

# **VACOR**

## **November 27-28, 2007 Minutes**

Board of Veterans Appeals  
Kenneth Eaton Room (819)  
Lafayette Building  
811 Vermont Ave  
Washington DC, 20005

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**Advisory Committee  
Department of Veterans Affairs**

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**Veterans' Advisory Committee on Rehabilitation**

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### Administration

Joseph Tucker  
Designated Federal Officer (DFO)  
Vocational Rehabilitation Counselor, VR&E Service  
Department of Veterans Affairs

The meeting began at 8:03 AM. Designated Federal Officer (DFO), Joseph Tucker, gave brief announcements and read a statement of the purpose of VACOR. The meeting was open to the public several members of the public attended at least part of the meeting. VACOR asked for written comments from the public.

### Members present:

- Griffin Dalianis
- Paul Andrew
- Paul Blanco
- Lynda Davis
- Col. Thomas Duffy
- Nancy Hogan
- John King
- Maureen McGuire-Kuletz
- Marvin Meyers
- Linda Shaw

### Ex-officio members present:

- Lucille Beck
- Ron Drach
- Jerry Elliott
- Ruth Fanning
- Constance Pledger

### VA employees present:

- Joe Tucker
- Phil Riggin
- Fred Steier
- Anthony Rango
- Holly Taylor

### Members of the public

- Estimated 5-6

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**Welcome**

Griffin Dalianis  
Chairman, VACOR  
Paul Andrew  
Vice-chairman, VACOR

Griffin Dalianis introduced himself as Chairman the Veterans' Advisory Committee on Rehabilitation (VACOR). Dr. Dalianis spoke about VACOR's current activities and discussed the agenda for the meeting. Paul Andrew gave an overview and additional details on the site visits and the planned activities for the meeting. Dr. Dalianis asked the appointed VACOR members, and the ex-officio VACOR members, to introduce themselves and say a few words about their current employment and credentials.

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**Ethics for Special Government Employees**

Jonathan I. Gurland  
Special Attorney  
Office of General Counsel (OGC)  
Department of Veterans Affairs

Jonathan I. Gurland, Special Attorney, reviewed the Ethical and Financial Disclosure requirements for Federal Advisory Committee Members, including both Special Government Employees (SGEs) and Regular Government Employees (RGEs). The definition of SGEs (slightly differs from a RGE in terms of ethics and time spent working for government) is a person who performs work for the government and works a maximum of only 130/365 days a year.

Mr. Gurland reminded members that in order to participate in the meeting, he must have received all members' confidential financial disclosure forms. He highlighted ethical and conduct and conflict of interest statutes for SGEs as well as for RGEs. Mr. Gurland gave all members his contact information for specific questions regarding ethics.

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**Polytrauma Visits: Richmond and Tampa**

Maureen McGuire-Kuletz  
Lynda Davis

Briefing on the visits to the Polytrauma Rehabilitation Centers in Richmond and Tampa were presented to the committee by a delegate from each workgroup. See attached site reports and synoptic report.

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**Remarks**

The Honorable Daniel Cooper  
Undersecretary for Benefits,  
Department of Veterans Affairs

Admiral Cooper discussed many of the upcoming and current initiatives related to veterans benefits and the administration of rehabilitation programs. VBA is in the

process of renovating the Compensation and Pension disability rating system in a number of ways including: 1) streamlining release from active duty and entry into VA system. 2) initiating an annual review of all *Individual Unemployability* cases to see if any are suitably employed. 3) expedited processing of Global War on Terror veterans. He also briefly discussed observations from a book Perilous Times by Jeffery Stone about the Alien and Sedition Act and the free press. Any “problem” with VA is widely publicized by the press, but the numerous things VA does right daily draw no significant interest from the media.

The Admiral then presented the certificates of appointment to the two newly appointed members of VACOR: Nancy Hogan and Colonel Thomas Duffy.

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**Remarks**

Lucille Beck, Ex-Officio Member  
Chief Consultant, Rehabilitation Services  
Veterans Health Administration

Doctor Beck spoke for about ten minutes about VHA. She commented that VHA has their own advisory committees to develop recommendations for health care practices. She asked VACOR to be sure at our next meeting to include a program update on VHA’s polytrauma and other physical rehabilitation services. Dr. Beck said this will help coordination of efforts needed between VHA and VBA. Some recent and current VHA initiatives are addressing many of the issues the VACOR polytrauma site visit teams observed. (E.G. burnout and stress). She reiterated VHA awareness of space issues. Dr. Beck made an official announcement that VA will create a fifth polytrauma center in San Antonio, at Audie L. Murphy Medical Center. Dr. Beck recommends having a briefing at the next VACOR meeting from Dr. Cooper-Smith, VA Office of Research. She reminded us that the Centers of Excellence, such as the PRC’s, do include a research component. She mentioned in passing VHA’s interactive family care map. Dr. Beck recommends VACOR see a demonstration of the family care map. The polytrauma network sites (PNS) are charged with finding private facilities local to polytrauma veterans’ home to assist veterans to receive fee-basis medical services.

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**Department of Defense and Department of Veterans Affairs Collaboration**

Lynda Davis

Doctor Davis briefed VACOR on current collaboration in the DoD/VA joint disability determination workgroup and up and coming activities. (see attached PowerPoint)

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## **Department of Labor Recent Initiatives Regarding Veterans' Employment**

Ron Drach,  
Director, Government and Legislative Affairs,  
Veterans' Employment and Training Service,  
Department of Labor

Mr. Drach briefed the Committee on Veterans' Employment and Training Service (VETS) initiatives initiated by Department of Labor. The purpose of the VETS program is focused on placement of qualified veterans with and without disabilities into suitable employment in the primary labor market. VETS assisting OIF/OEF transitioning veterans with USERRA rights were discussed. VETS participates in the DoD/VA collaboration, Transition Assistance Program and Disabled Transition Assistance Program (TAP/DTAP). These are benefits briefings offered to all servicemembers at the time of discharge from the military. In order to ensure priority processing for transitioning veterans VETS has developed a Key to Career Success program. A card identifying the veteran's entitlement to priority processing at all state and federal employment and rehabilitation agencies. This allows participants to go to head of the line literally and figuratively at any of the 30,000+ Career One Stop centers throughout the country as well as in rehabilitation programs. Mr. Drach gave VACOR a briefing on VETS supports federal internships for servicemembers on med-hold. Operation Warfighter currently only in the DC area, involves detailing the servicemember to a Federal Agency. Also a briefing on non-competitive appointments of disabled veterans. REALLifelines, lifelong one on one career mentorship type assistance to disabled veterans. The Recovery and Employment Assistance Lifelines (REALifelines) Advisor provides veterans and transitioning service members wounded and injured as a result of the War on Terrorism, and their family members, with the resources they need to successfully transition to a rewarding career. Helmets to Hardhats was briefed momentarily. One of the primary activities of VETS is funding and training of Disabled Veterans Outreach Program (DVOP) representatives and of Local Veterans' Employment Representatives (LVER). Office of Disability Employment Policy funded a project Heroes at Work, major focus is educating employers and service providers in symptoms and consequences of TBI. Generally there is a paucity of "best practices" in the field of TBI, especially relative to employment. Mr. Drach called for a clearer understanding of concurrent TBI and PTSD. Although there is frequently comorbidity with these two conditions, often they exist independent of each other or with one being the primary or greater source of symptoms. As a result there is a great need for education

Q: How do they keep track of all the programs

A: There were 38 programs and websites. The Wounded Warrior Project Inc. backpacks and mini backpacks. First a 500 page book developed on programs and services but then it was put as a file on a laptop for recipients.

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**Compensated Work Therapy Program**

Anthony Campinell, Ph.D  
Director,  
Therapeutic and Supported Employment Services  
Office of Mental Health Services Veterans Health Administration

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Mr. Campinell discussed funding for the Compensated Work Therapy (CWT) Program at Level I and Level II network sites for the polytrauma network of care. He indicated that 13 sites were funded last FY, and 7 proposed for this FY. He gave an overview of the model they use to implement the CWT program, a supported employment model, in which vocational rehabilitation counselors are used to assess vocational needs very early in the recovery process for a veteran. This model instills hope in veterans and their families and gives them a goal to work toward. Dr. Campinell also talked about the importance of early intervention for vocational counseling, citing professional research studies that indicate that an employment goal establishes a sense of identity and enables patients to take their treatment more seriously. (see attached PowerPoint)

**Polytrauma Visits: Palo Alto and Minneapolis**

John King  
Marvin Meyers

Basics of the visits to the polytrauma centers in Palo Alto and Minneapolis were presented to the committee by a delegate from each workgroup. See attached site reports and synoptic report.

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**Navy Safe Harbor Program**

Commander Michael Hartford

(A planned presentation on VR&E Independent Living services available in Tampa PRC was cancelled due to a problem getting a teleconference feed set up in the meeting room.) Commander Hartford, attending as an interested member of the public, graciously agreed to present some of his observation as a military liaison stationed in a polytrauma unit and also his unique perspective as a former VAMC Director. He discussed military liaisons' role in the polytrauma system of care.

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**Meeting Adjourned for the Day at 4:30 P.M.**

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## Minutes: November 28, 2006

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### Administration

Joseph Tucker  
Designated Federal Officer  
Department of Veterans Affairs

The meeting began at 8:11 AM with brief announcements. Mr. Dalianis welcomed everyone, and reminded the group to keep possible recommendations in mind for discussion.

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### Vocational Rehabilitation & Employment (VR&E) Service Update

Ruth A. Fanning  
Director, Vocational Rehabilitation &  
Employment Service  
Department of Veterans Affairs

As an introduction, Ms. Fanning briefed the Committee on her 27 year history of working in rehab. She provided an overview of the purpose and structure of Vocational Rehabilitation and Employment (VR&E) Service. 57 offices nationwide and one in the Philippines and is taking to improve the quality of service to veterans. She discussed services provided by VR&E under Title 38 United States Code, Chapter 31, 35 and 36. She gave the committee an in depth briefing on the Five Tracks to Employment and the resources that have been provided to field offices for counselors to use when working with veterans.

Ms. Fanning briefed the Committee on collaborative efforts with Department of Labor related to employment. VA has created ten new positions in a new job called "veterans employment coordinator" (VEC). This is a position responsible with recruiting qualified veterans to work for VA. VR&E is planning to coordinate with these VEC's to provide training directly to the VEC when possible and to provide qualified applicants to the VEC for placement in the VA.

Three outreach initiatives currently sponsored and promoted by VR&E are: the Disabled Transition Assistance Program (DTAP), [www.vetsuccess.gov](http://www.vetsuccess.gov), and the Coming Home to Work Initiative (CHTW).

VR&E's Independent Living (IL) program will be studied by a research group this year.

For more details see attached PowerPoint.

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## **VA Long Term Care Options in Home and Community; Progress of Geriatrics and Extended Care Polytrauma Rehabilitation Task Force**

Dr. Thomas Edes,  
Director, VA Home and Community Based Care,  
Chairman, Geriatrics and Extended Care Polytrauma Rehabilitation Task Force.

Dr. Edes briefed VACOR on health care needs of an increasing geriatric veteran population. He touched on the impact of health care needs on independence. Ten years ago 82% of VA geriatric care was provided in an institutional setting. Goal with which this VA Home and Community Based Care program began ten years ago is: maximum independence in the least restrictive environment. Dr. Edes discussed: Comprehensive home based primary medical care. The second half of his presentation was in briefing the Committee on foster family adoptions of geriatric veterans. These foster families adopt geriatric veterans and bring them into their homes to care for them. For more details see attached PowerPoint

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## **Life Care Planning: Anticipating and planning for disability related needs over the course of a lifetime**

Christine Reid, Ph.D. CRC,  
Professor, Rehabilitation Counseling  
Virginia Commonwealth University

A discussion of what life care planning is. What a life care plan consists of. Certification for life care planning. There is great potential for the discipline of life care planning to serve as a method and a tool to be incorporated for development of recovery plans. How to anticipate and include all needed goods and services. For more details see attached PowerPoint.

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## **Spinal Cord Injury Rehabilitation, VA's multidisciplinary approach**

Margaret Hammond,  
VA Chief Consultant  
Spinal Cord Injury and Disorders Services

Dr. Hammond discussed SCIDS approach to networking their services. It is a hub approach and intensive services are offered in the hubs, less intensive in the spokes. She provided an overview of how physical rehabilitation fits into the overall rehabilitation picture with vocational rehabilitation. For more details see attached PowerPoint.

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## **Deliberations on recommendations and reporting**

Griffin Dalianis, Ph.D.  
Chair, VACOR

Paul Andrew with the aid of an eraser board, working closely with the chairman and the Committee members laid out some rough schemas of topics VACOR discussed yesterday and today. The Committee deliberated on potential recommendations

derived from analysis of the Polytrauma Rehabilitation Centers' site visits and the presentations during the annual meeting. At the same time, Maureen McGuire-Kuletz created a word document mirroring the schemas Paul was putting up on the eraser board.

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**Wrap-up**

Griffin Dalianis, Ph.D.  
Chair, VACOR

Griffin discussed plans for the coming year; calendar year 2008. Through informal discussion, a consensus based decision was achieved for the committee to engage in the following activities for 2008, *tentative* dates are as follows:

1. May 2008 in Washington DC. This will be a deliberative meeting with presentations from subject matter experts within VA and the rehabilitation field.
2. July/August, VACOR members make site visits to Polytrauma Network Sites.
3. October/November, a deliberative meeting with presentations from subject matter experts within VA and the rehabilitation field.

**Meeting adjourned at 4:05 P.M.**

# APPENDIX

Site Visit Report: RICHMOND

## Hunter Holmes McGuire VA Medical Center

1201 Broad Rock Boulevard  
Richmond, VA 23249

VACOR Team Members: Griffin Dalianias (Team Captain) , Nancy Hogan, Paul Andrews and Maureen McGuire-Kuletz

### **\*Background for Formation of VA Polytrauma Centers:**

*a. Recent combat has resulted in new patterns of polytraumatic injuries and disability requiring specialized intensive rehabilitation processes and coordination of care throughout the course of recovery and rehabilitation. While serving in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), military service members are sustaining multiple severe injuries as a result of explosions and blasts. Improvised explosive devices, blasts, landmines, and fragments account for 65 percent of combat injuries (see subpar. 17a). Congress recognized this newly emerging pattern of military injuries with the passage of Public Law 108-422, Section 302, and Public Law 108-447.*

*b. Of these injured military personnel, 60 percent have some degree of traumatic brain injury (TBI) (see <http://www.dvbic.org/>). Operating under a national Memorandum of Agreement (MoA) with the Department of Defense (DOD), the four current Department of Veterans Affairs (VA) TBI Lead Centers have provided rehabilitation care to the majority of the severely combat injured requiring inpatient rehabilitation. Consequently, they have developed the necessary expertise to provide the coordinated interdisciplinary care required. This experience has demonstrated that treatment of brain injury sequelae needs to occur before, or in conjunction with, rehabilitation of other disabling conditions.*

*c. Recognizing the specialized clinical care needs of individuals sustaining multiple severe injuries, VA has established four PRCs. The PRC mission is to provide comprehensive inpatient rehabilitation services for individuals with complex physical, cognitive, and mental health sequelae of severe and disabling trauma and provide support to their families. Intensive case management is essential to coordinate the complex components of care for polytrauma patients and their families. Coordination of rehabilitation services must occur seamlessly as the patient moves from acute hospitalization through acute rehabilitation and ultimately back to the patient's home community.*

*d. The Secretary of Veterans Affairs designated four PRCs, co-located with TBI Lead Centers, at VA Medical Centers in Richmond, VA; Tampa, FL; Minneapolis, MN; and Palo Alto, CA (see App. A). It is VHA policy that the PRCs provide a full-range of care for all patients eligible for VA care, who have sustained varied patterns of severe and disabling injuries including, but not limited to: TBI, amputation, visual and hearing impairment, spinal cord injury (SCI), musculoskeletal injuries, wounds, and psychological trauma.*

\* Reprinted from VA Polytrauma Handbook (September 22, 2005)

The VACOR team visited McGuire Veterans Affairs Medical Center in Richmond, Virginia on the dates of September 17-21, 2007. Team members met with Polytrauma Staff and toured the facility. In addition, members visited with injured warriors on the unit and members of their families. (See attached schedule).

Overview:

Hunter Holmes McGuire VA Medical Center was built in 1946 with another building added in 1984. Currently the hospital has over 400,000 medical visits per year and employees over 2200 employees. In addition 700 volunteers also support the mission of the medical hospital.

The Polytrauma Center was founded in 2004 to serve soldiers who have experienced multiple injuries with traumatic brain injury (TBI) as a signature injury. It is one of four centers in the United States VA Hospital system. Over 1500 patients have received care from this unit since its inception. Staff is comprised of TBI clinical specialists, neurologists, professional nursing staff, physical/speech therapists, and rehabilitation counseling staff.

Team Visit:

The team met with staff and visited with patients in an effort to determine best practices and challenges on the unit. The following are themes noted by the team. Following these reported themes are recommendations:

Theme 1: Short term needs for injured soldiers discharged from the center/Community re-entry

<u>CURRENT</u>	<u>5 YEARS</u>	<u>10 YEARS</u>
Preliminary evaluations	More intensive treatments needs	Half of deficits recovered
Standardized Treatments		Half require chronic services including PT/OT/ Respite care

- Appropriate care post discharge from polytrauma centers
- 

Questions asked by injured service member at hospital admission:

1. Will I be the same?
2. Will I be able to return to my unit?
3. What will I do?

Theme 2: Long terms rehabilitation planning needs

- Long term medical needs
- Long term nursing needs
- Age appropriate

Theme 3: Research and data collection

- Develop Centers of Excellence
- Research to enhance medical/rehabilitation services

#### Theme 4: Family Issues

- Primary care givers needs
- Education
- Financial guidance/planning

#### Identified Best Practices:

1. Family orientation at intake
2. Family Care Map (BPP) in English/Spanish
3. Family Manual provided at intake
4. Video case staffing between Walter Reed and McGuire Hospital for polytrauma patients to facilitate smoother transfer of patients
5. One point of contact on unit for patient/families to facilitate communication
6. Uniformed service members providing family support

#### Recommendations:

1. Education of DOD in-theater on TBI guidelines for percussion injuries
2. Research – Develop Centers of Excellence with a Research Model next to Clinical care model. In addition, integrated research networks.
3. Funding for Polytrauma Rehabilitation Centers Model Systems Programs
4. \*\*Recommendations from Shalala-Dole report\*\*\*
5. Transition programs from long-term needs
6. Improved communications with injured service members, family, other medical professionals
7. Consistency of services
8. Designated teams of professionals in each of the 72 centers to monitor/review processes.\
9. Mentor program for medical professionals providing post center services.
10. VA needs to establish a level of care for severely injured soldiers to include long-term care. This level of care should be in close proximity to a VA Polytrauma Network Center.
11. Military liaison positions should remain uniformed service members.

Site Visit Report: TAMPA

VETERANS ADVISORY COMMITTEE ON REHABILITATION  
9/19/07 – 9/20/07

8:00am-9am Arrival, Opening Briefing  
Directors Conference Room

9:15am-10:15am Polytrauma/Rehab Clinic Tour

Interviews

	2L-183A	2L-159
10:30am	Sgt. Gunther	Keneshia Thornton
11am	Dr. Sharon Benedict	Dr. Dillard
11:30am	Bill Gregg	Dr. McNamee
12-1pm	Working lunch	Working lunch
1:00pm	Pat Rudd	Dr. Treven Pickett
1:30pm	Sue Cash	Edith Smith
2:00pm	Jeff Denzler	Beth Dameron
2:30pm	Teresa Crumpler	Marta Riquelme
3:00pm	Stewart Mullin	patient
3:30pm	Patient	patient

4pm-4:30pm Wrap-up, transportation to hotel

9/20/07 VACOR Site Visit Day 2

8:00am Transportation from hotel to medical center

8:30am-10am Additional meetings as needed, exit briefing prep

10-11:30am Exit briefing

11:30am Transportation to airport

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**November 28, 2007**

**The Veterans' Advisory Committee of Rehabilitation (VACOR)**

**James A. Haley Polytrauma Center**

**Tampa, FL**

## Introduction

The Veterans' Advisory Committee of Rehabilitation (VACOR) authorized reviews of the four polytrauma centers throughout the Federal VHA. This report pertains to the review of the James A. Haley Polytrauma Center located in Tampa, FL. This review took place September 20-21, 2007 with the VACOR team consisting the following members:

|                          |                                                                                                                       |
|--------------------------|-----------------------------------------------------------------------------------------------------------------------|
| Dr. Lynda Davis          | SES ASN MRA, Department of the Navy                                                                                   |
| Dr. Charlotte G. Dixon   | Associate Professor and Chair, Department of Rehabilitation and Mental Health Counseling, University of South Florida |
| Dr. Linda <u>R.</u> Shaw | Associate Professor and Program <u>Director</u> , <u>Rehabilitation Counseling Program</u> , University of Florida    |

The attachments are the individual observations of each team member. The Team Leader assumed the role of coordinating the responses, writing the summary and allowing for review of the draft report by the team members. A final report will be submitted to the Chair of VACOR, Mr. Griffin Delantis and a copy will be shared with the James A. Haley Polytrauma Center staff following the VACOR meeting in November, 2007.

## Executive Summary

The Site Review Team found the James A. Haley Polytrauma Unit to be exceptional in terms of modern construction and facilities, equipment and personnel. The atmosphere was friendly, upbeat yet professional and veterans and others (families) appeared well accommodated and generally pleased with the quality of services received.

The hospitality and professionalism extended to the VACOR team was exceptional. Ms. Angela Whitener (title) is to be commended for her work in scheduling of the event and accommodating the needs of the team members. Dr. Steven-Scott, Medical Director, deserves special credit and appreciation for taking time from his demanding job to interact extensively with the team. It is clear that the success and innovative ideals observed is a testament to Dr. Scott's leadership, willingness to embrace innovative ideas and determination not to allow territorial lines to interfere with, hinder or lessen the quality of care (both medical and psychosocial) available to wounded veterans and their families.

A major strength of the Haley Polytrauma Center is the way in which the Vocational Rehabilitation Team works hand-in-hand with medical personnel to meet the long-term vocational needs of veterans. Having the Vocational Rehabilitation unit housed within the hospital enhances its ability to effect a seamless transition from acute care to post-

acute care to community reintegration. Again, Dr. Scott is to be highly commended for recognizing, supporting and implementing a vision of healthcare which extends beyond traditional VHA horizons.

Several overarching areas of concerns emerged over the course of the two-day visit. The first and seemingly most pressing concern for the Haley personnel was the perception that DOD's initiatives to increase the number of medical facilities( identified as polytrauma capable) around the county and the concerns that such action would result in fragmenting the system of care currently in place. Dr. Scott and his staff felt strongly that a vast amount of resources should not be utilized to expand new centers, but to strengthen those centers which already exist and that other options should be explored to reach veterans in rural and remote areas. Some of these other options included (1) Tele-Health Care - whereby veterans in remote and less accessible areas would be able to access quality health care via telephone, web-cam; V-tels, Emma, and Tele-rehab program, all made possible via an integrated data base of veterans health records and .

Other areas of concern included: processing time for veterans leaving active duty, research restrictions and IRB procedures which are too restrictive and unrealistic to follow during war time, and concerns regarding "disastrous" limitations within the Tri-care Insurance system. Other areas of concern are expressed throughout the body of the report and generally pertain to opportunities for improvement within the DOD system.

## Summary

The VACOR Team would like to express our appreciation and sincere gratitude to all of the VA Official staff and partners who not only perform their jobs in an extremely professional manner, but also were very accommodating to the team, and open to outside review and feedback.

Dr. Lynda Davis

### Background:

Demographic data for injured soldiers treated at James A. Haley Veterans' Hospital Polytrauma Rehabilitation Center, Tampa, Florida (n = 50)

Source: *Pain and combat injuries in soldiers returning from Operations Enduring*

| <u>Characteristic</u> | <u>Mean ±</u><br><u>Standard</u><br><u>Deviation</u><br><u>or %</u> | <u>Standard</u><br><u>Deviation</u><br><u>or %</u> |
|-----------------------|---------------------------------------------------------------------|----------------------------------------------------|
| <b>Sex</b>            |                                                                     | <b>Military Service Branch</b>                     |
| Male                  | 98                                                                  | Army 40                                            |
| Female                | 2                                                                   | Marines 34                                         |
| Age (yr)              | 28.9 ± 8.7                                                          | Navy 18                                            |
| <b>Race/Ethnicity</b> |                                                                     | National Guard 8                                   |
| Caucasian             | 82                                                                  | <b>Duty Status Before Deployment</b>               |
| African American      | 8                                                                   | Active Duty 78                                     |
| Hispanic              | 8                                                                   | Active Reservist 22                                |
| American Indian       | 2                                                                   | <b>Deployment Length</b>                           |
| <b>Marital Status</b> |                                                                     | (mo) 5.3 ± 3.2                                     |
| Married               | 56                                                                  | <b>Deployment Theater</b>                          |
| Never Married         | 40                                                                  | Iraq 98                                            |
| Divorced              | 4                                                                   | Afghanistan 6                                      |
| Education (yr)        | 12.6 ± 1.1                                                          | Other Territories 2                                |

Characteristic Mean ±

Approximately 80 percent of these wounded service members incurred some type of combat-related TBI (penetrating = 58%, closed = 22%). All sustained multiple traumas among which orthopedic injuries (50%) were the most common, followed by soft-tissue damage (48%), hearing problems (48%), and eye injuries (44%).

#### Tampa Polytrauma Rehabilitation Center – Additional Rehabilitation Programs

- \_ Amputee Program
  - o goal is to maximize each client’s independence, mobility, and quality of life
- \_ Chronic Pain Rehabilitation Program
  - o VA’s leading chronic pain treatment center for over a decade and it remains the sole CARF-accredited pain center in the VA healthcare system
- \_ Spinal Cord Injury and Disorders
  - o provides outpatient, inpatient, and homecare services. The SCI Rehab Team is made up of physicians and therapists from many different disciplines to provide a unique rehabilitation approach, also provide ventilator weaning and rehabilitation
- \_ Blast Injury Outpatient Program

- an interdisciplinary team evaluates and manages the care of individuals who have experienced an explosion and been close enough to see or feel the blast wave
- Vocational Rehabilitation
  - provide education about VA Benefits, identify community based resources, and provide linkage with the Regional Office Representative who can assist with the application for VA benefits and answer questions related to those Benefits

### Issues:

1. The public and policy makers have a misconception on number of veterans and service members needing service and the number actually getting it.
2. The distribution of resources are not always balanced: focus on “critical” mass vs. geographic distribution
3. The planning necessary for professional training (especially for nursing staff) and the inclusion of rehabilitation on interdisciplinary team are not always accomplished.
4. The ability to access research funds is limited and the IRB process too slow.  
Access of clinicians to information on research grants and contracts and the dissemination of findings needs to be expedited.
5. The eligibility and distribution of patients among VAMC and Polytrauma Centers need to be reviewed with capability to prioritize the allocation of resources for infrastructure/personnel
6. The integration of data sharing among VAMC and w DOD is badly needed.  
*This is being addressed by Congressional requirements ALTHA/VISTA bi-directional sharing IM/IT through JEC oversight but line staff are not aware.*
7. The need exists to expedite MOUs between the military services and the VAMCs  
Need to clarify family support goals and resources and coordinate discharge planning and POCs.  
*This is being addressed for severely wounded, ill, injured through Federal Recovery Coordination Program, assignment of Federal Recovery Coordinators, and use of Federal Individual Recovery Plan.*
8. The reimbursement rates for TRICARE are too low in most places to acquire quality care for certain diagnosis including TBI. There is no pre authorization process – should be time limited pre authorization 1 month.

### Ward Visits:

1. Concern the sample was not representative of OEF/OIF patients.
2. Concern that family benefits payments are delayed (ITO’s, etc.)  
There is a transfer between VA and DoD for OEF/OIF.
3. Best practice the VA interdisciplinary team task MLO/  
reviews with the patient and family weekly –  
Tampa Model - Integration/Family Goal Planning/Innovation/Flexibility
4. Concern that Congress/DoD/VA do not recognize the need for greater family

support before transitions between facilities and the DoD disability evaluation process.

*This is being addressed through revised DES process pilot starting 26 Nov With PEBLOS and MSCs working more closely and expediting process with joint single physical and rating.*

### Voc Rehab:

1. Challenge to hire licensed, expert and experienced staff considerable - change to CHR Title 38/5 to expedite personnel hiring.
2. Revise the regulations for Independent Living Skills to provide greater eligibility for AD.
3. Create relevant forms for the diagnosis being evaluated/rehabilitated.

### DoD:

1. Address TSGLI benefits eligibility
4. DoD change eligibility for dual diagnosis - insufficient substance abuse treatment offered for TBI
5. Review exclusionary criteria – look at admission criteria/eligibility

### Best Practices:

1. Retain the VA policy of persistence with open ended services mixing long term care with rehabilitative care and support but monitor consequence to staff
2. Fear of “mistakes” among care givers might hinder outcome based performance
3. A single case manager like the proposed FRC need to handle patient and family needs and have oversight for complaints
4. Beware of over promising
5. Be conscious of the distinction between treatment and rehabilitation and identify the best location for service DoD vs. VA to provide best care and avoid duplication of services
6. Provide WII and veteran patients and families and care providers with accurate information on benefits and resources  
*My E Benefits and National Resource Directory will address this in part – ongoing joint education and training and collateral materials needed continuously.*
7. MOUs exist now w/DoD for TBI, SCI and blind treatment and rehabilitation – need to add polytrauma. TRICARE will denial w/o TBI and TRICARE does not fit to treatment. Simplify process for polytrauma treatment and rehabilitation (now separate authorizations).

### Address:

1. A “Telehealth” system needs to be utilized for global/rural reach – focus more on care coordination/not just facilities.
2. Studies should be conducted by GAO on authorization for rehabilitation.
3. Care for OEF/OIF and all vets should build on existing elaborate VA network of distributed care (e.g. SCI model)
4. Performance improvement processes should be built into all management.
- 5 TeleRehab-web based case management – should be available.

6. Joint training should be conducted on more regular and borad basis between DoD/VA on processes/language – staff rotations/joint therapeutic planning (CPRS not bi-directional)
7. Review criteria and process for a joint eligibility
8. Look at model One VA to create One VA/DoD

### Dr. Linda Shaw

#### Notes from visit to Haley

#### Strengths:

5.a.1.1 Family services appear to be a strength of the unit. The families with whom we spoke were very pleased with the services and the level of communication between themselves and the staff. Treatment appears to be very patient and family-focused and family recommendations are given serious weight in treatment planning.

5.a.1.2 The coordination and cooperation evident between and among the various vocational programs serving patients at this VA hospital appeared to be exemplary and might serve as a model for other polytrauma centers.

5.a.1.3 Patients appear to have a very high level of trust in Dr. Scott and the rehabilitation staff. Repeatedly we heard statements of gratitude and praise for the manner in which staff attend to patient and family needs. We observed a high level of involvement and commitment during our short visit.

#### Concerns/Recommendations:

5.a.1.4 Concerns were expressed by Nursing administration that nursing was not fully integrated in planning and in education. It was felt that this difficulty was related to the administrative placement of Nursing and Case Management within the Office of Seamless Transition while everyone else was in Patient Care within the VA.

5.a.1.5 Non-standardization regarding records among DOD and the VHA continues to be a major problem and this concern was expressed by multiple individuals during our visit.

5.a.1.6 The difficulties in transitioning from DOD to the VA were a continuing theme. It was noted that returning military personnel receive mixed messages about what their best options would be in terms of remaining on active duty versus becoming eligible for VA services. The delay in the time for processing individuals leaving active duty was cited repeatedly as a major barrier. One interesting suggestion was to build in a period of overlap where vets would be eligible for services under both statuses, or where people could receive VA services on a trial basis without losing their active duty status (and benefits & priveleges), similar to Social Security's trial work period.

5.a.1.7 Dr. Scott articulated a concern that the current Polytrauma Centers are underutilized and that funding new centers will detract from the existing centers' ability to effectively treat TBI patients as there will not be an ongoing critical mass of patients.

5.a.1.8 Frustrations were expressed about Tri-care with one individual referring to it as “a major disaster”. It was noted that it is difficult to get “top flight” providers for counseling who will accept tri-care, and that this makes discharge planning less than optimal.

5.a.1.9 I did not come away with a clear view as to how PTSD treatment is integrated into the rehabilitation program, as the polytrauma unit appears to rely on the PTS Clinic for treatment of their polytrauma patients who also have a diagnosis of PTSD.

5.a.1.10 The Wounded Warriors program appears to be a very valuable service, however concerns were expressed about the lack of a MOU with the VA. While it was noted that this is “in the works”, there is an immediate need for the individuals providing services to be able to access needed records.

5.a.1.11 Families generally appeared happy with their services. The Family meetings were well received and the Fisher House was repeatedly mentioned as being a primary source of support for families. The only comments noted from families about needed changes were observations that the hospital needs more help/staff and specifically, more speech therapy. The family member who mentioned this also stated, however, that her family member is receiving 45” per day except for Monday, so it appears that there is adequate coverage.

5.a.1.12 Frustrations were expressed by the VR personnel about the need to fill additional positions. They noted that this would be facilitated by the program going under Title 38 rather than Title 5. Such a change would allow them to expedite needed hires. Additionally, the VR & E staff noted that there is a need for better training in VR & E and among contractors in TBI. It was through the family goals meetings. as noted that many individuals are closed prematurely because they missed appointments, etc. (behavior typical of TBI, and more likely due to cognitive deficits than motivational deficits).

5.a.1.13 Some concern was expressed about the need for availability of better substance abuse programming for individuals with TBI

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Site Visit Report: PALO ALTO

**Veterans Affairs Committee on Rehabilitation (VACOR) Team Report  
Palo Alto, Polytrauma Clinic Review**

The VACOR Team concluded that the Palo Alto Polytrauma Clinic (PC) enjoys exceptional leadership. Resources were readily available, staff were receiving extensive training and the facilities were being quickly refurbished to accommodate the severely wounded patients. The director, Elizabeth Freeman, and her executive team were described by treatment staff as leaders who supported all of the requirements of this complicated program and aggressively resourced the program. Patients, families and staff consistently said that the director "Gets it."

Dr. Sandy Li and the staff of the PC were seen by the VACOR Team as a "highly functional team." The staff was observed and was reported by patients and family as: engaged, communicating, cross-trained and coordinated." The treatment team proved to be proactive, flexible and eager to learn as they experienced challenges, including numerous reviews from outside critics, such as the IMG review.

A key success factor is the fact that the VA and the community have been very responsive to resource requirements. Palo Alto Medical Center does an excellent job of involving the community which has proven to be very generous. The well developed relationship with the community is further enhanced by the co-location of the Stanford Medical Facility which brings expertise and human resources to the complex needs of the PC, as well as the entire Medical Center.

**Some of the ongoing issues and barriers to progress are as follows:**

- DOD is experiencing tremendous pressure to free up beds and is sometimes backed up overseas. DOD also tends to minimize problems as evidenced by low MEB ratings, especially TBI assessments. Families pressure to get their member into the rehabilitation process at the VA. Many patients are transported very long distances in very fragile and vulnerable conditions.
- Family allowances and accommodations are greatly curtailed once the patient is moved from DOD facilities to the VA and the transportation regulations are archaic in dealing with patients and their families.
- DOD needs more education on TBI and PTSD. Attitude is "Give it a year; you'll get over it," as relayed by treatment staff, DOD contractors, patients and families.
- Patients and wives reported that dental work was too low of a priority in the patients' rehabilitation, especially as it affects the individual's self-image.

- Concerns from PC staff that vocational rehabilitation services do not help coordinate transition in a comprehensive manner. Sustainable housing and community reintegration are not well coordinated to ensure success for patients and families. Education, vocational training and employment services are often unattainable due to the need for permanent, affordable housing and direct focused Case Management.
- Case management is somewhat overwhelming for patients and family members in relation to all the DOD coordinators, social workers and others involved, making it difficult for them to know who is in charge. Transition back to the community is challenging without a direct link to a case manager who is an advocate for the patients and their families.
- Hiring staff and competing with salary limitations greatly impede the PC's ability to quickly staff up to the enhanced level of funding. The VA HR processes are not adaptive to the quickened pace of today's requirements.

### **Possible VACOR Recommendation:**

Transition of patients and families from DOD facilities to VA PCs could be greatly enhanced by attending to a comprehensive and timely review of process issues.

- Family members should have continuing financial support at the same level when the patient is in a DOD facility.

Transportation regulations could be streamlined and tailored for the flexible applications needed to accommodate patients and families while at a PC facility. Note: VA staff at Palo Alto use their own POV's and meet the patient at Travis Air Force Base to ensure all the family members and their luggage are moved together. Ambulances simply cannot handle the requirements.

Madigan Hospital is reputed as having a "direct billing" process that takes much of the financial burden off of the families. Authorization and reimbursements for family expenses are inconsistent, very restrictive and untimely. DOD would do well to look at best practices to relieve families of these burdens.

Patient information should be simultaneously sent to patients and a designated family member at the patient's request.

- DOD needs to emphasize training and education regarding polytrauma, Traumatic Brain Injury and Post Traumatic Stress Disorder.

It was suggested that all NCO's and officers at the service unit have mandatory training. All service members should be briefed pre- and post-deployment regarding these risks and assessments should be conducted on troops at these

briefings. DOD should look at the relation and frequency of “Non-Judicial Punishment” and PTSD.

- Dental services should be made available as early as possible. Patients and spouses indicated that it would greatly assist in recovery if the physical and psychological impact of missing teeth were addressed early in their recovery.

**The entire arena of transitioning from the PC back to the community is of concern to all patients, family members and staff. VACOR should appropriately focus future reviews on the “transition to Home.”**

### **Recommendations regarding transition and follow-up:**

- Develop a more systematic presentation of benefits information for both patients and families. The timing of such information may be different enough in the VA setting that this information is more desired and will have more meaning than earlier presentations of the same information. Provide as much written benefit information as possible for this population.
- Consider a self-medication clearance for individuals who can manage their own medication, as part of transition to community living.
- Emphasize the need for early vocational information, planning and work activity. Recommend the inclusion of a vocational rehabilitation counselor as part of the PC and possibly the PNS teams to coordinate this activity. Consider staffing this position in the same way that vocational rehabilitation was added to the teams in the Spinal Cord Injury pilot programs—as a hospital position that coordinates and/or makes use of VR and E as appropriate, but also is involved in vocational programming within the hospital and in the community.
- Consider a more formal mentoring program where successful “graduates” of the PC programs and other individuals who have overcome TBI talk about their situations and successes in community living and work.
- Recommend that the VA begin looking at methods to fund long-term community support systems for independent living and work.
- Recommend that the VA look at ways to remove barriers that prevent veterans still on active duty from participating in compensated work therapy programs and/or similar in-hospital work programs.
- Recommend that the VA investigate access to the ASVAB for purposes of retesting veterans with TBI used to determine changes in cognitive functioning and skills. This may also have implications for disability ratings, vocational and community planning, and personal adjustment counseling.

## Veterans' Advisory Committee on Rehabilitation

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Recommendations regarding current PC services and transitional issues to VISN level services are as follows:

- Recommend that the blind rehabilitation program be extended to all PCs if this has not already been done.
- Recommend that the PC blind rehabilitation program include the services of optometry as implemented in the PA PC.
- Recommend that the PA PC blind rehabilitation program protocols for evaluation, screening, and evaluation of progress be formalized for dissemination if this has not already been done.
- Consider use of water-based therapies for emerging consciousness patients, although more information is needed to determine effectiveness.
- Recommend consideration of the two small pools designed for water-based therapies. More information is probably needed to determine whether the PA pool design is really unique and whether other VA hospitals already have similar pools for therapy purposes as opposed to large pools for recreational purposes.
- If this issue is consistently noted at all PCs, make recommendations related to relieving the DOD backup and inappropriate pressure to move prematurely to PCs.
- Suggest that a project be allowed to provide pilot authority to hire and pay competitive wages to cut through personnel red tape.
- Recommend review and revision of rules pertaining to transportation.
- Review use of donated funds to determine whether donated funds are supplanting VA funds, or whether some activities now provided through donated funds should be authorized to be paid for by VA funds. The current "era of good feeling" and high rates of donations may not last, and stable funding should be made available for necessary and appropriate supports.
- Support the PC consortium's research request. (See attachment to be included in final document.)
- Recommend training for non-polytrauma team medical staff in the VISNs to assist them to become knowledgeable about TBI and polytrauma issues and to become more comfortable in working with polytrauma patients who may be referred to them for care.

## Veterans' Advisory Committee on Rehabilitation

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- Recommend that interdisciplinary staff be hired and placed at appropriate locations throughout the VISN to support community treatment of polytrauma patients.
- Recommend that administrative positions be assigned to the PNS teams to alleviate some of the competition between administration and coordination duties and clinical duties.

Finally, the VACOR should accelerate its review and assessments of the transition of the severely wounded from Polytrauma Care to the VISN level of services. VACOR should pay attention to case management, specialty care and support services to the wounded and their family to ensure quality care for all members as soon as possible. No one should have to wait until the process improves to an acceptable level; the price has already been paid.

In response to this report, Palo Alto PRC said the following:

***“Recreation Therapy is addressing community reintegration and community based program activities which are focused on improving the transition process for our Veterans from PRC to home.***

***“Recreation Therapy trains Veterans and families on community and campus pathfinding and community transportation usage issues.***

***“Development continues regarding bringing community stakeholders into the picture for supports and encouragement of our families and Veterans while at PAVAHCS.”***

Site Visit Report: MINNEAPOLIS

**VACOR SITE VISITATION TO  
MINNEAPOLIS VETERANS ADMINISTRATION HOSPITAL  
POLYTRAUMA CENTER**

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**September 19-21, 2007**

The VACOR site visitation to the Minneapolis Veterans Hospital Polytrauma Center was conducted September 19-21, 2007. Team members participating were Marvin L. Meyers Team Captain, Brian Neuman, Edwin J. Salau and Joseph J. Tucker, VACOR Designated Federal Officer. Joining the team from the St. Paul, VA Office of Vocational Rehabilitation were Patrick Wilder and Arlyn Weieneth. All contributed very effectively bringing their professional experiences, training and expertise to bear throughout the site visit.

Mr. Meyers and Mr. Tucker met briefly with Steven P. Kleinglass, Medical Center Director and Ralph C. Heussner, Public Affairs Officer to informally discuss the site visit and to receive the proposed agenda for the following two days. The team's mission and purpose for the site visit was covered at both the entrance and exit interviews with Dr. Drucker, Medical Chief of Staff and Dr. Barbara Sigford, Polytrauma Center Director and all key hospital administrative staff in attendance. This was also reiterated at all interviews conducted by team members throughout the brief visit. Full cooperation and participation was extended to all members of our VACOR team by hospital staff, patients and family members during the site visit.

A thorough familiarization tour of all Polytrauma facilities, programs and resources were conducted by Dr. Sigford and her staff. Interviews were either conducted during the tours or in conference rooms with patients, family members and staff. All staff interviewed freely expressed their enormous pride in the quality of medical and therapeutic services provided to the veterans and of their positive relationship with family members. This became clearly evident to the team.

Family members candidly shared their satisfactions and frustrations with the system while veterans looked forward to returning home following treatment of many months. Staff had concerns for those veterans who had no home to which to return. Relationships with community resources are sought, developed and utilized, particularly in rural areas outside of major sized communities.

The team's thirteen-hour site visit at the Poly Trauma Center consisted of tours, observations and interviews. The following is the team's overview which is not all-inclusive of the fine work taking place on behalf of our veterans at the Polytrauma Center

## **ONSITE TOUR AND INTERVIEWS**

The team visited the Fourth Floor-Rehabilitation Unit, which was started in 1992. It was later remodeled in 2005 to serve combat injured. Later became the Polytrauma Unit, which opened in 2006. Many modifications were made into the area. Staff members were trained to handle the polytrauma patients . There are 28 beds in the unit with 12 dedicated to polytrauma patients.

The Third Floor- Transitional Apartment, Transitional Unit and Therapeutic Services were visited. Patients generally stay 4 – 5 days in the transitional apartment acquiring proficiency and activities of daily living (ADL). They arrange schedules, Veterans are driven to go shopping at local markets, plan and prepare their meals, etc. A drive simulator is available for driver training.

The Transitional Unit is a new specialty facility in the hospital dedicated, designed and furnished for polytrauma patients. This provides a meaningful experiences for veterans return to community living. This is a very comfortable, hotel like facility, having a capacity of 10 with 4 in occupancy.

The Fitness Center includes a comprehensive variety of exercise/workout equipment which is available for all patients. Instructors initially assist as needed. Staff would like to have family members use the equipment, however, liability is an issue.

The Recreation Integration Therapy program is staffed by three recreational therapists. Some work on weekends and after hours. Patients are taken into the community for reintegration activities, e.g., bowling, dining, shopping, etc. Emphasis is on the real world, yet maintaining a protective setting with staff monitoring. Goals are to improve health, motor functioning and social integration. Activities are geared to build self-confidence and increase self-esteem. Staff works on physical abilities and cognitive training. Internet capabilities are relearned or taught. Palm Pilots have been made available for patient use as needed.

### **Challenges**

There is a lack of community resources and programs outside of metro areas, especially in rural areas. Veteran service organizations such as American Legion and VFW Posts are available and welcome the young veterans but they are not interested. Most funding for community activities comes from the veteran service organizations.

## **OCCUPATIONAL THERAPY**

These therapists serve all patients in the hospital making it a challenge to provide confidential care for those assigned to the polytrauma unit. Scheduling can be an issue due to limited space and having to coordinate schedules with other services. Staff consists of 2 OT's for inpatient care and 2 OT's for outpatient care

### **Challenges**

The equipment is outdated. There is insufficient space for the therapists who share only 2 rooms in the same facility. All share the same facilities for TBI, Spinal injury, etc. There is a problem with coverage as there are no float people available when staff is out ill or gone to a conference. The average number of patients seen per day is six each with one-hour appointments. The OT's do their own scheduling which is time consuming, requiring coordinating with other services and appointments.

## **PHYSICAL THERAPISTS**

There are two dedicated PT's assigned to the unit. The equipment is very good. There is good continuing education/training available, however, sometimes they find it difficult to attend due to demands of their work schedules.

### **Challenges**

There is a timely need for proper helmets for patients requiring them. It some times weeks to get a properly fit helmet. The orthotic staff position. Remains vacant. It has been open for one year. S with the OT's scheduling and seeing patients can be challenging. There is a need for additional staff space. There is a need for staff debriefing to relieve stress in their workplace

## **UNIT PHYSICAN**

The physician completes the diagnosis of patients with traumatic brain injuries (TBI). Patients range from severely injured to highly functional. Plans and determination of patient needs are made within 24 hours of arrival, re: OT/PT and orthotic needs. Unlike HMO's, no time frames for length of stay between admission and discharge is set. Treatment team members provide education for the patients family members through modeling and communication. The psychologist runs Support group for families, The counseling psychologist works with family members, while a neuro-psychologist works with patients. The depth of education to the family is tailored to assist them to fully understand nature and extent of injuries. Staff members utilize the Minnesota Brain Injury Association and Courage Center as outside resources. All clinicians do TBI training. Substance abuse is an issue for patients. Further, staff is working on developing a research grant for a pain clinic.

### Challenges

Space and overtime continues to be an issue. A dedicated polytrauma staff education-

coordinator is needed.

## **FAMILY INTERVIEWS**

Six family members were interviewed. All were pleased with the services provided to their veteran family member. Several make periodic long distant trips of hundreds of miles to come to the hospital. One retired military father stated that he received insufficient information on his son's status and condition until he asked the right questions. He feels that staff needs to spend more time with families to review their family members progress and prognosis. He believes many other families have similar concerns. Family members indicated however they were involved with follow up information from their veteran's therapists.

One veteran's parent commented they had high expenses due to traveling several hundred miles to visit the PRC. Other veterans' family members concurred they had the same issue. PRC staff pointed out to the VACOR team that a one time \$100,000 payment was made to each PRC patient's family which was intended to defray costs such as travel. Two of our VACOR team members said they had previously encountered veterans' families who receive this \$100,000 payment, who are not aware that it is intended to pay travel expenses and other costs that the veterans injuries will cause the family to incur.

## **PATIENT INTERVIEWS**

Only three patients were seen. Two were looking forward to leaving the hospital soon and were pleased with services they received. A third had been severely injured and we were unable to communicate with him.

## **DIETICIAN**

The dietician's time is divided between the polytrauma and cardiac units. Weight is a problem requiring work with the patient and family on appropriate weight goals.

### **Challenges**

Having to work overtime, to adequately complete needed tasks is an issue and there is a need for a dedicated full-time dietician.

## **REGISTERED NURSE**

Patient referrals come from Walter Reed Hospital or Bethesda Naval Hospital. All records and notes are received from them, and veteran needs are determined and rooms are assigned. The nurse works with family and social worker, providing instruction and necessary information to family prior to discharge. There are many

excellent educational opportunities for assigned nurses.

### **Challenges**

RN's are confronted with problems with the lack of community facilities, services and resources in outlining areas. A shared information compatibility system between Walter Reed/Bethesda would expedite patient referral and set-up preparation faster.

## **SOCIAL WORKER**

There are 3 social workers who work closely with the patient, family and community resources. Their team is growing quickly.

### **Challenges**

There is a need to provide lifetime case management and follow-up services. They work with the level three-polytrauma support team in Sioux Falls, Iowa City and St. Cloud. Space is continues to be a issue with the social workers sharing one office. The social workers will be able to assist more patients when they go from military to veteran status.

## **BLIND REHABILITATION SYSTEMS SPECIALST**

The BROS specialist works with the veterans of OIF/OEF and their families. Her job also includes provides mobility training. To date she has seen 24, 2 having vision issues.

### **Challenges**

The Specialist indicated the need to use the services of the eye clinic at the hospital and need the patients services of a neuro ophthalmologist. Currently, services of staff ophthalmologist for only four hours a month.

## **CONCLUSION**

The changing challenges of services and needs of veterans, families, and staff in any evolving program of this magnitude, were freely shared with the team by everyone interviewed. The team's site visit to the Minneapolis Polytrauma Center confirmed the priority commitment our Nation and the Veterans Administration is fulfilling to provide exemplary services to our seriously wounded warriors and their families. We left with an exceedingly high and favorable impression of the quality of staff and of the wide and varied services our veterans are receiving.

Marvin L. Meyers  
Team Captain

