

BLIND REHABILITATION CENTER PROGRAM PROCEDURES

- 1. REASON FOR ISSUE.** This Veterans Health Administration (VHA) Handbook defines Blind Rehabilitation Centers (BRCs) and describes the procedures for the provision of comprehensive interdisciplinary blind rehabilitation and coordination of care.
- 2. SUMMARY OF CHANGES.** This new VHA Handbook defines the scope of the BRC Program and describes the procedures for providing inpatient blind rehabilitation services in VHA medical facilities.
- 3. RELATED ISSUES.** VHA Directive 1174 (to be published) and VHA Handbook 1174.02.
- 4. RESPONSIBLE OFFICE:** The Office of Patient Care Services, the Chief Consultant, Rehabilitation Strategic Healthcare Group (117) is responsible for the contents of this VHA Handbook. Questions may be referred to the Director, Blind Rehabilitation Service at 202-461-7355.
- 5. RESCISSIONS.** VHA Manual M-2, Part XXIII, Chapter 4, is rescinded.
- 6. RECERTIFICATION:** This VHA Handbook is scheduled for re-certification on or before the last working day of December 2014.

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BLIND REHABILITATION CENTER PROGRAM PROCEDURES**1. PURPOSE**

This Veterans Health Administration (VHA) Handbook defines Blind Rehabilitation Centers (BRCs) and describes the procedures for the provision of comprehensive interdisciplinary blind rehabilitation. Those individuals for whom these training services are available include visually-impaired Veterans and active duty service members.

2. BACKGROUND

- a. The roots of Department of Veterans Affairs (VA) Blind Rehabilitation Service can be traced directly to the extraordinary commitment made to the Nation's war-blinded servicemen when President Franklin D. Roosevelt signed an Executive Order on January 8, 1944, declaring: "No blinded servicemen from World War II (WWII) would be returned to their homes without adequate training to meet the problems of necessity imposed upon them by their blindness."
- b. In order to meet the demands of this obligation, the adjustment training of blinded soldiers became the military's duty. In the initial phase, the Army Medical Corps provided basic blind rehabilitation instruction to newly-blinded servicemen at Valley Forge General Hospital in Phoenixville, PA, and Dibble General Hospital in Menlo Park, CA.
- c. With the conclusion of WWII, the military deactivated their blind rehabilitation program. President Harry Truman subsequently transferred responsibility for the social adjustment training of blinded servicemen to the Veterans Administration when he signed an Executive Order on May 28, 1947. Within a month, all wartime rehabilitation programs for blinded servicemen were deactivated by the armed services.
- d. The first BRC was established at the Hines VA Hospital, located in the western suburbs of Chicago, IL. Russell C. Williams, a WWII blinded Veteran and former counselor at the Valley Forge Military Rehabilitation Program, was appointed as Chief. After four months of intensive staff training, the nine-bed unit admitted the first patient on July 4, 1948.
- e. Nine additional BRCs have been created since Hines was established in 1948, and are strategically placed within the VA system in order to meet the growing demand for comprehensive training. The sites include VA Medical Centers in Palo Alto, CA (1967); West Haven, CT (1969); American Lake, WA (1971); Waco, TX (1974); Birmingham, AL (1982); San Juan, PR (1990); Tucson, AZ (1994); Augusta, GA (1996); and West Palm Beach, FL (2000).
- f. At BRCs, through an association process, blinded Veterans learn to respect the ability of blind people. As Russell Williams noted: "Being in a BRC environment allows the newly-blinded Veteran to associate with others who have already experienced success during their progression through the various stages of the rehabilitation program. This creates a role model atmosphere in which the newly-blinded individual, who may be skeptical of achieving any success in overcoming the handicap of blindness, has the opportunity to observe the

accomplishments being attained by those who are further along in the program. Each day, the blind patient hears of or observes another blind person doing something else that they thought was impossible.”

g. The increasing incidence of co-morbidities in the patient population demands a medical center support system involving interdisciplinary treatment. Regardless of discipline, all interdisciplinary team members focus their efforts on promoting health, developing skills of independence, and improving the blinded Veteran’s adjustment to sight loss with the ultimate goal of successfully reintegrating the individual into the family and community environment.

3. DEFINITIONS

a. **Blind Rehabilitation Outpatient Specialist (BROS)**. A BROS is a multi-skilled university trained (Bachelor's or Master's Degree in Blind Rehabilitation) and experienced blind rehabilitation instructor who has advanced technical knowledge and competencies at the journeyman level in at least two of the following disciplines: orientation and mobility (O&M), living skills, manual skills, or visual skills. The BROS has been cross-trained to acquire broad-based knowledge in each of these disciplines along with knowledge of computer access training.

b. **Blind Rehabilitation Specialist (BRC Instructor)**. The Blind Rehabilitation Specialist (BRC Instructor) is a VA position title that refers to the BRC staff that assess, plan, and instruct in one of the BRC disciplines. It designates an instructor with a Bachelors, Masters, or higher degree in one or more of the specialized areas of working with persons who are visually impaired or a professional who possesses a Bachelors, Masters, or higher degree in an allied health profession who has expertise in one or more of the specialized areas of working with persons who are visually impaired.

c. **Blind Rehabilitation Specialist (VIST)**. VIST is a VA position title, which designates a Visual Impairment Services Team (VIST) Coordinator.

d. **Computer Access Training (CAT)**. CAT is the instructional area that teaches the use of specialized access equipment necessary for a visually-impaired person to independently operate computers. This includes evaluating and training the student to use large print, synthetic speech, or Braille access devices in order to perform basic computer operations and maintenance.

e. **Continuum of Care**. Continuum of Care refers to vision rehabilitation services ranging from basic outpatient low vision care provided by eye care professionals to outpatient low vision care involving a team of eye care specialists and rehabilitation professionals to outpatient blind rehabilitation services and finally to inpatient blind rehabilitation services. Patients are referred to the type program that best matches their functional needs.

f. **Cross-training**. Cross-training is professional training that extends beyond an instructor's formal training; it is intended to maximize the instructor's area of expertise by combining specific instruction from other closely-related disciplines. Cross-training is provided by instructors with verifiable competencies in the BRC program disciplines of living skills, O&M, manual skills, visual skills, and computer access.

g. **Excess Disability.** Excess disability refers to problems and task performance difficulties related to vision loss, which have a substantial impact on the person's functional independence or personal safety and that are out of proportion to the degree of visual impairment as measured by visual acuities or visual fields. Veterans whose vision is better than legal blindness may have excess disability due to:

- (1) Sudden or traumatic visual disorder (especially related to military service);
- (2) Disabling co-morbidities (e.g., hearing impairment, mobility impairment, etc.);
- (3) Systemic diseases that cause fluctuating visual impairment;
- (4) Combined losses of other vision functions (e.g., contrast sensitivity, visual field loss that is less than legal blindness, stereopsis, etc.);
- (5) Sudden changes in caregiver status; or
- (6) Other reasons.

h. **Instruction (Basic).** Basic instruction refers to introductory training that addresses skills utilized by visually impaired individuals in order to manage everyday life tasks. These may include, but are not limited to: pre-cane skills, such as use of a human guide and independent protective techniques; self-care techniques, such as eating skills and personal grooming; health management, such as labeling medicines; Activities of Daily Living (ADLs), such as telling time, dialing a telephone, and identifying money; using talking books; and simple adaptive kitchen skills.

i. **Instruction (Advanced).** Advanced instruction is skill training that takes place by sequencing lessons that are designed to integrate and expand techniques taught during basic skill instruction in order to perform more complex tasks. Examples include, but are not limited to:

- (1) Business area travel, such as crossing streets with traffic lights and using public transportation, and
- (2) Adaptive kitchen skills, such as hot meal preparation.

j. **Legal Blindness.** Legal blindness is when the best corrected central visual acuity in the better-seeing eye is less than or equal to 20/200 or visual field dimension in the better-seeing eye less than or equal to 20 degrees at the widest diameter, even if central visual acuity is better than 20/200.

k. **Licensed Eye Care Practitioner.** A licensed eye care practitioner is a professional who is licensed to provide eye examinations, treat visual problems, and prescribe optical corrections (i.e., an optometrist or ophthalmologist).

l. **Living Skills.** "Living skills" is an instructional area that addresses the skills necessary to manage a person's everyday activities. These skills encompass a broad range of activities, such

as personal grooming, eating skills, food preparation, and household management. Also included are communication skills, such as Braille, keyboarding, handwriting, and reading with the use of electronic scanners.

m. **Low Vision Clinical Examination.** A low vision clinical examination is a comprehensive eye examination that evaluates a visually-impaired person's clinical visual functions, provides best optical corrections, and determines the patient's ability to benefit from adaptive vision training and prescription optical low vision devices. This examination is usually performed by an optometrist or ophthalmologist with a special interest in low vision evaluation and training.

n. **Manual Skills.** "Manual skills" refers to the instructional area designed to enhance skills in sensory awareness with an emphasis on adaptive and safety techniques. Skill training focuses on organization, tactual awareness, spatial awareness, visual skills, memory sequencing, problem solving, and confidence building. Activities range from basic tasks using hand tools to advanced tasks using power tools and woodworking machinery.

o. **National Program Consultant (NPC).** An NPC is a field representative of the Director of Blind Rehabilitation Service (DBRS). The Consultant provides ongoing support and consultative services to the VA BRCs, BROS and VISTS.

p. **Ocular Health Examination.**

(1) An ocular health examination is an examination conducted by a licensed eye care practitioner that identifies the level of and reasons for a person's visual impairment. This examination includes:

(a) A refraction to establish best-corrected central visual acuities (not using a preferred retinal locus).

(b) A thorough assessment of the visual system and ocular health to establish the diagnosis primarily responsible for the impairment.

(c) Assurance that all ocular and visual disorders are being appropriately managed. **NOTE:** *If there is a significant visual field loss, a Goldmann Perimeter, Humphry Visual Field Analyser, or equivalent, is used to determine the extent of the field loss.*

(2) This examination provides the licensed eye care practitioner with information essential to conducting or directing additional assessments and management strategies centered on the delivery of optimal visual impairment rehabilitative services.

q. **Optical Low Vision Devices.** Optical low vision devices are instruments that optically alter the image focus, size (magnification or minification), contrast, brightness, color, or directionality of an object through the use of lenses or other technology. Such devices include, but are not limited to:

(1) Habitual prescriptive spectacles (with or without tint);

- (2) Microscopic spectacles;
- (3) Hand-held magnifiers;
- (4) Stand magnifiers;
- (5) Telescopes (monocular or binocular);
- (6) Head borne lenses;
- (7) Minifiers;
- (8) Prisms;
- (9) Closed circuit televisions (CCTVs); and
- (10) Electronic optical enhancement devices (EOEDs).

r. **Orientation and Mobility (O&M)**. The O&M is an instructional area that addresses the establishment and maintenance of orientation to the environment and safe, efficient, and confident movement in the environment. In O&M, Veterans use all remaining senses, available environmental information, and the use of protective techniques and devices.

s. **Preferred Practice Patterns**. Preferred Practice Patterns are guidelines for VIST Coordinators and Blind Rehabilitation Specialists (including BROS) that specify procedures, clinical indications for performing the procedure, clinical processes, setting, equipment specifications, documentation aspects, and expected outcomes (see the BRS Web site at: <http://vaww1.va.gov/blindrehab>).

t. **Visual Impairment Center To Optimize Remaining Sight (VICTORS)**. VICTORS is a short-term low vision rehabilitation program for visually impaired Veterans. Services may be inpatient or outpatient. ***NOTE:*** *There are currently four VICTORS programs, which are located in Lake City, FL, Chicago, IL, Northport, NY and Kansas City, MO.*

u. **Visual Impairment Services Outpatient Rehabilitation (VISOR)**. VISOR is an outpatient, hospital-based program providing an abbreviated rehabilitation program. ***NOTE:*** *There are currently two VISOR programs, which are located in Lebanon, PA and West Haven, CT.*

v. **Visual Impairment Services Team (VIST)**. VIST is a team comprised of health care and allied health care professionals charged with the responsibility of ensuring that blind Veterans are identified, evaluated, and provided health and rehabilitation services to maximize adjustment to sight loss. Representatives may include, but are not limited to social work, ophthalmology, optometry, prosthetics, primary care, vocational rehabilitation, library service, nursing, audiology, podiatry, nutrition, psychology, Veterans Benefits Administration (VBA),

blind Veterans' consumer organizations, blind consumers, and state or community agencies for persons who are blind.

w. **Visual Impairment Services Team (VIST) Coordinator.** The VIST Coordinator is a case manager who has major responsibility for the coordination of services for visually-impaired Veterans and their families. The VIST Coordinator is often the entry point into the continuum of care for visually-impaired Veterans. Duties include assessing needs, providing or arranging for the appropriate rehabilitation services and devices (e.g., referrals to BRCs , BROS or outsourced services) in order to enhance a blinded Veteran's functioning level. Other duties include identifying new cases of blindness, providing professional counseling, meeting specific objectives established by the VIST, arranging VIST reviews, and conducting educational programs relating to VIST and blindness.

x. **Visual Impairment Services Team (VIST) Annual Report.** The VIST annual report is the annual narrative completed by all VIST Coordinators and submitted to BRS, VA Central Office, through local administrative channels. The report details program developments, program highlights, and program goals. A copy of the report is sent to the NPC responsible for the VIST-designated area, and it is due no later than October 31st of each year and can be found on the BRS Web site at <http://www.va.gov/blindrehab>.

y. **Visual Impairment Services Team (VIST) Review.** A VIST review is when a VIST Coordinator conducts an interview identifying the Veteran's needs and advising the Veteran of the full range of services and benefits for which the Veteran is eligible plus a comprehensive physical examination, eye examination, and audiological examination (if deemed necessary). The review includes a VIST assessment of patient history, current skill levels, adjustment to blindness, and needs. It establishes a description of the Veteran's functional capabilities and limitations. The VIST Coordinator develops a treatment plan that includes recommendations for other needed exams, services, and follow-up, as indicated. If the VIST Coordinator utilizes reports from evaluations accomplished during the preceding year this is termed a "Component Annual Review."

z. **Visual Skills.** "Visual skills" is the instructional area that addresses the needs of persons with low vision. Visual skills training enables Veterans to gain a better understanding of their eye problems and teaches them how to effectively utilize their remaining vision through techniques that improve visual perceptual and visual motor function. Visual skills training includes assessment and intervention with special low vision devices designed to meet the various needs of the person served. These needs may include, but are not limited to reading, ADLs, O&M, and home repairs.

4. MISSION

The mission of each BRC is to enhance the quality of life of Veterans and military personnel who have experienced vision loss. Professional staff provides assistance to these individuals in the development of personal independence and reintegration into family and community. Each BRC provides comprehensive and individualized adjustment programs in a therapeutic atmosphere where privacy, dignity, personal values, and emotional needs are recognized and respected.

5. RESPONSIBILITIES OF THE FACILITY DIRECTOR

The Facility Director must ensure that:

- a. BRCs provide the highest quality blind rehabilitation and health care; the VA medical center housing the BRC is expected to provide the budget, space, equipment, and personnel deemed necessary;
- b. Facility equipment funds support the purchase of the equipment needed in the BRC training program; and
- c. BRC program beds and FTE employee capacity must be maintained at the 1996 levels, unless any proposed reductions are approved by VA Central Office. The Eligibility Reform Act of 1996 (Public Law 104-262) requires VA to maintain capacity in its special emphasis programs. *NOTE: This is required by the Eligibility Reform Act of 1996 (Public Law 104-262).*

6. SCOPE OF BRC SERVICES

- a. **Interdisciplinary Inpatient Blind Rehabilitation.** Interdisciplinary Inpatient Blind Rehabilitation team characterized by a variety of disciplines working together to conduct assessments, planning, and implementation of the patient's care plan characterized are interdisciplinary team to avoid fragmented care, continuous communication, collaboration and coordination is critical. The team functions as a unit, cooperating among disciplines to achieve maximum patient and family outcomes. Because the primary focus of the team is adjustment to blindness, the team activities are coordinated by a Blind Rehabilitation Specialist.
- b. **Continuity of Care.** Prior to admission, clients receive complete and timely information concerning their application status, admission date, patient rights, and the services being provided by BRC staff. Effective continuity of care is ensured by providing all necessary assistance to the client to ensure that their medical and personal needs are met when they are admitted to the program.
- c. **Safe Access in a Comfortable Physical Environment.** The BRC facilitates new skill acquisition and promotes emotional adjustment to a patient's disability by housing them in a self-contained physical facility that is architecturally accessible, conducive for safe training practices, and free of attitudinal barriers.
- d. **Peer Support Environment.** Peer support is critical to the adjustment process. The residential setting of the BRC maximizes the opportunity for blind patients to interact and support each other, unlike their home community where they are often isolated from other blind individuals. This peer interaction, along with the comprehensive training program, allows participants to function effectively and comfortably while they strive to achieve their best possible personal reorganization skills.

e. **Family Training and Education.** Family training and involvement is an integral part of all BRS programs. The purpose of this training is to provide family members or significant others the opportunity to learn about the functional losses caused by the patients' blindness, the benefits achieved in blind rehabilitation, and the supportive role of the family after blind rehabilitation.

f. **Prosthetic Issuance.** BRC staff recommends assistive devices based on justification of need and the ability of the blinded Veteran to effectively utilize the device.

g. **Community Education.** The BRC serves as a resource to an area usually comprised of multiple Veterans Integrated Service Networks (VISNs) and provides educational in-service programs to internal and external stakeholders.

h. **Research.** In order to assess the effectiveness of the blind rehabilitation program and to influence programmatic changes, research is conducted that utilizes patient satisfaction and outcome measurement tools. The BRC also conducts product evaluations to determine the effectiveness of new equipment and technology for the blind.

i. **Educational Affiliations.** Contractual relationships, which follow VHA guidelines, are established with appropriate university programs to train interns, externs, residents, and fellows in providing direct service to blind Veterans.

7. BRC SERVICES AUTHORIZED FOR VETERANS

a. **Assessments.** Each patient receives a full interdisciplinary assessment. Assessments are used to prepare individualized care plans for the patients. Blind Rehabilitation Specialists may also conduct assessments for blind patients on other medical units or for outpatients. Blind Rehabilitation Specialist assessments must include evaluations in O&M, living skills, manual skills, visual skills, and computer access.

b. **Interdisciplinary Treatment Plans.** Each patient must have a coordinated and integrated interdisciplinary plan of care that includes all required disciplines and reflects the goals of the patient and family.

c. **Training.** BRC staff members, who have demonstrated the required competencies, are authorized to provide blind rehabilitation instruction and training. Each BRC provides comprehensive instruction and training in the following blind rehabilitation skill areas: computer access, living skills, manual skills, leisure skills, O&M, visual skills, adaptive medication management, and diabetes education. Instructors use the latest teaching methodologies in blind rehabilitation supported by assistive devices and equipment.

d. **Prosthetic Equipment.** BRC staff, who have been formally trained to provide instruction with specific prosthetic devices and who have established discipline specific competencies, are authorized to determine a blind Veteran's need for assistive training devices. They may recommend issuance after the Veteran demonstrates the ability to effectively use the appliance.

e. **Prescriptive Eye Care.** Patients participating in the BRC Program are provided ocular health exams, assessment, and treatment services by licensed eye care practitioners. Prescriptive optics (e.g., eyeglasses, contact lenses, optical low vision devices, and electro-magnetic devices) deemed necessary to maximize the benefits of the Veteran's participation in the rehabilitation program may be provided when prescribed by a licensed eye care practitioner.

f. **Adjustment Counseling.** Various professionals assist blind Veterans in making maximum adjustment to sight loss. The psychologist, social worker, and outreach coordinator are members of the rehabilitation team who offer individual, group, and family counseling to Veterans in the rehabilitation program commensurate with their formal training. Blind Rehabilitation Specialists, who are educated in the social and psychological dynamics of blindness, integrate appropriate adjustment strategies into their instructional approach as well.

g. **Health Care.** A physician extender, who is a member of the interdisciplinary treatment team, is assigned to all BRCs to manage the medical needs of the patients. The BRC provides round-the-clock nursing coverage 7 days a week.

h. **Family Training.** The family training program promotes the continued personal development of the patient after returning to the home environment. Participants gain a greater understanding of the Veteran's visual impairment and obtain information on how BRC training has impacted the patient's adjustment to sight loss and independent function. Participation is restricted to those individuals who play a significant role in the patient's continued adjustment to community living following discharge. VA funds one participant for a family training program when recommended by the rehabilitation team; this includes roundtrip travel and lodging.

NOTE: *Other family members or caregivers may participate at their own expense.*

i. **Special Programs.** Each BRC is expected to offer comprehensive assessment and training designed to meet the expressed needs and goals of each Veteran. When eligible clients express an interest in specialized training in a single area to meet a specific need (e.g., new technology), the BRC attempts to establish a specialized focused training program designed to meet the identified need, if determined to be appropriate.

j. **Outpatient Services.** Each BRC is authorized to provide all assessment and training listed in this Handbook on an outpatient basis, if deemed appropriate. This can be accomplished using BRC instructional staff or the creation of a BROS position.

k. **Advanced Educational Training for Professionals.** Each BRC is authorized to establish affiliations with university programs for the advanced training of practicum students, interns, externs, residents, and fellows in the various fields serving the field of blind rehabilitation.

(1) These branches of learning include: O&M, vision rehabilitation therapy, low vision therapy, and optometry.

(2) Each BRC is expected to offer comprehensive education and training opportunities for BRC instructional staff, including cross training in other blind rehabilitation disciplines.

8. ELIGIBILITY

a. BRS is committed to serving all eligible Veterans and active duty personnel who need and can benefit from its unique services. Legal blindness, based on measurement of visual acuity and visual fields has long been recognized as indicators of disability and continue to be a primary test of eligibility for admission to a BRC. However, because of the complex relationship between visual function and the overall functional capacity of the individual, eligibility criteria for BRS must also address functional deficits and the rehabilitation needs of the person.

b. In order for a person to be eligible for admission to a BRC Program, the person must be eligible for VA health care and meet one of the following criteria:

(1) The best corrected central visual acuity in the better-seeing eye is less than or equal to 20/200, or visual field dimension in the better-seeing eye is less than or equal to 20 degrees at the widest diameter, even if central visual acuity is better than 20/200; or

(2) Comprehensive treatment at a BRC is needed for appropriate restoration of the individual's safety or functional independence or for establishment of their personal or social adjustment to vision loss.

c. If the visual impairment alone or in combination with excess disability factors presents needs which cannot be appropriately addressed by local components of the VHA continuum of care, admission to a BRC is authorized.

d. The following information is required with a Veteran's application:

(1) An assessment providing a comprehensive description of functional deficits and personal adjustment problems related to vision.

(2) Information that local services within the continuum of care are not available or are unable to adequately address the Veteran's blind rehabilitation needs.

(3) Concurrence by the VIST.

e. For active duty military personnel, a summary report must be requested from the referral source describing the individual's vision-related functional or adjustment problems.

f. If the referral source and the BRC do not agree on the need for BRC admission, the application must be forwarded to the Director, BRC for review.

9. PRIORITY OF CARE

a. Priority of care is provided to active duty military personnel, service-connected Veterans rated 50 percent or greater for any combination of disabilities, and Veterans who are service-connected for their visual impairment.

- b. The priority for admission also considers urgent need factors, such as:
 - (1) Safety issues;
 - (2) Medical issues;
 - (3) Lack of a caregiver;
 - (4) Vocational needs (e.g., attending school, employed);
 - (5) Active duty status;
 - (6) Never been to a BRC; and
 - (7) Direct patient transfer.
- c. In lieu of these priority circumstances, the BRC normally offers an admission date based on the date an approved application was received.
- d. If an admission is needed in order to maintain bed census, the BRC may give priority to Veterans who are willing to be admitted on short notice.

10. REFERRALS

- a. The relatively small number of blind Veterans within the community dictates that the delivery of services to blind Veterans must operate on a regional system of blind rehabilitation programs. Catchment areas are established by the Director, BRS, in consultation with the BRC Chiefs and affected VISN Directors.
- b. To support effective communication and cooperative treatment planning between VISTS and BRC staff, most Veteran referrals need to conform to assigned catchment areas. To accommodate the personal needs of Veterans, VIST Coordinators may refer individual Veterans to BRCs outside the assigned catchment areas with the approval of the Chiefs of affected BRCs.
NOTE: Under no circumstances are applications to be sent to more than one BRC for admission.
- c. Referral of active duty military personnel and patients at VA Polytrauma Rehabilitation Centers is determined by their personal needs and preferences and by their medical support requirements, without regard to BRC catchment areas.
- d. Referrals of active duty military personnel must be submitted by program case managers at Military Treatment Facilities or Polytrauma Rehabilitation Centers and must follow the procedures outlined in the current Memorandum of Agreement established by VA and the Department of Defense (DOD). VIST Coordinators must assist according to their expertise in blindness and visual impairment.

e. All Veteran referrals for admission to a BRC program must be submitted by a VIST Coordinator through the Blind Rehabilitation Version 5.0 (BR V5.0) database using the defined application procedures. At VA Polytrauma Rehabilitation Centers, VIST Coordinators must coordinate applications with the Case Manager.

f. Blind Veterans and military personnel may benefit in varying degrees from a comprehensive blind rehabilitation program despite limitations caused by other physical and mental problems. They need to be referred when they have the potential to benefit from the program, despite their limitations. When questions arise about the appropriateness of a referral for BRC training, the referral source needs to communicate directly with BRC administration for advice.

g. The presence of complicating medical or mental conditions does not preclude Veterans or military personnel from participation in the BRC program. To maximize benefit from the program, specific conditions that may adversely affect patient involvement (e.g., acute medical conditions, stroke residuals, alcohol or drug abuse, amputation with planned prosthesis, need for hearing aid, etc.) need to be addressed by the referring facility before admission to the BRC. Referral to a BRC best equipped to address a particular problem may be considered in consultation with the affected BRCs. Blind Veterans and military personnel who are hospitalized may be transferred directly to a BRC; however, this is done only when transfer is medically indicated and when they are able to participate in the BRC Program.

h. The Chief, BRC, has final authority to determine acceptability of applicants, but before doing so, may need to seek input from appropriate health care professionals (e.g., physician, psychologist, optometrist, nursing, etc.) regarding conditions that may impact the Veteran's health capacity and rehabilitation potential.

11. VETERAN APPLICATION PROCEDURE AND MANAGEMENT

During attendance at a BRC Program, a blinded Veteran is considered to be an inpatient of the VA facility. As such, application criteria and management are generally the same as for any Veteran receiving inpatient hospital treatment and care.

a. The VIST Coordinator refers Veterans for BRC training using the Blind Rehabilitation Version 5.0 National Database using the application procedures outlined in the VIST Handbook. All referrals are sent to the BRC of jurisdiction with special considerations for the Veteran's choice. Application material must be current (within 6 months of application submission date) and include the following:

(1) Information on date of referral, the Veteran's name and identifying information, type of BRC Program for which the application is being submitted, description of any significant problems or unique circumstances presented by the applicant, identification of the VIST Coordinator and referring facility.

(2) Any necessary eligibility determinations as required by the VA facility housing the BRC (e.g., VA Form 10-10EZ, Application for Health Care Benefits, VA Form 10- 10EZR, Health Benefits Renewal Form (Fillable), Hospital Inquiry (HINQ), Rating Decision Form).

(3) Documentation of severe functional visual impairment signed by an appropriately credentialed practitioner and documentation of visual impairment or legal blindness signed by a licensed eye care practitioner from which the following can be readily derived:

- (a) The diagnosis responsible for the vision loss;
- (b) The best corrected central visual acuity of each eye; and
- (c) The visual field of each eye.

(4) A physical examination and history detailing:

- (a) All medical conditions that may affect progress in the rehabilitation program;
- (b) Pertinent laboratory reports (e.g. CBC with differential, Chem 7, Urinalysis); and
- (c) Current medications (if applicable, include current oxygen prescription and provider of oxygen delivery equipment);
- (d) Medical Tests, such as:
 - 1. Negative Purified Protein Derivative (PPD) test (if positive, a Chest X-ray is required);
 - 2. Electrocardiogram (EKG); and
 - 3. Past medical reports when appropriate (as determined by Primary Care Medical Provider);
- (e) Information on medical stability by the Primary Care Medical Provider as it relates to the Veteran's capacity to participate in the BRC Program.

(5) When applicable, assessments from other consultative services that provide a description of the level of independence or assistance needed on ADLs:

- (a) Wound care;
- (b) Tracheotomy care;
- (c) Stoma or ostomy care;
- (d) Wheelchair transfers;
- (e) Oxygen use;
- (f) Medication management; and

(g) Personal hygiene.

(6) Applications with pending audiology exams may be submitted but audiology issues must be resolved within 90 calendar days or the application is considered incomplete and returned to the VIST Coordinator.

(7) A psychiatric or psychological report, if there is a history of central nervous system dysfunction, psychiatric diagnosis (including substance abuse), or any active treatment for a mental or emotional condition.

(8) An applicant with demonstrated current or recent alcohol or substance abuse or dependence requires individualized assessment by a mental health professional to determine whether the applicant is able to benefit from blind rehabilitation. Issues such as depression, sleep disorder, seizure, etc. can be successfully managed prior to admission and may require ongoing management in the BRC. In cases of suspected alcohol or substance abuse or dependence, the BRC psychologist or BRC admission committee utilizes clinical judgment and may request that a substance abuse evaluation be conducted by a mental health professional.

(9) A VIST assessment or psycho-social report is required, which includes the Veteran's expressed needs and goals, functional capabilities, as well as a description of any previous VA and non-VA blind rehabilitation training.

(10) If the Veteran has been evaluated or trained by a BROS or other specialist in preparation for admission to the BRC, any pre-admission evaluations, assessments, and training reports must be provided to the admitting BRC program prior to admission.

b. Upon receipt of an application, the BRC reviews it to confirm the Veteran's appropriateness for admission to the BRC Program. This review considers whether the:

(1) Application is administratively complete.

(2) Ocular and vision data documented in the eye exam is consistent with legal blindness, or an "excess disability" determination has been made by the VIST.

(3) Veteran's eye condition is stable and there are no pending treatment procedures. An exception to this may be made under the following circumstance: a direct hospital transfer for blind rehabilitation training to a BRC is permitted for a patient who is in immediate need of blind rehabilitation services in order to manage health care regimens and health literacy prior to hospital discharge. The Veteran must be medically stable and the BRC must have a bed available for admission. If a bed is not available, the Veteran awaiting transfer must be given highest priority for the next available bed.

(4) Veteran's medical and psychological status is stable in order to maximize the Veteran's potential to benefit from the program.

- c. Upon receipt of a referral, the BRC staff reviews it to confirm the Veteran's appropriateness for admission to the BRC Program. An application is considered complete if all information described in the paragraph 11 is included in the application.
- d. When additional information is needed in order to confirm the appropriateness of the Veteran for the program, the BRC must notify the VIST Coordinator. The VIST Coordinator must respond to the BRC with a plan of action within 10 working days and the requested information must be received within 30 days (except for audiology issues which have a 90 day time frame) or an explanation provided as to why the information cannot be submitted within the 30-day time frame. The application is placed in the "in review" status on the national database pending receipt of information. If information is not provided in the designated time frame, the application is cancelled (considered incomplete) and returned to the VIST Coordinator.
- e. When a review of an application indicates that the Veteran is not appropriate for admission, BRC administration must consult with the referring VIST Coordinator before a final decision is made in order to present the rationale for the decision and to consider any extenuating circumstances. Cancelled applications require notification from the BRC to the Veteran with a courtesy copy to the referring VIST Coordinator. This notification must provide the rationale for the cancellation along with a recommendation to consult the VIST Coordinator regarding alternative services.
- f. When an application is cancelled due to receipt of an incomplete application, the application is returned to the VIST Coordinator with notification sent to the NPC.
- g. Upon receiving a complete application, the BRC accepts or cancels the Veteran applicant for admission to the program within 20 workdays.
- h. Each application (referral) is added to the BRC wait list, and the Veteran is informed of this decision through formal correspondence. The letter must include an estimated wait time for admission as well as any cost that may be incurred by the Veteran. A courtesy copy of this letter is forwarded to the Veteran's VIST Coordinator. The BRC forwards the required documents to the Health Administration Service, or equivalent program office at the facility where the program is located, ensuring that applicants are properly enrolled in the VA system.
- i. After a Veteran has been accepted for the rehabilitation program, the BRC provides information regarding the scope of services and estimated duration of training to the Veteran. The BRC also provides the Veteran scheduled for admission with appropriate information concerning clothing, footwear, equipment, details of daily life at the BRC, and any pertinent local information. The Veteran and the BRC must mutually agree upon the reporting date and travel arrangements. The referring VIST Coordinator (and BROS where applicable) must be notified of these arrangements in a timely manner.
- j. The BRC cancels the application of any Veteran who declines three offers of admission to the BRC. The Veteran must be advised to reapply through the VIST Coordinator when ready to attend. Cancelled applications require notification from the BRC to the Veteran with a courtesy copy to the referring VIST Coordinator.

k. Whenever a BRC referral is cancelled, information must be entered in the comments section of the database by the BRC detailing the circumstances leading to the action taken on the referral.

l. **Legend for Application (Referral) Status**

Database entry	Definition
Pending	No action taken on application.
In Review	Awaiting acceptance
Accepted	The patient will receive care
Offered	First date of service offered
Scheduled	Actual care scheduled date
Admitted	Admitted to BRC for service
Discharged	Discharged from BRC
Completed	Non-BRC care was completed (not for BRC use)
Transferred	Transferred from BRC to other medical unit
Cancelled	Referral was cancelled by Blind Rehab
Withdrawn	Patient withdrew from service

12. WAITING TIMES

a. The waiting time for admission to a BRC is defined as the number of days between the date an application is received at a BRC and the first admission date offered to the applicant. The BRS National database must be used to automatically calculate this figure in days.

Applications (referrals) to the BRCs in the “pending,” “in review,” and “accepted” status make up the BRC waiting list. The actual admission date must be recorded on the national database, but is not be used for reporting a Veteran’s waiting time.

b. Each BRC is responsible for completing data entry in the national database on the application status of each application received at the BRC. The VIST Coordinator must submit a referral for BRC admission electronically through the BRS national database. The application-received date is automatically entered in the database. Each application received at the BRC is automatically placed in “pending” status until the BRC Chief (or designee) starts the review process of the application.

c. For the Veteran who receives health care at a VA facility, the VIST Coordinator must ensure that appropriate medical and eye information has been recorded in the Veteran’s Computerized Patient Record System (CPRS) file prior to the time of referral. This enables BRC staff to complete a timely decision-making process. For the Veteran who receives health care

from a non-VA provider, the VIST Coordinator must ensure that a hard copy containing appropriate medical and eye information is sent to the BRC.

d. Every BRC Chief or designee must adhere to the procedures and instructions for calculating waiting times for admission to BRC programs.

13. ASSESSMENT AND TREATMENT PLANNING

a. Dedicated interdisciplinary team members participate in assessment, planning, and implementation of each patient's care. The team performs an interdisciplinary assessment, establishes an interdisciplinary care plan, documents this care plan, and conducts team meetings when needed to monitor progress and update the care plan to reflect progress and new patient goals.

b. A BROS or BRC staff assessment is conducted in each of the blind rehabilitation skill areas. The assessment must address the Veteran's strengths, needs, preferences, and desired outcomes including information relating to the Veteran's lifestyle, age, medical condition, cognitive ability, previous training, and future plans.

c. Interdisciplinary treatment plans are a collaborative effort based on active involvement of the patient, family, and discipline-specific assessments of each patient. The treatment plan addresses the Veteran's goals and is individualized to meet the Veteran's needs relevant to lifestyle, age, level of capability, and future plans. Treatment plans identify problems, realistic and measurable goals, interventions to be used to achieve the goals, and the disciplines responsible for implementation. BRC staff continually evaluate performance results during the Veteran's rehabilitation program, as they relate to expected outcomes, in order to determine the appropriateness of the training being provided. Any revisions to the treatment plan are to be made with the Veteran's involvement and are to be based on demonstrated strengths, changing needs, and expected outcomes in order to ensure that goals remain achievable and meaningful to the person receiving services.

d. Because the primary focus of the program is rehabilitation for blindness, the coordination of the treatment plan is assigned to a Blind Rehabilitation Specialist who leads the interdisciplinary team meetings.

e. Discharge planning is a continuing process throughout treatment. The length of a Veteran's rehabilitation program varies depending on individual ability, the amount of remaining vision, medical complications, psychological conditions, needs, and goals. Discharge planning takes into account the Veteran's preferences and the availability of local services in the home community.

14. ORGANIZATION AND PROGRAM RESPONSIBILITIES

An interdisciplinary team approach is used within the rehabilitation context. This team approach takes advantage of each discipline represented within the Blind Rehabilitation Program and includes the following types of services:

- a. **CAT.** The CAT instructional area teaches participants how to use specialized access software and equipment to effectively and efficiently operate a computer. This includes evaluating the ability of the person served to use large print, synthetic speech, voice recognition, or Braille access devices in order to perform word processing functions and other computer-related activities.
- b. **Consumer Education.** Veterans are educated regarding about their rights and responsibilities as well as any VA and non-VA benefits and resources for which they may be eligible. Self-advocacy is promoted in order to achieve positive outcomes in community reintegration.
- c. **Family Training Program.** A family member or caregiver is afforded the opportunity to participate in the rehabilitation process for several days near the end of a Veteran's training program, as defined and prescribed by the rehabilitation team. The Family Training Program is educational and follows a normal training class schedule. Participants observe classes and meet with team members in order to learn about specific changes the Veteran made during the Veteran's training program. Participants are educated about blindness in general and receive specific information about their family member's vision loss. Family members learn of potential risks of health and safety, along with their shared responsibilities when the Veteran returns home. They are given an opportunity to enhance their advocacy skills. The Family Training Program, facilitated by the BRC Social Worker or Outreach Coordinator, serves to help family members better understand the patient's needs and appropriate ways to support those needs.
- d. **Leisure Skills.** The Leisure Skills consists of social, recreational, and vocational activities within the BRC and in the community. It is designed to enhance a patient's experience in the BRC Program and promote a positive adjustment to vision loss. Patients are encouraged to utilize the skills, techniques, and devices learned during these activities as they afford an opportunity for participation in leisure-time interests in their home and community following rehabilitation. Activities may include, but are not limited to attending sporting events, social gatherings, theatrical productions, movies, and concerts. Additional activities may also include participating in golf, fishing, hiking, cards and board games, or developing a hobby, such as leather crafts, copper tooling, and woodworking.
- e. **Living Skills.** The Living Skills instructional area addresses those tasks necessary to manage a person's everyday activities in order to remain independent. These skills encompass a broad range of activities including: personal grooming, food preparation, eating skills, communicating, household management, time management, and labeling techniques that serve to increase a person's independence in the home and personal life. Communication Skills training provides opportunities to learn Braille, keyboarding, handwriting, and the use of assistive technology to accomplish tasks such as storing and retrieving information, reading, and managing financial records, etc.
- f. **Manual Skills.** The Manual Skill is instructional area is designed to assess and enhance skills in all aspects of sensory awareness with an emphasis on adaptive and safety techniques. This skill training focuses on organization, tactful awareness, spatial awareness, memory sequencing, problem solving, confidence building, and integrating visual skills. Activities range from basic tasks using hand tools to advanced tasks using power tools and woodworking

machinery. Instructional areas include: leatherwork, copper tooling, home mechanics, small engine repair, woodworking, weaving, and ceramics.

g. **O&M.** The O&M instructional area is designed to train persons to independently travel in a safe, efficient, effective, and confident manner in both familiar and unfamiliar environments. Training focuses on teaching participants to effectively use their remaining senses in combination with protective techniques and assistive devices. Travel devices include the long cane, support canes, telescopic aids, sunglasses, and alternative mobility devices such as walkers, wheelchairs, and scooters. Travel situations include, but are not limited to: traveling in residential, rural, and business areas; crossing streets at controlled and uncontrolled intersections; and using public transportation.

h. **Visual Skills.** The Visual Skills instructional area addresses the needs of Veterans with partial vision and helps them to gain a better understanding of their eye problems through patient education. Instruction focuses on teaching participants how to effectively utilize their remaining vision through the development of visual skills, such as scanning and awareness and development of the use of a preferred retinal locus. It includes assessment and training with special optical low vision devices that are designed to meet the various needs of the person being served. Lessons are provided that employ a variety of visual devices, special equipment, and training modalities that address tasks performed at near, intermediate, and far distances. These tasks include, but are not limited to reading printed material, performing ADLs, activities of daily living, engaging in home repairs, and traveling independently.

i. **Wellness Education.** Wellness Education is comprised of learning activities intended to improve the patient's health status such as diabetes education, medication self-management, and nutritional instruction. Participants may also engage in an exercise program that includes training in the proper use of exercise equipment along with the necessary adaptations and modifications. Emphasis is placed on consistency and repetition with the goal of continuing the exercise program after rehabilitation. A wellness program may cover other activities outside of the realm of physical exercise such as: aspects of relaxation therapy; coping with stress; smoking cessation; and other overall health enhancing activities.

15. ROLE OF THE BRC DIRECTOR OR CHIEF

The BRC Director or Chief is a Blind Rehabilitation Specialist who has operational and programmatic responsibility for managing the budget, workload flow, staffing, and coordination of ancillary services. In addition, the BRC Director or chief is responsible for:

- a. Ensuring that all components of the program coordinate their activities so there is a unified, coherent, and consistent approach to rehabilitation.
- b. Determining the acceptability of BRC applicants and to determine the date of discharge from the program, (has final authority).
- c. Managing the blind rehabilitation component of each patient's inpatient program.

- d. Supporting efforts by blind rehabilitation staff to seek certification through Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP) or licensure.

16. ROLE OF SUPERVISORY STAFF

The supervisory staff assists the BRC Chief in managing the BRC Program. Because of the need for a highly individualized and comprehensive approach to patient treatment, supervisors must:

- a. Be capable of providing administrative and technical supervision, direction, and leadership for blind rehabilitation professional staff and
- b. Serve as subject matter experts for an instructional skill area.
- c. Evaluate the quality of clinical practices, adhere to preferred practice patterns and establish instructor competencies.
- d. Review, analyze, and evaluate the effectiveness of various components of the teaching discipline or team for which the supervisor is responsible.

17. ROLE OF THE INSTRUCTIONAL STAFF

The role of the instructional staff at the BRC includes:

- a. Assessing rehabilitation needs;
- b. Developing and implementing individualized rehabilitation plans;
- c. Recommending issuance of appropriate prosthetic equipment;
- d. Coordinating interdisciplinary treatment planning; and
- e. Making recommendations to VIST and BROS concerning rehabilitation program follow-up.

18. ROLE OF THE PROFESSIONAL STAFF

The professional staff serves as members of the interdisciplinary treatment team as needed by each individual patient. Core members of the interdisciplinary team include: blind rehabilitation, staff, physician or extender, nursing, psychology, social work, optometry and dietetics. Other medical and rehabilitation specialties included in interdisciplinary care as needed by the patient, such as occupational, physical, audiology, and speech therapies.

- a. Medical and nursing staff are essential members of the interdisciplinary treatment team. A physician or extender must be assigned to the BRC and is responsible for the health care needs of patients participating in the program. Nursing staff provide round-the-clock nursing care and medical support and are involved in health education activities that include teaching self-medication management skills, nutritional instruction, and diabetes education.

b. Low Vision Optometrists provide a detailed ocular health examination and patient education. Following a clinical assessment of the Veteran's remaining vision, they make an initial recommendation of optical low vision devices and visual skills training. They collaborate with the visual skills supervisor or low vision therapist to formulate the Veteran's initial low vision treatment plan and are involved with any subsequent revisions.

c. A psychologist and social worker are essential members of the interdisciplinary treatment team, provide individual, group, and family counseling to BRC participants as they explore their feelings concerning visual loss and its effects. They serve as consultants to BRC instructors regarding any impact the blind Veteran's psychological or social condition may have on the Veteran's training program. Blind Rehabilitation Specialists, educated in the social and psychological dynamics of blindness, support the group and individualized psychosocial counseling by integrating appropriate attitude adjustment into their instructional programs.

19. RESEARCH

The BRC program may conduct significant research that addresses the needs of blind Veterans and improves clinical programs for the rehabilitation of the blind. This research tends to be applied research and is utilized to:

- a. Develop assessment tools and outcome measures that assist stakeholders and the persons receiving services to understand the impact of BRC training upon blind Veterans.
- b. Measure the level of satisfaction blind Veterans achieve from their rehabilitation experience.
- c. Measure the level of satisfaction stakeholders have with the results of delivered services.
- d. Collect demographic data about Veteran characteristics to assist BRC management in identifying programmatic changes that may be necessary to achieve desired outcomes with maximum efficiency.
- e. Evaluate and develop sensory aids for the blind.

20. PROSTHETIC AND SENSORY AIDS SERVICE (PSAS)

Prosthetic and sensory aids development has been rapidly expanding to meet the needs of the visually impaired population. It is the responsibility of the BRC, working closely with Prosthetic and Sensory Aids Service (PSAS), to evaluate various aids and appliances for the blind to determine their effectiveness for blind Veterans. Because many of these devices are highly complex and difficult to use without instruction, the BRC develops instructional programs and guidelines for issuance for each device.

21. COOPERATIVE STUDIES

The development of cooperative studies is the responsibility of the BRC, within the limitations of the Privacy Act and the human subjects regulations. These studies may be developed with non-VA agencies serving the blind, as well as other VA programs. VA, in a consulting capacity, is responsible for sharing the experience and results gained from cooperative studies and research with non-VA programs for the blind.

22. ISSUANCE OF PROSTHETIC DEVICES

Prosthetics are issued in accordance with:

- a. VA Handbook 1173.5, Aids for the Blind Rehabilitation Service
- b. VA Handbook 1173.2, Furnishing Prosthetic Appliances and Services
- c. Prosthetics Clinical Management Program (PCMP) documents pertaining to issuance of prosthetics and services for the visually impaired:
 - (1) VHA PCMP Clinical Practice Recommendations for Prescription of CCTVs and EOED 2002.
 - (2) VHA PCMP Clinical Practice Recommendations for Audible Prescription Reading Devices.
 - (3) VHA PCMP Clinical Practice Recommendations for the Prescription of Computers and Peripheral Devices to Blind and Visually Impaired Veterans.
 - (4) VHA PCMP Clinical Practice Recommendations: Prescription and Provision of Optical Low-Vision Devices to Aid in Overcoming Visual Impairment.
 - (5) VHA PCMP Clinical Practice Recommendations: Prescription and Provision of Daily Living and Mobility Devices for Legally Blind and Visually Impaired Veterans.
- d. Prosthetics and Clinical Logistics Office, National Contract Guidelines specific to Sensori-Neuro Aids that includes Aids for the Blind and Visually Impaired, Optical Aids for the Blind, and CCTV etc. You may view the link at:
<http://vaww.infoshare.va.gov/sites/prosthetics/Prosthetics%20Compliance%20Guidelines/Forms/AllItems.aspx?RootFolder=%2fsites%2fprosthetics%2fProsthetics%20Compliance%20Guidelines%2fSensori%2dNeuro%20Aids&FolderCTID=&View=%7b7BBEA8EB%2d2ADE%2d4790%2d9120%2d298EE1DD049B%7d>.
- e. VHA Handbook 1173.12.

23. DOCUMENTATION

- a. The documentation of patient assessments, treatment plans, progress notes, and discharge summaries must be consistent with VA requirements as well as the requirements of The Joint Commission (TJC) and Commission on Accreditation of Rehabilitation Facilities (CARF).
- b. The BRC compiles data for an outcomes management system that measures effectiveness, efficiency, patient satisfaction, and stakeholder satisfaction.

24. BUDGET

- a. Budget levels vary and need to be modified when advances in the field of blindness, such as new technology and innovative programs, create a demand.
- b. Budget planning at the VA facility housing a BRC must take into account the regional or multi-VISN scope of the BRC. This coordinated budgetary decision process allows input from several sources, including the Director, BRS, VA Central Office.

25. SPACE

- a. BRCs are inpatient units where blind Veterans from multi-state areas reside for an extended period of time in order to immerse themselves in the rehabilitation process. Because of the unique needs of a blind rehabilitation unit, special accommodations for space are needed. The units need to provide a home-like atmosphere. The unit needs a therapeutic and safe environment that allows the patient to learn and practice new skills in close association with other blind patients and blind rehabilitation professional staff. In order to achieve this, the BRC patient treatment areas and patient living areas must be dedicated to the BRC and must not be shared with other hospital functions. To ensure a therapeutic atmosphere, pedestrian traffic unrelated to the BRC needs to be kept to a minimum, especially in patient living areas.
- b. Assigned BRC space must be sufficient to allow efficient and safe operation of the program and to enable blind Veterans to maximize their rehabilitation potential. To support safety and developing independence, each patient needs to have control of their private space, i.e., a private bedroom and bath.
- c. Care needs must be taken to ensure that environmental lighting, color, and contrast support the visual needs of patients.
- d. The BRC unit must:
 - (1) Contain a student laundry room that contains two washers, two dryers, an ironing board, and racks to hang up ironed clothing with easy access for students.
 - (2) Have dining facilities of sufficient size to accommodate all patients at one sitting.

- (3) Contain a multipurpose room that is adequate for the many patients who spend non-training hours watching TV, playing games, etc.
- (4) Have an exercise room.
- (5) Have adequate storage space sufficient for training equipment, recreational equipment, and the prosthetic items used by instructors in the disciplines of O&M, visual skills, living skills, manual skills, and CAT.
 - e. Clinical areas need to complement and enhance the rehabilitation process. A nursing communication center needs to be located so that it controls entry to the patient unit, in addition to providing oversight of the dining room and activity areas that are used after hours.

26. EQUIPMENT

BRCs must ensure that patients benefit from the adaptive equipment that best meets their needs. BRCs must evaluate emerging technology to ensure that the most effective equipment is used for BRC training and for issuance to patients as part of their individual programs.

27. PERSONNEL

- a. Sufficient instructional personnel must be allocated so the majority of training and adjustment efforts can be accomplished on a one-to-one basis. This is required for patient safety and to ensure the highest quality of care with an optimal length of stay. In order to operate at full capacity, there should be an instructor per patient bed ratio of one-to-one. Medical center Directors must ensure that BRCs have a sufficient number of appropriately qualified professional staff to accomplish the organizational and program responsibilities of the BRC.
- b. To ensure effective and efficient delivery of patient care, each BRC must have an adequate number of qualified Blind Rehabilitation Specialists to serve as supervisors and clinical care coordinators. The recommended staffing levels for 15 beds is:
 - (1) Two Supervisory Blind Rehabilitation Specialists, who are subject matter experts, to act as first line supervisors to the instructional staff in the BRC. To maintain clinical competence, each supervisor must also provide direct patient care.
 - (2) One journeyman level Blind Rehabilitation Specialist who serves as a Clinical Care Coordinator. Responsibilities may include management of applications and BRC waiting list and coordination of patient admissions and discharges. Duties may include quality improvement activities, management of TJC and CARF accreditation activities, and coordination of new product evaluations.
 - (3) Core members of the interdisciplinary team must be assigned to each BRC to enable the attainment of the program mission to include a physician or extender, nurses, psychologist, social worker, optometrist, and dietitian.

(a) Physician or extender and nursing staff are critical to ensure health maintenance and patient safety. Qualifications and staff numbers must be sufficient to enable the BRC to fulfill its commitment to serve all Veterans who could benefit from the BRC program regardless of the presence of complicating medical conditions.

(b) An essential element in vision rehabilitation is the active participation by Low Vision Optometrists. Inpatient BRCs having thirty or more operating beds will have a 1.0 FTE residency, trained Low Vision Optometrist or an optometrist with equivalent experience serving those patients. Those inpatient BRCs having fifteen or fewer operating beds must be assigned a 0.5 FTE residency trained Low Vision Optometrist or an optometrist with equivalent experience. *NOTE: When outpatient BRC care is provided in addition to inpatient BRC care, an additional 0.5 FTE residency trained Low Vision Optometrist, or an optometrist with equivalent experience, must be available to serve those patients.*

(c) The Clinical Psychologist and Social Worker both have a critical role in the BRC. They make a unique contribution to the successful rehabilitation of blind Veterans and military personnel. They must be full members of the interdisciplinary treatment team. A Clinical Psychologist and Social Worker must be assigned to all BRCs. For BRCs of 30 or more operating beds, each needs to be a full time position. For BRCs having 15 or fewer operating beds, each should be half time.

28. PROFESSIONAL TRAINING

a. The BRC Program develops core competencies that include discipline-specific and program-specific competencies in accordance with CARF and TJC guidelines. Discipline Subject Matter Expert (SMEs) must establish skill area competencies that verify an instructor's ability to assess and train Veterans using specific prosthetic devices.

b. Cross training must be offered to all staff, both blind rehabilitation specialists and other personnel assigned to the BRC, within professional standards.

c. Continuing education classes must be provided by the supervisory staff. Educational programs need to be designed within the framework of strategic planning, quality management, and performance improvement.

d. It is the responsibility of individual staff to pursue educational opportunities to attain certification and keep abreast of new developments in the field of blind rehabilitation. **NOTE:** These individual efforts, especially as they pertain to achieving ACVREP certification, need to be supported and encouraged by BRC administrative and supervisory staff.

29. EDUCATION FOR OTHER PROFESSIONS

a. Many professional disciplines serving BRC patients do not routinely offer training within their respective educational programs concerning blind rehabilitation. For this reason, the Blind Rehabilitation Program offers appropriate in-service education for these individuals so they may gain a greater understanding of the complexities of blindness and the rehabilitation process.

b. BRC programs must offer appropriate in-service education on blindness for volunteers, BROS, VIST Coordinators, and VIST members of referring VA facilities.

30. EDUCATIONAL AFFILIATIONS WITH UNIVERSITY PROGRAMS

a. In an effort to improve the quality of BRS in VA as well as the private sector, it is incumbent upon VA BRCs to establish educational affiliations with relevant university programs. Any contractual relationship with a university program must be developed within VA and medical center policies and be periodically reviewed for continued appropriateness and cost effectiveness.

b. Associated health trainee programs may include, but are not limited to O&M, vision rehabilitation therapy, low vision therapy, social work, psychology, and optometry.

31. REFERENCES

a. Rehabilitation Accreditation Commission (CARF), Comprehensive Blind Rehabilitation Services Standards Manual.

b. VHA Handbook 1172.1.

c. Joint Commission on Accreditation of Healthcare Organizations, Comprehensive Accreditation Manual for Hospitals.

d. Prosthetics Clinical Management Program (PCMP) documents:

(1) VHA PCMP Clinical Practice Recommendations for Prescription of CCTVs and EOEDs, July 2002.

(2) VHA PCMP Clinical Practice Recommendations for Audible Prescription Reading Devices, August 2004.

(3) VHA PCMP Clinical Practice Recommendations for the Prescription of Computers and Peripheral Devices to Blind and Visually Impaired Veterans, August 2004.

(4) VHA PCMP Clinical Practice Recommendations: Prescription and Provision of Optical Low-Vision Devices to Aid in Overcoming Visual Impairment, September 2004.

(5) VHA PCMP Clinical Practice Recommendations: Prescription and Provision of Daily Living and Mobility Devices for Legally Blind and Visually Impaired Veterans, September 2004.

f. VHA Handbook 1173.12.

g. Prosthetics and Clinical Logistics Office, National Contract Guidelines, Sensori-Neuro Aids that include Aids for the Blind and Visually Impaired, Optical Aids for the Blind, CCTV.

h. Disability Evaluation under Social Security: 2.00 Special Senses and Speech. Blue Book 2006. View online at: <http://www.ssa.gov/disability/professionals/bluebook/2.00-SpecialSensesandSpeech-Adult.htm>