chest pain in people with higher-level injuries, therefore, further diagnostic testing should be considered if there is any question of cardiac disease.

(d) Autonomic Dysreflexia Evaluation. Autonomic dysreflexia evaluation and education, as clinically indicated.

(e) Respiratory Complications. Respiratory complications are one of the leading causes of death and morbidity after an SCI.

1. Pulmonary function tests and chest x-ray should be obtained when clinically indicated and in high-risk patients (e.g., high tetraplegia, ventilator dependency, phrenic pacers, Chronic Obstructive Pulmonary Disease (COPD), asbestos exposure, etc.).

2. The prevalence of sleep-disordered breathing in persons with chronic tetraplegia is 25 percent to 40 percent. The prevalence is likely elevated in persons with chronic paraplegia as well as acute SCI. Patients with signs and symptoms of sleep disordered breathing, such as severe snoring or excessive daytime sleepiness without another cause, must undergo diagnostic evaluation. Full polysomnography with electroencephalographic monitoring is the most sensitive test for diagnosing sleep disordered breathing. Nocturnal pulse oximetry may be adequate for detecting severe cases; however, a normal study does not rule out sleep disordered breathing, particularly if performed with a standard oximeter.

(f) Annual influenza vaccine is recommended for all persons with SCI, unless there are specific contraindications. **NOTE:** *For those patients who will not be seen during the influenza vaccination season, every effort needs to be made to contact patients and inform them about resources in the community and document receipt in the medical record.*

(g) Pneumococcal vaccination is recommended for all persons with SCI, unless there are specific contraindications. A single revaccination is recommended if more than 5 years have elapsed since receipt of the first vaccination. **NOTE:** *The recommendations for revaccination may change and need to follow Recommendations of the Advisory Committee on Immunization Practices (ACIP).*

(h) People with SCI have an increased prevalence of cholelithiasis. The gall bladder should be visualized at least every 5 years, particularly in those people who do not have sensation of the body wall and peritoneum overlying the gall bladder (i.e., rostral to T8). If abdominal sensation is impaired, symptoms of acute cholecystitis may be subtle. Imaging (abdominal ultrasound or Computed Tomography (CT) should be obtained if there is any suspicion of an acute abdomen or acute cholecystitis in patients with neurologic levels rostral to T10.

(i) Annual digital rectal exam is recommended for all persons with SCI&D.

(j) Abnormalities of carbohydrate and lipid metabolism are more common in the SCI&D population, than in the general population. Since persons with SCI are believed to have increased prevalence of diabetes mellitus and accelerated and premature coronary heart disease, younger adults should be screened. Annual evaluation of serum glucose is recommended for all persons with SCI&D. **NOTE:** *Treatment needs to follow VA and U.S. Preventive Services Task Force recommendations.*

(k) Urinary tract evaluation to include:

1. Annual urine examination including UA and C&S.
2. Annual serum creatinine and BUN.
3. Annual anatomical exam (ultrasound or CT) and/or test of renal function (creatinine clearance or renal scan).
4. Cystoscopy is performed every ten years for a patient with an indwelling catheter or suprapubic catheter or a patient who has used tobacco products. Other indications for cystoscopy include hematuria, recurrent symptomatic UTI, recurrent asymptomatic bacteruria with a stone-forming organism, pieces of eggshell calculi observed in urine, or new-onset urinary retention.
5. Annual counseling regarding the advantages and disadvantages of prostate specific antigen testing.
6. Urodynamic evaluation should be performed when objective information on voiding function is needed. Indications for urodynamics include hydronephrosis, recurrent autonomic dysreflexia of unknown etiology, and urinary incontinence in the absence of UTI.

(l) Many of the musculoskeletal disorders after SCI are more prevalent than in the general population. Due to increased forces and repetition (e.g., upper limbs), extreme positions (e.g., during transfers), altered biomechanics (e.g., gait pattern due to weakness), and instrumentation, peripheral joint and periarticular soft tissue pathology are common.

1. Education about prevention of musculoskeletal problems should be periodically reviewed.
2. A thorough musculoskeletal and/or rheumatologic history and physical examination should be performed.

3. Basic biomechanical impairments at affected joints should be identified and treated (i.e., stiffness, weakness, and instability).

4. Laboratory and imaging studies should be ordered for diagnosis, monitoring, and/or treatment of musculoskeletal problems.

5. The evaluation of spine pain is a particular challenge in this population because musculoskeletal and/or neurologic problems may arise after traumatic injury. A thorough history, physical examination, and imaging studies should be performed in all persons with initial presentation of neck or back pain or a change in symptoms. Evaluation for instrumentation problems, instability, neuropathic arthropathies, radiculopathy, and spinal stenosis should be included.

(m) Decreased bone mineral content and bone mineral density have been demonstrated in persons with SCI&D. All reversible factors that exacerbate osteoporosis should be reviewed and treated annually. Fall prevention should be reviewed and include evaluation of intrinsic factors (cognitive impairment), sedating medications, and extrinsic factors (wheelchair in need of repair). Other risk factors should also be assessed and corrected (unsafe transfers, excessively zealous range of motion).

(n) Poor seating and postural abnormalities are common after SCI&D. Seating and postural evaluation by experienced therapists should be conducted when clinically indicated.

(o) Common neurologic complications (e.g., spasticity, pain) should be evaluated and treated when clinically indicated. A complete neurologic exam and recording of ASIA classification should also be completed for patients with traumatic SCI during each annual evaluation for early detection of neurologic decline.

(p) Rehabilitation functional assessment to include Activities of Daily Living (ADLs).

(q) Annual dietary and nutritional assessment is recommended since the SCI&D population has a higher prevalence of post-injury obesity and disorders of carbohydrate and lipid metabolism.

(r) Review of medications and supplies.

(s) Dental evaluation and recommendations for follow-up care when the patient has VHA eligibility for these services.

(t) Psychological, social, and vocational screening for service needs related to vocational rehabilitation potential and/or readiness, social role participation, sexuality, quality of life, behavioral health status, chemical dependency and/or use, living environment, and attendant training needs.

(4) Review of prosthetic equipment needs, function, and safety.

(5) The comprehensive preventive health evaluation findings are summarized with recommendations for follow-up care and shared with patients.

b. **Urologic Issues**

(1) Urological Surgery

(a) Any major surgical procedure on the urinary tract of SCI veterans can only be performed at VA SCI Centers, unless an emergency contraindicates transportation of the patient. In such cases, the SCI Chief must be notified as soon as possible.

(b) Experience derived from long-term follow-up of SCI veterans points to the conclusion that permanent urinary diversion is seldom indicated. No urinary diversion is to be undertaken without discussion and concurrence of the Chief, SCI Center.

(2) Urolithiasis. Frequent and recurrent urinary-lithiasis requires systematic and periodic evaluation for stone formation. **NOTE:** *Uro-endoscopy and lithotripsy have markedly decreased the indications and need for open surgery.* No invasive surgical procedure is to be undertaken without previous discussion and concurrence of the Chief, SCI Service.

(3) Urodynamics

(a) The Chief, SCI Service and/or Chief, Urology Service, is responsible for:

1. The planning and administration of the urodynamic laboratory
2. Providing consultation to other services requesting urodynamic studies.
3. Ensuring the radiology department routinely evaluates the radiographic equipment.
4. Ensuring the staff performing fluoroscopic procedures wear film badges.
5. Ensuring that the rates of post-study infections and autonomic dysreflexia are tracked.
6. Ensuring the clinical and laboratory records obtained from all examinations are included in the patient's medical record.

(b) All patients must be offered a complete urodynamics study during the initial admission. Non-invasive tests are to be used before urodynamic studies, where feasible. **NOTE:** *Urodynamic assessment includes a cystometrogram (CMG) with simultaneous sphincteric pressure measurement under fluoroscopy and/or rectal sonography. If concurrent fluoroscopy is not available, a separate voiding cystourethrogram (VCU) must be done. Urodynamic studies are to be done 3 to 6 months after injury, or after return of bladder activity, whichever comes first (urodynamic studies need to be done following stability of bladder function, which is*

typically, completely stable by 6 months post-injury.) Only competent personnel knowledgeable in urodynamics, urodynamic instrumentation, and technical analysis may perform and/or assist in the study. A physician competent in urodynamics and/or uroradiology must be present for consultation during the study. Appropriate emergency support and equipment must be available to the urodynamics suite.

(4) **Urological Cancer.** The increased risk of bladder tumors in SCI veterans, especially in the presence of a long-standing indwelling catheter, necessitates constant vigilance. Emphasis is placed on monitoring of urinary cytology and, when indicated, cystoscopy and bladder biopsy. When appropriate, non-invasive tests are to be used.

c. **Health Maintenance.** Following acute rehabilitation, a wide-range of services may be indicated to minimize unnecessary dependence on others and to ensure optimal opportunity for successful living in the community. The following areas of focus require continued monitoring as the person with SCI moves into the health maintenance phase of health care management.

(1) **ADLs.** Although training is provided in ADLs during initial rehabilitation at the SCI Center, all veterans need re-evaluation of ADL skills during follow-up visits. Some may need additional training in some aspects of ADLs (personal grooming and hygiene, dressing, transfers, cooking, housekeeping, etc.) to maximize their independence in the community. A consultation to the SCI Center, Physical Medicine Rehabilitation Service, and/or SCI Nursing is appropriate.

(2) **Personal Care Attendants (PCAs).** Recruitment, training, and retention of good PCAs present ongoing problems for the veteran with SCI&D. Veterans must be trained in meeting specific care needs so that they can in turn train their own personal care attendants. Possible resources for finding attendants include: local nursing schools, churches, employment agencies, and advertisements in newspapers and magazines. It is important that the veteran develop a back-up plan for care in case the veteran should lose the PCA. Veterans are provided training and assistance to assume responsibility for interviewing, hiring, and training PCAs.

(3) **Nutrition.** The SCI veteran is predisposed to nutritional risks and limitations for eating in both the acute and chronic phases. In the acute phase aggressive nutritional support may be necessary since weight loss is common, while in the chronic phase, there is a tendency to gain weight. Other nutrition related complications such as bone loss due to inactivity, pressure ulcers, and cardiovascular disease are not unique to the SCI population, but may be more commonly seen as complications in individuals with SCI. Follow-up needs to be continuous and include nutritional assessment and monitoring, intervention, education, and linkage with support groups.

(4) **Prosthetic Appliances and Medical Equipment.** The veteran's prosthetic appliances and medical equipment are to be evaluated on a regular basis, consistent with the veteran's health needs and home situation. Appliances and equipment may also need repair or replacement. Referral to the SCI primary care physician for a determination of medical need and a prescription for appliances or equipment is appropriate. Evaluation and specification for prosthetic items must be accomplished by individuals with the relevant clinical and technical knowledge. Requests for prosthetic appliances, equipment, or services are to be referred to the prosthetic activity or the prosthetic clerk for action and disposition. To help obtain the most appropriate

and cost effective appliances for eligible veterans, personnel from the SCI Center are to assist prosthetics personnel in the evaluation and specification of complex and/or high-tech equipment requests (see VHA Handbooks 1173.1 through 1173.15, for complete guidance regarding prosthetic appliances).

(5) **Vocational Rehabilitation.** Many SCI veterans are not "ready" to pursue vocational rehabilitation services, such as education or training during initial rehabilitation. Follow-up evaluation during clinic visits and hospitalization needs to be an integral part of treatment planning. *NOTE: Referral to the Case Manager for vocational rehabilitation, counseling, psychology, state vocational rehabilitation programs, and programs available through the Veterans Benefits Administration (VBA) (see Title 38 CFR Chapter 31 (Service connected (SC)), and Chapter 33 (GI Bill) for both the SC and non-service connected (NSC) veteran may be indicated. Contact with state rehabilitation programs to identify additional resources is recommended.*

(6) **Recreation.** It may be appropriate to involve recreation therapy for leisure skills training and for exposure to recreation options in the community. *NOTE: There are organized wheelchair sports associations on local and national levels that may also be referral sources. Fabrication of adaptive appliances (e.g., mouth sticks for typing, painting, or writing splints) may be useful in recreational pursuits.*

(7) **Family and Significant Others.** It is important to assess and respond to the impact of the SCI on the veteran's family and significant others. Many families need ongoing support regarding the changes in their lifestyles because of the veteran's injury. Support groups for spouses and families may be beneficial. Arrangements for respite care may be needed, especially where the family member is a full-time caregiver. Adult day care or temporary caregiver services may be used.

(8) **Transportation.** Transportation is a critical element in improving the quality of life for the veteran with SCI; otherwise, the veteran is essentially homebound.

(a) Driving evaluation and management services are available for persons with SCI&D at any of the VHA Driver's Rehabilitation Programs. Highly specialized driving adaptation, such as uni- or joystick controls, may only be available at Driver's Rehabilitation Programs that also have an SCI Center.

(b) If the veteran has not had driver training and is capable of operating a motor vehicle, referral to the nearest SCI Center or medical center with formal driver's training is appropriate. Requests for adaptive equipment must be referred to the Prosthetics and Sensory Aids Service (PSAS) for action and disposition. For travel unrelated to medical care, community resources must be explored, e.g., public transit, American Red Cross, local churches, etc. *NOTE: If a veteran does not have transportation for medical treatment, a referral must be made to the Beneficiary Travel department for travel.*

(9) **Income.** An assessment of the veteran's present and anticipated income is needed for financial planning. Referrals to the Veterans Benefits Counselor, Social Security

Administration, Supplemental Social Security Income, Aid to Families with Dependent Children, and other state and community resources may be indicated.

(10) **Benefits.** Some VA benefits to which SCI veterans may be entitled include: compensation, pension, higher aid and attendance for those who require skilled care daily, car grant, adaptive automotive equipment, home grant, clothing allowance, educational benefits, HISA programs, and life insurance waiver of premiums. *NOTE: Veterans who express an interest in any of these benefits or who may be entitled to additional benefits need to be referred to the VA Veterans Benefits Counselor or to a Veterans Service Organization (VSO) with knowledge of the benefits specific to SCI issues.*

(11) **Housing.** Wheelchair accessible housing is limited in many communities. In addition to traditional single family dwellings, other options to consider include: group homes (several veterans sharing residence), cluster housing (several veterans living in the same vicinity, i.e., apartment complex and sharing attendants), and the use of VA residential care homes. The local Housing Authority may be a resource for wheelchair accessible housing, since by law 5 percent of all new construction must be wheelchair accessible. *NOTE: Housing and Urban Development Housing Choice Voucher Program (Section 8), Rental Assistance Housing allows financial assistance through local Housing Authorities.*

d. **Medical Record Management.** Due to the complexity of SCI patients' medical problems, all written and imaging records must be maintained for the life of the patient.

e. **Infection Control.** Hospital-wide and/or SCI Service policies for the practice of body substance isolation and effective infection control must be used in the care of this population. *NOTE: Periodic evaluations of these policies occur as local VA medical center policy dictates.*

8. REFERRAL GUIDELINES

a. Referral guidelines recommend the conditions for treatment by each element of the hub and spokes system. It is important that all clinicians be aware of the specific conditions that may confront individuals with SCI&D to ensure that those individuals get the right care, at the right time, in the right place. What may be a relatively minor symptom or problem in the person without SCI may herald a grave and even life-threatening problem for the individual with SCI&D. Greater awareness, of the specialized health issues facing persons with SCI&D and guidance about the most appropriate sites of care for various health issues, is needed to ensure therapeutically appropriate clinical processes. The Community-based Outpatient Clinics (CBOCs) are not part of the continuum of specialty care for veterans with SCI&D.

b. Guidelines are made in order to:

- (1) Identify the most appropriate level of care and specific conditions,
- (2) Coordinate care through timely access to primary and specialty care,
- (3) Readily identify conditions for specialty care at SCI Centers, and

(4) Increase consumer satisfaction with services.

c. The underlying elements in the referral guidelines include:

(1) An awareness of which sites and programs possess appropriate levels of training and resources to provide specific services.

(2) A focus on continuity of care between providers as veterans transition between health care in facilities with and without an SCI Center.

(3) Consultation from an SCI specialist, which must be sought if the SCI condition is recurrent or not improving in a reasonable amount of time.

(4) Stabilization of patients needing emergent care before arranging transfer to an SCI Center.

(5) Awareness of the current state of clinical practice and community standards.

d. An outline of common presenting problems with recommendations for appropriate treatment levels within the SCI system of care, the SCI Hub and Spokes Referral Guidelines, follows. Exceptions are granted for those procedures needed to complete comprehensive preventive health evaluations at those SCI support clinics approved by the Chief Consultant, SCI&D.

SCI Hub and Spokes Referral Guidelines

Presenting Problem	Trained SCI Primary Care Teams	Certified SCI Support Clinics	SCI Centers
Addiction Rehabilitation Programs – Inpatient	X	X	X
Addiction Rehabilitation Services – Outpatient	X	X	X
Amputations			X
Annual Evaluations, unless exceptions approved by Chief			X
Autonomic dysreflexia – non-complex, resolvable		X	X
Baclofen Pump Refills – Routine	X	X	X
Baclofen Pump Trials			X
Bacteruria – Asymptomatic, non-complex		X	X
Behavioral Health Programs – Inpatient	X	X	X
Behavioral Health Services – Outpatient	X	X	X
Bladder Augmentations			X
Bladder issues, non-complex, no need for urodynamics		X	X
Bladder Stones and Abscess			X

Presenting Problem	Trained SCI Primary Care Teams	Certified SCI Support Clinics	SCI Centers
Bowel Care Evaluation and Management – consistent with Clinical Practice Guidelines (CPGs)	X	X	X
Bowel Care Evaluation and Management without rectal bleeding or sigmoidoscopy or colonoscopy		X	X
Burns – First and second degree with improvement	X	X	X
Cardiac Arrhythmias	X	X	X
Cholelithiasis	X	X	X
Colonoscopies			X
Colostomies - peri-operative care and teaching			X
Colostomy surgeries – peri-operative care and teaching			X
Congestive Heart Failure	X	X	X
Diarrhea – Chronic			X
Deep Vein Thrombosis (DVT), treatment consistent with CPGs	X	X	X
Exercise Programs – Comprehensive Development			X
Exercise Programs, Pre-screening	X	X	X
Fertility Services in consultation with SCI Center	X	X	X
Fevers responsive to treatment within 48 hours	X	X	X
Fractures - Acute with SCI specialty consultation	X	X	X
Gynecological Services	X	X	X
Heterotopic Ossification – conservative management		X	X
Ileus – Acute Adynamic with SCI specialty consultation	X	X	X
Immunizations	X	X	X
Impactions – Unresponsive			X
Lodging services - functionally accessible for individuals who are independent in self-care	X	X	X
Malaise	X	X	X
Malignancies - New Onset			X
Malnutrition	X	X	X
Medication Reviews and Management – Routine	X	X	X
Myocutaneous Flaps			X
Neoplastic Diseases – New Onset			X
Neurologic impairment changes			X
Neurologic level changes			X
Neurosurgeries or neurosurgical procedures			X
Nicotine Cessation	X	X	X
Non-acute Conditions not resolving in a reasonable time			X
Osteomyelitis, Acute	X	X	X

Presenting Problem	Trained SCI Primary Care Teams	Certified SCI Support Clinics	SCI Centers
Pain – Acute Elbow, Wrist, or Hand	X	X	X
Pain – Chronic, Comprehensive Management Program			X
Pain – Chronic, Initial Evaluation			X
Pain in Neck and/or Shoulder – acute, self-limited, and improving	X	X	X
Pain Management – Chronic, Follow-up Services	X	X	X
Personal Care Attendant Training not provided by patient		X	X
Post-surgical care after emergency surgeries			X
Pressure Mappings requested by other practitioners			X
Pressure Ulcers – Grades I and II with improvement	X	X	X
Pressure Ulcers – Grades III and IV			X
Pressure Ulcers for debridement – NOT IIIs or IVs		X	X
Psychological Services – Routine	X	X	X
Pulmonary – Uncomplicated Upper Respiratory Infections	X	X	X
Pulmonary Issues – Uncomplicated	X	X	X
Rectal Bleeding – Evaluations			X
Recurrent Conditions not resolving in a reasonable time			X
Rehabilitation – Acute			X
Rehabilitation – Advanced			X
Renal Stones with Abscess			X
Respite Care - Pre-Planned	X	X	X
SCI&D – New Onset			X
Seating Evaluations requested by other sites			X
Sexual Dysfunctions – Intensive Therapy			X
Sexual functioning or sexuality (permission, limited information and specific suggestions (PLISS))		X	X
Sigmoidoscopies			X
Social Services – Routine	X	X	X
Spasticity or spasms – routine evaluation and/or management		X	X
Sphincterotomies			X
Surgeries - all genitourinary (GU) surgeries			X
Surgeries - Elective including all abdominal surgeries			X
Surgeries – Plastic			X
Surgeries on Upper Extremities			X
Thromboses-Deep Venous, treatment consistent with CPGs	X	X	X
Tobacco Cessation	X	X	X
Upper Extremity Surgeries			X

Presenting Problem	Trained SCI Primary Care Teams	Certified SCI Support Clinics	SCI Centers
Ureteral Stones with Abscess			X
Urinary Tract Issues – Complex			X
Urodynamics			X
Vaccinations	X	X	X
Vocational Rehabilitation – Access to Services	X	X	X
Wheelchair Assessments and Fittings with Specialty Consultation for Complex Issues	X	X	X

9. SCI CENTERS

a. SCI Center Programs and Organization

(1) Designated SCI Centers (see App. E) provide primary (or principal) care and SCI specialty care with a full continuum of acute stabilization, acute rehabilitation, subacute rehabilitation, medical and surgical care, respite care, preventive services, sustaining health care, SCI home care, and long-term care services consistent with VHA policies. Sustaining health care is the spectrum of services after initial rehabilitation. Veterans living within the geographic area of an SCI Center will generally receive their SCI primary care services from a primary care provider on the SCI Service at the SCI center. *NOTE: Preventive and health maintenance examinations are to be offered to each veteran on an annual basis.*

(2) SCI Centers are approved by the Under Secretary for Health and organized as an independent service line reporting to the Chief of Staff, Chief Medical Officer, or equivalent, at the facility. Each SCI Center is organized with a catchment area of VA medical facilities that refer to that SCI Center (see App. A). The establishment of a new SCI Center must follow VA physical plant, staffing, resource requirements, and must be located at VA medical centers that are capable of providing complete tertiary care. *NOTE: VA and PVA have an agreement specifying that PVA is to be involved in construction of an SCI Center.*

(3) Designated SCI Long Term Care (LTC) Centers provide primary care and SCI specialty care within their focus on sustaining health and long term care services. Veterans living within the geographic area of a designated SCI LTC facility often receive their SCI primary care and long term care services at the SCI LTC Center through SCI Services.

b. Scope of SCI Center Services

(1) The scope of SCI Center services addresses the unique aspects of delivering primary care, specialty health care, and rehabilitation services to individuals with SCI. Because of the unique aspects of care, SCI Centers must be located at VA medical centers that are capable of providing complete tertiary care. The SCI&D program must include services to address:

- (a) Medical and/or physiological sequelae of SCI;
 - (b) Functional status following SCI;
 - (c) Psychological, social, and vocational needs;
 - (d) Participation in social roles;
 - (e) Education and training for persons with SCI and their families;
 - (f) Aging issues;
 - (g) Resource management;
 - (h) Planning for transitions in health care; and
 - (i) Primary and/or secondary prevention.
- (2) The following services are routinely available at all SCI Centers:
- (a) Primary health care,
 - (b) Specialty Services,
 - (c) Physiatry,
 - (d) Social Work,
 - (e) Urodynamics assessments,
 - (f) Driver's education and training,
 - (g) Vocational rehabilitation,
 - (h) Education,
 - (i) Respite care services,
 - (j) Rehabilitation management,
 - (k) Seating and mobility evaluations,
 - (l) Seating prescriptions,
 - (m) Respiratory therapy,

- (n) Clinical health psychology,
- (o) Nursing services and nursing staff with rehabilitation experience,
- (p) Physical therapy,
- (q) Sexuality counseling,
- (r) Clinical neuropsychology,
- (s) Fertility counseling,
- (t) Electro-diagnostic services,
- (u) Gait training,
- (v) Transfer training,
- (w) Wheelchair use,
- (x) Equipment maintenance,
- (y) Self-care skills,
- (z) Living skills training,
- (aa) Therapeutic recreation,
- (bb) Occupational therapy,
- (cc) Kinesiotherapy (KT),
- (dd) Urologic management,
- (ee) Audiology,
- (ff) Speech pathology,
- (gg) Home care services,
- (hh) Chaplain services,
- (ii) Prosthetics,
- (jj) Orthotics,

- (kk) Care coordination,
- (ll) Marriage and family counseling,
- (mm) Neuroradiology,
- (nn) Spasmolytic and/or neurolytic blocks, and
- (oo) Durable medical equipment.

(2) The SCI Centers make arrangements and linkages for provision of the following services in an integrated fashion, with team services, at all SCI Centers: orthotics, prosthetics, sensory aids, assistive technology, videofluoroscopic studies of swallowing, pulmonary function tests, chronic pain management, gynecology, environmental modifications, peer counseling, reproductive assessment, substance abuse treatment or rehabilitation, swallowing evaluation and training, blood flow testing for thrombosis, acute pain management, geriatrics and gerontology, durable medical equipment, medical nutrition therapy, rehabilitation engineering, speech and language pathology, vocational rehabilitation, oxygen saturation monitors, dental services, and services to address parenting issues.

c. **SCI Center Personnel**

(1) Chief, Assistant Chief, or Acting Chief, SCI Service. The position(s) of SCI Chief is a full-time position, and no one may be appointed to this position on less than a full-time basis.

(a) Recruitment and concurrence with appointment for these positions is undertaken with the involvement of the Chief Consultant, SCI&D SHG with consultation from appropriate veterans service organizations. *NOTE: The Chief Consultant, SCI&D SHG must approve exceptions to these criteria.*

(b) The candidate must meet existing VA requirements for physicians including credentialing and privileging requirements. *NOTE: Board certification in SCI Medicine is strongly encouraged. In accordance with VA qualification standards, non-citizens may be appointed to these positions if qualified United States citizens are not available.*

1. The candidate needs to have demonstrable clinical and administrative knowledge and experience in SCI medicine enabling the candidate to successfully direct an SCI Service, and to have completed either :

- a. An SCI fellowship training, or
- b. Equivalent training in the care of persons with SCI&D.

2. The candidate needs to present evidence or formal training or proven competence in leadership, administration, quality improvement, and risk management (e.g., executive medicine course, accrediting organizations) for the position of Chief.

3. The candidate needs to present evidence of interest and involvement in research and teaching.

4. The candidate needs to qualify for a faculty appointment if the medical center is affiliated with a university.

5. The candidate needs to be aware that the Chief, SCI&D has input into the annual performance evaluation of each SCI Staff and other staff assigned to SCI Service.

(2) Professional Staff Assigned to SCI Service

(a) All key staff, such as nurse manager, clinical nurse specialist, psychologist, social worker, and therapists must be assigned to SCI Service by the respective supervisors in consultation and with the approval of the Chief, SCI Service. All SCI staff are responsible to the Chief, SCI Service. Rotations and assignments recommended by supervisors outside of SCI Service Line must have the concurrence of the Chief, SCI Service.

(b) Each person served in an SCI Center is served by a team. The membership of the team is determined by the individual's needs, assessment, planning process, predicted outcomes, medical needs, and rehabilitation needs.

(c) The nurse manager and clinical nurse specialist for SCI must have SCI nursing and rehabilitation experience.

(d) Individual team members provide services consistent with: state practice acts, licensure requirements, registration requirements, certification requirements, requirements of their educational degrees, professional training to maintain established competency levels, on-the-job training requirements, and professional standards of practice.

(e) SCI Team composition must have adequate staffing to efficiently meet veterans' identified needs. The SCI Service needs to establish and document a system for determining the types and number of personnel needed by each discipline based on the needs of the patients and efficient achievement of projected outcomes. *NOTE: Present VHA policy mandates the minimum number of staff for certain aspects of the SCI program.* The SCI team commonly includes staff with SCI experience, but is not limited to:

1. One physician with SCI expertise assigned to or dedicated to SCI for every ten staffed SCI beds and an additional 0.5 physician to account for management activities as Chief.

2. Minimal nursing staff will be calculated based on 71 Full-time Equivalent (FTE) employee per 50 staffed beds. Rehabilitation nurses with SCI experience are necessary for accreditation. The nursing staff mix will approximate 50 percent Registered Nurses.

3. One psychologist for every twenty acute or sustaining available SCI beds and an appropriate corresponding panel of outpatients.

4. One social worker for every twenty acute or sustaining available SCI beds and an appropriate corresponding panel of outpatients.
5. Vocational rehabilitation specialists serving inpatients and outpatients.
6. One rehabilitation therapist (from a rehabilitation therapy mix of physical therapy (PT), occupational therapy (OT), KT, and certified therapeutic recreation specialists) must be available for every five available beds.
7. Occupational therapists with SCI experience serving inpatients and outpatients.
8. Physical therapists with SCI experience serving inpatients and outpatients.
9. Kinesiotherapists with SCI experience serving inpatients and outpatients.
10. Therapeutic recreation specialists with SCI experience serving inpatients and outpatients.
11. SCI health technicians with SCI experience serving inpatients and outpatients.
12. When SCI unit occupancy exceeds 85 percent, or patient acuities exceed the national average, nursing staffing needs to be increased accordingly.

(f) Administrative Officers, Secretaries, Clinic Clerks, Program Support Assistants, Pharmacists, Dietitians, Respiratory Therapists, Health Technicians, and Chaplain staff are also important team members and should be part of the SCI team.

(g) Health Technicians. SCI health technicians provide personal care and technical assistance to veterans with SCI. SCI technicians have defined criteria and specialized training and skills.

NOTE: The SCI Chief must establish training guidelines and continuing education, and shall define the scope of practice for SCI health technicians.

d. **SCI Center Inpatient Program**

(1) SCI Centers provide the full spectrum of health care needed by the population. Services must include: acute stabilization, acute and sub-acute rehabilitation, acute and sub-acute medical and surgical care, preventive health care, respite care, hospice care, as appropriate, and long-term care consistent with VHA policy.

(2) The program at SCI Centers includes services delivered by: chaplain, dentistry, dietetics, general surgery, geriatrics, gynecology, internal medicine, kinesiotherapy, neurology, neurosurgery, nursing, OT, orthopedics, pharmacy, physiatry, PT, plastic surgery, prosthetics, psychiatry, psychology, recreation therapy, respiratory therapy, social work, speech pathology, urology, and other support services, as necessary.

(3) All patients at the SCI Centers are carefully evaluated by the interdisciplinary treatment team.

(a) An individually tailored comprehensive treatment plan must be initiated for each patient and must reflect direct input and goal setting from the patient.

1. Documentation of the plan must be complete within 5 working days of admission.
2. Revision of the plan takes place as needed; however, at a minimum, it must be re-evaluated every 2 weeks, and it must reflect input from the patient.
3. Treatment conferences (initial or intake, family or discharge planning) are expected to include the patient.
4. The patient is permitted to have any family member, representative, or other requested individual present during treatment conferences, discussions with staff, and the development or revision of the treatment plan.

NOTE: *Patient privacy and confidentiality must be respected during treatment conferences and health care rounds.*

(b) The SCI veteran is assigned to an SCI physician who is responsible for the entire care of the SCI veteran for as long as the patient receives care at the facility. **NOTE:** *This approach promotes continuity and quality patient care.*

(4) If the complexity and acuity of the SCI veteran's care warrants physical transfer to a specialty ward outside the SCI Service, the patient's SCI physician must ensure the prescribed treatment is appropriate for the veteran. **NOTE:** *This requires the SCI physician and SCI nurse to visit the patient on a daily basis and document their findings in the progress notes. When medically stable, the patient will be transferred back to the SCI Service.*

(5) After having undergone surgery, SCI veterans must be returned to the SCI Center within 24 hours after leaving the recovery room, except in extenuating circumstances. In these cases, the patient's SCI staff physician and appropriate SCI team members must visit the patient daily and document their findings in the progress notes. Achievement of optimal functional ability of the veteran with SCI&D is expected following each course of hospitalization. **NOTE:** *Counseling must be offered as needed.*

(6) Patient education sessions provide the foundation for patient empowerment and responsibility in health maintenance, and are expected to continue throughout the rehabilitation course of treatment. Appropriate educational topics must include, but are not limited to: spinal cord function, skin care, bladder and bowel management, health maintenance and prevention of medical complications, psychological health, prosthetic awareness, nutrition, activities of daily living, sexuality and fertility, vocational issues, recreation, community accessibility, management of attendants, and equipment maintenance.

(7) Absences from the hospital during an episode of care can be authorized when, in the judgment of the patient and SCI treatment team, time at home would enhance and speed the patient's rehabilitation, or when necessary to facilitate a discharge plan.

(8) After maximum hospitalization benefits have been obtained at the SCI Center, the patient will be discharged to a suitable and appropriate environment. In the event the patient requires further hospitalization without SCI specialty care, the referring medical center will accept the return of the patient.

(9) Upon transfer, all pertinent records and x-rays must be sent with the patient, or mailed to be received before the patient's arrival. The patient's discharge summary and discharge planning progress notes are to be provided to the referring SCI Coordinator at the time of discharge from the SCI unit.

(10) Follow-up care is scheduled as clinically indicated for all discharged SCI patients, and it is provided by the SCI Center outpatient clinic, SCI outpatient support clinic, or SCI primary care team.

(11) A patient may choose to stop hospitalization against medical advice (AMA). All AMA discharges will be tracked within the Quality Improvement (QI) program of the SCI Center. When feasible, supportive services or referral to community resources may be provided.

(12) An SCI physician must be on call at all times for assistance and consultation. **NOTE:** Medical house staff at facilities having SCI Centers must have appropriate training in SCI emergencies and basic SCI care before assuming on-call duties. SCI physicians must be available for on-call consultations during non-duty hours.

e. **SCI Center Outpatient Programs**

(1) The SCI Center Outpatient Program provides the full spectrum of health care and rehabilitation needed by the SCI population. Every SCI Center provides an outpatient program of scheduled hours and treatment including unscheduled visits from patients with acute medical conditions. **NOTE:** *Any triage to non-SCI providers must include SCI consultation.*

(2) The scope of outpatient treatment at SCI Centers is comprehensive and interdisciplinary. Services provided to a particular patient are a part of a continuum of care and integrate SCI-HC when needed.

(3) Generally, the SCI physician is able to successfully address the wide array of medical conditions associated with the care of persons with SCI&D. However, SCI physicians generate a consultation to another discipline when the presenting problem is beyond the SCI physician's clinical skills.

(a) The consult should clearly indicate:

1. Whether the SCI physician is seeking an advisory consultation, or a consultation in which treatment by the consultant is requested.

2. That treatment by the consultant needs to be discussed in advance with the patient's SCI physician (the SCI physician retains the principal responsibility for the patient).

(b) 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 documented to reflect accurately the course of treatment provided to the patient.

(4) If it is necessary for the patient to remain overnight, lodging capabilities for persons with SCI who are functionally independent are to be available on the SCI unit.

f. **SCI-HC Program**

(1) SCI-HC (formerly SCI Home-based Primary Care) supports the transition and medical needs of patients to the home setting, decreasing the need for hospitalization when possible. This program renders important medical, rehabilitation, and preventive services determined necessary to sustain the SCI veteran in the community. **NOTE:** *Telehealth care may be used as an adjunctive measure to supplement the SCI-HC program.*

(2) All SCI centers must provide follow-up through SCI-HC. This follow-up consists of interdisciplinary services as an integral part of the SCI outpatient services.

(3) Patients living beyond a 100-mile radius of the SCI Center may be evaluated by SCI-HC if approved by the Chief, SCI Service. However, these patients may be referred to a closer VA medical center and SCI Coordinator for follow-up care.

(4) SCI Veterans who are placed in community nursing homes must be seen and followed by SCI-HC staff when they reside within the allotted transportation distance of the SCI-HC program. **NOTE:** *This specified distance is determined locally by the Chief, SCI Service.*

(5) SCI-HC Clinics are to be set up using clinic stop 215 and dedicated SCI HC resources will be charged to account 5112.00 of the Cost Distribution Report, or equivalent Decision Support System mappings.

(6) Before SCI-HC admission, the patient and the caregiver must be evaluated and provided with adequate education to ensure successful participation.

(7) Upon admission to the SCI-HC Program, a treatment plan must be developed in collaboration with the patient and family by the SCI-HC team. Specific goals of treatment and target dates for accomplishment are to be established. The care plan is to be reviewed and updated by the entire team no less than every 60 days and a determination made regarding the need for continuance in the program. **NOTE:** *An interdisciplinary approach to treatment planning and service delivery needs to be reflected in the medical record.*

(8) Medical records documentation must meet VA and appropriate accrediting organization requirements by using the Consolidated Health Record (CHR) or Computerized Patient Record System (CPRS) for documentation. **NOTE:** *In addition, the SCI-HC Program must submit reports to VHA Central Office as requested.*

(9) The SCI-HC participates in the service-based SCI QI Program.

(10) All SCI veterans in the SCI-HC Program are eligible for inpatient admission to the SCI Center, if medically indicated.

(11) **SCI-HC Admission Criteria**

(a) The patient must have a medical need for skilled services in the home and live within the geographic area covered by the SCI-HC program.

(b) The home environment must be physically suitable or adaptable for daily care to be provided at home.

(c) The patient's medical problems must be able to be managed or coordinated by the SCI-HC team.

(d) The patient and family (or others) must:

1. Assist in developing the proposed plan of care,
2. Give informed consent to be part of the program, and
3. Be in agreement with treatment plans.

(12) **SCI-HC Delivery of Services.** SCI-HC services provided include, but are not limited to:

- (a) Prevention of complications;
- (b) Education;
- (c) Home evaluation;
- (d) Medical management and care;
- (e) Psychological and social support;
- (f) Community agency referrals;
- (g) Nutritional counseling;
- (h) Direct nursing care, when indicated;
- (i) Assessment of equipment needs;
- (j) Education and support to patients, families, and caregivers;

- (k) Leisure counseling and training;
- (l) Vocational follow up;
- (m) Establishment of a therapeutic regimen in the home;
- (n) Assessment of needs for homemaker or home health aid services with appropriate referral to community or other resources; and
- (o) Training and assistance in ADLs.

(13) **Home Visits.** Home visits must be ordered by a physician; the frequency of home visits is determined by the individual needs of each patient. Each team member must write progress notes after every home visit. Patients admitted to the SCI-HC Program generally fall into one of three categories:

(a) Intensive patients, due to the scope or severity of problems, must receive a minimum of one visit per week by a discipline associated with the SCI patient care. Examples of such patients include:

1. The newly injured who are adjusting to community living following initial discharge from the medical center;
2. Those with acute problems, i.e., new diagnosis of diabetes or hypertension; and
3. Any patient with specific changes in the home and/or health environment, i.e., breakdown in community support system, change in attendant or equipment.

(b) Maintenance patients must receive a minimum of one visit every 2 or 3 weeks by a discipline associated with the SCI Center. Examples of such patients include those patients in need of regular laboratory work, functional rehabilitation evaluations, regular nutritional counseling, or those in need of family caregiver support.

(c) Preventive care patients must receive a minimum of one visit every quarter by a discipline associated with the SCI Center. Such patients have no ongoing major problems, but need periodic monitoring for support, assessment, and prevention of problems. These patients include individuals at risk for recurrence of problems; those with a history of high recidivism who may benefit from ongoing monitoring to avoid hospitalization; or those in special programs where monitoring is necessary.

(14) **Length of Participation.** Length of participation in the SCI-HC program is determined by clinical need. There is an expectation that patients with new injuries will be enrolled in the SCI-HC Program for less than 1 year, as the focus of services needs to be on independent community functioning. All patients are to be re-evaluated every 60 days regarding need for continuation of the program.

(15) **Education.** As part of the admissions process and on an ongoing basis, patients and caregivers must be offered education and training in home safety, infection control, and handling of emergencies.

(a) Patients are to be given written information regarding procedures of handling emergencies during the program's normal duty hours, as well as after hours. Plans are to be developed to ensure continuing and appropriate care in case of an emergency resulting in the interruption of patient services.

(b) Patients are to be 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.

1. The program must have infection control procedures that address: personal hygiene, isolation precautions, aseptic procedures, staff health, transmitted infections, and appropriate cleaning and sterilization of equipment.

2. All staff, patients, and caregivers must be instructed regarding their responsibilities in the infection control program.

3. A system must be developed to report and document all accidents, injuries, safety hazards, and infection control.

(16) **SCI-HC Discharge Criteria.** Any of the following is sufficient reason to discharge a veteran patient from the SCI-HC program.

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

(b) The patient is admitted to the medical center for an extended stay of more than 15 days.

(c) The patient requests termination.

(d) A persistent and intentional refusal of veteran, family, and/or significant other to cooperate with the SCI-HC Program team, resulting in an inability to provide services safely or effectively, will result in discharge from the program. Before the final decision is made, this will be discussed with the veteran, or with the veteran's approval their representative, family, and/or significant other and documented in the record. The veteran to be discharged must be notified in person and in writing. *NOTE: If a family member or significant other's interference in the provision of care through the SCI-HC Program results in discharge from the program, a referral will be made to an appropriate health care professional for additional intervention, services, or referral.*

(17) **SCI-HC Personnel**

(a) SCI Chief. The SCI Chief has the responsibility of:

1. The SCI HC program, both clinical and administrative. *NOTE: The SCI Chief may delegate the administrative responsibility for SCI-HC to the Program Coordinator.*
2. Ensuring that written policies and procedures are developed in compliance with all applicable VHA Central Office and accrediting organization standards and requirements, and that these be reviewed bi-annually, and updated as necessary.
3. Selecting an SCI-HC Program Coordinator in conjunction with the respective service chief.
4. Assigning the physician in charge of SCI-HC team members.
5. Providing input in the performance evaluation of all SCI-HC team members.
6. Providing liaison with other services.
7. Providing frequent contact and outreach to the facilities in the SCI catchment area for educational, consultative, advisory, and broad clinical oversight purposes.
8. Establishing training guidelines, continuing education, and defining the scope of practice for SCI health technicians.
9. Ensuring SCI-HC actively participates in the SCI QI program.
10. Maintaining documentation of continuing education.
11. Considering continuing education participation as a part of annual staff evaluation reports and in credentialing and/or privileging activities.

(b) SCI-HC Program Coordinator. The SCI-HC Program Coordinator:

1. Provides administrative direction to the program interpreting national SCI-HC, local VA medical center policy, and accreditation guidelines to the SCI-HC team and the facility.
2. Develops and implements local policies and procedures.
3. Coordinates the provision of services and administrative functions of the program.
4. Facilitates appropriate referrals to the program.
5. Monitors and controls program operation expenditures and advises the SCI Service Chief on budgetary requirements.
6. Coordinates and participates with selecting officials in the filling of SCI-HC personnel vacancies.
7. Arranges orientation of new SCI-HC staff.

8. Prepares and maintains program reports and statistics.
9. Evaluates program effectiveness.
10. Provides input to the performance appraisals of team members and forwards input through the SCI Service Chief.
11. Designates an SCI-HC QI representative.
12. Ensures appropriate documentation in the CHR and/or CPRS, according to agency policy.
13. Routinely supervises the SCI-HC clerk.
14. Maintains appropriate records for reporting purposes.

(c) SCI-HC Team. The SCI-HC team must be interdisciplinary and with appropriate personnel to meet the patient's identified needs and treatment goals, and include the SCI-HC Program Coordinator.

1. Staff members are selected and/or assigned by their respective service chiefs; however, the Chief, SCI Service, in consultation with the SCI-HC Coordinator, must concur in each selection.
2. All staff are programmatically accountable to the Chief, SCI Service.
3. All team members are expected to:
 - a. Participate in administrative and clinical team meetings.
 - b. Document in the CHR and/or CPRS according to agency policy.
 - c. Provide input to the QI process.
 - d. Conduct and arrange home visits and/or home evaluations as appropriate.
 - e. Share new developments pertaining to the patient, caregiver, and/or home situation with other team members.
 - f. Participate in inpatient discharge planning activities.
 - g. Evaluate safety and emergency preparedness in the home.
 - h. Participate in planning each patient's discharge from the program.
 - i. Report program needs, problems, or concerns to the coordinator.
 - j. Maintain required credentials and, if appropriate, clinical privileges.

k. Participate in orientation of new SCI staff.

l. Be involved in on-going staff development and continuing education activities for the SCI-HC Program.

m. Comply with the professional standards and guidelines of their respective disciplines.

g. **Evaluation of Quality**

(1) Each SCI Service must undertake service level QI activities that monitor critical aspects of care and provide an on-going and continuous evaluation of the program. A QI or Total Quality Improvement (TQI) committee is to meet at least quarterly to:

(a) Identify important aspects of care and monitor areas of service delivery identified as high-risk, high-volume (such as preventive health maintenance program), or problem-prone.

(b) Address patient access to care, patient satisfaction, patient outcomes, and risk management.

(c) Redefine, if necessary, the systematic plan used for collecting and analyzing data, taking corrective action, and reporting results.

(d) Ensure SCI Home Care and the preventive health maintenance program are actively participating in the SCI Service QI Program. *NOTE: The quality improvement plan is to comply with VHA Central Office and accrediting organizations' criteria, and be evaluated on an annual basis. The results need to be reported at SCI staff meetings and to the medical center quality management program.*

(2) All clinical staff must be appropriately credentialed and privileged through medical center and VA approved procedures. All privileges requested by potential or incumbent SCI clinicians must be routed through the Chief, SCI Service, for review, concurrence, and/or recommendations. The Chief, SCI Service, uses the information collected through quality management activities for reviewing and/or revising staff clinical privileges as governed by appropriate public law and VA regulations.

(3) Accreditation must be maintained with the Rehabilitation Accreditation Commission and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for acute care beds. *NOTE: Other accreditation standards are applicable to designated long-term care SCI beds.*

(4) Each SCI Service must follow and respond to VA established QI initiatives.

h. Continuing Education

(1) In-service continuing education must include topics identified through the QI process and the review of information and outcomes management data (the discussion is to include trends of high-risk and/or high-intensity patient care, missed diagnoses, complicated cases, morbidity-mortality conferences, etc.).

(2) All continuing education must be documented, and a formal review of each staff member's educational needs is to take place at least every 2 years.

i. Center Referral Guidelines. Referral Guidelines are discussed with emphasis on the role of the SCI Center within the SCI network continuum of care. *NOTE: See paragraph 8 for an overview of referral guideline recommendations.*

(1) Neurosurgical, plastic surgery, orthopedic surgery, and urologic services must be available on site at the SCI medical center facility.

(2) Surgical or diagnostic procedures to be conducted only at SCI Centers include, but are not limited to:

(a) All elective surgeries including neurosurgery, genitourinary, and plastic (excluding minor procedures) unless exceptions have been approved by SCI Chief. Patients with SCI&D requiring immediate surgical intervention are to receive care in a 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 must be advised of this fact as soon as possible. Such patients are retained only until they can be safely offered transfer to a VA medical center with an SCI Center.

(b) In light of the crucial importance of upper extremity functioning following SCI, all surgeries on the upper extremity need to be done at the SCI Centers, particularly those involving carpal tunnel surgeries and shoulder surgeries.

(c) Evaluation of colostomies, colostomy surgeries, and peri-operative care and/or teaching for colostomies.

(d) Amputations, including involvement of Preservation-Amputation Care and Treatment (PACT), PSAS, and other relevant services.

(e) Evaluation of rectal bleeding, etc.

(3) Due to the complexity of these conditions and the interdisciplinary team required, initial, comprehensive evaluations need to be performed at an SCI Center.

(4) All suspected changes in neurological level or neurological impairment (including new complaints of head, neck, and shoulder pain) need to be referred for further evaluation to the SCI Center.

(5) Veterans with SCI&D new to the VA system, who have new onset SCI or who are needing their first comprehensive preventive health evaluation, need to be referred to an SCI Center.

(6) Progressive kyphosis, lordosis, or scoliosis cases need to be referred to the SCI Center for initial evaluation or changes in condition.

(7) Veterans with SCI&D who also have new onset of neoplastic diseases need to be seen within the SCI Center.

(8) Complex urinary tract issues (e.g., new onset hydronephrosis, unresponsive ureteral reflux, recurrent urinary tract infections (UTIs), progressive renal insufficiency, or patients needing urodynamics), are to be evaluated within the SCI Center.

10. SCI SUPPORT CLINICS

a. SCI Support Clinics

(1) The SCI program has designated SCI Support Clinics to provide primary care, basic specialty care, and consultative services, within the designated staff's expertise. **NOTE:** *The list of SCI Outpatient Support Clinics is available through the Office of the Chief Consultant, SCI&D SHG (128N), 1660 South Columbian Way, Seattle, WA 98108-1597, Telephone (206) 768-5401.*

(2) There is variation in physician specialty practice (typically internists, family practitioners, physiatrists, neurologists) designated for such clinics.

(3) The designation as a support clinic by the Office of the Chief Consultant, SCI&D SHG requires that key health care staff of the SCI Support Clinic attend a national SCI Primary Care Team training program and be certified by the SCI Center Chief of the catchment area as successfully completing a 3- to 5-day clinical practicum at the SCI Center or have equivalent clinical training. Uncertified key personnel assigned to the Support Clinic must complete the 3- to 5-day clinical practicum at the designated SCI Center and attend a national SCI Support Clinic training program during the next available cycle. The designation as an SCI Support Clinic is contingent upon maintaining trained staff certified by the SCI Center Chief of the catchment area. Support Clinic nurses and social workers are to conduct a learning needs assessment as part of their annual competency review. Educational options include:

- (a) Review of clinical practices;
- (b) Literature reviews;
- (c) Clinical educational contact with SCI Center personnel;
- (d) Mentoring visit at an SCI Center; and

(e) Attendance at professional conferences

(4) At a minimum, SCI Support Clinic personnel consist of a physician, registered nurse (R.N.), and a social worker, who is designated as the SCI Coordinator.

(5) Typically, the SCI Support Clinic is at least 100 miles, or 2-hours driving time, from a VA SCI Center.

b. SCI Coordinators

(1) The Chief of Staff, or Chief Medical Officer, at each VA medical center without an SCI Center, designates a social worker as SCI Coordinator. The social worker selected as Coordinator must have, or be willing to acquire, appropriate knowledge about :

(a) SCI treatment and rehabilitation;

(b) Physical and psychosocial implications for the individual and family;

(c) Appropriate clinical interventions, including sexual counseling;

(d) Prosthetic services;

(e) VHA directives affecting veterans with SCI;

(f) VA benefits and other government entitlement programs for treatment, rehabilitation, and services;

(g) Community resources and services for the disabled;

(h) Local peer counseling programs or groups; and

(i) Federal laws or regulations regarding the disabled.

(2) The name and location of the SCI Coordinator must be posted in the Admissions and Ambulatory Care area, on all wards, and listed in the medical center telephone directory.

(3) Arrangements must be made for the designated SCI Coordinator to receive specialized training, to include a visit to one of the SCI Centers.

(4) When developing the SCI Coordinator's functional statement, the specialized training, independent functioning, and complex and unpredictable caseload requirements warrant consideration of an advanced practice General Schedule grade. At least .5 FTE needs to be allotted for the position of the SCI Coordinator, or 1.0 FTE, if caseload is 100 or more patients with SCI&D.

(5) The SCI Coordinator must be knowledgeable about all aspects of SCI and able to provide information to patients, families, the SCI Support Clinic, or SCI Primary Care Team. It is important that the Coordinator have the ability, insight, imagination, and drive to:

(a) Plan and coordinate services;

(b) Provide consultation and/or teaching; and

(c) Establish and maintain effective working relationships with local management, other disciplines and services, as well as with a variety of community organizations.

(6) The SCI Coordinator is responsible for:

(a) Facilitating appropriate and timely transfers to SCI Centers.

(b) Identifying new and established SCI veterans who come to the medical center, and developing a procedure for referral to the SCI Center.

(c) Providing support to the SCI Support Clinic or SCI Primary Care Team.

(d) Ensuring that a current assessment (based on a comprehensive social database) is completed and indicated psychosocial treatment and services are provided and documented in the medical record. This includes appropriate counseling, educational information and referrals to VA and community resources and services, and, as appropriate, to the vocational rehabilitation case manager.

(e) Preparing a current psychological, social, and vocational assessment and treatment plan based on a comprehensive psychological, social and vocational data base. This assessment includes identification of psychological, social, and vocational treatment and services to be provided with emphasis on:

1. Present living arrangement, i.e., housing type, access and mobility barriers, caregiver, caregiver attitude and experience in caring for disabled or handicapped persons, and health of the caregiver.

2. Support systems, i.e., family (origin and current), peer group, other community systems.

3. Educational, vocational, and avocational interests, levels of attainment, and work history.

4. Behavior patterns, coping and/or defense mechanisms, and sexual adjustment.

(f) Referring all SCI veterans to the veterans benefits counselor and, with the veteran's consent, to a veteran service officer.

(g) Developing a system of outreach to extend services to those SCI veterans not using VA for their health care needs. This involves maintaining contact with local SCI programs, VSOs, the community, and the nearest VA SCI Center.

(h) Establishing and maintaining the SCD-Registry of SCI veterans in the primary service area of the medical center.

(i) Organizing services to SCI veterans and reporting programmatic difficulties to the Chief, SCI Service, of the appropriate catchment area.

(j) Using the SCD-Registry in daily practice to identify SCI veterans admitted to, or discharged from, the medical center. *NOTE: This information is to be used for consultative visits, appropriate referrals, and sharing of pertinent discharge information with the SCI Centers, as deemed needed.*

(k) Notifying the Chief of the SCI Center, in the facility's catchment area, of admissions and discharges of SCI veterans. Medical records can be viewed electronically.

(l) Acting as a consultant to other staff members in developing individualized rehabilitation plans.

(m) Establishing liaison with, and fostering involvement of, physicians, nurses, and other disciplines, as appropriate.

(n) Using existing quality management mechanisms, national policies, local policies, procedures, and external reviews in evaluating and documenting this program's effectiveness.

(o) Ensuring that Progress Notes reflect treatment progress and goal changes. This includes a closing summary when treatment is completed or a patient is transferred.

c. **SCI Support Clinic Referral Guidelines.** Referral guidelines with specific emphasis on the role of the SCI Support Clinic within the SCI network continuum of care are available. See paragraph 8 for an overview of referral guideline recommendations.

(1) Although national training has occurred, on a regular basis SCI support clinic teams need to have frequent consultation and/or periodic educational sessions with SCI Center personnel. Staff members at SCI Support Clinics need to maintain valuable linkages with the SCI Center and other VHA health care staff in their service area. Services provided at these sites of care are often related to standard health issues facing individuals with SCI&D.

(2) SCI Support Clinic staff are familiar with management strategies specified in Clinical Practice Guidelines and current scientific and clinical literature. They are familiar with the conservative management of health care issues, but refer more complex cases to the SCI Center.

(3) Refer to the SCI Center Referral Guidelines for conditions that should only be treated at the SCI Centers. Paragraph 8 gives examples of conditions appropriate for treatment at SCI Support Clinics.

11. SCI PRIMARY CARE TEAMS

a. **Appointment of SCI Primary Care Teams.** The facility Chief of Staff, or Chief Medical Officer, appoints an SCI Primary Care Team at each VA Medical Center without an SCI Center. The SCI Primary Care Team provides primary care and consultative services to the local eligible SCI veteran patient. The SCI Primary Care Team personnel consist of a physician, registered nurse, and a social worker, who is designated as the SCI Coordinator.

b. **Education for SCI Primary Care Teams.** Only providers who have completed the Veterans Health Initiative (VHI) continuing medical education package on SCI or have equivalent training and experience are designated as SCI Primary Care Teams. Primary Care Teams are to have clinical educational contact with personnel from the SCI Center on a regular basis. SCI Primary Care Teams at non-SCI Center facilities are to conduct a learning needs assessment as part of their annual competency review. Educational options include:

- (1) Review of clinical practices;
- (2) Literature reviews;
- (3) Clinical educational contact with SCI Center personnel.
- (4) Mentoring visit at an SCI Center; and
- (5) Attendance at professional conferences.

c. **Training Initiatives for SCI Primary Care Teams.** The facility Chief of Staff, or Chief Medical Officer, must:

- (1) Notify the Chief Consultant, SCI&D SHG of any changes in SCI Primary Care Team members, and
- (2) Ensure that SCI Primary Care Team members are afforded educational funds for national and local SCI training initiatives.

d. **SCI Coordinators.** See subparagraph 10b for a description of SCI Coordinators and their roles.

e. **SCI Primary Care Team Referral Guidelines.** Referral Guidelines with specific emphasis on the role of the SCI Primary Care Team within the SCI network continuum of care are available (see par. 8).

- (1) Services provided at sites of care other than SCI Centers are often related to standard health issues facing individuals with SCI&D. Basic primary care may be provided unless contraindicated because of the SCI&D.

(a) Before making significant changes in pharmacological regimens, consultation from an SCI specialist is to be sought;

(b) Consultation from an SCI specialist is to be sought for any recurrent condition if the condition does not improve in a reasonable amount of time.

(c) Surgeries at non-VA or contract facilities are not to be performed on veterans with SCI, unless under emergent conditions. Veterans requiring emergent care are to be stabilized before arranging transfer to an SCI Center. **NOTE:** *At this time, CBOCs are not viewed as part of the VA continuum and/or system of care for veterans with SCI&D.*

(2) SCI Primary Care Teams may be asked to provide the initial evaluation and management of cholelithiasis, an ileus, or intestinal obstruction, which requires vigilance to spot a “silent acute abdomen.” **NOTE:** *Gastroenterological procedures involving the use of barium are to be avoided due to changes in motility and the difficulties involved in clearing this contrast medium from the gastrointestinal tract. Chronic diarrhea might represent impaction with liquefaction of stool; cases of impaction not responding to treatment within several days need to receive SCI specialty consultation.*

(3) SCI Primary Care Teams often evaluate complaints of malaise and fatigue or malnutrition.

(4) Pulmonary issues require vigilance from SCI Primary Care teams to spot unexplained erythrocytosis in persons with high tetraplegia.

(5) Detection and initial evaluation of cardiac arrhythmias, congestive heart failure, and coronary artery disease require practitioners to notice cases of silent ischemia. **NOTE:** *Practitioners need to be aware of the relationship between cardiac issues, autonomic dysreflexia, and exercise tolerance in this specialized population.*

(6) Comprehensive chronic pain management programs are to be initiated and formulated at each SCI Center for the SCI veteran with follow-up care by the SCI Primary Care Team in collaboration with the SCI Center.

(7) The SCI Primary Care Team needs to perform appropriate pre-screening of the veteran before the initiation of comprehensive exercise programs, which must be implemented by adequately trained health care professionals.

(8) SCI Primary Care Teams can provide direct consultation to staff about the full context of care for individuals with SCI&D requiring inpatient behavioral health or addictions programs.

(9) In the initial evaluation and brief treatment of neck and shoulder pain, SCI Primary Care Teams need to make sure they do not overlook a diagnosis of syrinxes, neurologic deterioration, or shoulder syndromes due to prolonged use of upper extremities. **NOTE:** *Even with apparently routine conditions such as these, SCI specialty consultation is often useful.*

(10) Respite care for individuals with SCI having significant needs for personal care can be provided at medical center facilities having SCI Primary Care Teams. *NOTE: Respite care is an essential component of health care for maintaining caregiver support to maintain non-institutional, community living.*

NOTE: Other conditions may be encountered in the routine care of this population, so this is not an all encompassing list, but merely illustrative examples.

f. **Lodging or Hoptel Arrangements.** Veterans with SCI&D can be provided with lodging or hoptel arrangements if the individual is totally independent in self-care, or arrangements have been made in accordance with hospital policy if assistance is required and the facility used for lodging or hoptel is functionally accessible for that person.

SPINAL CORD INJURY (SCI) CENTER REFERRAL AREAS

Spinal Cord Injury (SCI) Center VISN	SCI CENTER DESIGNATION	Veterans Integrated Service Network (VISN)	CITY	State
18	Albuquerque	18	Albuquerque	NM
		18	Amarillo	TX
		18	Big Spring	TX
		19	Cheyenne	WY
		19	Denver	CO
		18	El Paso	TX
		19	Fort Lyon	CO
		19	Grand Junction	CO
		19	Salt Lake City	UT
7	Augusta	6	Asheville	NC
		7	Atlanta	GA
		7	Augusta	GA
		7	Charleston	SC
		7	Columbia	SC
		7	Dublin	GA
		7	Montgomery	AL
		9	Mountain Home	TN
		7	Tuskegee	AL
1	Brockton/West Roxbury	1	Bedford	MA
		1	Boston	MA
		1	Brockton	MA
		1	Manchester	NH
		1	Newington	CT
		1	Northampton	MA
		1	Providence	RI
		1	Togus	ME
		1	West Haven	CT
		1	White River	VT
3	Bronx	3	Bronx	NY
		3	Brooklyn (Poly Pl)	NY
		3	Brooklyn (St. Albans-Div)	NY
		3	Montrose	NY
		3	New York	NY
		3	Northport	NY

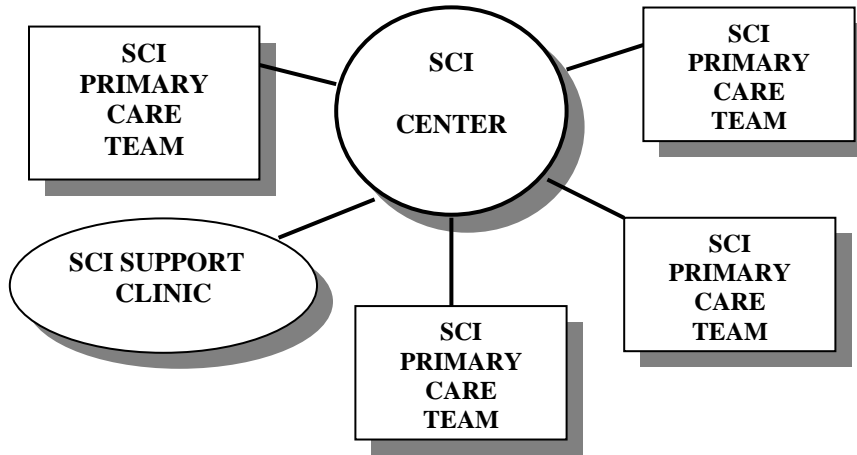
SCI Center VISN	SCI CENTER DESIGNATION	VISN	CITY	State
3	Castle Point	2	Albany	NY
		2	Bath	NY
		2	Canandaigua	NY
		3	Castle Point	NY
		2	Syracuse	NY
10	Cleveland	11	Allen Park	MI
		4	Altoona	PA
		11	Ann Arbor	MI
		2	Batavia	NY
		2	Buffalo	NY
		4	Butler	PA
		10	Chillicothe	OH
		10	Cincinnati	OH
		10	Cleveland	OH
		10	Cleveland/Brecksville	OH
		10	Dayton	OH
		4	Erie	PA
		4	Pittsburgh/Highland	PA
4	Pittsburgh/Univ. Dr	PA		
17	Dallas	17	Bonham	TX
		17	Dallas	TX
		17	Marlin	TX
		17	Waco	TX
3	East Orange	4	Coatesville	PA
		3	East Orange	NJ
		4	Lebanon	PA
		3	Lyons	NJ
		4	Philadelphia	PA
		4	Wilkes Barre	PA
6	Hampton	6	Hampton	VA

SCI Center VISN	SCI CENTER DESIGNATION	VISN	CITY	State
12	Hines	11	Battle Creek	MI
		12	Chicago/Lakeside	IL
		12	Chicago/West Side	IL
		11	Danville	IL
		14	Des Moines	IA
		11	Fort Wayne	IN
		12	Hines	IL
		13	Hot Springs	SD
		11	Indianapolis	IN
		14	Iowa City	IA
		14	Knoxville	IA
		11	Marion	IN
		19	Miles City	MT
		12	North Chicago	IL
		11	Saginaw	MI
19	Sheridan	WY		
16	Houston	16	Alexandria	LA
		16	Biloxi	MS
		16	Houston	TX
		16	New Orleans	LA
		16	Oklahoma City	OK
		16	Shreveport	LA
22	Long Beach	22	Las Vegas	NV
		22	Loma Linda	CA
		22	Long Beach	CA
		22	Los Angeles	CA
		22	Sepulveda	CA
		22	West Los Angeles	CA
9	Memphis	7	Birmingham	AL
		16	Fayetteville	AR
		16	Jackson	MS
		16	Little Rock	AR
		9	Memphis	TN
		9	Murfreesboro	TN
		16	Muskogee	OK
		9	Nashville	TN
7	Tuscaloosa	AL		
8	Miami	8	Miami	FL
		8	West Palm Beach	FL

SCI Center VISN	SCI CENTER DESIGNATION	VISN	CITY	State
12	Milwaukee	13	Fargo	ND
		13	Fort Meade	SD
		12	Iron Mountain	MI
		12	Madison	WI
		12	Milwaukee/Wood	WI
		13	Minneapolis	MN
		13	Sioux Falls	SD
		13	St. Cloud	MN
		12	Tomah	WI
21	Palo Alto	21	Fresno	CA
		21	Honolulu	HI
		21	Manila	PI
		21	Martinez	CA
		21	Palo Alto	CA
		21	Reno	NV
		21	San Francisco	CA
6	Richmond	5	Baltimore	MD
		6	Beckley	WV
		4	Clarksburg	WV
		6	Durham	NC
		6	Fayetteville	NC
		5	Fort Howard	MD
		9	Huntington	WV
		5	Martinsburg	WV
		5	Perry Point	MD
		6	Richmond	VA
		6	Salem	VA
		6	Salisbury	NC
		5	Washington	DC
		4	Wilmington	DE
17	San Antonio	17	Kerrville	TX
		17	San Antonio	TX
		17	Temple	TX
22	San Diego	18	Phoenix	AZ
		18	Prescott	AZ
		22	San Diego	CA
		18	Tucson	AZ
8	San Juan	8	San Juan	PR

SCI Center VISN	SCI CENTER DESIGNATION	VIS N	CITY	State
20	Seattle	20	American Lake/Seattle	WA
		20	Anchorage	AK
		20	Boise	ID
		19	Fort Harrison	MT
		20	Portland/Vancouver	OR
		20	Roseburg	OR
		20	Spokane	WA
		20	Walla Walla	WA
		20	White City	OR
15	St. Louis	15	Columbia	MO
		14	Grand Island	NE
		15	Kansas City	MO
		15	Leavenworth	KS
		9	Lexington	KY
		14	Lincoln	NE
		9	Louisville	KY
		15	Marion	IL
		14	Omaha	NE
		15	Poplar Bluff	MO
		15	St. Louis	MO
		15	Topeka	KS
		15	Wichita	KS
8	Tampa	8	Bay Pines/Fort Myers	FL
		8	Gainesville	FL
		8	Lake City	FL
		8	Orlando	FL
		8	Tampa	FL

SPINAL CORD INJURY AND DISORDERS (SCI & D) HUB AND SPOKES



**SPINAL CORD INJURY (SCI) CENTERS ACCEPTING
DEPARTMENT OF DEFENSE REFERRALS**

1. Department of Veterans Affairs (VA) New Mexico Health Care System (HCS) (128), 1501 San Pedro Southeast, Albuquerque, NM 87108. (505) 256-2849
2. Augusta VA Medical Center (128), One Freedom Way, Augusta, GA 30904-6285. (706) 823-2216
3. VA Boston HCS (128), 1400 VFW Parkway, West Roxbury, MA 02132. (617) 323-7700, extension 5128.
4. VA Medical Center (128), 130 West Kingsbridge Road, Bronx, NY 10468. (718) 584-9000, extension 5423.
5. Louis Stokes VA Medical Center (128W), 10701 East Boulevard, Cleveland, OH 44106. (216) 791-3800, extension 5219.
6. VA North Texas HCS (128), 4500 South Lancaster Road, Dallas, TX 75216. (214) 857-1757.
7. Edward Hines, Jr. VA Medical Center (128), Fifth Avenue and Roosevelt Road, Hines, IL 60141-5000. (708) 202-2241.
8. Houston VA Medical Center (128), 2002 Holcombe Boulevard, Houston, TX 77030-4298. (713) 794-7128.
9. VA Long Beach HCS (128), 5901 East 7th Street, Long Beach, CA 90822. (562) 826-5701.
10. VA Medical Center (128), 1030 Jefferson Avenue, Memphis, TN 38104. (901) 577-7373.
11. VA Medical Center (128), 1201 Northwest 16th Street, Miami, FL 33125. (305) 575-3174.
12. Clement J. Zablocki VA Medical Center (128), 5000 West National Avenue, Milwaukee, WI 53295. (414) 384-2000, extension 41230.
13. VA Palo HCS (128), 3801 Miranda Avenue, Palo Alto, CA 94304. (650) 493-5000 ext 65870.
14. HH McGuire VA Medical Center (128), 1201 Broad Rock Boulevard, Richmond, VA 23249. (804) 675-5282.
15. South Texas Veterans HCS (128), 7400 Meront Minter Blvd., San Antonio, TX 78284. (210) 617-5257.

16. VA San Diego HCS (128), 3350 La Jolla Village Drive, San Diego, CA 92161. (858) 642-3117.
17. VA Medical Center (128), 10 Casia Street, San Juan, PR 00921-3201. (787) 641-7582, extension 14130.
18. VA Puget Sound HCS (128), 1660 South Columbian Way, Seattle, WA 98108-1597. (206) 764-2332.
19. Saint Louis VA Medical Center (128JB), One Jefferson Barracks Drive, St. Louis, MO 63125. (314) 894-6677.
20. James A. Haley VA Medical Center (128), 13000 Bruce B. Downs Blvd., Tampa, FL 33612-4798. (813) 972-2000, extension 6399.

BILLING FOR SERVICES

Claims for services provided to active duty personnel under national Department of Veterans Affairs (VA)-Department of Defense (DOD) Specialized Services Agreements for spinal cord injury (SCI) will be billed using CHAMPUS Maximum Allowable Charge (CMAC) rates less 10 percent (CMAC-10%) or Diagnosis Related Group (DRG) code rates less 10 percent (DRG-10%) as the reimbursement methodology for health care reimbursement between medical facilities for institutional and professional charges consistent with VA/DoD Health Executive Council Memorandum of Agreement Health Care Resource Sharing Reimbursement Methodology. The costs of transportation, prosthetics, durable medical equipment, dental services, ambulance, home care, some separate professional fees, and personal care attendants are not included in the CMAC-10 percent rates and will be billed at the interagency rate, or if not available, the actual charge. VA medical centers providing care to active duty members in accordance with national Veterans Health Administration (VHA)-DOD agreements are to be paid by the respective Service as outlined in the following:

1. Army.

- a. Send bills to the Army Medical Command; the address is:

Military Medical Support Office
ATTN: Army VA Claims
P.O. Box 886999
Great Lakes, IL 60088-6999
Telephone number 888-647-6676

NOTE: Claims need to include the Transportation Command Regulating and Command and Control Evacuation System (TRACES) authorization number and approval of transfer documentation from GPMRC.

2. Air Force

- a. Send bills to referring Air Force Military Treatment Facility (MTF).
- b. **Point of Contact (for other than billing)**. Master Sgt. Jeannine Kepner, or designee or replacement, Financial Management, Headquarters, USAF Surgeon General, Bolling AFB at (202) 767-5424.

3. Navy and Marine Corps

- a. **Military Medical Support Office (MMSO)**. The address is:

MMSO
P.O. Box 886999
Great Lakes, IL, 60088-6999
- b. **Point of Contact**. Janice Mays, or designee or replacement, at (888) 647-6676, ext. 615.

SPINAL CORD INJURY (SCI) CENTERS

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3. VA Boston HCS (128), 1400 VFW Parkway, West Roxbury, MA 02132.
4. VA Medical Center (128), 130 West Kingsbridge Road, Bronx, NY 10468.
5. VA Hudson Valley HCS (128), Castle Point, NY 12511.
6. Louis Stokes VA Medical Center (128W), 10701 East Boulevard, Cleveland, OH 44106.
7. VA North Texas HCS (128), 4500 South Lancaster Road, Dallas, TX 75216.
8. VA New Jersey HCS (128), 385 Tremont Avenue, East Orange, NJ 07018-1095.
9. VA Medical Center (128), 100 Emancipation Drive, Hampton, VA 23667.
10. Edward Hines, Jr. VA Medical Center (128), Fifth Avenue and Roosevelt Road, Hines, IL 60141-5000.
11. Houston VA Medical Center (128), 2002 Holcombe Boulevard, Houston, TX 77030-4298.
12. VA Long Beach HCS (128), 5901 East 7th Street, Long Beach, CA 90822.
13. VA Medical Center (128), 1030 Jefferson Avenue, Memphis, TN 38104.
14. VA Medical Center (128), 1201 Northwest 16th Street, Miami, FL 33125.
15. Clement J. Zablocki VA Medical Center (128), 5000 West National Avenue, Milwaukee, WI 53295.
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17. HH McGuire VA Medical Center (128), 1201 Broad Rock Boulevard, Richmond, VA 23249.
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