

## SPINAL CORD INJURIES AND DISORDERS SYSTEM OF CARE

**1. REASON FOR ISSUE:** This Veterans Health Administration (VHA) directive defines the policies, procedures, standards, requirements, and operations of the Spinal Cord Injuries and Disorders (SCI/D) System of Care.

**2. SUMMARY OF MAJOR CHANGES:** This VHA directive combines five previous handbooks and directives (see Rescissions below). This directive contains the essential resources, structure, procedures, policies, staffing, and beds of the SCI/D System of Care so all enrolled Veterans with SCI/D have access to lifelong, coordinated, team-based, comprehensive care. This directive removes the Spinal Cord Injury and Disorders Outcomes (SCIDO) section previously in VHA Handbook 1176.01, Spinal Cord Injury and Disorders (SCI/D) System of Care, dated February 28, 2011. This directive updates:

a. Staffing requirements previously outlined in VHA Directive 2008-085, Spinal Cord Injury Center Staffing and Beds, dated December 18, 2008 (see Appendix D).

b. Responsibilities previously outlined in VHA Directive 1176, Spinal Cord Injury and Disorders System of Care, dated October 21, 2010 (see paragraph 5).

c. The SCI/D System of Care description (see paragraph 6).

d. Guidance regarding inclusion criteria for the population served (see Appendix A).

**3. RELATED ISSUES:** VHA Directive 1094, Inter-Facility Transfer Policy, dated January 11, 2017.

**4. RESPONSIBLE OFFICE:** The Executive Director, SCI/D National Program Office, is responsible for the contents of this VHA directive. Questions may be referred to the SCI/D National Program Office at (214) 857-1760.

**5. RESCISSIONS:** VHA Directive 1176, Spinal Cord Injury and Disorders System of Care, dated October 21, 2010; VHA Handbook 1176.01, Spinal Cord Injury and Disorders (SCI/D) System of Care, dated February 28, 2011; VHA Directive 2008-085, Spinal Cord Injury Center Staffing and Beds, dated December 18, 2008; VHA Handbook 1176.02, Spinal Cord Injury and Disorders (SCI&D) Extended Care Services, dated June 13, 2007; and VHA Directive 2011-032, Availability of Medical and Surgical Products for Veterans with Spinal Cord Injury and Disorders, dated August 22, 2011, are rescinded.

**6. RECERTIFICATION:** This VHA directive is scheduled for recertification on or before the last working day of September 2024. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

September 30, 2019

VHA DIRECTIVE 1176

**BY DIRECTION OF THE OFFICE OF  
THE UNDER SECRETARY FOR HEALTH:**

/s/ Renee Oshinski  
Deputy Under Secretary for Health  
for Operations and Management

**NOTE:** *All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.*

**DISTRIBUTION:** Emailed to the VHA Publications Distribution List on October 1, 2019.

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## SPINAL CORD INJURIES AND DISORDERS SYSTEM OF CARE

### 1. PURPOSE

This Veterans Health Administration (VHA) directive outlines VHA's Spinal Cord Injuries and Disorders (SCI/D) Veteran-centric, team-based, accessible, efficient, comprehensive, coordinated, and lifelong System of Care. The mission of VHA SCI/D System of Care is to support, promote, and maintain the health, independence, quality of life, and productivity of Veterans with SCI/D throughout their lives. This directive requires that SCI/D Center beds and staffing must be provided to meet or exceed requirements as described in this directive. **AUTHORITY:** Title 38 United States Code (U.S.C.) 1706(b), 7301(b), 8111; Title 38 Code of Federal Regulations (CFR) 17.38.

### 2. BACKGROUND

a. **History.** Since World War II, lifelong care for Veterans with SCI/D has been recognized as a foundational service in the Department of Veterans Affairs (VA) not available elsewhere in the United States. Coordinated and integrated primary and specialty services are delivered through a hub and spokes system of care and are built upon interdisciplinary, comprehensive services provided at SCI/D Centers.

b. **Use of Evidence-Based and Clinical Practice Guidelines.** Evidence-based and clinical practice guidelines are published in peer-reviewed literature and developed by established and expert organizations such as the Consortium for Spinal Cord Medicine. These guidelines must be used in the care of Veterans with SCI/D to the extent supported by current medical evidence and state-of-the-science practice. The Chief, SCI/D Center, incorporates evidence-based practice, best practices, and clinical practice guidelines into the appropriate medical care settings. These clinical practice guidelines can be found at <http://vaww.sci.va.gov/> under the training link. **NOTE:** *This is an internal VA Web site that is not available to the public.*

c. **Related Legislation.** The Veterans' Health Care Eligibility Reform Act of 1996 mandated that VA maintain its capacity to provide services for Veterans with SCI/D. VA developed policy that maintained beds and staffing, as well as mechanisms to report capacity to Congress. The requirement to provide Congress with an annual capacity report that included SCI/D staffing and beds expired in 2008 but was reinstated in the Continuing Appropriations and Military Construction, Veterans Affairs and Related Agencies Appropriations Act for fiscal year (FY) 2017.

### 3. DEFINITIONS

a. **Amyotrophic Lateral Sclerosis.** Amyotrophic lateral sclerosis (ALS) is a progressive neurodegenerative disease that affects the motor neurons in the spinal cord, brainstem, and motor cortex resulting in weakness, atrophy, and corticospinal tract damage in varying combination that typically results in death from respiratory failure within three to five years from onset of symptoms.

b. **Beds: Authorized and Operating.** Authorized beds are the mandated number of beds at each SCI/D Center, which is the sum of operating beds and beds that are temporarily not available. Operating beds are those that are staffed and available for admission of patients. Operating beds exclude unavailable beds.

c. **Institutional Long-Term Care.** Institutional long-term care (LTC) typically is provided in residential facilities in which total care is provided for the residents. Institutional LTC is provided for Veterans with SCI/D in VA SCI/D Centers, VA Community Living Centers (CLCs), community contract nursing homes, community non-contract nursing homes, State Veterans Homes, assisted living care, and community residential care.

d. **Interdisciplinary Team.** The interdisciplinary team is SCI/D professionals from various disciplines that work together to provide the support and resources necessary for Veterans with SCI/D to initially obtain and then maintain independence and good health. This team carefully evaluates each Veteran to develop an individually tailored comprehensive treatment plan. This team may include, but is not limited to: a medical provider, nurse, social worker, psychologist, physical therapist, occupational therapist, kinesiologist, recreational therapist, vocational rehabilitation, dietician, clinical pharmacist, and speech therapist.

e. **Multiple Sclerosis.** Multiple Sclerosis (MS) is an inflammatory, degenerative disease of the central nervous system and the most common progressive neurological disorder of young adults. MS may involve the spinal cord and result in spinal cord dysfunction.

f. **Non-Institutional Extended Care.** Non-institutional extended care refers to the range of residential, VA, and community-based programs available for supporting Veterans with SCI/D to live in the least restrictive environment possible. Non-institutional extended care services are offered in several discrete programs that offer skilled and unskilled services in a variety of settings.

g. **Patient Centered Management Module.** The Patient Centered Management Module (PCMM) is an application in Veterans Health Information Systems and Technology Architecture (VistA) that allows input of facility-specific and panel-specific data, and allows national roll-up of this data for tracking, case finding, and comparison purposes. PCMM supports set up and definition of the health care team, assignment of staff to positions within the team, and assignment of patients to the Patient Aligned Care Team (PACT). **NOTE:** *For additional information, see VHA Directive 1406, Patient Centered Management Module (PCMM) for Primary Care, dated June 20, 2017. See also VHA Handbook 1101.10(1), Patient Aligned Care Team (PACT) Handbook, dated February 5, 2014.*

h. **Prosthetic Appliances and Medical Equipment.** A prosthetic appliance, as described in VHA Handbook 1173.1, Eligibility, dated November 2, 2000, is any aid, device, part or accessory which patients require to replace, support, or substitute for impaired or missing anatomical parts of the body. Medical equipment, as described in

VHA Handbook 1173.08, Medical Equipment and Supplies, dated June 15, 2007, includes all items of a therapeutic or rehabilitative nature, which are determined as medically necessary for home treatment of eligible veterans, e.g., equipment for transfers, mobility, repositioning, and transport; hospital beds; bathroom equipment; stair glides; room air conditioners; portable ramps; and environmental control units (ECUs). A wide array of prosthetic appliances and medical equipment is critical to support Veterans with SCI/D to function and live independently.

i. **SCI/D Center.** VA SCI/D Centers across the country serve as regional hubs, providing primary and specialty care by an interdisciplinary group of expert SCI/D providers in all settings including inpatient, outpatient, consultative, home care, extended care, and telehealth services. SCI/D Centers may provide acute/sustaining and/or LTC. SCI/D Centers also provide rehabilitation, which aims to enhance and restore functional abilities, lessen disability, prevent secondary complications, and maximize quality of life to Veterans with SCI/D. SCI/D Centers are sometimes referred to in this directive as Hubs for purposes of the SCI/D hub and spokes system.

j. **SCI/D Center Patient Aligned Care Team.** The SCI/D Center PACT is a team of health care professionals that provides comprehensive primary and SCI/D specialty care in partnership with the Veteran and manages and coordinates comprehensive health care services consistent with agreed-upon goals of care.

k. **SCI/D Nurse Staffing Methodology.** SCI/D nurse staffing methodology is a process to determine SCI/D staffing levels in SCI/D Centers based on an analysis of multiple variables that includes Veteran care needs, environmental factors, organizational supports, trends in performance metrics, qualified experts' guidance and research, and professional judgment to provide safe, effective, high-quality care at all points of care. See VHA Directive 1351, Staffing Methodology for VHA Nursing Personnel, dated December 20, 2017, for additional information.

l. **SCI/D Spoke.** SCI/D Spokes are VA medical facilities that do not have SCI/D Centers. They are geographically aligned with SCI/D Centers and deliver primary care by providers that received SCI/D training. See the SCI/D intranet site (<http://vaww.sci.va.gov>) for a list of SCI/D Centers and aligned Spokes. **NOTE:** *This is an internal VA Web site that is not available to the public.*

m. **SCI/D Spoke Patient Aligned Care Team.** The SCI/D Spoke PACT is a team of health care professionals that provides comprehensive primary care in partnership with the Veteran and manages and coordinates comprehensive health care services consistent with agreed upon goals of care. SCI/D Spoke PACT professionals have received education and training about SCI/D to better understand unique SCI/D conditions, manage primary care conditions, and collaborate with SCI/D experts in SCI/D Centers.

n. **SCI/D System of Care.** The VA SCI/D System of Care is an integrated and coordinated system based on a hub and spokes infrastructure to provide comprehensive, lifelong services to Veterans with SCI/D.

o. **Spinal Cord Disorders.** Spinal cord disorders (SCD) are non-traumatic conditions that result in spinal cord dysfunction and caused by non-traumatic conditions such as infections, neoplasms, demyelinating diseases, degenerative neurologic diseases, arthritis, and degenerative spine problems.

p. **Spinal Cord Injury.** A spinal cord injury (SCI) usually begins with a sudden, traumatic injury to the spine and spinal cord. The damage begins at the moment of injury when the spinal cord is injured by surrounding tissues such as bone, intervertebral disks, and ligaments.

q. **Sustaining Medical and Surgical Care.** Sustaining medical and surgical care is the assessment and treatment of conditions, complications, and co-morbidities that affect Veterans with SCI/D.

r. **Vocational Rehabilitation.** Vocational rehabilitation is a process which enables Veterans with SCI/D to overcome barriers to accessing, maintaining, or returning to employment or other occupational activities.

s. **Whole Health.** Whole Health is an approach to health care that empowers and equips people to take charge of their health and well-being, and live their lives to the fullest. Whole Health is personalized, proactive, integrative, Veteran-centric care that affirms the importance of the relationship and partnership between Veterans and their community of providers. The focus is on self-care strategies, integrative health coaching, appropriate therapeutic approaches, and the components of health and well-being.

#### 4. POLICY

It is VHA policy that Veterans with SCI/D have access to a full spectrum of clinically appropriate interdisciplinary primary and specialty services throughout their lives, including acute care following new SCI/D; comprehensive interdisciplinary rehabilitation; sustaining medical and surgical care; primary and preventive care; psychological, social, and vocational care; therapies; prosthetics and assistive technologies; Veteran and family education; research; professional training; and Whole Health care, including complementary and integrative health services.

***NOTE:*** *The provision of care and decisions related to Veterans with SCI/D must ensure consistency with relevant requirements in VHA Ethics directives and handbooks. This includes but is not limited to VHA Directive 1041, Appeal of VHA Clinical Decisions dated, October 24, 2016; VHA Handbook 1004.01(2), Informed Consent for Clinical Treatments and Procedures dated, August 14, 2009; VHA Handbook 1004.02, Advanced Care Planning and Management of Advanced Directives, dated December 24, 2013; VHA Handbook 1004.03, Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences, dated January 11, 2017; and VHA Directive 1004.04, State Authorized Portable Orders (SAPO), dated February 26, 2019. Veteran preference must be considered in determining care options.*

## 5. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for:

(1) Ensuring overall VHA compliance with this directive.

(2) Approving any changes which impact the organization of the SCI/D System of Care, including but not limited to the mission, scope, staffing, bed level, and clinical services.

b. **Principal Deputy Under Secretary for Health.** The Principal Deputy Under Secretary for Health is responsible for recommending to the Under Secretary for Health proposed changes which impact the organization of the SCI/D System of Care, including but not limited to the mission, scope, staffing, bed level, clinical services, and reorganization.

c. **Deputy Under Secretary for Health for Operations and Management.** The Deputy Under Secretary for Health for Operations and Management is responsible for:

(1) Communicating the contents of this directive to each of the Veterans Integrated Services Networks (VISNs).

(2) Ensuring that each VISN Director has the sufficient resources to fulfill the terms of this directive in all of the VA medical facilities within that VISN.

(3) Providing oversight of VISNs to assure compliance with this directive, relevant standards, and applicable regulations.

(4) Recommending to the Principal Deputy Under Secretary for Health any proposed changes which impact the organization of the SCI/D System of Care, including but not limited to the mission, scope, staffing, bed level, and clinical services.

d. **Assistant Deputy Under Secretary for Health for Clinical Operations.** The Assistant Deputy Under Secretary for Health for Clinical Operations is responsible for recommending to the Deputy Under Secretary for Health for Operations and Management any proposed changes which impact the organization of the SCI/D System of Care, including but not limited to the mission, scope, staffing, bed level, and clinical services.

e. **Executive Director, Spinal Cord Injuries and Disorders National Program Office.** The Executive Director, SCI/D National Program Office, is responsible for:

(1) Providing national operational, programmatic, administrative, management, and strategic leadership for SCI/D health care, health services, workforce requirements, resources, programmatic development, and quality of care for the SCI/D System of Care in all settings to include inpatient, outpatient, consultative, home care, extended care and telehealth services, to ensure that eligible Veterans with SCI/D receive timely,

Veteran-centric, data-driven, interdisciplinary-team-based, comprehensive, coordinated, and high-quality care.

(2) Proposing to the Assistant Deputy Under Secretary for Health for Clinical Operations any changes which impact the organization of the SCI/D System of Care, including but not limited to the mission, scope, staffing, bed level, and clinical services.

(3) Reviewing and approving the recruitment, concurrence, and appointment of all Chiefs or Acting Chiefs, SCI/D Centers.

(4) Ensuring that the SCI/D Centers undertake service-level quality improvement (QI) activities that monitor critical aspects of care.

(5) Serving, or identifying a designee, as the national subject matter expert for VA and VHA issues that pertain to Veterans with SCI/D and the SCI/D System of Care.

(6) Ensuring that total number of authorized and operating beds are maintained in the SCI/D System of Care.

(7) Developing the annual capacity report of SCI/D staffing and beds for submission to Congress as required by the Continuing Appropriations and Military Construction, Veterans Affairs and Related Agencies Appropriations Act for FY 2017.

(8) After seeking input from internal and external stakeholders, through the chain of command, providing the Under Secretary for Health with any recommended changes to the bed and staffing levels for each facility listed in this directive at the end of the FY.

**NOTE:** Paralyzed Veterans of America (PVA) is given the opportunity to comment on significant changes to the program.

f. **Veterans Integrated Services Network Director.** The VISN Director is responsible for:

(1) Ensuring Veterans' timely and full access to SCI/D services by implementing and supporting the SCI/D System of Care and ensuring VISN-level and facility-level responsiveness to the health care needs of Veterans with SCI/D.

(2) Ensuring the education and training of all health care providers and staff that care for Veterans with SCI/D in the SCI/D System of Care.

(3) Facilitating transfers for care between VA facilities and transferring Veterans with SCI/D from community facilities to SCI/D Centers, according to established standards in this directive. Coordination of travel and services may cross VISN boundaries requiring coordination and collaboration between VISN Directors. A SCI/D Center may serve Veterans and SCI/D Spokes located in different VISNs.

(4) Ensuring that there are appropriate resources, processes, structures, services, staffing, and beds, as described in this directive, for medical, primary, specialty,

emergent, surgical, rehabilitative, Whole Health, extended care, and LTC for the SCI/D population by providers trained in SCI/D health care. This includes ensuring that medical and surgical supply product needs deemed a medical necessity by providers for Veterans with SCI/D are met as described in this directive.

(5) Providing and facilitating necessary communication, access, knowledge and skills acquisition, and QI efforts to maintain expertise and high-quality services in the SCI/D Centers and SCI/D Spokes throughout the SCI/D System of Care.

(6) Ensuring the awareness of the SCI/D System of Care among non-SCI/D providers so that Veterans with SCI/D are promptly referred to SCI/D providers for consultation and/or transfer.

(7) Ensuring and facilitating travel to SCI/D Centers in the designated SCI/D catchment area, in accordance with VHA Directive 1094, Inter-facility Transfer Policy, dated January 11, 2017, established criteria for travel eligibility, and use of hardship criteria, as appropriate.

(8) Communicating proposed changes which may impact the organization of the SCI/D System of Care, including but not limited to the mission, scope, staffing, bed level, and clinical services, to the SCI/D National Program Office.

g. **VA Medical Facility Director.** The VA medical facility Director is responsible for ensuring that:

(1) All health care providers and staff who care for Veterans with SCI/D in the SCI/D System of Care complete education and training. See paragraph 13.

(2) SCI/D capacity and staffing in the VA medical facility adheres to this directive.

(3) A Veteran with SCI/D admitted to the facility is assessed and offered transfer to a SCI/D Center within 72 hours of admission, if medically stable, for acute medical or surgical conditions and non-self-limiting conditions, according to established guidelines in this directive.

(4) For transfers of Veterans with SCI/D from a community facility, the VA medical facility arranges transfer to the geographically designated SCI/D Center when the Veteran is medically stable and able to travel. If the VA medical facility does not have a SCI/D Center, arrangements must be offered to transfer the patient directly to an accepting SCI/D Center.

(5) Provision is made for SCI/D patients to have emergent, medical, and primary care at the facility, provided that admission to the facility is not a prerequisite for coordinating arrangements for admission to a SCI/D Center.

h. **VA Medical Facility Chief of Staff or Chief Medical Officer.**

(1) **Facilities without a SCI/D Center.** The Chief of Staff (CoS) or Chief Medical Officer at each VA medical facility without a SCI/D Center is the accountable official for SCI/D Spoke PACTs and is responsible for:

(a) Designating SCI/D Spoke PACT staff, as described in Appendix D, to provide SCI/D primary care to, and consultative services for the SCI/D population served at the local facility.

(b) Notifying the Executive Director, SCI/D National Program Office and designated SCI/D Center of any changes in SCI/D Spoke PACT members.

(c) Ensuring that designated SCI/D Spoke PACT members are provided adequate education, including training funds and protected time to participate in national and local SCI/D training initiatives.

(2) **Facilities with a SCI/D Center.** The CoS or Chief Medical Officer at each VA medical facility with a SCI/D Center is responsible for:

(a) Ensuring that the SCI/D Center has the support, resources, staffing, and beds available to fully implement the SCI/D policies, services, and care described in this directive.

(b) Providing direct line oversight over SCI/D Centers as independent service lines.

(c) Ensuring the planning and administration of the urodynamics laboratory takes place.

1. **Safety.** Ensuring routine evaluations of radiographic equipment, training of staff, and ensuring staff members wear radiation dosimeters will follow facility procedures. Since autonomic dysreflexia is a risk during urodynamics, blood pressure monitoring equipment must be available and medications to treat autonomic dysreflexia must be readily available in the room. Appropriate emergency support must be available to the urodynamics suite.

2. **Urodynamics Studies.** Ensuring urodynamics evaluation are offered to Veterans with SCI/D during their initial evaluation after onset of SCI/D or after the period of spinal shock has ended, if clinically indicated, unless there are specific contraindications to performing urodynamics. Urodynamics studies should be performed and/or repeated as clinically indicated. Video-fluoroscopy may provide helpful anatomic information.

3. **Personnel.** Ensuring only competent personnel knowledgeable in urodynamics, urodynamic instrumentation, and technical analysis may perform and/or assist in the study. A physician competent in urodynamics or uroradiology must be available for consultation during the study.

i. **VA Medical Facility Associate Director of Patient Care Services.** The VA medical facility Associate Director of Patient Care Services/Nurse Executive (ADPCS/NE) is responsible for:

(1) Ensuring that the SCI/D Center has the nursing support, resources, staffing, and beds available to fully implement the SCI/D policies, services, and care described in this directive.

(2) Implementing plans to provide nursing care, treatment, and services to Veterans with SCI/D.

(3) Implementing programs, policies, and procedures that address how nursing care needs of the SCI/D population are assessed, met, and evaluated.

(4) Implementing an effective, ongoing program to measure, analyze, and improve the quality of nursing care, treatment, and services to Veterans with SCI/D.

(5) Ensuring that designated SCI/D nursing staff are provided adequate education, including training funds and protected time, to participate in national and local SCI/D training initiatives.

j. **Chief, SCI/D Center.** The Chief, SCI/D Center or designee is responsible for:

(1) **SCI/D Centers and Spokes.**

(a) Developing and maintaining the processes, standard operating procedures (SOPs), communication, access, education, knowledge, skills acquisition, and QI to ensure that Veterans with SCI/D receive efficient, Veteran-centric, data-driven, interdisciplinary team-based, comprehensive, coordinated, and high-quality care.

(b) Overseeing and directing all clinical and administrative aspects of the SCI/D Center including SCI/D Inpatient Care, SCI/D Home Care (SCI/D-HC), SCI/D LTC, SCI/D telehealth, and the SCI/D Outpatient Clinic.

(c) Coordinating all care and transfers in the SCI/D System of Care including notification of the SCI/D Spoke Coordinator of discharges from the SCI/D Center.

(d) Reviewing and approving cases for treatment outside of the designated SCI/D Center. **NOTE:** *For conditions that are treated in the SCI/D Center, see Appendix H.*

(2) Admitting eligible Veterans with SCI/D consistent with the SCI/D mission, scope of services, diagnostic etiologies, criteria for population served, medical condition, functional requirements, and criteria in this directive. **NOTE:** *SCI/D-specific criteria and utilization, rather than non-SCI/D criteria used in other areas of the VA medical facility, are used to make decisions about admissions of Veterans with SCI/D.*

(3) Approving consultation by SCI/D staff to a Veteran, treating providers, or service outside the SCI/D System of Care when the SCI/D staff has particular, specialized

knowledge (such as expertise in neurogenic bowel care) that is needed to provide high-quality care to Veterans with diagnoses other than SCI/D.

(4) Ensuring prompt and appropriate communication between the SCI/D Center and other clinical settings and facilitating communication as outlined in paragraph 6. Establishing and sustaining these lines of open communication is critical to optimize care for Veterans with SCI/D.

(5) Ensuring all key SCI/D staff members are assigned or dedicated to the SCI/D Service in a service line management structure.

(a) SCI/D Service Line Management. All SCI/D staff report to the Chief, SCI/D Center or designee (such as SCI/D department heads). The management responsibilities of the Chief, SCI/D Center or designee include:

1. Staffing levels: tracking, analysis and advocacy, including recommendations to the facility Director and CoS, ensuring appropriate staffing levels to support Veteran access.

2. Hiring of staff.

3. Daily assignments.

4. Evaluations and performance appraisals.

5. SCI/D educational activities for staff.

6. SCI/D competencies.

(b) Responsibilities of the Chief, SCI/D Center in collaboration with facility-level service chiefs include:

1. Licensure requirements.

2. Standards of practice.

3. Non-SCI/D competencies.

4. Requirements of educational degrees.

5. State practice requirements.

**(6) Comprehensive Annual Evaluations.**

(a) Ensuring an interdisciplinary team trained in SCI/D care provides annual Comprehensive Preventive Health Evaluations at a SCI/D Center (see Appendix B).

(b) Educating Veterans with SCI/D on the benefits of routine evaluations and performing regular outreach efforts to Veterans with SCI/D who have historically chosen not to participate in such evaluations.

**(7) SCI/D Registry.**

(a) Ensuring the Management of Information and Outcomes (MIO) Coordinator at each SCI/D Center works closely with the Chief, SCI/D Center to maintain the SCI/D Registry, with guidance from the SCI/D National Program Office.

(b) Ensuring the modernization and optimization of documentation procedures to support information and outcomes, with guidance from the MIO Coordinator and the SCI/D National Program Office.

**(8) SCI/D Evidence-Based Care and Best Practices.** Incorporating SCI/D clinical practice guidelines and evidence-based care within the appropriate medical care, rehabilitative, and psychosocial settings.

(a) Sharing SCI/D best clinical practices within the SCI/D System of Care.

(b) Encouraging SCI/D Center providers and Veterans with SCI/D served by their local Center to participate in SCI/D System of Care Field Advisory Councils and similar forums and contribute to the modernization and growth of the SCI/D System of Care.

**(9) Veterans in Long-Term Care Settings.** Ensuring that Veterans with SCI/D in LTC settings are tracked and that their care is appropriately managed.

(a) Ensuring that Veterans with SCI/D in all LTC settings are tracked by the designated SCI/D Center and Spoke teams through VHA administrative databases (for example, diagnostic codes, treating specialty codes) and other appropriate means.

(b) Ensuring SCI/D-HC visits all Veterans with SCI/D in LTC settings within a 100-mile radius of the SCI/D Center quarterly. For those Veterans living beyond a 100-mile radius, quarterly assessments must be made using a combination of telehealth modalities by SCI/D-HC teams in SCI/D Centers and/or SCI/D Spokes, face-to-face visits at SCI/D Spokes, and/or Home-Based Primary Care (HBPC) visits. All Veterans with SCI/D in institutional LTC settings must be contacted on a regular basis by the SCI/D-HC Program Manager at the designated SCI/D Center or Spoke, offered annual evaluations at the designated SCI/D Center, and contacted as needed for health care and equipment needs.

**(10) Guidelines and Procedures.** Ensuring that written guidelines and procedures are developed in compliance with all applicable VHA policies and accrediting organization standards and requirements, which must be reviewed annually and updated as necessary.

(11) **SCI/D Staff Hiring and Performance Evaluations.** Hiring, supervising, providing input into the annual performance evaluation of staff that work on the SCI/D Service.

(12) **Outreach.** Providing frequent contact and outreach to all VHA and community-based facilities in the SCI/D Center catchment area for SCI/D-related educational, consultative, advisory, and broad clinical oversight purposes. The Chief, SCI/D Center or designee must visit SCI/D Spokes annually.

(13) **Relationships with Non-SCI/D Services that Provide Care for Veterans with SCI/D.** Developing and maintaining productive working relationships with all staff and leaders in disciplines that care for Veterans with SCI/D to cultivate a safe and high-quality health environment and collaborating with other service chiefs in those disciplines.

(14) **Quality Improvement Activities.**

(a) Managing service-level QI activities that monitor critical aspects of care. An ongoing and continuous evaluation of SCI/D programs must be conducted to ensure the quality and appropriateness of care provided to patients. A QI committee must meet quarterly, and more frequently as needed, to identify important aspects of care and to monitor areas of service delivery, which are identified as high-risk, high-volume, or problem-prone.

(b) In collaboration with the SCI/D National Program Office and the SCI/D MIO Coordinator, providing all QI committees and work groups with reliable and valid data to support improvement activities and accountability.

(15) If an eligible Veteran with SCI/D cannot be accepted for admission at the designated SCI/D Center to which the Veteran is normally referred, that Chief, SCI/D Center, working with the Executive Director, SCI/D National Program Office, VISN Director, and VA medical facility Director, is responsible for ensuring the necessary steps are taken to facilitate care and transfer as indicated in Appendix A.

(16) Approving treatment of complex seating and/or postural abnormalities outside of the SCI/D Center.

## 6. VA SCI/D SYSTEM OF CARE

a. **Purpose.** The purpose of the VA SCI/D System of Care is to honor America's Veterans with SCI/D by providing exceptional, comprehensive, and lifelong care that improves their health, well-being, function, and quality of life. The SCI/D System of Care includes health care services designed to provide resources and care to optimize physical and mental health, educational and vocational opportunities, community reintegration, and resumption of social roles; SCI/D interdisciplinary teams of experts from many disciplines (including medicine; nursing; occupational, physical and recreation therapies; rehabilitation psychology; social work; nutrition; pharmacy) work with the Veteran to achieve and maintain independence and a good quality of life. Care

focuses on self-management and healthy behaviors, which are important for Veterans with SCI/D to prevent additional problems, maintain function, and optimize health and well-being.

**b. Overview of SCI/D System of Care.**

(1) VA has the largest SCI/D System of Care in the United States. Services provided include but are not limited to: acute care following new SCI/D; comprehensive interdisciplinary rehabilitation; sustaining medical and surgical care; primary and preventive care; psychological, social, and vocational care therapies; prosthetics and assistive technologies; Veteran and family education; research; professional training; and Whole Health care, including complementary and integrative health services. Care is provided through the SCI/D System of Care, designed as a hub and spokes model by interdisciplinary teams of SCI/D experts in the SCI/D Centers (Hubs) and designated SCI/D primary care teams at all other VA medical facilities (Spokes) that do not have SCI/D Centers. There are three unique aspects of the VA SCI/D System of Care: 1) care is comprehensive, integrated, and lifelong; 2) Veterans with both SCI and disorders are seen in the System of Care; and 3) the system is composed of Hubs with designated catchments and Spoke facilities.

(2) VA's SCI/D System of Care is an integrated service delivery network. SCI/D Centers (Hubs) provide primary and specialty care for Veterans with SCI/D. All VA medical facilities without a SCI/D Center (Spokes) have responsibility for the provision of emergent and primary care for Veterans with SCI/D by designated and trained providers.

(a) Designated catchment areas reflect longstanding linkages and are used for the transfer of Veterans from a local VA, Department of Defense (DoD), or community facility to the SCI/D Center for care in accordance with VHA travel regulations (see VHA Directive 1094). To preserve continuity of care and respecting a Veteran's right to choose, preferences will be respected for a Veteran to go to any SCI/D Center for care. See <http://vaww.sci.va.gov>. **NOTE:** *This is an internal VA Web site that is not available to the public.*

(b) Once information is received that a Veteran with SCI/D is receiving emergency, medical, or surgical care in the community, every effort must be made to provide information and consultation to the community facility by the SCI/D Spoke and SCI/D Center. The designated SCI/D Spoke and SCI/D Center must also expedite transfer to a VA medical facility as soon as possible. When safe, the Veteran is transferred to the closest or designated SCI/D Center. If the Veteran is transferred to the SCI/D Spoke, immediate referral and transfer to the designated SCI/D Center should occur if the Veteran is stable and if there is a need for further hospitalization. Referrals received from the community directly to a SCI/D Center are to be handled as a direct admission, if safe and feasible. If the Veteran desires, follow-up care is subsequently coordinated with the Veteran's local SCI/D Spoke PACT. Transportation for transfers must be expedited and follow VHA Directive 1094.

c. **SCI/D Population Served.** The SCI/D System of Care provides the full range of care for all enrolled Veterans who have SCI and SCD. See Appendix A for eligibility criteria.

d. **SCI/D Centers.**

(1) **Designated SCI/D Centers.** Designated SCI/D Centers provide SCI/D primary and specialty care with the full continuum of services.

(a) SCI/D Centers serve as regional hubs for Veterans with SCI/D, located in most regions of the country and in most VISNs. See the SCI/D intranet site (<http://vaww.sci.va.gov>) for a list of SCI/D Centers. **NOTE:** *This is an internal VA Web site that is not available to the public.*

(b) Each SCI/D Center is organized with a catchment area of VA medical facilities (Spokes) that do not have a SCI/D Center and that work closely with and refer to that SCI/D Center. See the SCI/D intranet site (<http://vaww.sci.va.gov>) for a list of SCI/D Centers. **NOTE:** *This is an internal VA Web site that is not available to the public.*

(2) **Approval and Design of SCI/D Centers.** SCI/D Centers are approved by the Under Secretary for Health and organized as an independent service line reporting to the CoS, Chief Medical Officer, or equivalent at the VA medical facility.

(a) The establishment of a new SCI/D Center must follow VA's physical plant, staffing, and resource requirements, and must be located at VA medical facilities that are capable of providing complete primary, specialty, and tertiary care, as addressed in VHA Directive 1043, Restructuring of VHA Clinical Programs, dated November 2, 2016. Uniform Federal Accessibility Standards and the Office of Facilities Management Design Guides are used in construction of all new sites.

(b) VA and PVA have an agreement specifying that PVA is offered involvement in all major, minor, and non-recurring SCI/D projects. **NOTE:** *For additional information, see VA Directive 7501, Construction Project Liaison with Paralyzed Veterans of America (PVA), dated January 15, 2009.*

(3) **Chief, SCI/D Center.** The position of Chief, SCI/D Center must be a full-time position and no one may be appointed to this position on less than a full-time basis. The following criteria are used in selecting a Chief, SCI/D Center:

(a) **Recruitment and Hiring.** The appointment of the Chief, SCI/D Center must be reviewed and approved by the Executive Director, SCI/D National Program Office and with consultation from appropriate Veterans Service Organizations (VSOs).

(b) **Requirements.** The candidate needs to meet existing VHA requirements for physicians, including credentialing and privileging requirements. Board certification in SCI Medicine is strongly encouraged. The candidate must:

1. Have completed either a SCI fellowship training or equivalent training in the care of persons with SCI/D and demonstrate clinical and administrative knowledge in SCI/D medicine enabling the candidate to successfully direct a SCI/D Center.

2. Present evidence of formal training and proven competence in leadership, administration, QI, and risk management (for example, executive/leadership courses for physicians, accrediting organizations) for the position of Chief, SCI/D Center.

3. Present evidence of interest and involvement in research and teaching.

4. Qualify for a faculty appointment if the VA medical facility is affiliated with a university.

5. The Executive Director, SCI/D National Program Office must approve exceptions to these criteria.

#### **(4) Types of Care.**

(a) Acute and Sustaining Care. Other than one SCI/D Center that provides only LTC, all SCI/D Centers provide acute and sustaining care. These Centers provide acute stabilization after onset of SCI/D; acute and subacute rehabilitation; medical, surgical, primary and preventive care; ventilator management; respite care; and end-of-life care.

(b) Long-term Care. Some SCI/D Centers also provide SCI/D LTC, providing primary care and SCI/D specialty care within their focus on sustaining health and LTC services. Veterans living in the geographic area of a designated SCI/D LTC Center often receive their SCI/D primary care and LTC services at the SCI/D LTC Center.

**NOTE:** *Uniform Federal Accessibility Standards and the Office of Facilities Management Design Guides are used in construction of all new sites. VA and PVA have an agreement specifying that PVA is offered involvement in all major, minor, and non-recurring SCI/D projects.*

(5) **Scope of SCI/D Center Services.** The scope of SCI/D Center services is to deliver comprehensive, lifelong, interdisciplinary services to Veterans with SCI/D.

(a) Services. Services provided at SCI/D Centers include but are not limited to: medical and nursing care, therapies (including physical, occupational, kinesiotherapy, therapeutic recreation), psychology, social work, vocational and rehabilitation counseling, fertility services, sexual health counseling, ventilator management and weaning, respiratory care, orthotics, prosthetics, sensory aids, assistive and emerging technologies, pain management, women's health, mental health, environmental modifications, peer counseling, substance abuse treatment and/or rehabilitation, nutrition education and counseling, weight management services, rehabilitation engineering, driver training, attendant management, parenting issues, speech and language pathology, dental services, spiritual care, respite care, Whole Health, hospice/end-of-life care, and palliative care.

(b) Settings. Each SCI/D Center must maintain access to inpatient, outpatient, consultative, SCI/D-HC, extended care, and SCI/D telehealth services as outlined in this directive.

(c) Consultative Services. VA medical facilities with SCI/D Centers must be capable of providing complete primary, specialty, and tertiary care to Veterans with SCI/D. Due to the involvement of other body systems, co-morbid conditions, complications, and other complex sequelae after SCI/D, it is imperative that Veterans with SCI/D are provided consultative services and care when needed from urology, neurosurgery, orthopedics, general surgery, plastic surgery, internal medicine, critical care, pulmonary medicine, neurology, cardiology, anesthesiology, women's health, pain medicine, radiology, oncology, palliative care, infectious disease, nephrology, dialysis, gastroenterology, and mental health services.

(d) Interdisciplinary Teams. Veteran-centric care is provided by interdisciplinary teams that provide care in inpatient, outpatient, home care, and telehealth settings. These interdisciplinary teams include providers, nurses, therapists (including physical, occupational, kinesio-, and recreation therapists), psychologists, social workers, nutritionists, clinical pharmacists, respiratory therapists, speech and language pathologists, vocational rehabilitation/compensated work therapy (CWT) and prosthetics staff.

(e) Rehabilitation. Comprehensive, coordinated, integrated, and interdisciplinary rehabilitation is provided to eligible Veterans and Active-Duty Service Members (ADSMs). (See Appendix A.)

1. The Veteran/ADSM, in collaboration with the treatment team, develops rehabilitation goals. These goals typically are focused on maximizing recovery and function; addressing barriers and obstacles that impede return to home and the community; realizing full potential for personal, psychological, social, educational, and vocational adjustment; and achieving personal independence, financial stability, and resumption of social roles. Best practices and services are available at SCI/D Centers; in the best interests of Veterans and ADSMs with SCI/D, rehabilitation must be provided in SCI/D Centers.

2. Rehabilitation Program. A SCI/D rehabilitation program is a set of interventions and integrated services to treat the SCI/D, optimize functioning, reduce disability, and prevent secondary complications. Rehabilitation programs, provided in all settings at the SCI/D Center including inpatient, outpatient, SCI/D-HC, and telehealth, are guided by principles of medical rehabilitation, community accessibility and reintegration, vocational rehabilitation/CWT, and independent living. An interdisciplinary team provides these services to Veterans/ADSMs with SCI/D and includes family members and caregivers. Rehabilitation programs are designed to:

a. Focus on the Veteran/ADSM's goals and life plans.

b. Assist the Veteran/ADSM to reach the fullest possible physical, psychological, social, vocational, educational, and vocational potential.

c. Continue as long as the Veteran/ADSM makes significant and observable improvement.

d. Promote outcomes that maximize function, minimize impairments, reduce activity restrictions, and return to meaningful social role participation.

e. Enhance quality of life and life as independently as possible.

(f) Sustaining Medical and Surgical Care. Care is provided in the SCI/D setting whenever possible and safe to ensure the best possible care for SCI/D-related issues. If necessary, care is provided in intensive care when medical care and/or monitoring dictates that level of care. When on other floors, it is essential to have SCI/D team members visit the Veteran daily and then transfer the Veteran to a SCI/D inpatient unit as soon as it is safe.

(g) Respite Care. SCI/D respite care is recognized as an important provision for families and caregivers of physically dependent Veterans. Each Veteran using attendant care is offered respite care in the SCI/D Center, unless a Veteran requests respite care in another setting. The total duration of respite care for a Veteran in a year, absent complicating factors, does not exceed 30 days as per VHA Handbook 1140.02, Respite Care, dated November 10, 2008.

(h) Services for Family, Significant Others, and Caregivers. It is important to assess and respond to the impact of SCI/D on the Veteran's family. Many families need ongoing support regarding the changes in their lives because of the Veteran's SCI/D. SCI/D social workers and psychologists are available to support and assist families of Veterans with SCI/D. Support groups for spouses and families are often beneficial. Arrangements for respite care may be needed, especially where the family member is a full-time caregiver. Non-institutional extended care services may provide additional support for the Veteran and family.

(i) Mental Health Services. Mental health services are provided or coordinated throughout the SCI/D 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 assessments, including vocational rehabilitation potential and/or readiness, social role participation, sexuality, quality of life, behavioral and mental health status, chemical dependency and use, and attendant training needs.

1. SCI/D-trained psychologists are members of the SCI/D Center inpatient, outpatient, and home care teams. They serve as excellent resources and mental health providers for Veterans with SCI/D. There are circumstances that arise in which more intensive mental health services are needed. Delivery of the highest quality of care should guide where Veterans with SCI/D and mental health conditions receive care.

Referrals are made to mental health programs on an as-needed basis and are facilitated by the SCI/D Center or Spoke PACT.

2. General mental health problems and a number of specific conditions such as substance use disorder, Post-Traumatic Stress Disorder, military sexual trauma, homelessness, and suicide prevention may be co-managed by the SCI/D psychologist and mental health services.

(j) Nutrition. Involvement of the dietician in the interdisciplinary team and nutritional assessment are critical at SCI/D Centers. Veterans with SCI/D are predisposed to obesity, diabetes, dyslipidemia, and other metabolic disorders. Other nutrition-related complications, such as cardiovascular disease, are not unique to the SCI/D population, but are more prevalent and develop earlier in life. Some complications such as pressure ulcers require close monitoring of nutritional status and interventions. Finally, nutritional assessment, monitoring, intervention, and education are important parts of the annual evaluation.

(k) Peer Counseling Services, Programs, and Referrals. Peer counseling services and programs must be provided directly at the SCI/D Center. Additional programs and services are available through VSOs and community-based peer counseling programs. VA and community-based peer counseling programs help Veterans with SCI/D and their family: adjust to the onset of new impairments and disabilities, better understand 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 SCI/D, listening to the concerns of the individual, and responding in such a way as to facilitate the rehabilitation process and enhance quality of life.

1. Coordinator for Peer Counseling. The coordinator for peer counseling referrals, programs, and services must be a SCI/D social worker or psychologist. The coordinator screens, recruits, and trains persons to serve as peer counselors and identify appropriate Veterans for participation in the program. The coordinator also monitors the involvement of peer counselors, serves as the liaison between Veteran peer counselors, community peer counselors, and VA Voluntary Services, and communicates issues and problems to the Chief, SCI/D Center.

2. Role Models. Peer counseling has been shown to be a key factor in adjusting to life with SCI/D. Peer support is valued by many Veterans with SCI/D. Based on the philosophy that the person who can be most effective in providing support is the one who has shared similar experiences, peer counseling offers the Veteran insight and practical suggestions in dealing with a variety of issues that arise after SCI/D. In selecting peer counselors, it is important to identify peers who have healthy and productive lifestyles, returned to school and/or work, are involved in successful interpersonal relationships, and have successfully reintegrated in social roles and the community. Referrals to community support groups (for example, VSOs) are also a viable option.

(l) Prosthetics Appliances and Equipment. Most Veterans with SCI/D need one or more prosthetic appliances to function throughout the day. Therefore, a regular evaluation of the Veteran's prosthetic appliances and medical equipment for maintenance, repair, and replacement is critically important. At a minimum, this evaluation should occur annually during the annual evaluation. Evaluations must also address impairments in mobility, activities of daily living (ADL), function, accessibility, communication, instrumental ADL, transportation, and barriers in the home and environment. Referral to the SCI/D Center or SCI/D Spoke for a determination of medical need and a prescription for equipment is crucial to maintain fully functional equipment. Individuals with the expertise and relevant clinical experience must perform the evaluation and complete the prescription for prosthetic items. For more complex equipment, appliances, and assistive technology devices, referral to the SCI/D Center is required.

(m) Vocational Rehabilitation. Vocational rehabilitation services must be provided to interested Veterans with SCI/D. For Veterans interested in returning to work or additional education and training, referral to the Vocational Rehabilitation Counselor on the SCI/D Center team, VHA Compensated Work Therapy Program, State vocational rehabilitation programs, a VSO, and programs available through the Veterans Benefits Administration (VBA) is recommended. Successful vocational outcome, as defined by return to work and job satisfaction, is one measure of successful rehabilitation, in addition to personal independence, community re-integration, economic self-sufficiency, and life adjustment following SCI/D that accompanies return to work.

(n) Independent Living Programs. Independent Living Programs (ILPs) are an important link in the transition of the Veteran with SCI/D from the VA medical facility 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 Veteran's reliance on others. Non-institutional extended care services are established to support the Veteran in the least restrictive environment possible. All interdisciplinary SCI/D team members serve as advocates for the Veteran with SCI/D by educating the Veteran about community resources, rehabilitation services, personal assistance programs, attendant management, economic self-sufficiency, transportation options, ramping programs, accessible housing, non-institutional extended care programs, and maximization of function to achieve community living.

**e. SCI/D Spoke Facilities.**

(1) Recognizing the need for a highly developed, efficient and integrated SCI/D health care system for Veterans with SCI/D, designated SCI/D Spoke primary care teams were implemented in 1996. Over the years, these teams have been designated by a variety of names; most recently, they were re-named as SCI/D Spoke PACTs.

(2) The main purpose of the SCI/D Spoke PACT is to ensure that primary care is provided to Veterans with SCI/D as close to their residence as possible. Knowledge of SCI/D is requisite for the efficient and effective delivery of primary care by SCI/D Spoke PACTs.

(3) **Primary versus Specialty Care.** There is no simple distinction between primary and specialty care for Veterans with SCI/D. The SCI/D Spoke PACT members must be knowledgeable about health care issues that relate to SCI/D so there is appropriate provision of primary and preventive care and to ensure that they make informed decisions about which issues need to be referred to the SCI/D Center.

(a) Primary Care.

1. Veteran-centric, personalized, proactive, team-based, comprehensive and coordinated preventive and primary care must be offered to every eligible Veteran with SCI/D. Care is frequently provided for health maintenance and common illnesses at the VA medical facility closest to the Veteran's home. Early detection of new problems is also an important function of the SCI/D Spoke PACT because Veterans with SCI/D have an extremely narrow margin for any additional health problems or complications. Relatively minor new problems may result in disproportionate new functional losses such as shoulder pain affected transfers and pressure reliefs. The prevention and early detection of new complications is of paramount importance to the Veteran with SCI/D.

2. Location of Primary Care. Veterans with SCI/D that live a long distance from the SCI/D Center often choose to get primary care from a SCI/D Spoke PACT that is closer to their home. Veteran preference, distance, and driving time are all important factors in deciding where to get primary care. Frequently, care is offered and provided at both the SCI/D Center and SCI/D Spoke PACT.

(b) Specialty Care. SCI/D Spoke PACTs will often provide care for some impairments and complications that relate to the SCI/D. For example, the SCI/D Spoke PACT typically treats urinary tract infections (UTI), autonomic dysreflexia, and spasticity. That is why it is critically important that the primary care providers and nurses are knowledgeable about SCI/D and related issues. In contrast, Veterans having SCI/D-related problems that persist or complex problems that require advanced SCI/D knowledge must be referred to the SCI/D Center. There is no simple algorithm or comprehensive list to guide the decision to refer to the SCI/D Center (more specific referral information can be provided, as referenced in paragraph b.2. below and Appendix H); therefore, close and frequent communication between the SCI/D Spoke and SCI/D Center is essential. This results in the optimal coordination of, and collaborative care between SCI/D Spoke PACTs and SCI/D Centers. The following examples are provided to clarify the importance of awareness and close communication on order to appropriately refer problems to the SCI/D Center:

1. Awareness of SCI/D-related Impairments. Providers in SCI/D Spoke PACTs must understand the unique conditions and problems that Veterans with SCI/D may develop related to underlying spinal cord dysfunction. Some of these conditions can be life-threatening (e.g., autonomic dysreflexia). There are also unique aspects of SCI/D that result in diagnostic challenges (e.g., an acute abdomen may present with subtle symptoms and signs due to impaired abdominal sensation in Veterans with higher level SCI). The following illustrative examples underscore the need to understand these

unique issues and the importance of close collaboration and communication between SCI/D Spoke PACTs and SCI/D Centers.

a. Sensory Impairments. Sensory impairments result in diagnostic challenges below the level of neurologic injury. In Veterans with SCI/D, there may be no pain during cardiac ischemia (with neurologic injuries above T2). There may be subtle symptoms and signs of cholecystitis or nephrolithiasis (with neurologic level above the mid-thoracic level). Burns and fractures may not result in typical symptoms or pain. Abdominal tenderness during palpation or rebound may be absent. UTI is often without dysuria. Painful symptoms and signs of joint pathology may be absent (e.g., arthritis, infection, Charcot joint) below the level of injury.

b. Autonomic Dysreflexia. Despite the lack of perceived pain, nociception below the level of SCI may result in autonomic dysreflexia for individuals with a neurologic level at or above T6. This is critically important to understand in treating autonomic dysreflexia and in anticipating problems following trauma and other causes of nociception below the level of injury. Treatment of autonomic dysreflexia is well described in “Acute Management of Autonomic Dysreflexia: Individuals with Spinal Cord Injury Presenting to Health-Care Facilities” [http://www.pva.org/media/pdf/cpg\\_autonomic%20dysreflexia.pdf](http://www.pva.org/media/pdf/cpg_autonomic%20dysreflexia.pdf), a clinical practice guideline developed by the Consortium of Spinal Cord Medicine. **NOTE:** *This linked document is outside of VA control and may not be conformant with Section 508 of the Rehabilitation Act of 1973.* Severe autonomic dysreflexia may occur during diagnostic tests and procedures such as cystoscopy, colonoscopy, and arthroscopy. Autonomic dysreflexia may persist following burns, fractures, the development of pressure ulcers, and surgical procedures. Distending a hollow viscus may result in severe autonomic dysreflexia. For example, clamping a Foley catheter or distending the colon with barium or air may result in life-threatening hypertension. Veterans with persistent autonomic dysreflexia that is refractory to treatment must be referred to a SCI/D Center.

c. Musculoskeletal Problems. Functionally-impairing new musculoskeletal problems must be referred to the SCI/D Center. What may be a relatively minor symptom or problem in someone without SCI/D is often a serious, challenging problem in a Veteran with SCI/D. For example, rotator cuff tendinitis in a Veteran with paraplegia can cause difficulties with transfers, pressure releases, and wheelchair propulsion. The development of a new pressure ulcer frequently follows the onset of shoulder pain. Rehabilitation, change in technique, and new equipment may be necessary following the onset of new upper limb pain. Seemingly straightforward musculoskeletal problems may be signs of distant pathology (e.g., syringomyelia presenting as shoulder or neck pain). New spine problems (e.g., instrumentation failure, progressive scoliosis, Charcot joint) are difficult to diagnose and treat.

d. Neurogenic Bowel. Diagnosis and management of problems related to neurogenic bowel often require input from an expert provider. Since management of the neurogenic bowel involves diet, fluid intake, activity, medications, a bowel program, and specialized equipment, optimal care often requires close communication and coordination between the SCI/D Spoke PACT and SCI/D expert nurses at the SCI/D

Center. An apparently simple problem such as diarrhea might be a symptom of impaction. Diarrhea in a person with SCI/D is complicated by lack of sensation, difficulty with frequent transfers to a commode, difficulties in cleaning up and changing clothes repeatedly, and the risk of skin breakdown. A seemingly straightforward preparation for colonoscopy is complicated in a person with SCI/D because there may be multiple episodes of incontinence, episodes of autonomic dysreflexia, and no sensation of stool evacuation.

e. Pulmonary Issues. The treatment of pulmonary issues, particularly in Veterans with SCI/D with impaired cough, is often problematic. Impaired cough is a result of paralysis or weakness of expiratory muscles. Mid-thoracic neurologic injuries and tetraplegia often result in impaired cough resulting in difficulty clearing secretions. An initial uncomplicated upper respiratory infection may evolve and result in lower respiratory complications including pneumonia. Veterans with tetraplegia often have unopposed parasympathetic innervation of the bronchial tree resulting in bronchoconstriction. Atelectasis, mucus plugging, and respiratory failure may occur in Veterans with higher-level SCI/D. Techniques such as assisted cough and postural drainage along with specialized equipment (e.g., Cough Assist Mechanical Insufflator-Exsufflator) are often needed.

f. Urinary Tract Complications. The assessment and treatment of urinary tract complications are often complex and require subspecialty care by expert providers in urology and spinal cord medicine. Complex urinary tract problems (e.g., new onset hydronephrosis, recurrent UTI, nephrolithiasis, and progressive renal insufficiency) often require specialized diagnostic tests (e.g., urodynamics), trained staff (e.g., transfers and positioning of a person with SCI/D for urodynamics or cystoscopy are often difficult), and close surveillance for complications such as autonomic dysreflexia. Determinations of optimal bladder management, botulinum toxin injections, sphincterotomy, the use of electrical stimulation, bladder augmentation, urinary diversion, and other urologic procedures must occur in the SCI/D Center.

2. Referral to the SCI/D Centers. The following are examples of problems that must be referred to the SCI/D Center (see Appendix H for referral guidelines):

a. Recurrent or persistent problems. Examples such as new persistent pain, recurrent UTI, autonomic dysreflexia that persists despite appropriate treatment, and musculoskeletal pain that does not resolve must be referred to the SCI/D Center for further assessment and management.

b. Complex problems that require SCI/D expertise. Unique and/or complex problems that require specialized knowledge such as complications with spine instrumentation, complex seating issues, implementation of new/emerging assistive technology devices, urodynamics, rotator cuff tear, and pneumonia in Veterans with higher-level neurologic SCI/D must be referred to the SCI/D Center.

c. Complex problems that require interdisciplinary treatment. Problems that require assessment and management by the SCI/D interdisciplinary team, such as the

initial development of a Stage 3 or 4 pressure injury, lower limb fracture, persistent incontinence, and new functional impairments must be referred to the SCI/D Center.

d. Rehabilitation. Acute and subacute rehabilitation must be referred to SCI/D Centers; rehabilitation may be for new SCI/D as well as rehabilitation for new problems that arise in Veterans with existing SCI/D (for example, new onset upper limb pain that interferes with self-care, wheelchair propulsion, and transfers).

e. All elective surgeries must be performed at the SCI/D Center unless specifically approved by the SCI/D Center Chief. Seemingly straightforward surgeries may be complicated by SCI/D-related impairments. Planned surgeries through care in the community must also be discussed with the SCI/D Center Chief. Resources, expertise, post-operative care, and coordination may be sub-optimal in non-SCI/D Center settings. All major surgeries must be transferred to a VA medical facility with a SCI/D Center unless an emergency requires immediate attention and transfer is not safe.

f. Veterans with SCI/D hospitalized in a VA medical facility that does not have a SCI/D Center must be transferred to the SCI/D Center if a longer duration hospitalization is anticipated. Close communication with the SCI/D Center is essential. Recognizing that some hospitalizations will be of short duration and uncomplicated, the SCI/D Spoke PACT should assess the Veteran daily and determine if transfer is appropriate within 72 hours of admission. The SCI/D Spoke PACT should visit the Veteran with acute care needs daily to address SCI/D-specific issues such as management of neurogenic bowel.

g. Complex and emerging technologies must be referred to the SCI/D Center including such things as new wheelchair prescriptions and fitting, evaluation and prescription of environmental control units, and vehicle adaptations for driving.

f. **Community-Based Outpatient Clinics.** Use of a VA Community-Based Outpatient Clinic (CBOC) is discouraged for Veterans with SCI/D due to lack of SCI/D-trained staff and services. However, Veterans often choose to go to CBOCs. If that is the case, the CBOC and parent VA medical facility must assist with tracking, consultation, and referrals for the Veteran. Education of the Veteran must occur about advantages in receiving care (for example, annual evaluation) at the SCI/D Center. Education of CBOC staff must occur by the SCI/D Center and/or the SCI/D National Program Office to ensure appropriate and safe care. Use of telehealth between the CBOC and SCI/D Center will facilitate best practices and introduce the Veteran to SCI/D Center staff.

g. **Principles of Care for Veterans with SCI/D.** Veterans with SCI/D are a vulnerable, complex population due to ongoing impairments, functional limitations, and disabilities from the underlying SCI/D and the high risk of developing new complications and co-morbid conditions. Ongoing primary and preventive, rehabilitative, and sustaining care are critically important to maintain independent living and a high quality of life.

(1) **Access and Timeliness.** Access and timeliness are essential components of high quality health care particularly for Veterans with SCI/D due to the complexity of their health care and the extremely narrow margin for any additional health problems or complications. Relatively minor new problems may result in disproportionate new functional losses. The prevention and early detection of new complications is of paramount importance. Utilizing resources in all settings at the SCI/D Center and throughout the SCI/D System of Care are important to prevent relatively minor complications from becoming major health issues.

(2) **Comprehensiveness.** Comprehensiveness in the SCI/D PACT ensures that Veterans with SCI/D are offered and provided all necessary and appropriate health care. Care must be delivered that meets the needs and preferences of the Veteran with SCI/D. The SCI/D interdisciplinary team provides primary and specialty care. Non-SCI/D primary care providers are often unaware of the unique conditions and complications that accompany SCI/D. The SCI/D PACT team is able to treat the wide array of impairments, conditions, and complications associated with SCI/D. The addition of a primary care provider to the SCI/D PACT recognizes the complexity of care in this population, facilitates the SCI/D PACT team in delivering comprehensive care to the Veteran with SCI/D, and improves the overall quality of care for Veterans with SCI/D.

(3) **Shared Care Plan.** Often, a care plan will be developed in the SCI/D Center and follow-up care must be shared between the SCI/D Spoke and SCI/D Center. For example, developing a comprehensive treatment program for chronic neuropathic pain must occur in the SCI/D Center; however, assessment of changes and treatment over time may involve both settings. The assessment and treatment of spasticity, pressure ulcers, prescribing and modifying a wheelchair, pressure mapping, and seating are initiated in the SCI/D Center; subsequently, the Veteran is often followed in both settings. Close communication between the SCI/D Spoke and SCI/D Center is critically important in all of these cases to provide the best possible care for Veterans with SCI/D. Care plans will also include mutually-established health goals based on Veterans' values, priorities, and perspectives.

(4) **SCI/D Patient-Centered Care.** SCI/D rehabilitation and SCI/D medicine must always focus on personalized, proactive, and Veteran-centric health care. Planning based on the individual needs and preferences of the Veteran with SCI/D is a central tenet of SCI/D rehabilitation, the standards of the Commission on Accreditation of Rehabilitation Facilities (CARF), and of the SCI/D System of Care. The SCI/D Center PACT works with each Veteran with SCI/D to acquire and maintain knowledge and skills, engage in self-care and self-management, while providing resources, support, and coaching to succeed in living as independently as possible. Education, resources, and communication must be available to each Veteran so the prevention and early detection of complications occurs.

(a) SCI/D Interdisciplinary Team-Based Care. Team-based principles guide inpatient and outpatient interdisciplinary care. Living in the community with severe impairments and disabilities from SCI/D is complex. Encountering obstacles and

barriers that interfere with life is the norm. SCI/D professionals from various disciplines (medicine, nursing, physical therapy, occupational therapy, therapeutic recreation, social work, psychology, nutrition, and pharmacy) are required to provide the support and resources necessary for Veterans with SCI/D to maintain independence and good health. Required staffing for the SCI/D Center PACT interdisciplinary team is included in this directive (see Appendix D).

(b) Care Coordination and Continuity of Care. Providing care to Veterans with SCI/D is complicated and involves large teams of providers, frequently across long distances and between facilities. Strategies to establish and maintain relationship continuity across settings and facilities may include: simplify point(s) of contact at the SCI/D Center and SCI/D Spoke so the Veteran can easily reach the team; establish points of accountability for sending and receiving care (for example, use of consults); adopt standardized ways to exchange information; utilize clinical decision support to alert providers that additional information is needed and/or has arrived; increase the use of case management and care coordination; use technology to support transitions and continuity of care; use QI methodologies at the SCI/D Centers to enhance continuity infrastructure and processes; use secure messaging and other virtual health modalities; and establish measures, monitor continuity, and develop performance metrics that focus on care coordination and continuity of care.

(5) **Women Veterans with SCI/D.** Care for women Veterans with SCI/D is to be provided in accordance with VHA Directive 1330.01(2), Health Care for Women Veterans, dated February 15, 2017.

(a) The special needs of women Veterans with SCI/D must be met through provisions for privacy (private rooms or shared rooms with other women), appropriate supplies, apparel, and access to women's health care services as outlined by the Women Veterans Health Care Group. The designated SCI/D primary care providers provide or arrange for efficient women's health care and gender-specific screenings during the Veteran's comprehensive evaluation. Consideration must be given to provide the services in the SCI/D clinic examination rooms so there is SCI/D nursing expertise, accessibility, safe handling, and appropriate equipment.

(b) When the SCI/D primary care provider and/or Veteran chooses to have these screenings done by Women's Health Care, pre-arrangements for this care during the annual evaluation, or when issues arise, must be made with Women's Health Care. Close communication between Women's Health Care and SCI/D providers is essential to provide high-quality care. If Women's Health Care is provided through the Community Care Program (including the Choice Program), all efforts must be made by the Chief, SCI/D Center or designee to educate community providers about SCI/D-related issues and possible complications (for example, skin breakdown, autonomic dysreflexia).

(6) **Lesbian, Gay, Bisexual, Transgender, and Intersex Veterans with SCI/D.** Care for Veterans with SCI/D who identify as lesbian, gay, or bisexual is to be provided in accordance with VHA Directive 1340(1), Provision of Health Care for Veterans Who

Identify as Lesbian, Gay, or Bisexual, dated July 6, 2017. Care Veterans with SCI/D who identify as transgender or intersex is to be provided in accordance with VHA Directive 1341(1), Providing Health Care for Transgender and Intersex Veterans, dated May 23, 2018.

**h. Availability of Medical and Surgical Supply Products for Veterans with SCI/D.**

(1) The VA National Formulary (VANF) contains a section dedicated to outpatient medical and surgical supply products. Medical and surgical supply products listed on VANF are intended to provide each VISN and local facility direction in the selection of the formulary items that must be made available at all facilities for the care of Veterans. The medical and surgical supply section of VANF is a generic listing of the broad range of products that must be made available.

(2) The medical and surgical supply section of VANF is not intended to be exclusionary or to preclude a patient from receiving a product deemed medically necessary. SCI/D specialty care needs often require the use of a brand of product for which a normally interchangeable alternative may not be adequate or medically acceptable. It is acknowledged by SCI/D experts that a number of Veterans with SCI/D have used a particular medical and surgical supply product for years, and that the continued availability of those products in lieu of a standardized product is necessary.

(3) VISN practices are expected to include the medical and surgical supply products necessary to achieve the intent of this directive.

**(4) Processes.**

(a) Medical Necessity for Veterans with SCI/D. Medical and surgical supply product needs deemed a medical necessity for Veterans with SCI/D are documented in the medical record by SCI/D providers.

(b) Non-Formulary Request Process. VISN Commodities Standards Committee and the VANF non-formulary request process are used to address unique patient needs for medical and surgical supply products. According to VHA Directive 1108.08(1), VHA Formulary Management Process, dated November 2, 2016, when patient care is transferred between VA facilities, previously approved non-formulary or prior authorization products are to be provided without requiring a second non-formulary or prior authorization request.

(c) Education and Communication. Clinicians educate Veterans with SCI/D about any differences between standardized medical and surgical supply products and the requested non-standardized product. Before any change in a medical or surgical supply product is made, both prescriber and Veteran acceptance issues must be addressed. Once non-standardized medical or surgical supply products are deemed medically necessary by a SCI/D provider, the products must be made available.

## 7. SCI/D CENTERS INPATIENT PROGRAM

a. **Full Spectrum of Care.** SCI/D Centers provide comprehensive, lifelong, interdisciplinary SCI/D services to Veterans, including but not limited to: acute stabilization after new SCI/D, acute and subacute rehabilitation, medical care, surgical care, primary and preventive care, nursing care, therapies (including physical, occupational, kinesiotherapy, therapeutic recreation), psychology, social work, vocational and rehabilitation counseling, fertility services, sexual health, ventilator management and weaning, respiratory care, orthotics, prosthetics, sensory aids, assistive and emerging technologies, videofluoroscopic studies of swallowing, pulmonary function tests, pain management, women's health, mental health, environmental modifications, peer counseling, substance abuse treatment and/or rehabilitation, geriatrics and gerontology, nutrition education and counseling, weight management services, rehabilitation engineering, driver training, attendant management, parenting issues, speech and language pathology, dental services, spiritual care, respite care, hospice/end-of-life care, palliative care, and LTC.

b. **Accreditation.** SCI/D Centers with acute care beds must maintain accreditation from CARF and The Joint Commission for acute care beds. Survey oversight for SCI/D LTC beds is in development in collaboration with the Office of Geriatrics and Extended Care (GEC).

c. **Location of Patients.**

(1) All inpatients with SCI/D should be located on the SCI/D unit unless there is a need for critical care or monitoring that is not possible or safe on the SCI/D unit or if there are other issues that compromise the Veteran's safety or the safety of others on the SCI/D unit or there are other exceptional clinical circumstances. Safety must always be the primary consideration in placing a Veteran with SCI/D in a particular location. Since there are many SCI/D care considerations and unique issues, the SCI/D unit is usually the safest place for the Veteran.

(2) **Veterans with SCI/D Located in Non-SCI/D Bed Sections.** If a Veteran with SCI/D is physically located on a unit other than the SCI/D unit, the Veteran's SCI/D provider or the Chief, SCI/D Center must ensure that SCI/D needs are addressed. This requires a SCI/D provider and a SCI/D nurse to visit the patient on a daily basis and the assessment and clinical recommendations must be documented in the Veteran's medical record. Other SCI/D interdisciplinary team members must visit the Veteran as needed and provide care. As soon as it is safe and the patient is stable, the Veteran must be transferred back to the SCI/D unit.

d. **Inpatient Interdisciplinary Comprehensive Treatment Plan.** See Appendix H for the required components and processes of the inpatient interdisciplinary comprehensive treatment plan.

## 8. SCI/D CENTERS OUTPATIENT PROGRAM

a. The SCI/D Center Outpatient Program provides the full spectrum of health care and rehabilitation that is patient-centered, interdisciplinary team-based, accessible, efficient, comprehensive, coordinated, and provides continuity of care. Every SCI/D Center must have an Outpatient Program of scheduled hours and treatment, including SCI/D primary care, specialty care, and the ability to accommodate unscheduled visits from Veterans with SCI/D. Any triage to non-SCI/D providers must include SCI/D consultation.

b. The scope of outpatient treatment at SCI/D Centers is comprehensive and interdisciplinary. Services provided to a particular patient are a part of a continuum from inpatient services to outpatient care and other services including SCI/D Home Care (SCI/D-HC) and telehealth when needed. Communication with the SCI/D Spoke PACT is critically important when the Veteran is seen at both a SCI/D Center and Spoke.

### c. SCI/D Center PACTS.

(1) **SCI/D PACT Principles.** SCI/D PACT principles establish the foundation for high-quality primary and specialty care for Veterans with SCI/D. In SCI/D Centers, the SCI/D PACT follows the purposes, principles, operations, and processes described in VHA Handbook 1101.10(1) and this directive (see Appendix J).

(2) **SCI/D Center PACT Members and Staffing.** The SCI/D Center PACT includes the Veteran with SCI/D, the Veteran's support person(s) (for example, family members, caregivers, or others at the discretion of the Veteran), and the SCI/D Center PACT interdisciplinary team (see Appendix D).

## 9. SCI/D CENTERS HOME CARE PROGRAM

### a. SCI/D Center Home Care Principles and Operations.

(1) SCI/D-HC follows the purposes, principles, operations, and processes described in VHA Directive 1411, Home-Based Primary Care Special Population Patient Aligned Care Team Program, dated June 5, 2017, and in this directive.

(2) SCI/D-HC administered from the SCI/D Center supports the transition and health care needs of Veterans with SCI/D in the home setting or the institutional LTC setting. SCI/D-HC consists of interdisciplinary services as an integral part of the SCI/D System of Care under the clinical and administrative responsibility of the Chief, SCI/D Center. All SCI/D Centers must have a dedicated SCI/D-HC program as described in this directive with dedicated SCI/D-HC staff (see Appendix D).

(3) In some cases, the care is episodic and single-problem focused; however, in many cases, the care is longitudinal and comprehensive, targeting high-risk Veterans with complex, chronic problems. SCI/D-HC services include but are not limited to: rehabilitation, primary care, specialty care, disease management, caregiver assistance and support, and coordination of care.

(4) SCI/D-HC is not designed to supplant SCI/D inpatient and outpatient services; rather the program enhances the continuum of services to support Veterans with SCI/D in the community. All Veterans in SCI/D-HC are eligible for inpatient admission to, and outpatient services at, the SCI/D Center. The interdisciplinary nature of SCI/D-HC is consistent with the overall mission and philosophy of the SCI/D System of Care.

(5) SCI/D-HC renders important medical, rehabilitation, and preventive services determined necessary to support Veterans with SCI/D in the community and assists the VHA Medical Foster Home (MFH) Care Coordinator in specialized home assessments, the provision of caregiver training for the MFH caregiver, and routine care visits to ensure proper management of bowel and bladder care, skin care, and pain management.

(6) Telehealth technologies and devices may be used to supplement SCI/D-HC and extend care to Veterans that live beyond a 100-mile radius from the SCI/D Center.

b. **SCI/D Home Care Standards.** SCI/D-HC must meet all of the following standards:

(1) An interdisciplinary team must be dedicated to SCI/D-HC as detailed in this directive (see Appendix D).

(2) Episodic and longitudinal comprehensive services are provided directly by the SCI/D-HC team in the home or using telehealth technologies.

(3) The SCI/D-HC Program Director provides oversight of interdisciplinary team meetings and is accessible and responsive when time-sensitive situations arise.

(4) Adequate support staff is available to support clerical, administrative, and clinical demands.

(5) SCI/D-HC must meet and maintain VHA standards including the home care standards necessary for accreditation of the parent VA medical facility, as referenced in VHA Directive 1411.

(6) Each SCI/D-HC program must have a local patient information guide. Veterans with SCI/D in SCI/D-HC have the same rights and responsibilities as other Veterans in the VA health care system. The rights of each Veteran will be outlined in that patient information handbook. Every effort will be made to ensure that Veterans understand and exercise their rights and responsibilities in relation to their own care. The patient information handbook is to be drafted in accordance with VHA Handbook 1120.04, Veterans Health Education and Information Program Requirements, dated September 24, 2015.

(7) Before admission to SCI/D-HC, the Veteran and caregiver must be evaluated by a SCI/D-HC clinician and provided with adequate education from all appropriate disciplines to ensure successful participation.

(8) Upon admission to SCI/D-HC, a treatment plan must be developed by the interdisciplinary team in collaboration with the Veteran, and if desired, the family or caregiver. Specific goals of treatment and target dates for accomplishment must be included. The SCI/D-HC interdisciplinary team must conduct appropriate assessments and clinical reviews in the home to develop individual treatment goals and plans based on a comprehensive interdisciplinary assessment of the Veteran.

(9) A provider must order home visits.

(10) Each team member must write progress notes after every home visit.

(11) Formal consults are not required among the core clinical team members unless otherwise required by discipline-specific license, scope of practice, or reimbursement guidelines. Consults may also be useful for specific workload capture or tracking purposes. Disciplines that require provider orders will operate under those orders.

(12) The interdisciplinary SCI/D-HC team must implement the plan of care through home visits or video telehealth, as indicated and appropriate.

(13) SCI/D-HC must participate in the service-based SCI/D Quality Improvement (SCI/D-QI) program.

c. **SCI/D Home Care Services and Settings.** SCI/D-HC provides a full array of health care services in the home and extended care settings.

(1) These services include but are not limited to: rehabilitation; prevention of complications; direct medical and nursing care to manage co-morbid conditions; management of common impairments that follow SCI/D such as pressure ulcers, autonomic dysreflexia, neurogenic bladder, and neurogenic bowel; home evaluation; education, support, and SCI/D-related training for the Veteran, family members, caregivers, and/or community agencies that provide care for the Veteran; therapies (physical and occupational for such issues as mobility, ADL, transfers, activities and exercise); psychological, mental health, and social support; nutritional counseling; coordination of care and services; clinical pharmacist medication review and management; assessment of equipment and assistive technology needs; education and vocational follow-up; leisure counseling and training; spiritual support; and assessment of needs for homemaker or home health aide services with referrals to VHA programs and/or community referrals.

(2) SCI/D-HC provides services in the home, which is defined as the private residence in which the Veteran resides. This includes MFHs, adult foster care, and community residential care settings.

(a) SCI/D-HC team members provide education and training to staff in extended care settings including but not limited to: VA Community Living Centers (CLCs), contract nursing homes, and community nursing homes.

(b) The SCI/D-HC team supports the development of SCI/D MFHs as resources allow and as supported by State laws. SCI/D-HC provides home health care and monitors care provided by the MFH caregiver. To support the MFH, SCI/D-HC will:

1. Provide home health care services to Veterans in MFH in accordance with VHA Directive 1411 or SCI/D-HC.

2. Educate the MFH caregiver and relief caregivers in specialized Veteran care needs.

3. Evaluate the need for adaptive medical equipment and appropriate home improvements and assist eligible Veterans with Home Improvements and Structural Alterations (HISA) Grants, Specially Adapted Housing (SAH) Grants, or Special Housing Adaptation (SHA) Grants when indicated as provided under Public Law 93-538 and in accordance with VHA Directive 1173.14, Home Improvements and Structural Alterations (HISA) Program, dated December 26, 2017.

4. Identify any need for community resources and support appropriate choice of community home care services.

5. Support the MFH caregiver and Veteran through efficient communication and problem solving.

6. Update the Veteran's family or surrogate regarding changes in the Veteran's medical condition in accordance with VHA privacy policy and procedures.

7. Assist the MFH Coordinator in monitoring the MFH environment with special emphasis on safety, potential for abuse and neglect, signs of caregiver stress or burnout, and any other issues and concerns that may arise.

8. Report any MFH violations or medical, psychiatric, or psychosocial concerns to the MFH Coordinator.

9. Assist in scheduling respite care to alleviate caregiver stress and fatigue.

d. **Determination of Patient Appropriateness for SCI/D Home Care.** Before the Veteran is admitted to SCI/D-HC, at least one initial admission evaluation home visit by a SCI/D-HC clinician must be completed. If appropriate, this clinician will recommend admission, with concurrence by the interdisciplinary team. If not appropriate for admission, the SCI/D-HC team makes and communicates recommendations regarding an alternate plan for managing the Veteran's needs. The following considerations are to be used in determining whether the Veteran is appropriate for admission to SCI/D-HC:

(1) The Veteran must be enrolled in the VA health care system.

(2) Enrolled Veterans with SCI/D living within a 100-mile radius of the SCI/D Center are eligible to be enrolled in SCI/D-HC. Veterans living beyond 100 miles of the SCI/D Center may be evaluated by SCI/D-HC if approved by the Chief, SCI/D Center.

(a) If the Chief, SCI/D Center makes an exception, SCI/D-HC must be able to provide safe and efficient health care and service delivery.

(b) Alternatively, Veterans living beyond 100 miles may be referred to a closer VA medical facility (SCI/D Spoke) and SCI/D Spoke PACT, and/or Home Based Primary Care (HBPC) for follow-up care. Virtual health modalities such as telehealth may be used by the SCI/D-HC team to provide care for Veterans with SCI/D living beyond a 100-mile radius from the SCI/D Center.

(3) The Veteran must have a need for health, rehabilitative, preventive, primary care, and/or SCI/D-related services in the home.

(4) The home environment must be safe for the Veteran and SCI/D-HC staff. The home environment must also be physically suitable or adaptable for care to be provided in the home.

(5) The Veteran's health care and needs must be able to be managed or coordinated by the SCI/D-HC team.

(6) The Veteran must voluntarily accept SCI/D-HC staff into the home and care by the SCI/D-HC team.

(7) Veterans with SCI/D who are enrolled in VHA and institutional care settings (for example, VA CLCs, community contract and non-contract nursing homes) and MFHs must be seen and followed by SCI/D-HC staff (at a minimum quarterly and more frequently as indicated) when they reside within a 100-mile radius of the SCI/D Center.

e. **Admission.** The medical record must contain a note with an admission title or a clear statement of admission to SCI/D-HC within a progress note. This will serve as the admission date to SCI/D-HC. After the Veteran with SCI/D is determined to meet SCI/D-HC admission criteria, the Veteran is scheduled for comprehensive, interdisciplinary team assessments. All SCI/D-HC assessments must be completed no later than 30 days from the SCI/D-HC admission date.

f. **Plan of Care.** Once the assessment is completed, the SCI/D-HC team develops a plan of care within 30 days of the SCI/D-HC admission date. Plans of care should be reviewed on a quarterly basis on all SCI/D-HC patients. Utilizing screening and assessment results and taking patient and caregiver input and preferences into consideration, the SCI/D-HC team develops an interdisciplinary plan of care during a regularly scheduled team conference. The plan of care for each patient is customized to include the Veteran's health goals, problems identified by the members of the team, Veteran and caregiver goals and preferences, a current medication profile and goals of care with specific interventions, timeframes, and assigned team member responsibility. The SCI/D-HC interdisciplinary team members acknowledge and concur with the plan of care in the medical record, which is signed by the SCI/D-HC Program Director, or designee. As the Veteran's goals and/or health conditions change, the plan must be updated as needed. Interdisciplinary team conferences must be held on a weekly basis to ensure timeliness of care planning for new and established patients. The

interdisciplinary care plan must be reviewed and updated by the entire team no less than on a quarterly basis (or more frequently when there is a change in the patient's condition) or as required by accrediting organizations and a determination made regarding the need for continuance in the program.

g. **Delivery of Care.** SCI/D-HC staff provides direct care, care management, and coordination of care in the Veteran's home. Care is organized and provided to maintain a therapeutic home environment that supports the Veteran to remain in the community.

(1) Duration of care and frequency of home visits are determined by clinical judgment using a process of continuous reassessment and monitoring of clinical needs. Veterans with SCI/D may have problems that are focused on a single issue (for example, pressure ulcer healing) or complex problems that involve many members of the rehabilitation team (for example, recent onset of SCI/D). The types of problems and suggested frequency of home visits include but are not limited to:

(a) **Recent Onset of SCI/D.** Veterans with new onset SCI/D are adjusting to community living and likely have several complex issues related to impairments, function, the home environment, education, and coping with changes related to SCI/D. Due to the scope and/or severity of problems, these Veterans might receive a visit once per week, or more frequently, by the appropriate disciplines to address ongoing issues and to assist with problem-solving.

(b) **Change in Attendant Care.** Veterans may be at risk when they have a new attendant. If desired by the Veteran, weekly visits should be conducted until the Veteran is comfortable that the attendant is fully trained.

(c) **Ongoing Maintenance Needs.** Veterans with SCI/D need to focus on prevention and health maintenance. Such maintenance includes but is not limited to: nutrition counseling, physical activity, stress management, and/or review of chronic problems such as review of stable pressure ulcers. These types of issues may be addressed once per month, or more often as clinically indicated.

(d) **Preventive Care.** Veterans seen for preventive care may receive a visit every quarter, or more frequently as clinically indicated, by an appropriate discipline associated with the SCI/D Center. These Veterans include individuals at high risk for recurrence of problems who may benefit from ongoing monitoring to avoid hospitalization.

(2) Length of participation in SCI/D-HC is determined by clinical need. There is an expectation that Veterans with new SCI/D will be enrolled in SCI/D-HC. The general philosophy and focus of services is on independent living in the community, however, length of participation in SCI/D-HC for newly injured Veterans may be longer because the adjustment to life at home is sometimes difficult and complicated. All Veterans must be re-evaluated every 90 days, or as required by accrediting organizations, regarding need for continuation of the program.

h. **Responsibilities of the SCI/D Home Care Team.**

(1) **SCI/D Home Care Team.** SCI/D-HC team members must be interdisciplinary and qualified to meet the Veteran's identified needs and treatment goals. Each Veteran within SCI/D-HC is assigned the appropriate staff members from the SCI/D-HC team.

(a) All clinical SCI/D-HC team members must participate in the development of a local manual of SOPs that define and govern the clinical and administrative aspects of the program at the VA medical facility. This manual is a dynamic document that reflects local team practices. It is to be reviewed and revised by the team including the SCI/D-HC Program Director. Some of the SOP elements should include but are not limited to: prevention, early detection, and management of SCI/D complications in the home environment; Veteran and staff safety; environmental safety; emergency preparedness; medication management including the handling of high risk medications in the home; infection prevention and control in home care; management of patients Do Not Resuscitate (DNR) / Do not intubate (DNI) / Medical Orders for Life Sustaining Treatment (MOLST) / Patient Orders for Life Sustaining Treatment (POLST); confidentiality; information security; and addressing Veteran concerns and complaints.

(b) All team members must:

1. Participate in administrative and clinical team meetings.
2. Provide input to the individualized plan of care through the initial and ongoing team care planning for each Veteran, review the plan of care at least quarterly or as required by accrediting organizations, and implement the plan of care through home evaluations, home visits and/or telehealth, as indicated.
3. As a team, review progress toward goals on a quarterly basis, or more frequently when there is a change in the Veteran's condition.
4. Share new developments with other team members, pertaining to the Veteran and home situation.
5. Evaluate safety and emergency preparedness in the home.
6. Participate in inpatient discharge planning activities.
7. Identify areas for continuing education and participate in training activities, on-going staff development, and continuing education activities for SCI/D-HC.
8. Participate in developing and implementing the process for continuous performance improvement.
9. Report program needs, problems, or concerns to the SCI/D-HC Program Director.

(2) **SCI/D Home Care Program Director.** The SCI/D-HC Program Director is dedicated to SCI/D-HC program management. The role may be titled as the SCI/D-HC Program Coordinator or SCI/D-HC Program Manager. The SCI/D-HC Program Director

reports directly to the Chief, SCI/D Center. The SCI/D-HC Program Director provides the vision of the SCI/D-HC program, working to ensure the proper framework is in place to support the transition and health care needs of Veterans with SCI/D in the home setting or the institutional LTC setting. Functions of the SCI/D-HC Program Director include but are not limited to: planning, staffing, directing, budgeting, ensuring the development and tracking of outcomes, ensuring evaluation and tracking of the program, and developing VHA and community relationships. Resource management responsibilities include assuring appropriate resources are designated for the support of SCI/D-HC and safety of the SCI/D-HC staff. These resources include appropriate space, time, medical and information technology and communications equipment, as well as vehicles for the daily use of SCI/D-HC staff. The SCI/D-HC Program Director provides administrative direction to the program, including interpreting national SCI/D-HC handbooks and directives, local VA medical facility policy, and accreditation guidelines to the SCI/D-HC interdisciplinary team and the VA medical facility. The SCI/D-HC Program Director is also responsible for:

(a) Directing the clinical services offered by the program to ensure that the program is in compliance with local and national VHA standards and policies as well as accreditation standards for home care organizations.

(b) Developing and continuing effective functioning of the interdisciplinary SCI/D-HC team. The SCI/D-HC Program Director recognizes and effectively utilizes the skills, knowledge, and contributions of each team member.

(c) Collaborating with other SCI/D-HC Program Directors and the SCI/D National Program Office staff on issues of program development and operation.

(d) Interpreting and communicating VHA policies and accreditation guidelines to the SCI/D-HC team, VA medical facility staff, and SCI/D staff.

(e) Managing program SOPs and activities to include but not limited to: performance improvement, patient safety, utilization review, emergency preparedness, and staff safety.

(f) Designating a SCI/D-HC QI representative.

(g) Coordinating and managing of the SCI/D-HC program. Duties related to coordination and management of the SCI/D-HC program may be designated, upon approval of the SCI/D Chief:

1. Evaluating outcomes and the effectiveness of the SCI/D-HC program (for example, program reports, program outcomes, and performance improvement).

2. With guidance from the Chief, SCI/D Center, Management of Information and Outcomes (MIO) Coordinator, and the SCI/D National Program Office, modernizing and optimizing documentation procedures to support information and outcomes.

3. Acquiring, managing, and remaining accountable for program resources and resource utilization.

4. Processing, assigning, facilitating, and monitoring referrals to SCI/D-HC to ensure timely access and care coordination.

5. Managing an Electronic Wait List (EWL) for SCI/D-HC referrals, as necessary.

6. Collaborating with the appropriate data and technology departments to ensure accurate SCI/D-HC clinical, administrative, and workload data.

7. Ensuring a signed plan of care is present in the medical record of every Veteran receiving SCI/D-HC services.

i. **Veteran Education.** SCI/D-HC establishes a partnership with the Veteran. SCI/D-HC team members collaborate with the Veteran to ensure an understanding of needs, preferences, perspectives, lifestyle considerations, and self-directed goals. Information and education are provided to the Veteran with emphasis on available options and expected outcomes as well as the actions and commitment required of the Veteran to achieve desired outcomes.

(1) For meeting care needs, the SCI/D-HC team assists in mobilizing additional VHA and/or community non-institutional resources as needed.

(2) As part of the ongoing SCI/D-HC processes, Veterans, and if requested family members and caregivers, must be offered education, written information, and training in handling of emergencies, infection prevention and control, and home safety.

(a) Emergency preparedness should include planning for issues that affect all people (for example, plan for evacuation, emergency rations and water) and SCI/D-specific issues (for example, supplies and planning for neurogenic bowel program, access issues for Veterans in wheelchairs). Plans must be developed to ensure appropriate care in case of an emergency. Veterans must also be educated about local emergency services (for example, fire and police services) and encouraged to communicate with the residential building management (for example, when living in an apartment or condominium) on emergency protocol in the event of any life-threatening event such (for example, fire, hurricane, earthquake, or power failure).

(b) The program must have infection prevention and control procedures that address personal hygiene, isolation precautions, aseptic procedures, handling and disposal of wastes, staff health, transmitted infections, and appropriate cleaning and sterilization of equipment. All staff, Veterans, and caregivers must be instructed regarding their responsibilities in the infection prevention and control program.

(c) A system must be in place to report and document all accidents, injuries, safety hazards, and new complications (for example, pressure ulcers and infections) that will also be reviewed by the SCI/D-QI Committee.

j. **Discharge from SCI/D Home Care.** As clinically appropriate, discharges from SCI/D-HC should be mutually planned by the SCI/D-HC team in full partnership with the Veteran and caregiver. Veterans may elect to be discharged from SCI/D-HC at any time. A formal discharge note must be entered into the medical record. Hand-off communication is required when transferring to other caregivers and should include the opportunity for discussion between the SCI/D-HC team and providers that will be taking over care to ensure a seamless transition and coordinated continuity of care.

(1) Circumstances under which Veterans are discharged from SCI/D-HC include: the Veteran's request to be discharged from SCI/D-HC, relocation out of the SCI/D-HC area, accomplishment of goals and reaching maximum benefits from the program, lack of participation, unsafe home environment, hospitalization for an extended stay (greater than 15 calendar days), needs exceed the capabilities of SCI/D-HC, or death.

(2) Discharge from SCI/D-HC will also occur if there is a persistent and intentional refusal of a Veteran, family, significant other, or caregiver to cooperate with SCI/D-HC staff, resulting in an inability to provide services safely or effectively. Before the final decision is made, the situation must be discussed with the Veteran and if requested, the Veteran's representative, family, and/or significant other. The Veteran to be discharged must be notified in person and in writing, or by written notice if in-person notice is not possible.

## 10. SCI/D SPOKES

a. **SCI/D System of Care Spokes.** VA's SCI/D System of Care is an integrated service delivery network. SCI/D Centers (Hubs) provide comprehensive, lifelong primary and specialty care for Veterans with SCI/D as described in this directive. Each SCI/D Center has a delineated catchment area with designated SCI/D Spoke facilities. SCI/D-educated primary care teams in SCI/D Spoke facilities integrated with SCI/D Centers is a practice unique to VA. Veterans can receive care for relatively uncomplicated health care issues closer to home in SCI/D Spokes. More complex problems are referred to the SCI/D Center. The list of SCI/D Centers and their associated SCI/D Spokes can be found on the SCI/D Web site at <http://vaww.sci.va.gov>. **NOTE:** This is an internal VA web site that is not available to the public.

b. **SCI/D Spoke PACTs.** SCI/D Spoke PACTs must function as direct access to care by Veterans with SCI/D. SCI/D Spoke PACTs must use clinic stop 210 to track workload and be listed in the Patient Centered Management Model (PCMM). See Appendix J.

(1) **SCI/D Spoke PACT Principles.** SCI/D Spoke PACT principles establish the foundation for high-quality primary care for Veterans with SCI/D. As with the SCI/D Center PACTs, SCI/D Spoke PACTs practice Veteran-centric care. The Veteran and SCI/D Spoke PACT are partners in addressing the Veteran's goals of care. The SCI/D Spoke PACT practices team-based care that delivers comprehensive primary care to the Veteran with SCI/D. Access and timeliness are essential components of SCI/D Spoke PACT care and support VHA's goals to provide prompt and appropriate

treatment for Veterans with SCI/D. The SCI/D Spoke PACT care coordination with the SCI/D Center is of particular importance so the Veteran with SCI/D receives the best care possible. Working across care settings and between facilities is complex; frequent and open communication between the SCI/D Coordinator at the SCI/D Spoke and the SCI/D Center will ensure alignment, support integrated primary and specialty care, and avoid redundancy of services. See Appendix J.

(2) **SCI/D Spoke PACT Members and Staffing.** See Appendix D for the required positions in the SCI/D Spoke PACT.

## 11. TELEHEALTH AND VIRTUAL CARE SERVICES

a. VHA supports the provision of patient care using telehealth technologies, which increase a Veteran's access to care and supports a Veteran's self-management. This includes developing and delivering virtual and digital technologies that help Veterans communicate synchronously and asynchronously with their health care teams and coordinate, track, and manage their health care. These technologies may include but are not limited to: synchronous Clinical Video Telehealth (CVT), asynchronous Store and Forward Telehealth (SFT), video conferencing, VA Video Connect (VVC), VA Mobile, My HealthVet (MHV), remote patient monitoring home telehealth, and other virtual applications. These technologies are used to deliver care to Veterans located at various institutional and non-institutional settings, such as VA medical facilities, CBOCs, State Veteran Homes, Vet Centers, homeless shelters, Indian Health Services (IHS) clinics, DoD facilities and other affiliated organizations as well as directly to Veterans in their home by utilizing innovative telecommunication technologies. All SCI/D Centers and the majority of SCI/D Spoke PACTs have telehealth coordinators, equipment, and resources to complement health care, improve coordination of care between teams and facilities, enhance case management, and improve the health of Veterans with SCI/D.

b. **Telehealth for Veterans with SCI/D.** The SCI/D National Program Office and the Office of Connected Care/Telehealth Services collaborate to support the development and implementation of national and local SCI/D telehealth programs that address the specific needs of Veterans with SCI/D. All SCI/D Centers must implement the use of telehealth technologies in their routine clinical operations in order to improve access to care for Veterans with SCI/D. SCI/D Centers and SCI/D Spokes must ensure that clinical, business, and technical processes are aligned with VA medical facility and VISN telehealth policies and procedures, in accordance with VHA Telehealth Services standards.

c. **Telehealth Services Available to Veterans with SCI/D.** Real-time CVT is used to enhance communication between facilities, improve access to primary and specialty care for the Veteran particularly in rural areas and during inclement weather, and connect Veterans in their homes with the SCI/D Center interdisciplinary team. Veterans who do not own a video enabled device can be provided a VA issued device in order to take advantage of video-based technology. There are peripheral devices that can be attached to video conferencing equipment, which allows interactive examinations. SFT allows images, such as photographs of pressure ulcers, to be transmitted from a remote

location to the treatment team. Home telehealth uses disease management technologies to facilitate ongoing care, provide monitoring and ongoing treatment, improve self-management, and promote evidence-based care.

d. **SCI/D Telehealth and Telephone Stop Codes.** See Appendix G.

e. **My HealtheVet.**

(1) My HealtheVet (<https://www.myhealth.va.gov/mhv-portal-web/home>) is an online personal health record that provides several virtual tools to improve communication and health for Veterans with SCI/D. Veterans can access and manage their VHA medical records and keep track of test results. My HealtheVet's prescription refill feature allows Veterans to request a refill online and track prescription delivery. Veterans can also keep a food and activity journal and store vital signs.

(2) **Secure Messaging.** Secure Messaging through My HealtheVet is a Web-based message system that allows participating VHA patients and VA health care teams to communicate non-urgent, health related information in a private computer environment. Secure Messaging provides a safe, alternative communication means that is convenient and flexible for the Veteran with SCI/D and designated providers.

## **12. SCI/D NON-INSTITUTIONAL EXTENDED CARE SERVICES AND INSTITUTIONAL LONG-TERM CARE**

a. **Non-Institutional Extended Care and Institutional Long-Term Care Services.**

Non-institutional extended care and institutional LTC services are critically important for the health, safety, independence, and quality of life for Veterans with SCI/D. VA's SCI/D System of Care is required to provide and maintain access to a full continuum of care for Veterans with SCI/D, including non-institutional extended and institutional LTC. The complex, serious, and unique impairments and disabilities that accompany SCI/D require specialized knowledge, coordination of care, and adequate resources to provide safe extended care services for Veterans with SCI/D. The goals of extended care services are to support the Veteran in the least restrictive environment; promote, preserve, and restore the health of the individual; facilitate and maximize Veteran independence and enhance quality of life; provide high quality institutional LTC when needed; and provide support for family members and caregivers. These extended and LTC services address health and social needs; they also enable Veterans with SCI/D to receive the support and care from others consistent with their needs, rights, and personal dignity.

(1) **Non-Institutional Extended Care.** Non-institutional extended care services are essential in supporting Veterans with SCI/D to live independently. A broad range of support and assistance is needed because Veterans with SCI/D live with complex functional limitations, impairments, co-morbid and chronic conditions, and disabilities. The SCI/D System of Care links to the Office of Geriatrics and Extended Care (GEC) including the many services available through GEC and community care. When Veterans with SCI/D live in the community, there are several non-institutional extended

care services that are available to support independence and enhance quality of life including but not limited to: skilled home health, day care programs, HBPC, homemaker/home health aide, bowel and bladder care, specialty care, therapies, psychosocial services, case management, assistance with ADL, respite care, palliative care, and hospice care.

(2) **Institutional Long-Term Care.** High quality institutional LTC services for Veterans with SCI/D are crucial in supporting short-term and long-term institutional care when the need arises. Addressing the Veterans' health care and social needs, developing and maintaining SCI/D specialized knowledge by staff, and developing appropriate environments of care are critical. Maintaining a Veteran-centric focus in LTC is as important as in all other settings in VHA. Eligible Veterans with SCI/D, who meet the inclusion criteria for SCI/D care and identified by SCI/D staff as appropriate for institutional LTC services, must be considered for placement in any available SCI/D Center LTC bed, CLC bed, or other appropriate institutional LTC setting. See Appendix F for a list of SCI/D Centers with dedicated SCI/D LTC units and CLCs with dedicated SCI/D LTC beds.

b. **Principles.** Planning for the optimal comprehensive range of extended care services is best done at the onset of SCI/D and subsequently during annual evaluations. The SCI/D System of Care must maintain the infrastructure, processes, and trained workforce to offer a continuum of non-institutional extended care and institutional LTC services so each Veteran with SCI/D is supported in an environment that can provide the necessary health, social, and case management services that are needed to accomplish life goals. A Veteran-centric approach, identifying the least restrictive level of care, supporting a safe and secure place to live, and proximity to family/support systems must be incorporated in the planning for extended and LTC services.

(1) **Non-Institutional Extended Care.**

(a) A Veteran-centric team approach must be used in planning for the non-institutional extended care needs of the Veteran. The continuum of extended care services for Veterans with SCI/D is a mix of services designed to meet eligibility requirements, individual needs, personal preferences, and promote independent community living whenever possible. Broadly, extended care services provide assistance with basic health care needs and personal tasks of everyday life including ADL, housework, shopping, and other instrumental ADL. Timely access to high-quality specialty extended care services is essential for Veterans with SCI/D.

(b) **Personal Care Attendants.** Recruitment, training, and retention of good Personal Care Attendants (PCAs) present ongoing challenges for the Veteran with SCI/D. Veterans must be trained in meeting specific care needs so that they can in turn train their own PCAs. Possible resources for finding attendants include: local nursing schools, churches, employment agencies, and advertisements in newspapers and magazines. It is important that the Veteran with SCI/D develop a back-up plan for care in case the Veteran's PCA is not available to provide services. Veterans are provided

training and assistance to assume responsibility for interviewing, hiring, and training PCAs.

(2) **Institutional Long-Term Care.** Veterans with SCI/D sometimes need or want to live in an institutional LTC facility. Options for high-quality institutional LTC facilities for Veterans with SCI/D are limited due to the specialized knowledge required to provide safe and high-quality care. The primary goal for Veterans with SCI/D who live in institutional LTC settings is to maintain a high quality of life. LTC placement must prioritize environments that promote privacy, dignity, autonomy, independence, and activities. See Appendix I for placement decision guiding principles.

c. **Delivery of Services.** Early, comprehensive planning for the optimal combination of non-institutional care services to foster participation in meaningful personal and societal roles while minimizing activity limitations and secondary complications can often minimize the need for institutional LTC services. A holistic care plan is developed by the SCI/D team and Veteran for non-institutional extended care services to support independent living in the community. The plan should be seen as dynamic and reviewed each year during the SCI/D comprehensive preventive health evaluation.

d. **Location of Services.** Whenever possible, services need to occur in close proximity to the Veteran's residence and active social support systems. The overriding principle is that availability and access to a unique comprehensive combination of extended care resources will address the needs of Veterans with SCI/D to assist in accomplishing their goals.

e. **Access to Specialty Services.** Veterans with SCI/D receiving care in a LTC setting will continue to have access to acute and sustaining SCI/D specialty care on a regular and recurring basis as determined by the Veteran's needs. The SCI/D Center and SCI/D Spoke staff members provide consultative care to Veterans in institutional LTC settings, and facilitate referrals for annual evaluation. SCI/D specialty care needs are referred to the SCI/D Center as per referral guidelines in this directive, regardless of the Veteran's primary placement. The SCI/D Center and Spoke will consult with LTC staff and residents with SCI/D on a regular and recurring basis, as determined by the Veteran's needs.

(1) **SCI/D Center Services.**

(a) **Admissions.** Decisions for admission to a SCI/D LTC Center or VA CLCs are to be made by a designated SCI/D or CLC admission coordinator and/or the SCI/D or CLC interdisciplinary screening/admissions committee.

(b) **SCI/D Comprehensive Preventive Health Evaluation.** The annual evaluation is an important component of maintaining health for all Veterans with SCI/D. Particularly as Veterans with SCI/D get older, the annual evaluation will focus on new issues associated with aging, loss of function, potential ventilator use, modified equipment needs, loss of function, new impairments, and quality of life. All Veterans with SCI/D in

LTC settings must be offered an annual evaluation at the designated SCI/D Center (see Appendix B).

(c) The SCI/D Centers provide many components of extended care services and institutional LTC including:

1. SCI/D Long-Term Care Centers. Discharge to SCI/D LTC Centers is the ideal placement for Veterans with SCI/D since all aspects of care by well-trained staff are addressed. Dedicated SCI/D LTC Centers provide LTC, long-stay services beyond 90 days, chronic ventilator care, skilled nursing or rehabilitation care for specific conditions or interventions, respite care, hospice care, palliative care; restorative time limited care; rehabilitation therapies; psychological assessment and treatment; social work services; and age-appropriate programs for transportation, therapeutic recreation (including outings), and peer support. Recognizing that these Centers and SCI/D long-term beds are very limited, other LTC settings must also be used.

2. SCI/D Home Care. SCI/D-HC is provided through the SCI/D Center to Veterans with SCI/D in need of this care and living within a 100-mile radius of the SCI/D Center or beyond a 100-mile radius of the SCI/D Center if approved for enrollment by the Chief, SCI/D Center (see paragraph 9).

3. SCI/D Respite Care. SCI/D respite care is recognized as an important provision for families and caregivers of physically dependent Veterans. Each Veteran using attendant care is offered respite care in the SCI/D Center, unless a Veteran requests respite care in another setting. The total duration of respite care for a Veteran in a calendar year, absent complicating factors, is limited to 30 days.

## **(2) Bowel and Bladder Care.**

(a) Bowel and bladder care for Veterans with SCI/D are supportive and necessary medical services when they are unable to manage bowel and bladder functions independently. Inadequate care will lead to complications and problems that result in illness and hospitalization. Bowel and bladder care is essential to support Veterans with SCI/D in non-institutional settings, improve quality of life, optimize health, and prevent complications from neurogenic bowel and bladder.

(b) The clinic of jurisdiction, or VA medical facility, authorizes such care under the Community Care Program (formerly known as the Non-VA Medical Care Program and the Purchased Care Program) to enrolled Veterans with SCI/D who are dependent upon others for bowel and bladder care while residing in the community.

(c) Authorizations for Care. Veterans with SCI/D who qualify for bowel and bladder care may receive that care through a home health agency, a family member, or an individually employed caregiver.

1. A caregiver, family member, or other individual may receive reimbursement for provision of bowel and bladder care after educational and training requirements administered by VHA personnel, including initial competency validation, are completed.

2. The designated SCI/D Center must be involved in the initial approval process for a Veteran to qualify for bowel and bladder care. Review and concurrence from the designated SCI/D Center should be obtained before medical services for bowel and bladder care are denied to any Veteran with SCI/D.

3. Reimbursement for an employed caregiver, individual, or family member may not exceed the fifth step of the General Schedule hourly rate paid to nursing assistants who provide this care at a VA medical facility.

4. In no instance shall bowel and bladder care be authorized for a Veteran who can perform this function unassisted. Bowel and bladder care at VHA expense may be authorized for all Veterans based on clinical need, including those receiving Aid and Attendance benefits.

f. **VHA Geriatrics and Extended Care.** Veterans with SCI/D may be eligible for non-institutional extended care services and institutional LTC through the GEC Program. VHA's extended care services are described in VHA Directive 1140.11, Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics, dated October 11, 2016, and include but are not limited to: VA CLCs, Contract Community Nursing Home Care, State Veterans Homes, Community Residential Care (CRC) Program, MFHs, Adult Family Homes (AFH), Assisted Living Facilities (ALFs), domiciliaries, Skilled Home Health, Adult Day Health Care (ADHC), Homemaker or Home Health Aide (H/HHA), Respite Services, Veteran-Directed Home and Community-Based Services, HBPC, Bowel and Bladder Care, Palliative Care, and Hospice Care (see <https://www.va.gov/geriatrics/>).

### 13. TRAINING

a. **Education and Training.** For all clinicians working with Veterans with SCI/D, particularly those that are members of the interdisciplinary team in SCI/D Centers and SCI/D Spokes, accredited continuing education is critically important to improve practice and care for Veterans with SCI/D. These educational activities are offered at SCI/D hub and spokes training, national conferences, and in-service continuing education activities. All efforts should be made to provide continuing education annually to members of the interdisciplinary team from the various disciplines.

b. **In-Service Continuing Education.**

(1) In-service continuing education must address the local and national needs of the SCI/D System of Care to include topics identified through the SCI/D National Program Office, local QI processes, the review of information and outcomes management data, trends of high-risk and high-intensity patient care, missed opportunities, errors, complex cases, and system-wide issues.

(2) **Review and Documentation of Continuing Education Activities.** All continuing education must be documented, and a formal review of each staff member's educational needs is to take place annually by the supervisor or designee.

c. **Education for SCI/D Spoke Patient Aligned Care Team.** Only providers who have completed training designated by the SCI/D National Office and the designated SCI/D Center, or who have equivalent training and experience may be appointed to SCI/D Spoke PACTs. At a minimum, SCI/D Spoke PACT clinical staff must have an initial training session at the SCI/D Center and then annual clinical educational activities with the SCI/D Center. SCI/D Spoke PACTs must conduct learning needs assessments as part of the annual competency review. SCI/D Spoke PACT clinical staff must familiarize themselves with program standards through involvement in the following:

(1) New SCI/D Spoke PACT staff must complete education specifically developed by the designated SCI/D Center, coordinated with the SCI/D National Program Office, within three months of their appointment.

(2) Review of SCI/D-related clinical practice guidelines and evidence-based recommendations (for example, clinical practice guidelines developed by the Consortium for Spinal Cord Medicine).

(3) An initial visit to the designated SCI/D Center for education and training.

(4) Annual hub and spokes educational activities with the SCI/D Center.

(5) Attendance at professional conferences.

(6) Attendance at quarterly SCI/D Center conference calls, or more often as needed.

(7) Annual consultative visits from the SCI/D Center to the SCI/D Spoke, or more often as needed/scheduled.

(8) Participation in national SCI/D Spoke PACT training initiatives.

#### **14. RECORDS MANAGEMENT**

All records regardless of format (paper, electronic, electronic systems) created in this directive shall be managed per the National Archives and Records Administration (NARA) approved records schedules found in VA Records Control Schedule 10-1. Questions regarding any aspect of records management should be addressed to the appropriate Records Manager or Records Liaison.

#### **15. REFERENCES**

(a) Pub. L. 93-538.

(b) Pub. L. 108-364.

(c) Pub. L. 111-163.

(d) Pub. L. 114-223.

(e) 10 U.S.C. 1104.

(f) 38 U.S.C. 1706(b).

(g) 38 U.S.C. 1781 – 1786.

(h) 38 U.S.C. 7301(b).

(i) 38 U.S.C. 8111.

(j) 38 CFR 17.38.

(k) 38 CFR 17.380.

(l) 38 CFR 17.412.

(m) VA Directive 7501, Construction Project Liaison with Paralyzed Veterans of America (PVA), dated January 15, 2009.

(n) VHA Directive 1004.04, State Authorized Portable Orders (SAPO), dated February 26, 2019.

(o) VHA Directive 1026, VHA Enterprise Framework for Quality, Safety, and Value, dated August 2, 2013.

(p) VHA Directive 1041, Appeal of VHA Clinical Decisions dated, October 24, 2016.

(q) VHA Directive 1043, Restructuring of VHA Clinical Programs, dated November 2, 2016.

(r) VHA Directive 1094, Inter-Facility Transfer Policy, dated January 11, 2017.

(s) VHA Directive 1100.16, Accreditation of Medical Facility and Ambulatory Programs, dated May 9, 2017.

(t) VHA Directive 1101.06, Multiple Sclerosis System of Care, dated April 14, 2017.

(u) VHA Directive 1108.08(1), VHA Formulary Management Process, dated November 2, 2016.

(v) VHA Directive 1120.02, Health Promotion and Disease Prevention Core Program Requirements, dated February 5, 2018.

(w) VHA Directive 1130, Dental Program for Department of Veterans Affairs (VA) Medical Facilities, dated October 26, 2016.

(x) VHA Directive 1137, Provision of Complementary and Integrative Health, dated May 18, 2017.

(y) VHA Directive 1140.11, Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics, dated October 11, 2016.

(z) VHA Directive 1170.01, Accreditation of Veterans Health Administration Rehabilitation Programs, dated May 9, 2017.

(aa) VHA Directive 1173.14, Home Improvements and Structural Alterations (HISA) Program, dated December 26, 2017.

(bb) VHA Directive 1173.16, Driver Rehabilitation for Veterans with Disabilities Program, dated November 28, 2017.

(cc) VHA Directive 1178(1), Animal-Assisted Activities and Animal-Assisted Therapy, dated September 14, 2018.

(dd) VHA Directive 1330.01(2), Health Care for Women Veterans, dated February 15, 2017.

(ee) VHA Directive 1332(1), Infertility Evaluation and Treatment, dated June 20, 2017.

(ff) VHA Directive 1340(1), Provision of Health Care for Veterans Who Identify as Lesbian, Gay, or Bisexual, dated July 6, 2017.

(gg) VHA Directive 1341(1), Providing Health Care for Transgender and Intersex Veterans, dated May 23, 2018.

(hh) VHA Directive 1351, Staffing Methodology for VHA Nursing Personnel, dated December 20, 2017.

(ii) VHA Directive 1406, Patient Centered Management Module (PCMM) for Primary Care, dated June 20, 2017.

(jj) VHA Directive 1411, Home-Based Primary Care Special Population Patient Aligned Care Team Program, dated June 5, 2017.

(kk) VHA Directive 1611, Safe Patient Handling and Mobility Program, dated March 23, 2018.

(ll) VHA Handbook 1004.01(2), Informed Consent for Clinical Treatments and Procedures dated, August 14, 2009.

(mm) VHA Handbook 1004.02, Advanced Care Planning and Management of Advanced Directives dated, December 24, 2013.

(nn) VHA Handbook 1004.03, Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences dated, January 11, 2017.

(oo) VHA Handbook 1050.01, VHA National Patient Safety Improvement Handbook, dated March 4, 2011.

(pp) VHA Handbook 1101.07 Amyotrophic Lateral Sclerosis System of Care Procedures, dated July 7, 2014.

(qq) VHA Handbook 1101.10(1), Patient Aligned Care Team (PACT) Handbook, dated February 5, 2014.

(rr) VHA Handbook 1120.04, Veterans Health Education and Information Program Requirements, dated September 24, 2015.

(ss) VHA Handbook 1120.05, Coordination and Development of Clinical Preventive Services Guidance, dated July 29, 2015.

(tt) VHA Handbook 1140.02, Respite Care, dated November 10, 2008.

(uu) VHA Handbook 1143.2, VHA Community Nursing Home Oversight Procedures, dated June 4, 2004.

(vv) VHA Handbook 1163.02, Therapeutic and Supported Employment Services Program, dated July 1, 2011.

(ww) VHA Handbook 1173.08, Medical Equipment and Supplies, dated June 15, 2007.

(xx) VHA Handbook 1173.1, Eligibility, dated November 2, 2000.

(yy) Deputy Under Secretary for Health for Operations and Management Memorandum, VA-DoD Sharing Agreements, November 30, 2014.

(zz) VHA CBO Procedure Guide:

<http://vaww.va.gov/CBO/apps/policyguides/index.asp?mode=contents&id=IV.01>.

**NOTE:** *This is an internal VA Web site that is not available to the public.*

## APPENDIX A

## ELIGIBILITY, ENROLLMENT, AND ADMISSIONS

## 1. SPINAL CORD INJURIES AND DISORDERS POPULATION SERVED

a. **Inclusion Criteria.** The Spinal Cord Injuries and Disorders (SCI/D) System of Care provides a full range of care for all enrolled Veterans who have spinal cord injuries (SCI) and spinal cord disorders (SCD). These include:

(1) **Traumatic SCI.** All traumatic SCI due to such events as motor vehicle accidents, falls, and acts of violence; and

(2) **Nontraumatic SCD.** Nontraumatic (atraumatic) disorders and diseases of the spinal cord.

b. **Principles and Conditions.** The following principles and conditions describe the population served in the SCI/D System of Care:

(1) **Level of Injury.** Any level of injury of the spinal cord, conus medullaris, or cauda equina is included.

(2) **Severity.** Includes complete and incomplete injuries. The resultant sequelae are significant resulting in problems such as impairments of mobility and activities of daily living (ADL), impaired bowel and bladder function, and/or SCI/D-related medical co-morbidities such as autonomic dysreflexia, spasticity, and pressure ulcers.

c. **Neurologic Stability.**

(1) **Stable or Slowly Progressive SCI/D.** Veterans with stable or slowly progressive SCI/D are best served in the SCI/D System of Care.

(2) **More Rapidly Progressive Spinal Cord Disorders.** Delivery of the highest quality of care should guide where Veterans with progressive SCDs receive care. In some instances, the full spectrum of care is best served within the SCI/D Center and within the SCI/D System of Care. In others, the SCI/D staff provides focused consultation. In most cases, close collaboration between SCI/D, neurology, and rehabilitation medicine will result in optimal outcomes. If the full spectrum of care is provided within the SCI/D Center, adequate resources must be provided. For example, if Veterans with multiple sclerosis (MS) and/or amyotrophic lateral sclerosis (ALS) are primarily served by a SCI/D Center, additional staffing for speech therapy, assistive technology, respiratory therapy, psychology, and other essential services for these patient populations must be provided.

(3) **Site of Neurologic Injury/Disorder.** The primary problem is related to SCI/D as opposed to a primary brain pathology, peripheral nerve problem, or muscle disease. When there is significant extra-spinal involvement, local expertise and delivery of the highest quality of care should decide where Veterans receive care.

(4) **Illustrative Examples.** The following are examples of SCDs best served in the SCI/D System of Care:

(a) Myelopathy secondary to herniated nucleus pulposus, spinal stenosis, or other vertebral column degenerative changes with significant impairments that involve weakness, impaired ADL, and/or bladder and bowel dysfunction.

(b) Spinal cord infarction or ischemia due to dural arteriovenous fistula or other vascular etiologies.

(c) Spinal cord dysfunction due to epidural abscess, other infectious, or inflammatory etiologies.

(d) Spinal cord dysfunction due to intramedullary tumors (ependymoma, astrocytoma) or due to extramedullary or extradural tumors (for example, meningioma, vertebral) with favorable life expectancy prognosis.

(e) Other non-traumatic conditions with neurological deficits that are primarily due to spinal cord dysfunction, such as radiation myelitis, decompression sickness, subacute combined degeneration, syringomyelia, or transverse myelitis.

(5) **Multiple Sclerosis.** Delivery of the highest quality of care should guide where Veterans with MS and spinal cord involvement receive care.

(a) Treatment services and programs for the MS population are the primary responsibility of the National Director of Neurology.

(b) See VHA Directive 1101.06, Multiple Sclerosis System of Care, dated April 14, 2017, regarding health care services for Veterans with MS.

(c) The delivery of care for Veterans with MS is often shared by the Neurology Service, Rehabilitation Medicine Service, SCI/D Service, and Primary Care Medicine according to the Veteran's needs and the professional expertise available from each of these programs.

(d) In some cases, care within the SCI/D System of Care for individuals with spinal cord involvement is appropriate and delivers the highest quality of care.

(6) **Amyotrophic Lateral Sclerosis.** Delivery of the highest quality of care should guide where Veterans with ALS receive care.

(a) The ALS System of Care is the primary responsibility of the National Director of Neurology.

(b) VHA Handbook 1101.07 Amyotrophic Lateral Sclerosis System of Care Procedures, dated July 7, 2014, describes the essential components and procedures for health care services for Veterans with ALS.

(c) The delivery of care for Veterans with ALS is often shared by the Neurology Service, Rehabilitation Medicine Service, SCI/D Service, and Primary Care Medicine according to the Veteran's needs and the professional expertise available from each of these programs.

## 2. EXCEPTIONS AND QUALIFIERS TO SCI/D POPULATION SERVED

The following etiologies are not treated in the SCI/D System of Care:

a. **Intracranial Etiologies.** Quadriparesis or other paralytic conditions due to intracranial processes such as traumatic brain injury, brainstem, or cerebrovascular accident.

b. **Peripheral Neuromuscular Processes.** Sensory and motor impairments due to peripheral nerve pathologies such as diabetic neuropathy or other peripheral neuropathies, Guillain-Barre, plexopathies, muscular dystrophies, myasthenia gravis or myopathies.

c. **No Spinal Cord Involvement.** Etiologies and diseases that do not involve the spinal cord including conversion disorder and/or hysteria manifested as paraplegia or tetraplegia.

d. **Other Etiologies.** Veterans with other etiologies that result in SCD (for example, intramedullary malignancy with a poor prognosis) may be accepted by the Chief, SCI/D Center on a case-by-case basis for rehabilitation and treatment with follow-up consultation to the patient's non-SCI/D primary provider. Delivery of the highest quality of care should guide where these Veterans are treated as well as humanitarian reasons.

## 3. ENROLLMENT

a. Veterans with SCI/D are considered to be Catastrophically Disabled (Priority Group 4) when they have SCI/D that permanently compromises their ability to carry out ADL. Veterans with SCI/D who apply for care within the Department of Veterans Affairs (VA) and are assigned to Priority Groups 5 through 8 must be offered a Catastrophically Disabled Veteran Evaluation by a Veterans Health Administration (VHA) SCI/D-designated staff for consideration and possible re-assignment to Priority Group 4. Social workers at SCI/D Centers and Spokes should work with VHA eligibility/enrollment staff to facilitate these evaluations for new applicants or to change enrollment status for existing Veterans with SCI/D.

b. **Related Legislation.** Public Law 111-163 Section 511 of the Caregivers and Veterans Omnibus Health Services Act of 2010, provides Veterans determined by VHA to be Catastrophically Disabled an exemption from inpatient, outpatient and prescription copays. Veterans with catastrophic disabilities are also exempt from co-payments applicable to the receipt of non-institutional extended care services.

#### 4. ADMISSION

##### a. Admission of Active Duty Service Members.

(1) **Memoranda of Agreement.** Memoranda of Agreement (MOA) between VA and Department of Defense (DoD) are established under sharing authority Title 38 United States Code (U.S.C.) 8111 and 10 U.S.C. 1104. MOA between VA and DoD describe the treatment and transfers of Admission of Active Duty Service Members (ADSMs) with SCI/D (“Memorandum of Agreement between the Department of Veterans Affairs (VA) and the Department of Defense (DoD) for Medical Treatment Provided to Active Duty Service Members (ADSM) with Spinal Cord Injury, Traumatic Brain Injury, Blindness, or Polytraumatic Injuries” and “Memorandum of Understanding between Veteran Affairs (VA) and Department of Defense (DoD) For Interagency Complex Care Coordination Requirements for Service Members and Veterans of 29 July 2015”). The objective is to provide the highest quality care for ADSMs that sustain SCI/D. Refer to the current VA-DoD MOA for criteria for safe and effective transfer, operational specifics, and expectations.

(a) When the ADSM is medically stable and ready for transfer, arrangements are to be effected immediately.

(b) The SCI/D Center staff will coordinate with DoD military treatment facilities (MTF) and community hospitals so that VA-eligible ADSMs with SCI/D ready for transfer are transported directly from an MTF, community hospital, or VA facility that does not have a SCI/D Center to a VA SCI/D Center.

1. DoD and VA Lead Coordinators serve as a primary point of contact for ADSMs during their transition between DoD and VA.

2. Information about Lead Coordinators and transition processes can be found on the Navigation, Advocacy, and Community Engagement (NACE) Web site <https://www.va.gov/nace/ic3/index.asp>.

(c) All VA medical facilities with acute/sustaining SCI/D Centers are capable of providing the comprehensive care and intensive rehabilitation required by recently spinal cord injured military service personnel.

(d) VA SCI/D Centers will assist DoD MTFs and ADSMs with SCI/D in selecting the most appropriate VA SCI/D Center to provide treatment under the VA-DoD MOA. Consideration will be given to selecting a VA SCI/D Center closest to the ADSM’s home of record or other location requested by the ADSM (guardian, conservator, or designee), subject to availability of beds at the VA medical facility and approval by Tricare Management Activity (TMA). If the preferred or approved VA SCI/D Center is unable to accept the patient, DoD in coordination with VA will assist in locating an appropriate VA medical facility with a SCI/D Center for transfer of the ADSM. The Executive Director, SCI/D National Program Office will assist when needed.

(e) VA will provide sufficient medical information and documentation for the designated DoD MTF to conduct a medical evaluation board for disability determination.

(f) ADSMs with acute SCI/D who are transferred to VA SCI/D Centers must be reported bi-annually through the new injury report to the SCI/D National Program Office.

**b. Admission of Veterans with SCI/D.**

(1) **Admission of Eligible Veterans.** The Chief, SCI/D Service, or designee is responsible for the admission of eligible Veterans with SCI/D. Admissions must be predicated on the SCI/D System of Care mission, scope of services, diagnostic etiologies, inclusion criteria for the population served (see paragraph 1.a. above), medical condition, functional requirements of the Veteran, and criteria in this directive rather than non-SCI/D admission or utilization criteria. SCI/D-designated beds are captured under Appendices E and F for location and treating specialty purposes.

**(2) Contact and Communication with SCI/D Center.**

(a) It is the responsibility of the VA medical facility first contacted for admission to proceed with communication and arrangements for transfer to the nearest appropriate SCI/D Center.

(b) Admission to the local VA medical facility may take place if medically necessary and/or to facilitate transfer, but it is not a prerequisite for coordinating arrangements for the Veteran's admission to the SCI/D Center. The SCI/D Coordinator at the admitting VA medical facility or referring provider must provide a complete patient history and physical examination note, pertinent progress notes, and provider interim or discharge summary for review by the SCI/D Center considering the patient for transfer. An electronic consultation should be sent to document, request, and track the request for transfer.

(3) **Interfacility Transfer Date.** The SCI/D Center admitting provider must coordinate with the referring SCI/D Coordinator at the SCI/D Spoke, provider, and/or the community provider on the date of transfer to the SCI/D Center. The logistics and timing of the transfer are assessed based upon provider-to-provider contact ensuring a safe and efficient transition.

(4) **No Available Operating Beds.** If an eligible Veteran with SCI/D is in need of acute or sustaining SCI/D care and cannot be accepted for admission at the designated SCI/D Center to which the Veteran is normally referred, the Chief of that SCI/D Center, working with the Executive Director, SCI/D National Program Office, is responsible for:

(a) Activating SCI/D authorized beds that are not operational; this must be facilitated to accommodate admissions if the census and referrals to the SCI/D Center exceed the required operating bed numbers.

(b) Arranging for care at another SCI/D Center and communicating those arrangements with the Veteran, the Veteran's representative, the SCI/D Coordinator, and the referring provider.

(c) Consulting and communicating with the Veteran's attending provider during the interim to optimize care for the Veteran with SCI/D.

(d) Tracking delays in admissions.

(5) **Choice of SCI/D Center.** Although a Veteran may request care at any SCI/D Center, emphasis is placed upon addressing the Veteran's needs in the SCI/D Center serving the catchment area where the Veteran lives. In the interests of preserving continuity of care and respecting Veteran preference, Veterans with an existing relationship and treatment history at a SCI/D Center outside the designated catchment area will continue to receive care at that VA medical facility. However, travel benefits are only to the nearest SCI/D Center. Other factors are considered by the Chief, SCI/D Center or their designee in addressing the needs of SCI/D applicants, such as the urgency of the Veteran's condition, the need for specialized medical care, the availability of resources, eligibility, and entitlement priorities.

(6) **Interfacility Transfer of Veterans with Acute or New SCI/D.** Veterans with acute onset SCI/D must be transferred immediately, once the Veteran is stable, to a SCI/D Center. If medically stable to travel, Veterans with SCI/D admitted to a VA medical facility without a SCI/D Center must be transferred to the SCI/D Center within 72 hours after the Veteran is safe to travel for acute medical stabilization, surgical procedures, and/or non-self-limiting conditions. The SCI/D Coordinator at facilities without a SCI/D Center must communicate with the Chief, SCI/D Center as frequently as the Veteran's clinical status indicates. While hospitalized at a VA medical facility without a SCI/D Center and awaiting transfer, SCI/D Spoke personnel must evaluate Veterans with acute care needs on a daily basis.

(7) **Direct Admission to the SCI/D Unit.** Veterans with acute care issues in a VA medical facility with a SCI/D Center are admitted directly to the SCI/D unit unless the Chief, SCI/D Center, approves admission to an alternate unit. Veterans with SCI/D are to be located on the SCI/D unit unless it is not safe and there is a need for an intensive care unit, monitoring that cannot safely be provided on the SCI/D unit, or there are other exceptional clinical circumstances.

(a) If on another unit in the same facility, the Veteran with SCI/D is transferred to the SCI/D unit when medically stable and the transfer is safe.

(b) A SCI/D provider and SCI/D nurse must evaluate any Veteran with SCI/D not on the SCI/D unit on a daily basis and the assessment and clinical recommendations must be documented in the Veteran's medical record.

c. **Admission of Non-Veteran SCI/D Patients.** When indicated, per the criteria and approval processes in this directive, the SCI/D Center will admit non-Veterans with SCI/D, other than ADSMs, consistent with 38 U.S.C. 1781 - 1786, Health Care of

Persons other than Veterans. This does not apply to VA SCI/D services furnished under a pre-approved sharing agreement.

(1) **Admission Criteria.** Admission must be considered necessary for humanitarian or emergency reasons because appropriate specialized facilities outside of VA are not available in the patient's area. Patients must meet the admission criteria as outlined in this directive. Patients who are not yet hospitalized and in need of immediate care (where the absence of care would be life threatening to the patient) are to be given the highest priority for consideration for admission. Admission is to be accomplished within one week following onset of SCI/D, if the patient is stable for transfer, and before the beginning of acute rehabilitation.

(2) **Approval.** Requests for admission are to be made to the nearest Chief, SCI/D Center, as soon as possible, post SCI/D. The Chief, SCI/D Center, must, in consultation with the facility Chief of Staff and/or Director, approve all requests for admission of non-Veterans with acute SCI/D. The Executive Director, SCI/D National Program Office, must then approve these cases.

(3) **Costs and Billing.** The cost of VA care, including prosthetic and orthotic devices and the cost of transportation to and from the SCI/D Center, is not borne by VA.

(4) **Length of Stay.** Length of stay in a VA SCI/D Center is limited to a maximum of three months unless the patient's medical condition does not allow discharge. The VA medical facility 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 community facility.

(5) **Effects on Veterans with SCI/D.** If a non-Veteran with SCI/D is considered for admission to a VA SCI/D Center, SCI/D leadership and VA medical facility Director, or designee, must ensure that the quality of care available to Veterans on the SCI/D unit must not be diminished and the admission of eligible Veterans must not be delayed.

d. **SCI/D Inpatient Bed Location.** SCI/D designated beds are captured under bed section 22 for location and treating specialty purposes.

## APPENDIX B

**SPINAL CORD INJURIES AND DISORDERS COMPREHENSIVE PREVENTIVE HEALTH EVALUATION****1. SCI/D COMPREHENSIVE PREVENTIVE HEALTH EVALUATION****a. Principles.**

(1) The Spinal Cord Injuries and Disorders (SCI/D) Comprehensive Preventive Health Evaluation includes health promotion, prevention, early identification and treatment of complications related to lifestyle, aging, and living with SCI/D. Annual Comprehensive Preventive Health Evaluations must be offered to all Veterans with SCI/D and performed at SCI/D Centers by a multidisciplinary team trained in SCI/D care. Every effort must be made to educate Veterans with SCI/D about the importance of the SCI/D Comprehensive Preventive Health Evaluation and the advantages to have the evaluation at the SCI/D Center.

(2) If the Veteran refuses or is unable to travel, clear documentation that the annual evaluation was offered and refused must be entered into the medical record and the designated Chief, SCI/D Center must be notified. The SCI/D Spoke Patient Aligned Care Team (PACT), in close collaboration with the SCI/D Center, must provide an evaluation as comprehensive as possible. Use of synchronous Clinical Video Telehealth between the SCI/D Center and Veteran and/or SCI/D Spoke should be utilized for annual evaluations performed at the SCI/D Spoke to involve all SCI/D Center disciplines in the Comprehensive Preventive Health Evaluation (for example, medical, nursing, psychology, social work, and therapies). These SCI/D Comprehensive Preventive Health Evaluations should be viewed as collaborative, team-based, and coordinated between the SCI/D Center and Spoke.

(3) **Scope.** The Veteran must be offered the full scope of comprehensive annual evaluation services to include both general and SCI/D-specific elements. The degree to which the Veteran participates is determined by the Veteran's values and wishes. When evaluating risk and discussing prevention, the SCI/D provider and health care team will engage the Veteran with SCI/D about values systems and health goals.

(4) **General Elements of Health Promotion, Disease Prevention, and Whole Health.** Elements of health promotion, disease prevention, and Whole Health defined for the general Veteran population by the Veterans Health Administration (VHA) National Center for Health Promotion and Disease Prevention and VHA Office of Patient Centered Care & Cultural Transformation (OPCC&CT) must be completed, if there are no specifications in this directive or evidence-based literature to do otherwise for Veterans with SCI/D. Associated requirements are found in VHA Directive 1120.02, Health Promotion and Disease Prevention Core Program Requirements, dated February 5, 2018; VHA Handbook 1120.05, Coordination and Development of Clinical Preventive Services Guidance, dated July 29, 2015; and VHA Directive 1137, Provision of Complementary and Integrative Health, dated May 18, 2017. Specific National

Center for Health Promotion and Disease Prevention and Whole Health elements are defined by VHA program offices and are not listed here due to their periodic revision. As standards of care are developed or modified for the general Veteran population, they will be implemented in the SCI/D System of Care in the same manner as in other Department of Veterans Affairs (VA) primary and specialty care settings.

(5) **SCI/D-Specific Elements.** The SCI/D specific evaluation includes the following elements:

(a) Medical History and Physical Examination. In addition to the standard medical history and physical examination, the SCI/D-specific evaluation must include evaluation of unique elements that reflect complications, co-morbidities, and/or physiologic changes following SCI/D. These include but are not limited to the following: integumentary (for example, pressure ulcers), cardiovascular (for example, postural hypotension, autonomic dysreflexia, cardiovascular risk factors), pulmonary (for example, impaired cough, pneumonia, and respiratory failure), gastrointestinal (for example, neurogenic bowel), endocrine (for example, low testosterone), genitourinary (for example, neurogenic bladder), metabolic (for example, diabetes mellitus and dyslipidemia), musculoskeletal, and neurologic systems. The risk for secondary problems and co-morbid conditions following SCI/D is considerable in many of these systems. For example: the integumentary system undergoes anatomical and physiologic changes after SCI/D, sensation is impaired, and pressure reliefs may not be possible and/or routinely performed, all of which result in increased risk for the development of pressure ulcers; the risk of cardiovascular disease is considerable because Veterans with SCI/D are paralyzed, less active, and have adverse changes in soft tissue composition (that is, gain fat and lose muscle); the physiology of the urinary and gastrointestinal systems are altered thereby resulting in high risks of complications, such as the development of stones, urinary tract infections (UTI), incontinence, and obstipation.

(b) Integumentary System. The risk for pressure ulcer development and recurrence is high in Veterans with SCI/D. All Veterans with SCI/D with impaired sensation and/or mobility must have an annual comprehensive assessment of risk factors, a review of prevention strategies, a thorough inspection of skin/body wall, and recommendations for pressure ulcer prevention (that is, a pressure ulcer prevention plan). If there is an existing pressure ulcer(s), a treatment plan and follow-up must be developed with the Veteran. Evaluation, education, prevention, and treatment of pressure ulcers should follow evidence-based literature and/or the clinical practice guideline entitled, "Pressure Ulcer Prevention and Treatment following Spinal Cord Injury," as developed by the Consortium for Spinal Cord Medicine. See <https://www.ncbi.nlm.nih.gov/pubmed/11958176>.

(c) Cardiovascular Screening. Risk factors for cardiovascular disease are common in the SCI/D population due to inactivity, obesity, and dyslipidemia. Cardiovascular screening is particularly important in the SCI/D population since persons with SCI/D often have increased risk factors for cardiovascular disease (for example, inactivity, obesity, hypercholesterolemia, tobacco use, and hypertension). In higher-level spinal

cord injuries (SCI) (that is, tetraplegia) coronary artery disease, angina, and cardiac ischemia may not manifest with chest pain due to sensory impairment, and lack of intact cardiac afferents (particularly in injuries above the neurological level of T2). Cardiovascular risk factors frequently present in younger adults with SCI/D as compared with the general population (for example, inactivity as a result of paralysis, early onset of impaired glucose tolerance or diabetes mellitus, dyslipidemia, hypertension, higher rates of tobacco use, and increased inflammatory mediators).

1. Cardiovascular risk factor assessment must include hypertension screening with annual blood pressure measurement. A fasting complete lipoprotein profile should be obtained regularly for all Veterans with SCI/D. Because mobility deficits, lack of physical activity, and obesity are common following SCI/D, screening for dyslipidemia should be performed more frequently than recommended in the VA/Department of Defense (DoD) and National Cholesterol Education Program guidelines (<https://www.nhlbi.nih.gov/files/docs/guidelines/atglance.pdf>) and in accordance with the clinical practice guideline, "Identification and Management of Cardiometabolic Risk after Spinal Cord Injury" ([https://pva-cdnendpoint.azureedge.net/prod/libraries/media/pva/library/publications/cpg\\_cardiometabolic-risk\\_digital.pdf](https://pva-cdnendpoint.azureedge.net/prod/libraries/media/pva/library/publications/cpg_cardiometabolic-risk_digital.pdf)). **NOTE:** *This linked document is outside of VA control and may not be conformant with Section 508 of the Rehabilitation Act of 1973.*

2. At a minimum, Veterans with SCI/D, normal lipid profiles, and less than three non-lipid cardiovascular risk factors should be screened once every five years. Non-lipid cardiovascular risk factors are: age 35 years or older for males, age 45 years or older for females, family history of premature cardiovascular disease, hypertension, smoking, diabetes mellitus, abdominal obesity, male gender. Veterans with SCI/D with abnormal values and/or more than three non-lipid cardiovascular risk factors warrant annual testing and should be counseled and treated in accordance with VA/DoD national guidelines.

3. Evaluation and treatment of Veterans with SCI/D who have ischemic heart disease should follow VA/DoD Clinical Practice Guidelines (<https://www.healthquality.va.gov/guidelines/CD/ihd/>). In Veterans with higher levels of neurologic impairment, symptoms and signs of ischemic heart disease may be subtle or absent. Cardiac ischemia may not result in chest pain. A 12-lead electrocardiogram should be obtained in all individuals with neurologic lesions in the mid-thoracic region and higher, age 35 years and older. Obtaining an electrocardiogram is mandatory for all symptomatic individuals or if there is clinical suspicion of cardiac disease.

(d) Autonomic Dysreflexia. Evaluation, education, and treatment for autonomic dysreflexia must be performed as clinically indicated following the recommendations of evidence-based literature and/or the clinical practice guideline, "Acute Management of Autonomic Dysreflexia" ([http://www.pva.org/media/pdf/cpg\\_autonomic%20dysreflexia.pdf](http://www.pva.org/media/pdf/cpg_autonomic%20dysreflexia.pdf)). **NOTE:** *This linked document is outside of VA control and may not be conformant with Section 508 of the Rehabilitation Act of 1973.*), as developed by the Consortium for Spinal Cord Medicine. This condition can represent a medical emergency; recognizing and treating the earliest

signs and symptoms can avoid dangerous sequelae of severely elevated blood pressure in Veterans with SCI/D with neurologic injuries at T6 and higher.

1. The annual evaluation offers a time to review problems with autonomic dysreflexia and patient knowledge, ensuring that preventive strategies are employed by the individual, and that medications for acute treatment are available and renewed.

2. Because episodes of autonomic dysreflexia may be asymptomatic yet occur regularly, it may be helpful to document and record blood pressure fluctuations during activities of daily living (ADL) such as morning transfers, following meals, and during bowel programs.

(e) Orthostatic Hypotension. Many Veterans with SCI/D have decreased blood pressure with position change that may result in symptoms such as light-headedness and impaired cognition. Assessment, education, and treatment should include recommendations for change in fluid and salt intake, compressive stockings, abdominal binder, regular physical activity, and medications.

(f) Respiratory Complications. Respiratory complications are one of the leading causes of death and morbidity when living with SCI/D. Evaluation and treatment should follow the clinical practice guideline, "Respiratory Management following Spinal Cord Injury" ([https://pva-cdnendpoint.azureedge.net/prod/libraries/media/pva/library/publications/cpg\\_resmgmt.pdf](https://pva-cdnendpoint.azureedge.net/prod/libraries/media/pva/library/publications/cpg_resmgmt.pdf)). **NOTE:** *This linked document is outside of VA control and may not be conformant with Section 508 of the Rehabilitation Act of 1973*, as developed by the Consortium for Spinal Cord Medicine and/or other evidence-based literature.

1. Pulmonary function tests and chest X-ray must be obtained when clinically indicated and should be considered in high-risk patients (for example, high tetraplegia, ventilator dependency, phrenic pacers, asthma, and chronic obstructive pulmonary disease (COPD)). Consider obtaining baseline pulmonary function tests in patients with motor-complete tetraplegia and no respiratory symptoms.

2. The prevalence of sleep-disordered breathing in persons with chronic tetraplegia may be as high as 60 percent. The prevalence is likely elevated in persons with chronic paraplegia as well as acute SCI/D. Patients with a high clinical suspicion and signs and symptoms of sleep-disordered breathing, such as severe snoring or excessive daytime sleepiness without another cause should 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.

3. Annual seasonal influenza vaccine is strongly recommended for all persons with SCI/D, unless there are specific contraindications. For those Veterans with SCI/D who will not be seen during the influenza vaccination season, every effort must be made to

contact and inform them about resources in the community and document receipt of vaccination in the medical record.

4. Pneumococcal vaccination is also highly recommended for all persons with SCI/D, unless there are specific contraindications. The decision to revaccinate should follow recommendations of the Advisory Committee on Immunization Practices (ACIP) and/or the Centers for Disease Control and Prevention (CDC).

(g) Gastrointestinal System. Gastrointestinal complications that result from SCI/D and neurogenic bowel include peptic ulcer disease, gastroesophageal reflux, fecal impaction, diarrhea, antibiotic-associated diarrhea/colitis, and incontinence. Many of these complications may result in hospitalization or can be life-threatening. Complaints of symptoms related to gastrointestinal dysfunction are some of the most common following SCI/D, and they result in a negative impact on quality of life.

1. Neurogenic Bowel. Evaluation, education, and treatment of neurogenic bowel needs to follow the clinical practice guideline, “Neurogenic Bowel Management in Adults with Spinal Cord Injury” ([http://www.pva.org/atf/cf/%7BCA2A0FFB-6859-4BC1-BC96-6B57F57F0391%7D/cpg\\_neurogenic%20bowel.pdf](http://www.pva.org/atf/cf/%7BCA2A0FFB-6859-4BC1-BC96-6B57F57F0391%7D/cpg_neurogenic%20bowel.pdf)). **NOTE:** *This linked document is outside of VA control and may not be conformant with Section 508 of the Rehabilitation Act of 1973.*), as developed by the Consortium for Spinal Cord Medicine, and other evidence-based recommendations. A screening assessment of neurogenic bowel function and related problems needs to be performed on an annual basis.

2. People with SCI/D have an increased prevalence of cholelithiasis. If gall bladder afferents and/or afferents in the overlying peritoneum are impaired, symptoms of acute cholecystitis may be subtle or absent. In patients with clinical suspicion or signs and symptoms of cholecystitis, diagnostic tests to visualize the gall bladder (abdominal ultrasound or computed tomography) must be performed.

3. Gastroesophageal reflux disease (GERD) may be asymptomatic in SCI/D. This may be the result of loss of afferent pathways that mediate substernal burning pain (heartburn) and odynophagia. Failure to diagnose GERD may lead to more serious complications, including aspiration, esophagitis, Barrett’s esophagus, and esophageal strictures.

4. Persons with SCI/D are exposed to many antibiotics, increasing the likelihood of diarrhea resulting from Clostridium difficile (C. difficile) infection. Early treatment and prevention are essential in this population. Antibiotics must be used judiciously, avoiding overuse, to prevent C. difficile infections.

(h) Genitourinary System. Several common complications that follow SCI/D are related to neurogenic bladder. Assessment, education, and treatment of the neurogenic bladder should follow the clinical practice guideline, “Bladder Management for Adults with Spinal Cord Injury,” developed by the Consortium for Spinal Cord Medicine, and other evidence-based recommendations. See <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1949036/>. Complex and recurrent

problems need to be assessed and treated in the SCI/D Centers (for example, assessment of hydronephrosis and nephrolithiasis: diagnostic tests such as cystoscopy and urodynamics).

1. The annual evaluation of the genitourinary system must include:

a. Urinalysis, culture and sensitivity.

b. Serum creatinine and Blood Urea Nitrogen (BUN).

c. Assessment of upper tract function including an anatomical test (for example, abdominal ultrasound) and a serum creatinine. Diagnostic tests such as computed tomography (CT) and intravenous pyelogram should be ordered only when clinically indicated.

2. A urodynamics evaluation must be offered to Veterans with SCI/D during their initial evaluation after onset of SCI/D or after the period of spinal shock has ended, if clinically indicated, unless there are specific contraindications to performing urodynamics. Urodynamics studies should be repeated as clinically indicated. Video-fluoroscopy may provide helpful anatomic information.

3. Each Veteran with SCI/D who uses intermittent catheterization must be offered and provided sufficient catheters so a new catheter can be used at each catheterization.

4. In Veterans with SCI/D, screening for bladder cancer remains controversial. Close collaboration with an expert SCI/D urologist is recommended to decide when to perform screening tests for bladder cancer.

(i) Abnormalities of Carbohydrate and Lipid Metabolism. Abnormalities of carbohydrate and lipid metabolism are common in Veterans with SCI/D in all age groups. Annual evaluation of fasting serum glucose and hemoglobin A1C is recommended for all Veterans with SCI/D. Follow-up and treatment of diabetes should follow VA/DoD guidelines. Dilated eye examination in accordance with VA/DoD guidelines should be performed.

(j) Musculoskeletal Disorders. Many musculoskeletal disorders after SCI/D are common and disabling. Due to increased forces and repetition (for example, upper limbs used for transfers and wheelchair propulsion), extreme positions (for example, during uneven transfers), altered biomechanics (for example, gait pattern due to weakness), and instrumentation of the spine, peripheral joint and spine pathology are common. Quantitative assessment of upper limb function and treatment should follow the clinical practice guideline, "Preservation of Upper Limb Function Following SCI," developed by the Consortium for Spinal Cord Medicine, and other evidence-based recommendations. See <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1808273/>.

1. The evaluation of spine pain is a particular challenge in Veterans with SCI/D. A thorough history, physical examination, and if indicated, imaging studies must be performed in all persons with the new onset of, or significant changes in neck or back

pain, evaluating for instrumentation problems, instability, neuropathic arthropathies, syringomyelia, radiculopathy, and spinal stenosis. The Veteran must be referred to the SCI/D Center for new spine pathology or complications.

2. Osteoporosis and fracture due to decreased bone mineral content and bone mineral density have been demonstrated in persons with SCI/D. All correctable factors that exacerbate osteoporosis must be reviewed and, if indicated, treated (that is, vitamin D, calcium, hyperthyroidism, hypogonadism). Fall prevention must be reviewed and include evaluation of intrinsic factors (cognitive impairment), sedating medications, and extrinsic factors (wheelchair set-up). Other risk factors must also be assessed and corrected (for example, unsafe transfers, excessively zealous range of motion). Although anti-osteoporotic drugs and mechanical interventions hold promise, no treatment modality has been proven to prevent bone loss at time of acute/subacute SCI or to have lasting benefit in chronic SCI to improve bone substance strength or to prevent fractures.

3. Seating and postural abnormalities are common after SCI/D. An evaluation of seating and posture must be done annually by a therapist experienced in SCI/D seating complications. Pressure mapping may be used as an evaluative tool, when clinically indicated, but in of itself is not an adequate evaluation. Treatment by experienced therapists in the SCI/D Center must be conducted when indicated. The Chief, SCI/D Center must approve treatment of complex seating and/or postural abnormalities outside of the SCI/D Center.

(k) Neurologic Complications.

1. Neurologic complications (for example, spasticity and pain) are common and must be evaluated and treated when clinically indicated.

2. Neurologic decline.

a. The International Standards for Neurological Classification of Spinal Cord Injury must be used and documented in the medical record for patients with traumatic SCI/D during each annual evaluation for early detection of neurologic decline. See <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3232636/>.

b. An accepted, standardized assessment tool must be used to assess and document the neurologic status in Veterans with atraumatic SCI/D annually (for example, International Standards for Neurological Classification of Spinal Cord Injury, Kurtzke Expanded Disability Status Scale for Multiple Sclerosis (MS), Amyotrophic Lateral Sclerosis (ALS) Functional Rating Scale for ALS).

c. Findings of new or worsening neurological deficit in Veterans with known non-progressive neurological disorders must be evaluated for central and peripheral causes of neurological decline such as peripheral nerve entrapments, syringomyelia, and spinal stenosis causing worsening myelopathy.

(l) Chronic Pain. Chronic pain following SCI/D is common. Thorough evaluation and comprehensive management must be done at initial presentation, annually, and if there is new pain or a change in symptoms at the SCI/D Center.

(m) Rehabilitation Functional Assessment. A rehabilitation functional assessment that includes ADL, transfers, proper wheelchair propulsion, and other aspects of mobility must be performed annually if indicated. An experienced SCI/D therapist should perform an annual review of home exercise programs and options available for increased activity.

(n) Dietary and Nutritional Assessment. Annual dietary and weight management assessments must be performed since the SCI/D population has a high prevalence of obesity and disorders of carbohydrate and lipid metabolism. Review of weight changes over time must be completed and discussed with the Veteran. If desired by the Veteran, weight management educational programs, support, activities and exercise in the community should be provided.

(o) Medications and Supplies. Review and renewal of medications and supplies must be performed annually. Refer to paragraph 6.h. in the body of the directive regarding availability of medical and surgical supply products.

(p) Dental Evaluation. A dental evaluation needs to be made and follow-up care for issues identified by the evaluation need to be provided when VHA eligibility criteria for dental services are met, as listed in VHA Directive 1130, Dental Program for Department of Veterans Affairs (VA) Medical Facilities, dated October 26, 2016.

(q) Psychological, Social, and Vocational Needs. Psychological, social, educational, and vocational needs must be reviewed annually. Broadly, the social determinants of health should be reviewed and discussed with the Veteran so barriers and obstacles are addressed. Satisfactory life adjustment and quality of life are often defined by personal independence, economic self-sufficiency, and life opportunities. The annual evaluation is an opportunity to review social role participation, work and vocational rehabilitation potential, educational goals, behavioral health status including Post-Traumatic Stress Disorder and depression, economic stressors, substance use disorder, tobacco cessation, accessible housing, transportation, life care planning, and attendant training needs.

(r) Prosthetic Equipment. Review of prosthetic equipment needs, function, and safety must be performed annually.

(s) Assistive Technology. Review of assistive technology to maximize function and access in the home and community must be performed annually.

(t) Comprehensive Preventive Health Evaluation Findings. The Comprehensive Preventive Health Evaluation findings must be documented in the medical record, summarized with recommendations for follow-up care, and shared with Veterans.

(u) Sexuality and Fertility Counseling.

1. Infertility evaluation, management, and select treatment may be provided in accordance with VHA Directive 1332(1), Infertility Evaluation and Treatment, dated June 20, 2017. VA may provide Assisted Reproductive Technology (ART)/In-Vitro Fertilization (IVF) to certain Veterans who have a service-connected disability that results in their inability to procreate without ART under 38 Code of Federal Regulations (CFR) 17.380. VA may also provide ART to spouses of Veterans authorized to receive provide ART, as well as fertility counseling and treatment that is available under the medical benefits package, under 38 CFR 17.412. VA cannot provide ART/IVF to Veterans that do not meet the above criteria because it is specifically excluded from the VA medical benefits package (38 CFR 17.38(c)(2)).

2. All Veterans with SCI/D must be offered the opportunity to undergo sexuality and fertility counseling by means of formal urological, fertility, and psychological consultation. If the Veteran chooses, the spouse, or significant other, may be involved in the process.

3. Sexuality counseling should be facilitated by use of “Sexuality and Reproductive Health in Adults with Spinal Cord Injury: A Clinical Practice Guideline” produced by the Consortium of Spinal Cord Medicine and/or other evidence-based literature. See <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2941243/>.

## APPENDIX C

## EVALUATION OF QUALITY, ACCESS, AND PERFORMANCE IMPROVEMENT

## 1. SPINAL CORD INJURIES AND DISORDERS CENTER QUALITY IMPROVEMENT ACTIVITIES

a. Each Spinal Cord Injuries and Disorders (SCI/D) Center must undertake service-level Quality Improvement (QI) activities that monitor critical aspects of care and provide an ongoing and continuous evaluation of the program.

b. A SCI/D-QI committee must meet at least quarterly to evaluate:

(1) **Access.** In collaboration with the SCI/D National Program Office, evaluate access to all segments of care including inpatient services, outpatient clinic, consultative services, SCI/D Home Care (SCI/D-HC), extended care, and SCI/D telehealth.

(2) **Outreach.** In collaboration with the SCI/D National Program Office, evaluate outreach to Veterans with SCI/D that live within the SCI/D Center catchment to include but not limited to Veterans who: have never been seen at the SCI/D Center, were seen at the SCI/D Center in the past but have not been seen recently, have been inpatients at other Department of Veterans Affairs (VA) medical facilities but were not transferred to the SCI/D Center, have been followed by non-SCI/D services but not SCI/D Center or Spoke Patient Aligned Care Teams (PACTs), have been seen at VA Community-Based Outpatient Clinics (CBOCs) but not in the SCI/D System of Care, have been seen in community settings, and/or are in institutional long-term care (LTC) settings (for example, VA Community Living Centers (CLCs), contract nursing homes, non-contract nursing homes).

(3) **SCI/D Comprehensive Preventive Health Evaluation.** In collaboration with the SCI/D National Program Office, evaluate the percentage of Veterans included in the SCI/D Center Registry who received a SCI/D Comprehensive Preventive Health Evaluation at the SCI/D Center. The SCI/D-QI committee must maintain a continuous improvement project to fully maximize the number of Veterans with SCI/D that receive a SCI/D Comprehensive Preventive Health Evaluation at the SCI/D Center.

(4) **SCI/D Center Registry and Outcomes.** In close collaboration with the Management of Information and Outcomes (MIO) Coordinator, Chief, SCI/D Center, and the SCI/D National Program Office, support the modernization and optimization of the SCI/D Center Registry and Outcomes Program.

(5) **SCI/D Center Veteran Satisfaction.** In collaboration with the SCI/D National Program Office, evaluate Veteran satisfaction in all care settings to include SCI/D inpatient, outpatient, home care, LTC, and telehealth.

(6) **SCI/D Center Initiated Outcomes and Quality Improvement Initiatives.** Identify important aspects of care, and monitor areas of service delivery identified as high-risk, high-volume, problem-prone areas, and risk management. Each SCI/D

Center must follow and respond to Veterans Health Administration (VHA) and SCI/D National Program Office established QI initiatives according to VHA Directive 1026, VHA Enterprise Framework for Quality, Safety, and Value, dated August 2, 2013.

(7) **Quality Improvement Process.** Define the systematic plan used for collecting and analyzing data, taking corrective action, and reporting results.

(8) **Engagement of SCI/D Staff.** Ensure SCI/D staff members from all settings are actively participating in SCI/D-QI.

(9) **Coordination and Compliance of Quality Improvement Activities.** The SCI/D-QI Committee, QI activities, and the QI plan are to coordinate and comply with VHA policies, SCI/D National Program Office and accrediting organizations' criteria, and be evaluated according to VHA Handbook 1050.01, VHA National Patient Safety Improvement Handbook, dated March 4, 2011; VHA Directive 1100.16, Accreditation of Medical Facility and Ambulatory Programs, dated May 9, 2017; and VHA Directive 1170.01, Accreditation of Veterans Health Administration Rehabilitation Programs, dated May 9, 2017.

(10) **Quality Improvement Reporting.** QI processes and results must be reported at SCI/D staff meetings, to the VA medical facility quality management program, and, for national measures, to the SCI/D National Program Office.

## APPENDIX D

**SPINAL CORD INJURIES AND DISORDERS STAFFING**

The Spinal Cord Injuries and Disorders (SCI/D) interdisciplinary team composition must have adequate staffing to efficiently meet Veterans' identified needs and all facets of the SCI/D System of Care as specified in this directive. The SCI/D Center must 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. All key SCI/D staff members assigned and dedicated to the SCI/D Service are outlined in paragraphs a-d below. Additional staff must be provided based on patient needs and local factors in order to meet all program elements.

a. **SCI/D Center Inpatient Staffing (Acute/Sustaining Care).** The following minimum staffing levels are for SCI/D Center inpatient acute/sustaining care staffing.

(1) **SCI/D Nurses.**

(a) Nurse staffing must be calculated based on 125 full-time employee equivalents (FTEE) per 50 operating acute/sustaining beds. This equates to 2.5 FTEE per operating bed and is derived from a SCI/D systemwide average of 585 hours of patient care required per day for 50 operating beds. Operating beds for each SCI/D Center are identified in Appendix E. For acute/sustaining SCI/D Center bed staffing, nursing staff mix must consist of 50 percent or more registered nurses (RN).

(b) When patient care needs associated with the patient's functional status, complications, co-morbidities, and/or complexity of a patient's condition increases, thus increasing the required Nursing Hours Per Patient Day (NHPPD), nurse staffing levels must be modified according to Veterans Health Administration (VHA) Directive 1351, Staffing Methodology for VHA Nursing Personnel, dated December 20, 2017.

(c) NHPPD is the total number of nursing hours of care available divided by the number of patients in a 24-hour period. NHPPD is a nurse staffing ratio proxy and can be proportioned by skill mix and shift distribution. See VHA Directive 1351 for additional information.

(2) **SCI/D Provider: Medical Doctor, Doctor of Osteopathic Medicine, Physician Assistant or Nurse Practitioner.** One full-time Medical Doctor (MD) / Doctor of Osteopathic Medicine (DO) / Physician Assistant (PA) / Nurse Practitioner (NP) must be dedicated for every ten operating acute/sustaining beds. An additional .75 FTEE must be allocated for administrative responsibilities of the full-time Chief, SCI/D Center. The provider staff mix must consist of 60 percent or more MD/DO.

(3) **SCI/D Social Workers.** One full-time social worker must be dedicated for every 20 operating beds.

(4) **SCI/D Psychologists.** One full-time psychologist must be dedicated for every 20 operating beds.

(5) **SCI/D Therapists.** One full-time rehabilitation therapist (from a rehabilitation mix of physical therapists, occupational therapists, kinesiotherapists, and therapeutic recreational specialists) must be dedicated for every five operating beds.

(6) **SCI/D Vocational/Rehabilitation Counselor.** One full-time vocational/rehabilitation counselor must be solely dedicated to each acute/sustaining SCI/D Center, either directly assigned to the SCI/D Center or via collaboration with Compensated Work Therapy vocational rehabilitation program.

(7) **SCI/D Clinical Pharmacist.** One full-time clinical pharmacist must be solely dedicated to each SCI/D Center for inpatient acute/sustaining care.

(8) **SCI/D Management of Information and Outcomes Coordinator.** One full-time Management of Information and Outcomes (MIO) Coordinator must be dedicated to each SCI/D Center. The MIO Coordinator daily activities are exclusively dedicated to modernizing and managing the SCI/D Registry and Outcomes program for the SCI/D Center per direction of the Chief, SCI/D Center and per guidance from the SCI/D National Program Office. The MIO Coordinator daily activities will not include additional administrative, clinical, research, general educational duties, inpatient or outpatient care, Commission on Accreditation of Rehabilitation Facilities (CARF) responsibilities, care coordination, research responsibilities, or other non-MIO work. The MIO Coordinator will report directly to the Chief, SCI/D Center. The MIO Coordinator will also work closely with and follow guidance from the SCI/D National Program Office.

(9) **SCI/D Telehealth Coordinator.** At least one SCI/D telehealth coordinator must be solely dedicated to each SCI/D Center without additional non-telehealth, administrative, clinical, research, educational, or non-SCI/D duties.

(10) **Wheelchair Repair Technician.** At least one SCI/D wheelchair technician must be dedicated to each SCI/D Center.

(11) **Registered Dietician.** One full-time dietician must be dedicated to each SCI/D Center for inpatient acute/sustaining care. The SCI/D dietician may serve more than one SCI/D setting, based on caseload.

(12) **Prosthetic Purchasing Agent.** One full-time prosthetic purchasing agent must be solely dedicated to each SCI/D Center.

(13) **Additional Inpatient SCI/D Staffing Needs.** In addition to the preceding defined staffing, additional needs for instituting key program elements within the SCI/D Center programs are to be implemented with categories of staff determined based on needs of the individual SCI/D Center. Additional staff and resources are necessary to address the complex needs of Veterans with SCI/D; however, these additional staff may or may not be solely dedicated to the SCI/D Center as determined by unique local

needs. Examples of additional staff include respiratory therapists, rehabilitation engineers, and dentists.

b. **SCI/D Center Inpatient Staffing (Long-Term Care)**. The following staffing levels are for SCI/D Center inpatient long-term care (LTC) staffing.

(1) **Nursing**. Minimal nurse staffing must be calculated based on 60 FTEE for 30 operating beds. This equates to 2.0 FTEE per authorized bed. Authorized beds for each SCI/D Center are identified in Appendix F. For SCI/D Center LTC bed staffing, nursing staff mix must consist of 40 percent or more RN.

(2) **SCI/D Provider: Medical Doctor, Doctor of Osteopathic Medicine, Physician Assistant or Nurse Practitioner**. One full time provider for every 25 authorized beds (plus 0.75 full-time employee (FTE) for administrative responsibilities of the full-time Chief, SCI/D Center for SCI/D LTC Centers that are not associated with a SCI/D acute/sustaining Center). The provider staff mix must consist of 60 percent or more MD/DO.

(3) **Therapists**. One full-time rehabilitation therapist (from a rehabilitation mix of physical therapists, occupational therapists, kinesiotherapists, and therapeutic recreational specialists) must be dedicated for every 14 operating LTC beds.

(4) **Social Workers**. One FTE for every 40 authorized beds.

(5) **Psychologists**. One FTE for every 40 authorized beds.

(6) **SCI/D Clinical Pharmacist**. One full-time clinical pharmacist must be solely dedicated to each SCI/D LTC Center.

(7) **SCI/D Management of Information and Outcomes Coordinator**. One full-time MIO Coordinator must be dedicated to each SCI/D LTC Center that is not associated with a SCI/D acute/sustaining Center. The MIO Coordinator daily activities are exclusively dedicated to modernizing and managing the SCI/D Registry and Outcomes program for the SCI/D Center per direction of the Chief, SCI/D Center and per guidance from the SCI/D National Program Office. The MIO Coordinator daily activities will not include additional administrative, clinical, research, general educational duties, inpatient or outpatient care, CARF responsibilities, care coordination, research responsibilities, or other non-MIO work. The MIO Coordinator will report directly to the Chief, SCI/D Center. The MIO Coordinator will also work closely with and follow guidance from the SCI/D National Program Office.

(8) **SCI/D Telehealth Coordinator**. At least one SCI/D telehealth coordinator must be dedicated to each SCI/D LTC Center that is not associated with a SCI/D acute/sustaining Center.

(9) **Wheelchair Repair Technician**. One SCI/D wheelchair technician must be dedicated to each SCI/D LTC Center.

(10) **Registered Dietician.** One full-time dietician must be dedicated to each SCI/D LTC Center. The SCI/D dietician may serve more than one SCI/D setting, based on caseload.

(11) **Prosthetic Purchasing Agent.** One full-time prosthetic purchasing agent must be dedicated to each SCI/D LTC Center.

(12) **Additional Inpatient SCI/D Long-Term Care Staffing Needs.** The need for other personnel such as physician assistants, NPs, administrative support staff, speech pathologists, vocational rehabilitation specialists, and respiratory therapists, is critical to SCI/D LTC programs and will be determined based on local needs.

c. **SCI/D Center Patient Aligned Care Team Staffing.** SCI/D Patient Aligned Care Team (PACT) staffing at SCI/D Centers must be sufficient to ensure that all Veterans with SCI/D assigned to the SCI/D Registry and seen by the SCI/D PACT receive appropriate and desired primary and specialty care. Staffing of the SCI/D PACT is separate from inpatient staffing. SCI/D PACT staffing at each SCI/D Center must include at least one dedicated SCI/D PACT per full-time employee equivalent (1.0 FTEE) to support panel capacity as follows:

(1) Primary care MD/DO/PA/NP (400). PA/NP panel capacity will not exceed 75 percent of MD/DO capacity (300).

(2) SCI/D specialist MD/DO (600).

(3) RN position (SCI/D nurse) (400).

(4) Licensed Practical Nurse/Licensed Vocational Nurse/Health Technician (LPN/LVN/HT) position (SCI/D Clinical Associate) (400).

(5) SCI/D social worker (600).

(6) SCI/D psychologist (600).

(7) SCI/D therapist (400).

(8) Clerk position (SCI/D Administrative Associate) (600).

(9) SCI/D registered dietician (1200). The SCI/D PACT registered dietician may serve both SCI/D PACT and SCI/D Home Care (SCI/D-HC), based on caseload to equal a minimum total of 1.0 FTEE.

(10) SCI/D clinical pharmacist (1200). SCI/D PACT clinical pharmacist may serve both SCI/D PACT and SCI/D-HC based on caseload to equal a minimum total of 1.0 FTEE.

(11) **Additional Outpatient SCI/D Staffing Needs.** In addition to the preceding defined staffing, additional needs for instituting key outpatient programs within the

SCI/D Center programs are to be implemented with staff based on needs of the individual SCI/D Center. These additional staff may or may not be solely dedicated to the SCI/D Center, as determined by unique local needs. Examples of additional staff include respiratory therapists, prosthetics, and rehabilitation engineers.

(a) Additional staffing may be needed for specialty multiple sclerosis (MS) and/or amyotrophic lateral sclerosis (ALS) programs.

(b) Additional staffing may be needed for additional SCI/D Center PACTs as outpatient panels increase.

(12) **SCI/D PACT Responsibilities.** In addition to outpatient responsibilities, the SCI/D PACT is responsible for care coordination with SCI/D Spokes, care coordination with Veterans with SCI/D in LTC settings (for example, Department of Veterans Affairs (VA) Community Living Centers (CLCs) and community nursing homes), outreach, and virtual care (for example, telehealth).

d. **SCI/D Center Home Care Staffing.** Each SCI/D Center must provide additional staff, separate from inpatient and SCI/D PACT, for SCI/D-HC. SCI/D-HC staffing must include, but is not limited to, a SCI/D-HC Program Director MD/DO (1.0 FTE) and SCI/D-HC team. The SCI/D-HC team must be staffed per FTEE (1.0 FTEE) to support caseloads (Veteran caseloads are listed in parentheses after each position) as follows:

(1) SCI/D-HC MD/DO/PA/NP (250). PA/NP caseload capacity will not exceed 75 percent of MD/DO capacity (188).

(2) SCI/D-HC nurse (20).

(3) SCI/D social worker (100).

(4) SCI/D psychologist (200).

(5) SCI/D therapist (100).

(6) SCI/D medical support assistant (600).

(7) SCI/D registered dietician (1200). The SCI/D-HC registered dietician may serve both SCI/D Center PACT and SCI/D-HC based on caseload to equal a minimum total of 1.0 FTEE.

(8) SCI/D clinical pharmacist (1200). The SCI/D-HC clinical pharmacist may serve both SCI/D Center PACT and SCI/D-HC based on caseload to equal a minimum total of 1.0 FTEE.

(9) Additional SCI/D-HC staff may be added based on caseload, consistent with VHA Directive 1411, Home-Based Primary Care Special Population Patient Aligned Care Team Program, dated June 5, 2017.

(10) **Additional SCI/D Home Care Staffing Needs.** In addition to the preceding defined staffing, additional needs for instituting key home care programs within the SCI/D Centers are to be implemented with staff based on needs of the individual Veteran and SCI/D Center. Additional staff and resources are necessary to address the complex needs of Veterans with SCI/D who live in the community. Additional staff may or may not be solely dedicated to SCI/D-HC, as determined by unique local needs.

**NOTE:** *Caseload numbers indicated are to be viewed as numbers not to be surpassed rather than as a target capacity to avoid programs experiencing negative consequences. Determination of maximum caseload is dependent on many factors including geography, coverage area, patient complexity, patient attrition, staff recruitment and retention, staff experience, team composition, pharmacy support, medical record sophistication, and program support including vehicles, computers, and other technology requirements.*

e. **SCI/D Spoke PACT Staffing.** The VA medical facility Chief of Staff appoints a SCI/D PACT at each VA medical facility without a SCI/D Center. Each VA medical facility without a SCI/D Center and with a SCI/D Registry of at least 75 Veterans with SCI/D must have a fully staffed SCI/D Spoke PACT. Each VA medical facility without a SCI/D Center and with a SCI/D Registry of less than 75 Veterans must have a SCI/D Spoke PACT staffed as follows:

SCI/D Registry (Number of Veterans)	Dedicated FTEE per position	Total PACT FTEE
75+	1.00	5.00
50-74	0.75	3.75
25-49	0.50	2.50
24 or fewer	0.25	1.25

f. SCI/D Spoke PACT staff is responsible for all enrolled Veterans with SCI/D in the facility's designated catchment area (that is, all Veterans who live closer to the SCI/D Spoke PACT facility than any other VA medical facility). The required positions in the SCI/D Spoke PACT are:

(1) **Primary Care Provider.** The SCI/D primary care provider has advanced training and knowledge of SCI/D. The primary care provider is a dedicated primary care clinician with training in SCI/D medicine to provide primary care and consultative services throughout the facility for eligible Veterans with SCI/D. Panel size must reflect the complexity of caring for Veterans with SCI/D, increased frequency and duration of appointments, case management responsibilities, required inpatient consultative services, coordinative care with the designated SCI/D Center, and telehealth care.

(a) The preferred provider for this position is a primary care physician.

(b) A specialty care physician (for example, a neurologist or physiatrist) may be selected for this position if there is also an advanced practice provider (NP or PA) trained in primary care on the SCI/D Spoke PACT. The primary responsibility of the SCI/D Spoke PACT is to provide primary care to Veterans with SCI/D.

(2) **Registered Nurse Care Manager.** The SCI/D Registered Nurse Care Manager (RNCM) or NP care manager has advanced training and knowledge of SCI/D and primary care. The SCI/D RNCM/NP provides expertise in many SCI/D-related areas including but not limited to: neurogenic skin, pressure ulcers, neurogenic bladder and neurogenic bowel management, and management of autonomic dysreflexia. The SCI/D RNCM/NP assists the Veteran, as needed, with transfers, donning/doffing clothing for the physical examination, positioning, pressure reliefs, and other dependent tasks. The SCI/D RNCM/NP also must be available to assist the Veteran and VHA staff, in all locations (for example, Home-Based Primary Care (HBPC), inpatient units, CLCs) in troubleshooting medication and supply issues, skin care assessment, review of SCI/D practices and protocols, referrals to the SCI/D Center, SCI/D telehealth visits, care planning, and telephone triage.

(3) **SCI/D Coordinator.** The SCI/D Coordinator role is to be filled by a licensed social worker who has, or will obtain advanced training and knowledge of SCI/D including but not limited to: the physical and psychosocial implications of SCI/D on the Veteran and family; appropriate clinical interventions; prosthetic services and policies; VHA policies that affect Veterans with SCI/D; VA benefits and other governmental entitlement programs for rehabilitation, treatment, and services; community resources and services for individuals with disabilities; local peer counseling programs; and Federal laws, regulations, and rights for Veterans with SCI/D.

(a) Contact information for each SCI/D Coordinator must be posted in the Admissions and Ambulatory Care area, listed in the VA medical facility telephone directory, and on the SCI/D System of Care Web site <http://vaww.sci.va.gov>. **NOTE:** *This is an internal VA Web site that is not available to the public.*

(b) Designated SCI/D Coordinators must receive specialized training including a visit to the designated SCI/D Center.

(c) SCI/D Coordinators are required to make annual contact with all Veterans with SCI/D in their facility's designated catchment area (all Veterans who live closer to their VA medical facility than any other VA medical facility) unless otherwise indicated by Veteran preference.

(d) When developing the SCI/D Coordinator's functional statement, the specialized training, independent functioning, and complex and unpredictable caseload requirements warrant consideration of an advanced practice General Schedule grade.

(e) The SCI/D Coordinator must be knowledgeable about all aspects of SCI/D and able to provide information to Veterans, families, caregivers, and other members of the SCI/D Spoke PACT.

(f) The SCI/D Coordinator's responsibilities include but are not limited to: facilitating appropriate and efficient transfers to SCI/D Centers; identifying new and established Veterans with SCI/D who are admitted or discharged from the Spoke facility; providing support to SCI/D Spoke PACT staff; referring all Veterans with SCI/D to the Veterans Benefits Counselor and/or, with the Veteran's consent, to a Veteran Service Officer; developing a system of outreach to extend services to Veterans with SCI/D not using the VA SCI/D System of Care or VA for their health care needs; establishing, maintaining, and modernizing the SCI/D Registry database in close collaboration with the SCI/D Center; and using existing quality management mechanisms, national and local policies, procedures, and external reviews to evaluate and document the SCI/D Spoke PACT program's effectiveness.

(4) **Licensed Practical Nurse Position (Clinical Associate).** The Clinical Associate is a LPN, LVN or unlicensed assistive personnel (for example, certified nursing assistant, medical assistant, or HT). Responsibilities include: providing evaluation and care consistent with licensure, certification, and functional statement with elements of practice, to Veterans assigned to the SCI/D Spoke PACT; collaborating with SCI/D Spoke PACT staff to develop comprehensive primary care and care management plans for Veterans with SCI/D; managing clinic workflow; ensuring Veterans are placed in examination rooms in an efficient manner; and providing direction to Veterans as they move through the clinic environment.

(5) **Clerk (Administrative Associate).** The Administrative Associate provides clerical support and administrative functions to the SCI/D Spoke PACT staff. The clerk is also responsible for incorporating the logistical elements of care coordination into comprehensive care management plans, providing guidance and direction to Veterans and personal support persons for navigating the VA health care system and administrative functions in VA, and coordinating care for Veterans assigned to the SCI/D Spoke PACT.

(6) Additional discipline-specific team members for SCI/D Spoke PACTs can be assigned in Patient Centered Management Module (PCMM) as follows: pharmacist (Clinical Pharmacy Specialist), dietician (Registered Dietician), wound care specialist (Wound Care Nurse), therapist (Physical Therapist, Occupational Therapist, Kinesiotherapist, Recreation Therapist), psychologist position (Psychologist), and respiratory therapy position (Respiratory Therapist).

## APPENDIX E

**SPINAL CORD INJURIES AND DISORDERS CENTER ACUTE AND SUSTAINING BEDS BY FACILITY****BED LEVELS**

a. **Related Legislation.** The Veterans' Health Care Eligibility Reform Act of 1996 mandated that the Department of Veterans Affairs (VA) maintain its capacity to provide services for Veterans with Spinal Cord Injuries and Disorders (SCI/D). VA developed policy that maintained beds and staffing, as well as mechanisms to report capacity to Congress. The requirement to provide Congress with an annual capacity report that included SCI/D staffing and beds expired in 2008 but was then reinstated in the Continuing Appropriations and Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2017, and Zika Response and Preparedness Act (Public Law 114-223 section 250).

b. **Authorized and Operating Beds.** Appendix E lists the specific number of authorized and operating acute/sustaining SCI/D beds for each SCI/D Center. Appendix F lists the specific number of authorized and operating long-term care (LTC) beds for SCI/D Centers and dedicated SCI/D beds in VA Community Living Centers (CLCs). Any decrease in beds or staffing levels in SCI/D Centers below those described in these appendixes requires prior approval of the Under Secretary for Health. Proposed changes must be submitted through, and approved by, the Executive Director, SCI/D National Program Office and then the Deputy Under Secretary for Health for Operations and Management, through the chain of command to the Under Secretary for Health.

(1) **Total Authorized and Operating Beds.** A minimum total of 1,341 authorized beds are to be maintained for SCI/D patients, including 1,159 operating beds, as specified in this directive in Appendices E and F. The operating beds are composed of:

(a) **Acute/Sustaining Beds.** The 1,080 authorized beds in SCI/D Centers must include 915 operating beds which must be staffed as specified in this directive in Appendix D.

(b) **Long-Term Care Beds.** The 198 authorized LTC beds at SCI/D Centers must include 181 operating beds, which must be staffed as specified in this Directive in Appendix D. All 63 of the authorized beds in CLCs must be maintained as operating beds as specified in Appendix F. The Office of Geriatrics and Extended Care determines SCI/D CLC staffing.

(2) Assess the status of the SCI/D System as of September 30, each year. After seeking input from internal and external stakeholders, the Executive Director, SCI/D National Program Office, must provide the Under Secretary for Health with any recommended changes to the bed and staffing levels for each facility listed in this directive.

Veterans Integrated Service Network (VISN)	Facility	SCI/D Authorized Beds	SCI/D Operating Beds	Pending Construction Authorized Beds	Pending Construction Operating Beds	In Planning
18	Albuquerque	30	26			
7	Augusta	71	60			
2	Bronx	62	53			
1	Boston (West Roxbury)	36	31			
10	Cleveland	32	27			
17	Dallas	30	26			
19	Denver* (Aurora)	30	20			
2	East Orange	18	18			
12	Hines	68	58			
16	Houston	40	40			
22	Long Beach	90	77			
9	Memphis	70	60			
8	Miami	36	31			
12	Milwaukee	38	32			
23	Minneapolis	30	26			
21	Palo Alto	43	37			
6	Richmond**	100	68			
17	San Antonio	30	26			
22	San Diego	30	26			
8	San Juan	20	20			
20	Seattle	38	32			
15	St Louis^	38	33			
2	Syracuse	30	26			
8	Tampa	70	62			
<b>Total</b>	<b>Acute/ Sustaining Beds</b>	1080	915	0	0	0

\* Denver: Planned SCI/D Operating Beds – 30 effective October 1, 2019.

\*\* Richmond has 20 Hoptel Beds.

^ St. Louis: SCI/D Authorized Beds – 32 at Jefferson Barracks and 6 at John Cochrane; SCI/D Operating Beds – 27 at Jefferson Barracks and 6 at John Cochrane.

APPENDIX F

**SPINAL CORD INJURIES AND DISORDERS (SCI/D) LONG-TERM CARE BEDS BY FACILITY**

VISN	SCI/D Center	SCI/D Authorized Beds	SCI/D Operating Beds	Pending Construction Beds	Pending Construction Operating Beds	In Planning
1	Boston (Brockton)	36	34			
10	Cleveland	26	22			
17	Dallas					30
6	Hampton*	64	54			
12	Hines	30	30			
22	Long Beach	12	12			
22	San Diego					20
8	Tampa	30	29			
	<b>Total</b>	198	181	0	0	50
VISN	SCI/D Authorized Beds in CLCs	SCI/D Authorized Beds	SCI/D Operating Beds	Pending Construction Beds	Pending Construction Operating Beds	In Planning
20	American Lake	8	8			
21	Menlo Park	10	10			
8	Miami	10	10			
12	Milwaukee	10	10			
8	Orlando	15	15			

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8	San Juan	10	10			
	<b>Total</b>	63	63	0	0	0

\*Hampton: Operating beds - 47 due to construction temporarily reducing bed availability.

## APPENDIX G

## STOP CODES

## 1. SCI/D CENTER PACT STOP CODE

a. **Stop Codes.** Stop Codes, formerly known as Decision Support System (DSS) Identifiers, are three-digit standardized codes used to identify Veterans Health Administration (VHA) outpatient clinics.

b. Stop Code 210 must be used for all face-to-face clinic visits between the Spinal Cord Injuries and Disorders (SCI/D) Center Patient Aligned Care Team (PACT) and Veterans with SCI/D. Stop Code 210 is to be used for the primary Stop Code. However, if another Stop Code is required by other policy to be in the primary Stop Code position, Stop Code 210 is to be used for the secondary Stop Code. See [http://vaww.dss.med.va.gov/programdocs/pd\\_oident.asp](http://vaww.dss.med.va.gov/programdocs/pd_oident.asp). **NOTE:** *This is an internal Department of Veterans Affairs (VA) Web site that is not available to the public.*

(1) **SCI/D Center PACT Stop Code Purpose.** For purposes of SCI/D workload credit, managerial accounting, SCI/D hub and spokes program evaluation, identifiers for SCI/D Registry purposes, assigning SCI/D Center PACT panels, right-sizing clinical activities to ensure access, and resolving issues such as co-pays, the accurate use of Stop Code 210 for SCI/D Center PACTs is critical. Past and current coding by some SCI/D PACTs has been inaccurate.

(2) **Clinic Names.** The Chief, SCI/D Center, Management of Information and Outcomes (MIO) Coordinator, and SCI/D National Program Office collaborate in modernizing clinic names and Stop Code use to optimize the SCI/D Registry and Outcomes program.

## 2. SCI/D SPOKE PACT STOP CODE

a. **Stop Codes.** Stop Codes, formerly known as DSS Identifiers, are three-digit standardized codes used to identify VHA outpatient clinics.

b. Stop Code 210 must be used for all clinic visits between the SCI/D Spoke PACT and Veterans with SCI/D. Stop Code 210 is to be used for the primary Stop Code. However, if another Stop Code is required by other policy to be in the primary Stop Code position, Stop Code 210 is to be used for the secondary Stop Code. See [http://vaww.dss.med.va.gov/programdocs/pd\\_oident.asp](http://vaww.dss.med.va.gov/programdocs/pd_oident.asp). **NOTE:** *This is an internal VA Web site that is not available to the public.*

(1) **SCI/D Spoke PACT Stop Code Purpose.** For purposes of SCI/D workload credit, managerial accounting, SCI/D hub and spokes program evaluation, identifiers for SCI/D Registry purposes, assigning SCI/D Spoke PACT panels, right-sizing clinical activities to ensure access, and resolving such issues as co-pays, the accurate use of Stop Code 210 for SCI/D Spoke PACTs is critical. Past and current coding by some SCI/D Spoke PACTs has been inaccurate.

(2) **Clinic Names.** SCI/D Spoke PACTs must collaborate with the SCI/D Center Chief, MIO Coordinator, and SCI/D National Program Office in modernizing clinic names and Stop Code use in service of optimizing the SCI/D Registry and Outcomes program.

### 3. SCI/D HOME CARE STOP CODE

SCI/D Home Care (SCI/D-HC) clinics must use Stop Code 215 as the primary Stop Code for all SCI/D-HC encounters.

### 4. SCI/D TELEHEALTH AND VIRTUAL CARE SERVICES STOP CODE

a. **SCI/D Telehealth Stop Code.** Stop Code 225 is the Stop Code associated with SCI/D telehealth services. Stop Code 225 is to be used for the primary Stop Code. However, if another Stop Code is required by other policy to be in the primary Stop Code position, Stop Code 225 is to be used for the secondary Stop Code. In the case that other policy requires the use of other Stop Codes in both the primary and secondary positions, the SCI/D Telehealth CHAR4 code, CNSI, is to be used. This code records SCI/D telehealth services when at least one of the sites is a SCI/D Center or Spoke facility. When paired with the appropriate telehealth codes, these services can accomplish via Clinical Video Telehealth (CVT), Store and Forward Telehealth (SFT) or Home Telehealth. When paired with the appropriate virtual care activity codes, these services can include Secure Messaging activities. This includes assistance with clinical examinations, screening, assessment, monitoring, medical record review, provision of consultation or direct care/treatment of patients with SCI/D under the auspices of a Spinal Cord Injury (SCI) Telehealth Program. It also includes provider and support services. See [http://vaww.dss.med.va.gov/programdocs/pd\\_oident.asp](http://vaww.dss.med.va.gov/programdocs/pd_oident.asp).  
**NOTE:** This is an internal VA Web site that is not available to the public.

b. **SCI/D Telephone Stop Code.** Stop Code 224 must be used as the primary Stop Code for all SCI/D telephone services. This records patient consultations or medical care management and advice or referral provided by the SCI/D Center or Spoke staff. These telephone contacts are typically between SCI/D staff and a patient, the patient's next of kin, or a caregiver or others with whom the patient has a meaningful relationship.

## APPENDIX H

**INPATIENT INTERDISCIPLINARY COMPREHENSIVE TREATMENT PLAN**

The interdisciplinary treatment team must carefully evaluate all Veterans on the Spinal Cord Injuries and Disorders (SCI/D) unit.

a. **Treatment Plan Processes and Components.** An individually tailored comprehensive treatment plan must be initiated for each Veteran with SCI/D in an acute rehabilitation program and must reflect direct input and goal setting from the Veteran.

(1) Documentation of the plan must be complete within five working days of admission.

(2) Revision of the plan takes place as needed; however, at a minimum, it must be re-evaluated every two weeks, and it must reflect input from the Veteran.

(3) Veteran and team conferences take place periodically (for example, upon admission and prior to discharge) and are expected to include the Veteran, family members and caregivers at the discretion of the Veteran, and when appropriate, members of the Veteran's SCI/D Spoke Patient Aligned Care Team (PACT) via telehealth. There may be additional conferences, such as a family conference, to review progress and goals with the Veteran and family members.

(4) The Veteran is permitted to have any family member, representative, or other requested individual present during Veteran and team conferences, discussions with staff, and when revisions of the treatment plan are discussed. Veteran privacy and confidentiality must be respected during all interactions, treatment conferences, and health care rounds.

b. **Designated Provider.** To promote continuity and high-quality patient care, a SCI/D provider is designated as the treating provider for the Veteran and is responsible for the care of the Veteran during the full length of stay on the SCI/D unit and while at the Department of Veterans Affairs (VA) medical facility. There are circumstances (for example, an inpatient stay that lasts for months or longer) in which providers might rotate responsibilities and settings.

c. **Veteran Education.** Education is the foundation for patient empowerment, self-care, and the adoption of good health behaviors following SCI/D. Throughout rehabilitation, the following educational topics must be presented to the Veteran: spinal cord anatomy and function; skin care and avoidance of pressure ulcers; bladder and bowel management; the importance of the annual evaluation, screening tests, and immunizations; prevention of medical complications; psychological health; prosthetic and orthotic services, durable medical equipment, equipment maintenance, and assistive technology; nutrition and prevention of weight gain; activities of daily living (ADL); sexuality, reproductive health, and fertility; educational and vocational rehabilitation; recreation and leisure activities; community accessibility; and management of attendants.

d. **Inpatient Absences.** Absences from the hospital during an inpatient episode of care can be authorized when, in the judgment of the Veteran and SCI/D treatment team, time at home would enhance and speed the patient's rehabilitation, or when necessary to facilitate a discharge plan. For example, a weekend pass toward the end of the rehabilitation stay to use knowledge and practice skills at home is often instructive and helpful.

e. **Discharge From the SCI/D Center.** After maximizing rehabilitation, care, education, training, and other benefits from hospitalization at the SCI/D Center, the Veteran is discharged to a suitable and appropriate environment. The least restrictive environment that allows the greatest independence in the community is the goal for the majority of Veterans with SCI/D. Home-based, community-based, non-institutional care, and attendant/personal care services are often used to support the Veteran in the home.

f. **Transfer From the SCI/D Center.** Upon transfer, all pertinent records including diagnostic and imaging studies must be available electronically, sent with the patient, or mailed to the receiving facility to arrive before or with the Veteran. The Veteran's discharge summary and all other pertinent information must be provided to the SCI/D Spoke Coordinator at the time of discharge from the SCI/D unit for coordination of care and follow-up needs.

g. **Follow-up Care.** Follow-up care at the SCI/D Center and/or SCI/D Spoke is scheduled as clinically indicated for all discharged patients.

h. **Discharge Against Medical Advice.** A Veteran with SCI/D may choose to stop hospitalization and leave against medical advice (AMA). All AMA discharges are tracked in the Quality Improvement (QI) Program of the SCI/D Center. When feasible, supportive services or referral to community resources may be provided.

i. **SCI/D Physician Availability.** A SCI/D physician must be on call at all times for consultation. Medical house staff at facilities with SCI/D Centers must have appropriate training in SCI/D emergencies and basic SCI/D care before assuming on-call duties. SCI/D physicians must be available for on-call consultations during non-duty hours.

j. **Referral Guidelines.** The following referral guidelines are provided for clarification of conditions that must be treated in the SCI/D Center, unless there is a specific justification for not transferring the Veteran. This is not a comprehensive list, reinforcing the need for communication with the SCI/D Center to ensure the Veteran receives quality care in the optimal setting and location. All cases that will be treated outside of the SCI/D Center must be discussed with, and approved by the Chief, SCI/D Center of the designated SCI/D Center. These conditions, diagnostic procedures, and surgeries must be referred to the SCI/D Center because specialized knowledge is required and/or there is significant risk of adverse outcomes:

(1) Amputation.

(2) Annual evaluation (SCI/D Comprehensive Preventive Health Evaluation).

(3) Autonomic dysreflexia that is complex, persistent, and does not resolve after appropriate interventions.

(4) Bladder stone(s).

(5) Colonoscopy and preparation.

(6) Exoskeleton training.

(7) Fertility services.

(8) Hospitalizations (longer duration).

(9) Impaction that is unresponsive to simple interventions.

(10) Incontinence that is persistent and uncontrolled.

(11) Intrathecal (for example, Baclofen) pump trial.

(12) Neurologic deterioration.

(13) Malignancy (new onset).

(14) Pain that is chronic (initial evaluation and comprehensive management program).

(15) Pneumonia.

(16) Post-surgical care after emergency surgeries.

(17) Pressure injury initial assessment and management, Stages 3 and 4.

(18) Pressure mapping.

(19) Pressure ulcer debridement and all pressure ulcer surgical procedures.

(20) Pressure ulcers that are deteriorating or worsening.

(21) Rectal bleeding evaluation and treatment.

(22) Rehabilitation.

(23) Renal stone.

(24) Respiratory failure.

(25) SCI/D (new onset).

(26) Seating evaluation.

(27) Sexual functioning and sexuality.

(28) Sigmoidoscopy.

(29) Spasticity and/or spasm initial evaluation, initial management, and change in spasticity.

(30) Surgeries (all non-emergent).

(31) Ureteral stones.

(32) Urinary tract issue (complex).

(33) Urodynamic studies.

(34) Ventilator management and weaning.

(35) Vocational rehabilitation.

(36) Wheelchair assessment and prescription.

## APPENDIX I

**INSTITUTIONAL LONG-TERM CARE PLACEMENT GUIDING PRINCIPLES**

The following principles should guide placement decisions to institutional long-term care (LTC) settings:

a. **Decision-Making.** The decision to place a Veteran in a LTC setting must be guided by Veteran-centric care and quality of life, and based on Veteran preference, health status, intensity of health care needs, complexity of medical and personal needs, social circumstances, resources, eligibility, community support and capabilities.

b. **Aging.** As life expectancy for Veterans with Spinal Cord Injuries and Disorders (SCI/D) has increased in past years, the complexity of aging with a severe disability has been realized. As these Veterans get older, they usually experience changes in their health and abilities related to aging superimposed on SCI/D. The aging Veteran with SCI/D has special needs (for example, supplies, assistive technology, quality of life concerns, and desires for supportive living environments). Such needs are to be incorporated into the Veteran's treatment plan. Whenever possible, increasing non-institutional extended care support in the Veteran's home environment should be instituted. When appropriate and desired by the Veteran, institutional long-term options should be pursued.

c. **Discharge to Institutional Long-Term Care.** When all other alternatives have been exhausted and if the Veteran chooses, institutional LTC options must be reviewed with the Veteran. Discussions with the Veteran and the Veteran's choice of family members, caregiver(s), and advocates with the SCI/D team are important to provide education, present options that are available, and fully explore the Veteran's preferences. The ideal placement for institutional LTC is the SCI/D LTC Center yet these resources are limited. Other options include available beds in SCI/D Centers without LTC Centers, dedicated SCI/D beds in Community Living Centers (CLCs), CLCs without dedicated SCI/D beds, contract nursing homes, and non-contract community nursing homes.

d. **Location.** If the Veteran prefers to be close to home and there are no SCI/D LTC or SCI/D congregate CLC beds in close proximity, Department of Veterans Affairs (VA) CLCs or contract community nursing homes should be considered and evaluated. The limited availability of non-contract community nursing homes that provide services, accessibility, and knowledgeable staff to care for Veterans with SCI/D heightens the need to ensure proper care will be rendered before establishing placement. Non-contract community nursing homes must be evaluated very carefully since there are many facilities that do not provide services, accessibility, or knowledgeable staff to care for Veterans with SCI/D.

e. **Accessibility and Design.** The LTC care setting must be a functionally accessible unit for the Veteran, and be in accordance with the current Americans with Disabilities Act (ADA) and Architectural Barriers Act (ABA). In discharge planning, the

SCI/D team must make every reasonable effort, by assurances and report, that requisite knowledge, accessibility, and essential equipment (for example, lifts, bowel-care chairs, gurneys) are available and appropriately maintained and configured for the Veteran with SCI/D.

f. **Services.** The LTC unit must provide an appropriate and full range of support and rehabilitative services for Veterans with SCI/D. Appropriate care and services must be ensured prior to discharge to the facility.

g. **Regulations.** The LTC facility must conform to all required State and Federal regulations as addressed in VHA Handbook 1143.2, VHA Community Nursing Home Oversight Procedures, dated June 4, 2004.

h. **Communication and Referral.** The LTC facility referral must include the interdisciplinary team's recommendations on specific services and resources that the Veteran requires to maintain functional status, achieve maximal independence, reduce social role limitation, and enhance quality of life.

i. **Review of the Long-Term Care Facility.** During the pre-placement planning process, careful review of the Veteran's needs must be compared to the expertise that is available at the LTC facility. Before LTC placement, a site visit by the Veteran and SCI/D team must be considered to ensure that the Veteran's needs will be addressed. If the Veteran chooses, a guardian, advocate, representative, caregiver and family members may visit the LTC facility during the planning process.

j. **Equipment Needs.** The SCI/D interdisciplinary team must ensure that all equipment needs in the LTC facility are met for eligible Veterans with SCI/D including items normally required by contract such as hospital beds, mattresses, Safe Patient Handling and Mobility technology, side rails, over-bed tables, and bedside tables. If contract community nursing homes or State homes are required by contract or regulation to provide specified appliances, equipment, or supplies, the SCI/D team needs to ensure that the appropriate items are furnished as delineated in the care plan and contract. Items should also be provided to the eligible Veteran which are not normally furnished by a community nursing home by contract and which are intended for the personal use of the Veteran such as orthotics, walkers, canes, crutches, wheelchairs, and cushions.

k. **Education.** SCI/D Center and Spoke personnel must maintain a proactive educational approach to the care of Veterans with SCI/D in LTC facilities. Appropriate educational activities and materials include educational brochures, virtual educational materials, training sessions, and consultative visits. The SCI/D Center team serves as a specialty resource with quarterly meetings or more frequently if dictated by the Veteran's clinical condition.

l. **Contact Information.** The institutional LTC placement plan must include the designated SCI/D health care provider who is the point of contact at the VA medical

facility for the Veteran with SCI/D. A single number that can be reached during normal business hours must be provided to the LTC facility.

m. **Hospitalized Veterans with SCI/D Transferred from a Long-Term Care Facility.** Veterans with SCI/D who develop urgent medical conditions will be transferred from the LTC facility to an appropriate VA medical facility. The designated VA SCI/D Center and SCI/D Spoke Patient Aligned Care Teams (PACTs) must be informed immediately when the Veteran is transferred. Once stable, the Veteran must be transferred to the SCI/D Center, if the hospitalization is anticipated to be complicated or long in duration.

n. **Follow-up and Care Coordination.** After the Veteran is discharged to the LTC facility, communication must be maintained with the designated SCI/D Center and SCI/D Spoke PACT. Within the parameters of a LTC facility's policies regarding credentialing and privileging, SCI/D Home Care (SCI/D-HC) must make a quarterly visit to each Veteran in a CLC or contract nursing home within a 100-mile radius of the SCI/D Center. Telehealth should be used for quarterly meetings with facilities beyond a 100-mile radius. The designated SCI/D Center, in coordination with the SCI/D Spoke PACT, needs to be in regular contact with the Veteran and continue to offer annual Comprehensive Preventive Health Evaluations, acute care, and follow-up care as needed. Care coordination between providers in extended care settings and providers in the SCI/D System of Care is vital in providing the best care to Veterans with SCI/D. Open, efficient communication across care settings is the key element in addressing the complex specialty needs of Veterans with SCI/D.

## APPENDIX J

**SPINAL CORD INJURIES AND DISORDERS PATIENT ALIGNED CARE TEAMS****1. SCI/D CENTER AND SPOKE PACT PRINCIPLES AND CARE**

a. All eligible Veterans with Spinal Cord Injuries and Disorders (SCI/D) in the catchment of the Department of Veterans Affairs (VA) medical facility SCI/D Center and Spoke must be offered services and benefits for which they are eligible as established in this directive and related policies including Veterans Health Administration (VHA) Handbook 1101.10(1), Patient Aligned Care Team (PACT) Handbook, dated February 5, 2014.

b. This foundation of preventive care requires a working knowledge of the specialized care and needs of Veterans with SCI/D. The SCI/D Center and Spoke PACTs address primary care needs, while utilizing their knowledge of SCI/D and related issues to detect and prevent complications. When appropriate, Veterans with SCI/D are referred to the SCI/D Center for specialty care.

c. The SCI/D Center and Spoke PACTs work with each Veteran with SCI/D to acquire and maintain knowledge and skills, engage in self-care and self-management, while providing resources, support, and coaching to succeed in living as independently as possible. Education, resources, and communication must be available to each Veteran so the prevention and early detection of complications occurs.

d. SCI/D Center and Spoke PACTs must use Stop Code 210 to track workload and be listed in the Patient Centered Management Model (PCMM).

**2. SCI/D CENTER PACT**

a. SCI/D PACT staffing at SCI/D Centers must be sufficient to ensure that all Veterans with SCI/D assigned to the SCI/D Registry and seen by the SCI/D PACT receive appropriate and desired primary and specialty care. Staffing of the SCI/D PACT is separate from inpatient staffing. SCI/D PACT staffing at each SCI/D Center must include at least one dedicated SCI/D PACT.

b. Each SCI/D Center PACT staff member is responsible for:

(1) Providing outpatient primary and/or specialty care for Veterans with SCI/D in the designated catchment area of, and receiving care at the SCI/D Center PACT.

(2) Collaborating with the SCI/D Center Management of Information and Outcomes (MIO) Coordinator and Chief, SCI/D Center with guidance from the SCI/D National Program Office, to modernize the SCI/D Registry and Outcomes program as it pertains to identifying, tracking, and coordinating care for Veterans with SCI/D who choose to receive care at the SCI/D Center.

- (3) Utilizing the SCI/D Registry, to enable effective and efficient identification of, communication with, and intervention for Veterans with SCI/D.
- (4) Ensuring appropriate evaluation of, and access for qualifying Veterans with SCI/D to VA resources and services.
- (5) Participating in team performance improvement and sustainment activities to optimize team efficiency and care delivery to Veterans with SCI/D.
- (6) Managing communications and facilitating safe transitions of Veterans with SCI/D between the SCI/D Spoke PACT, the SCI/D Center, and other health care settings.
- (7) Providing health education and health coaching on wellness, disease prevention, chronic care management, and self-management skills to Veterans with SCI/D.
- (8) Engaging Veterans with SCI/D in identifying and understanding their goals, using health care in a proactive manner, encouraging Veterans to engage in preventive care and early identification of complications from SCI/D.
- (9) Communicating with all team members (including the Veteran with SCI/D) in a manner that is respectful, effective, efficient, and bidirectional to convey significant, clinically relevant information for the care of the Veteran.
- (10) Collaborating with informatics technology staff (for example, modernizing documentation procedures, clinic names/Stop Codes, and encounter information) to develop and implement systematized, electronically supported, standardized tools to support SCI/D Center PACT care delivery processes (for example, pre-visit reminder calls, post-hospitalization follow-up calls, recall scheduling procedures, new patient orientation, and SCI/D Registry and primary care protocols for chronic disease management).
- (11) Reaching out to Veterans with SCI/D who have not been seen or lost to follow-up in the SCI/D System of Care.
- (12) Remaining available to Veterans with SCI/D during scheduled clinic hours and for unscheduled visits throughout the week.

c. **Accountable Official.** The accountable official for the SCI/D Center PACT is the SCI/D Chief, or designee.

### 3. SCI/D SPOKE PACT

- a. Each VA medical facility without a SCI/D Center and with a Registry of at least 75 Veterans with SCI/D must have a fully staffed SCI/D Spoke PACT.
- b. The SCI/D Spoke PACT staff is responsible for all enrolled Veterans with SCI/D in the facility's designated catchment area (that is, all Veterans who live closer to the

SCI/D Spoke PACT facility than any other VA medical facility). See Appendix D for staffing requirements.

c. **Accountable Official.** The accountable official for the SCI/D Spoke PACT is the Chief of Staff (CoS) (see paragraph 5 in the body of the directive).

d. **Contact Information.** Contact information for the SCI/D Coordinator must be posted in the Admissions and Ambulatory Care area, listed in the VA medical facility telephone directory, and listed on the SCI/D National Program Office Web site <http://vaww.sci.va.gov>. **NOTE:** *This is an internal VA Web site that is not available to the public.*

e. The list of SCI/D Spoke PACTs and their designated SCI/D Centers is available at <http://vaww.sci.va.gov/Facilities.asp>. **NOTE:** *This is an internal VA Web site that is not available to the public.*

f. The SCI/D National Program Office and designated SCI/D Center must be informed by the VA medical facility CoS of any change in SCI/D Spoke Staff.

g. Each SCI/D Spoke PACT staff member is responsible for:

(1) Ongoing, continuous primary care of Veterans with SCI/D in the designated catchment area of the SCI/D Spoke VA medical facility.

(2) Collaborating with the SCI/D Center MIO Coordinator and Chief, SCI/D Center with guidance from the SCI/D National Program Office, to modernize the SCI/D Registry and Outcomes program as it pertains to identifying, tracking, and coordinating care for Veterans with SCI/D who choose to receive care at the SCI/D Spoke facility.

(3) Utilizing the SCI/D Registry and all other tools, to enable effective and efficient identification of, communication with, and intervention for individual Veterans with SCI/D.

(4) Ensuring appropriate evaluation of, and access for, qualifying Veterans with SCI/D to VA resources and services.

(5) Participating in team performance improvement and sustainment activities to optimize team efficiency and care delivery to Veterans with SCI/D.

(6) Managing communications and facilitating safe transitions of Veterans with SCI/D between the SCI/D Spoke PACT, the SCI/D Center and other health care settings.

(7) Providing health education and health coaching on wellness, disease prevention, chronic care management, and self-management skills to Veterans with SCI/D, commensurate with the documented expertise or professional training of the SCI/D Spoke PACT member.

(8) Engaging Veterans with SCI/D in identifying and understanding their goals, using health care resources in a proactive manner, encouraging Veterans to engage in preventive care and early identification of complications from SCI/D.

(9) Communicating with all team members, including the Veteran, in a respectful, effective, efficient, and bidirectional manner to convey significant, clinically relevant information.

(10) Collaborating with informatics technology staff (for example, modernizing documentation procedures, clinic names/stop codes, and encounter information) to develop and implement systematized, electronically supported, standardized tools to support SCI/D Spoke PACT care delivery processes (for example, pre-visit reminder calls, post-hospitalization follow-up calls, recall scheduling procedures, new patient orientation, and SCI/D Registry and primary care protocols for chronic disease management).

(11) Collaborating with the SCI/D Center and the SCI/D National Program Office to identify Veterans and refer those Veterans to the SCI/D Center that require specialty care, annual evaluations, surgery, and other interventions that require complex, SCI/D interdisciplinary care.

(12) Reaching out to Veterans that have known SCI/D who have not been seen or were lost to follow-up in the SCI/D System of Care.

(13) Being available during scheduled clinic hours and throughout the week for unscheduled visits of Veterans with SCI/D.

(14) Receiving initial training at the designated SCI/D Center and ongoing SCI/D hub and spokes annual training.

#### **4. PATIENT CENTERED MANAGEMENT MODULE CONFIGURATION FOR SCI/D CENTER AND SPOKE PACTS**

a. **Assignment.** All Veterans with SCI/D should have a SCI/D PACT assigned to them. This assignment should be made in the PCMM according to VHA Directive 1406, Patient Centered Management Module (PCMM) for Primary Care, dated June 20, 2017. For Veterans who get their primary care at a SCI/D Center or Spoke, their SCI/D primary care team must serve in this role. Veterans with SCI/D who have chosen to see primary care providers who are not part of a SCI/D PACT at either a Center or Spoke must have a SCI/D PACT listed in PCMM.

(1) PCMM Team Title Indicator is \*SCI/D\*.

(2) Required Team positions: see Appendix D.

b. **SCI/D Dual Providers.** Veterans with SCI/D may be assigned to more than one SCI/D PACT in PCMM due to the shared responsibility for caring for these Veterans.

**September 30, 2019**

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Generally, a Veteran with SCI/D will be assigned to a SCI/D Center PACT, as well as a SCI/D Spoke PACT if the Veteran receives care at a Spoke.