

**Manual M-2, Professional Services. Part XIX, Extended Care Service (Domiciliary)**

M-5, Part I was to rescind M-2, Part XIX; M-5, Part I, however, was never written.

**Chapter 1, Operational Standards (Paragraphs 1.01 through 1.09)**

This document includes:

Title page and title page verso for M-2, Part XIX, dated **May 15, 1970**

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PART XIX  
**M-2**

VETERANS ADMINISTRATION  
DEPARTMENT OF MEDICINE AND SURGERY MANUAL

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# PROFESSIONAL SERVICES

*Rescission 11/93  
pending incorporation  
in M-5, Part I*



PART NINETEEN  
EXTENDED CARE SERVICE  
(DOMICILIARY)

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WASHINGTON, D.C. 20420

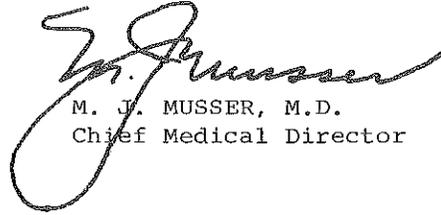
MAY 15, 1970

M-2, Part XIX

Department of Medicine and Surgery  
Veterans Administration  
Washington, D. C. 20420

May 15, 1970

Part XIX, "Extended Care Service (Domiciliary)," VA Department of Medicine and Surgery Manual M-2, "Professional Services," is published for the compliance of all concerned.



M. J. MUSSER, M.D.  
Chief Medical Director

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## CHAPTER 1. OPERATIONAL STANDARDS

## 1.01 GENERAL

- a. Domiciliary care is authorized by 38 U.S.C. 610.
- b. Domiciliary care provides necessary medical treatment and other appropriate therapeutic measures to eligible ambulatory veterans in a homelike setting.
- c. Comprehensive professional care will be provided to fulfill the three-fold mission of the domiciliary within the programs of:
  - (1) Preventive medicine, public health and rehabilitative measures for veterans who require continued treatment in a protective environment.
  - (2) Special behavioral and medical rehabilitation on a temporary basis for those who require intermittent, short-term services.
  - (3) Restoration for those who can be helped sufficiently to enable them to return to the community, usually within a period of 1 year.

## 1.02 PROGRAMS

- a. The purpose of this manual is to provide direction for administrative and program functions in domiciliaries and to present an outline for program achievement. This manual is intended to encourage innovation, originality, creativity, and the development of specialty programs which are necessary to develop and implement new approaches to the problems presented by patient-members in VA domiciliaries.
- b. The domiciliary is now oriented toward the provision of definitive treatment, rehabilitation, restoration, and habilitation. Inherent in these approaches are three main concepts:
  - (1) A discontinuance of the outdated philosophy of the domiciliary providing only shelter and care.
  - (2) A positive approach to programs and operations which are directed toward enabling patient-members to achieve a noninstitutional level of adjustment.
  - (3) An atmosphere which encourages and expects new approaches, techniques and experimental programs while accepting accountability for the evaluation of effectiveness.
- c. Types of carefully planned and executed programs that can be incorporated within and represent the primary thrust of domiciliary functioning include:
  - (1) New techniques of behavioral modification.
  - (2) Vocational training and retraining.
  - (3) Experimental social groupings.
  - (4) Patient-Member Councils.
  - (5) Prophylactic and preventive medical procedures.
  - (6) Unit systems of operation.
  - (7) Diversified volunteer activities.
  - (8) Programs of learning and relearning.

- (9) Work organizations.
- (10) Attitude therapy.
- (11) Community affiliation in all of its medical, social, psychological and vocational aspects.

d. With these medical and behavioral modifying programs there is a necessary corollary. This involves the initial building of methods for data collection so that comparison of one approach with another will demonstrate the effectiveness of all the therapeutic programs.

### 1.03 ORIENTATION PROGRAM

a. Veterans, on admission, will ordinarily be assigned to a reception area that is staffed and organized for the primary purposes of providing orientation and evaluation. Orientation will take place within 1 week following admission to the domiciliary.

b. The administrative and professional staff will implement an orientation and evaluation program which will:

- (1) Fully acquaint the veteran with therapeutic programs.
- (2) Explore with the veteran his interests in the treatment programs provided in the domiciliary.

c. Veterans will be assigned to living areas and programs by the Therapeutic Programing Board appropriate to their needs and consonant with their capacities and physical limitations.

### 1.04 THERAPEUTIC PROGRAMING BOARD

a. A Therapeutic Programing Board (formerly Activity Planning Board) will be established at all domiciliaries. This multidisciplinary board is the principal vehicle through which the treatment and rehabilitation efforts of the domiciliary are implemented. The board has the specific function of aligning the therapeutic resources within and outside the domiciliary for the maximum benefit of patient-members. Also, the board is responsible for the assignment of activities that are in keeping with the goals of the patient-member. All new admissions will be interviewed individually by professional and administrative domiciliary personnel before the patient-member is scheduled to meet with the Therapeutic Programing Board. During this meeting the patient-member will be informed of the expectations and goals of his individual regimen and afforded the opportunity to actively participate in the final formulation. A review of all individual patient-member programs by the Therapeutic Programing Board shall be undertaken as frequently as needed but in no case at intervals of more than 6 months. This review will evaluate the effectiveness of the ongoing therapeutic program and will normally involve the participation of the individual patient-member. These reviews will be conducted collectively or individually in a manner deemed most efficient by the Therapeutic Programing Board.

b. The station Director will designate such a board and assign membership to it from each of the professional services working in the domiciliary. The Chief, Domiciliary Operations, in addition to board membership, will be responsible for the full implementation of the therapeutic assignments approved by the Therapeutic Programing Board. The Chief, Domiciliary Operations, or his designee will report to the board on the effectiveness of the therapeutic assignments and may recommend review of resource allocations and/or individual patient-member programs. The chairman of the board will be selected by the board member. Additional boards serving the same functions and objectives may be designated if the workload requires more than one board.

### 1.05 PLANNED THERAPEUTIC PROGRAM

a. Each patient-member will be assigned a daily therapeutic activity schedule. The assignment will be related to his abilities, interests, and therapeutic goals. The reasons for the assignment will be explained to the patient-member.

b. The patient-member's activity assignments, hours of participation, and any specific limitations will be given to the person responsible for the activity. The responsible person will be required to submit attendance and program reports as scheduled.

c. The type of assignment must be approved by the Therapeutic Programing Board. Temporary assignments prior to board action may be authorized with medical clearance.

d. Any patient-member medically excused from his therapeutic program for more than 1 month will be reevaluated at that time to determine his medical need to continue in the domiciliary or the previously prescribed therapeutic program.

#### 1.06 INCENTIVE THERAPY

a. Incentive therapy is a rehabilitation approach utilizing constructive work therapy assignments with nominal remuneration.

b. Monetary reinforcement has a significant value in the rehabilitation of patient-members when used in a direct relationship to meaningful work. Assisting veterans to reestablish their occupational potential for gainful employment and forestalling institutionalization has proven merit.

c. Incentive therapy utilizes a basic psychological process; namely, learning and reinforcement (money), to effect positive changes in behavioral characteristics such as dependency needs, self-responsibility, self-concept, attitudes, work habits, self-esteem, and interpersonal relationships.

d. A sound rehabilitation program involving incentive therapy requires sophisticated assessment of physical, psychological, social and environmental factors, and hence must go far beyond a simple assessment of the specific handicap itself. Therefore, incentive therapy requires multidisciplinary approaches in planning and operating a successful program.

e. A patient-member will not participate in incentive therapy unless the assignment is approved by the Therapeutic Programing Board under the requirements of paragraph 1.05. The Therapeutic Programing Board must determine that pay as an incentive will increase the possibility of restoration of the patient-member to the community or will have significant therapeutic value to the individual while in the domiciliary.

f. The amount of hourly pay will relate to the development of the patient-member, and will not be adjusted to the nature of the job. Rate of pay per hour will range from 30 to 90 cents as determined by the Therapeutic Programing Board in keeping with the individual patient-member's therapeutic needs.

g. Incentive therapy pay will be considered as an award or inducement subject to income tax and a part of total income in relation to eligibility for VA pension.

h. Patient-members are not to be considered as employees of the Government. They may undertake part-time employment with a Federal agency other than the VA when the goal for such employment is the eventual discharge of the patient-member to the community. Since the provisions of 38 U.S.C. 618 do not contemplate employment of a patient-member by the VA under terms other than those providing for nominal remuneration, full-time or part-time employment by the VA of such patient-members under civil service laws and regulations is prohibited.

i. References: M-1, part I, paragraph 8.30; M-2, part I, chapter 14; and M-2, part VIII, paragraph 5.03.

### 1.07 COMMUNITY EMPLOYMENT AND TRAINING

a. Patient-members with a plan approved by the Therapeutic Programing Board may qualify for training or work-for-pay in the community. In each instance, there must be reasonable expectation that satisfactory adjustment to the job will lead to successful community living. This will usually involve a step-by-step progression in the program scheduling for each patient-member. Such scheduling will begin initially with assignment to a therapy detail and followed by assignments to a training situation, incentive therapy, part-time work in the community and finally actual employment or training in the community. Any step in this progression will be omitted when regarded as therapeutically beneficial for the patient-member.

b. Early return to full community living will be expected of patient-members who are training or working in the community part time. Review of such patient-members' progress should be conducted at least every 60 days. A patient-member will in no case remain in such a training or working status beyond 6 months except when deemed necessary by the Therapeutic Programing Board.

c. Patient-members will be required to maintain their own living area and account daily for their presence. Except for medical appointments, patient-members approved for this program will be excused, as appropriate, from other scheduled domiciliary activities.

d. At domiciliaries where restoration programs are authorized, the patient-member entering the training or work-for-pay program should be considered for transfer into the restoration program.

### 1.08 RESTORATION PROGRAMS

a. Restoration programs are authorized for domiciliaries. However, the implementation of this program at a domiciliary must have the approval of the Chief Medical Director.

b. The purpose of the restoration program is to provide training in vocational and interpersonal skills and to prevent institutionalization by restoring the veteran to the community, self-supporting through employment or capable of sustaining himself by his own resources.

c. The integration of restoration programs into domiciliary operations is described in M-1, part VI (to be published).

### 1.09 SPECIAL THERAPEUTIC PROGRAMS

a. The professional and administrative staff are encouraged to establish and operate special therapy programs. The specific types of programs will be determined by the talents and interests of the professional staff in accordance with established qualification standards required for the conduct of the programs. Such programs usually will be established for patient-members with select and identifiable common needs. Examples of special programs include:

- (1) Alcoholic Rehabilitation.
- (2) Speech Training.
- (3) Epilepsy Treatment and Rehabilitation.
- (4) Training for Visually Impaired and Blind.
- (5) Specialized Geriatric.
- (6) Nutrition Instruction.
- (7) Personal Health Training.

(8) Neuropsychiatric Followup.

(9) Human Relations Training.

b. Developers of such programs will be cognizant of the extra-VA environmental and community resources, and strive to complement VA services to the mutual benefit of the VA and the community.

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NAME MYRLA SMITH	PHONE NUMBER 3692	

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MESSAGE TO BE TRANSMITTED (Use double spacing and all capital letters)

**TO:**

DIRECTORS, SELECTED MEDICAL CENTERS, AND DOMICILIARY

00/ THIS IS INTERIM ISSUE 10-80-35

A. BASIC ADMINISTRATIVE ISSUE AFFECTED: M-2, PART XIX,

B. OTHER ~~ISSUES~~ ISSUES AFFECTED: IIs 10-79-33 AND 10-79-48

C. REASON FOR ISSUE: TO EXTEND RESCISSION DATES OF IIs 10-79-33/<sup>S</sup>10-79-48<sup>AND</sup>  
PENDING INCORPORATION IN A MANUAL.

D. TEXT OF ISSUE: THE RESCISSION DATES OF IIs 10-79-33 AND 10-79-48  
ARE EXTENDED UNTIL AUGUST 30, 1981.

E. RESCISSION: THIS INTERIM ISSUE WILL NOT BE CONFIRMED WITH A  
PRINTED COPY AND IS RESCINDED AUGUST 30, 1981. 181/10

*Ronald B. Thompson*  
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II 10-79-48

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TO:

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(SEE ATTACHED LIST)

00/THIS IS INTERIM ISSUE 10-79-48

- A. BASIC ADMINISTRATIVE ISSUE AFFECTED: M-2, PART XIX
- B. OTHER ISSUES AFFECTED: INTERIM ISSUE 10-79-33
- C. REASON FOR ISSUE: TO REMIND SELECTED MEDICAL CENTERS AND DOMICILIARIES TO REPORT ON ANY RESEARCH ACTIVITIES TAKING PLACE AT THE DOMICILIARIES THROUGH THE ANNUAL NARRATIVE REPORT FOR DOMICILIARY PROGRAM, RCS 18-7
- D. TEXT OF ISSUE: II 10-79-33, PARAGRAPH D4:  
INSERT A NEW SUBPARAGRAPH "L. RESEARCH," AND CHANGE EXISTING SUBPARAGRAPH "L" TO "M."
- E. RESCISSION: THIS ISSUE IS RESCINDED AUGUST 30, 1980, AND WILL NOT BE CONFIRMED BY PRINTED ISSUE. 181/10

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II 10-79-33  
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00/ THIS IS INTERIM ISSUE 10-79-33

A. BASIC ADMINISTRATIVE ISSUE AFFECTED: M-2, PART XIX

B. OTHER ISSUES AFFECTED: NONE

C. REASON FOR ISSUE: TO ESTABLISH ANNUAL NARRATIVE REPORT FOR  
DOMICILIARY PROGRAM, RCS 18-7

D. TEXT OF ISSUE:

1. BACKGROUND. CURRENTLY THE OFFICE OF EXTENDED CARE IN VACO HAS  
NO SYSTEMATIZED METHOD OF LEARNING ABOUT PROGRAM CHANGES AND DEVELOP-  
MENTS IN THE DOMICILIARY PROGRAM. NO OTHER REPORT PROVIDES INFORMATION  
REGARDING MAJOR PROGRAM ELEMENTS THAT HAVE ADMINISTRATIVE, PROFESSIONAL,  
OR BUDGETARY SIGNIFICANCE ON THE PROGRAM.

2. REPORT, RCS 18-7

A. THE ANNUAL NARRATIVE REPORT WILL BE PREPARED BY THE  
CHIEF, DOMICILIARY OPERATIONS, IN COORDINATION WITH PROFESSIONAL AND  
ADMINISTRATIVE SERVICES PROVIDING PROGRAM AND STAFF SUPPORT TO THE  
DOMICILIARY. THE REPORT WILL BE PREPARED IN TRIPLICATE ON LETTER-SIZE

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<p><b>TO:</b></p> <p>PAPER, DATED AND IDENTIFIED BY THE MEDICAL CENTER'S OR DOMICILIARY'S NAME AND THE REPORT CONTROL SYMBOL, RCS 18-7</p> <p>INFORMATION CONTAINED IN THE REPORT WILL BE CONCISE AND BRIEF, NOT TO EXCEED THREE TYPEWRITTEN PAGES, EXCLUSIVE OF ATTACHMENTS.</p> <p>B. THE REPORT WILL BE PREPARED ANNUALLY AT THE CLOSE OF THE FISCAL YEAR.</p> <p>3. THE NARRATIVE REPORT IS THE REPORT OF THE CHIEF, DOMICILIARY OPERATIONS. THE ORIGINAL AND ONE COPY WILL BE FORWARDED THROUGH THE ASSISTANT DIRECTOR, CHIEF OF STAFF, AND THE MEDICAL CENTER OR DOMICILIARY DIRECTOR; EACH OF WHOM MAY COMMENT ON ANY MATERIAL IN THE REPORT BY ENDORSEMENT. THE REPORT IS TO REACH CENTRAL OFFICE WITHIN 15 WORKING DAYS AFTER THE CLOSE OF THE FISCAL YEAR. REPORTS WILL BE ADDRESSED TO THE ACMD FOR EXTENDED CARE THROUGH THE APPROPRIATE REGIONAL MEDICAL DIRECTOR (10BA ___/181).</p> <p>4. ONLY SIGNIFICANT DEVELOPMENTS OR CHANGES NEED TO BE REPORTED. THE REPORT WILL INCLUDE A COPY OF THE TABLE OF ORGANIZATION AND FUNCTIONAL CHART IN DOMICILIARY OPERATIONS AND A LISTING OF PROFESSIONAL STAFF ASSIGNED TO THE DOMICILIARY</p>		
		SECURITY CLASSIFICATION
PAGE NO. <b>2</b>	NO. OF PGS. <b>4</b>	<b>AUG 30 1979</b>

II 10-79-33  
August 30, 1979

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**TO:**  
PROGRAM, IF THERE HAVE BEEN CHANGES IN CEILINGS OR PROGRAMS, AND  
WILL FOCUS ON PROGRESS IN DOMICILIARY TREATMENT PROGRAMS. REPORT  
SHOULD BE ORGANIZED IN RELATION TO THREE TYPES OF DOMICILIARY RESIDENTS  
AS DESCRIBED IN CHAPTER 1, M-2, PART XIX, AND INCLUDE REFERENCE TO  
AREAS OUTLINED BELOW:

- A. PSYCHOSOCIAL
- B. ALCOHOLISM
- C. DISCHARGE PLANNING AND COMMUNITY OUTPLACEMENT
- D. BEHAVIORAL COUNSELLING
- E. MEDICINE, SURGERY, AND NEUROLOGY
- F. VOCATIONAL REHABILITATION
- G. THERAPEUTIC PLANNING BOARD
- H. USE OF COMMUNITY RESOURCES
- I. QUALITY OF LIFE
- J. RESIDENT COUNCIL
- K. SOCIALIZATION
- L. RESEARCH
- M. REMARKS

*BY III 10-79-48*

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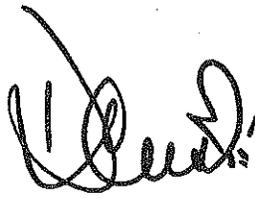
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5. SPECIAL PROJECTS, INNOVATIVE PROGRAM DEVELOPMENTS OR PROBLEMS

NOT REPORTED UNDER 4 SHOULD BE INCLUDED.

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