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The journal provides a national forum for research and discussion on the needs of persons with disabilities, problems confronting the profession, new vistas of service, and receiving therapeutic recreation services.

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The PATH-Way Home

Promoting Access, Transition, and Health for Veterans with Disabilities

Allison Wilder
Patricia J. Craig
Janet R. Sable
Jill Gravink
Cara Carr
Jennifer Frye

Abstract

The purpose of this article is two-fold; first it describes an effective and efficient community-based recreation therapy program, and second, it explains how recreation therapists can successfully interface with the VA healthcare system by utilizing this or other programs. PATH (Promoting Access, Transition, and Health) is an in-home/community health promotion program delivered by state licensed Certified Therapeutic Recreation Specialists to veterans who have sustained disabilities in current combat, Operations Enduring Freedom (OEF), Iraqi Freedom (OIF), and New Dawn (OND). The PATH program is guided by Healthy People 2020 concepts, the World Health Organization’s ICF health framework, and Bandura’s (1986) self-efficacy theory. The description of the PATH intervention protocol includes the referral process, assessment, treatment planning and interventions focused on veteran needs, discharge planning, documentation and reimbursement. A case example of one veteran who completed the PATH program is presented to illustrate ways in which the intervention addresses unique veteran issues.

Keywords: Health promotion intervention, VA health care system, veterans with combat-related disabilities, veteran transitions, Healthy People 2020, ICF, self-efficacy
Soldier's Creed

I am an American Soldier. I am a Warrior and a member of a team. I serve the people of the United States and live the Army Values. I will always place the mission first. I will never accept defeat. I will never quit. I will never leave a fallen comrade. I am disciplined, physically and mentally tough, trained and proficient in my warrior tasks and drills. I always maintain my arms, my equipment and myself. I am an expert and I am a professional. I stand ready to deploy, engage, and destroy the enemies of the United States of America in close combat. I am a guardian of freedom and the American way of life. I am an American Soldier. (U.S. Army)

The American soldier is trained to be formidable. The Soldier's Creed reflects the warrior ethos which encompasses the central belief that victory is the goal. This ethos “compels soldiers to fight through all conditions to victory no matter how much effort is required. It is the soldier's selfless commitment to the nation, mission, unit, and fellow soldiers. It is the professional attitude that inspires every American soldier” (LaMotte, 2004, para 6). The warrior ethos is the guiding tenet in all that the Army does and is the key doctrine to which new recruits are inculcated (Riccio, Sullivan, Klein, Salter, & Kinnison, 2004). Whether they have spent months, years, or decades in service to our country, they have lived, breathed and cultivated the warrior ethos. The ethos leads to the military's “Can Do” mindset. Understanding the warrior mindset is critical to understanding effective treatment strategies when working with military personnel (LaMotte). As thousands of injured service members return from the current combat Operations Enduring Freedom (OEF), Iraqi Freedom (OIF), and New Dawn (OND), they don a new warrior status, that of wounded warrior.

Overview

Today, it is much more likely that a soldier wounded in conflict will survive. “In the Vietnam era, five out of every eight seriously injured service members survived; today, seven out of eight survive, many with injuries that in previous wars would have been fatal” (United States, 2007, p. 2). When the traumas of war inflict physical and emotional damage, the service member must engage in a different kind of battle. Initially, it may be one of survival, but eventually, it will be one of reclamation. While both battlefield and clinical care have improved from previous wars, problems for soldier-patients still persist, most notably in the hand-off from inpatient to outpatient and when moving from the Department of Defense to Veteran's Administration health care systems and then to the general disability system (United States). As the ranks of wounded service members continue to grow, the adequacy and effectiveness of transition services is a central concern to veterans and their families and those who support them (Glazer, 2010).
Ultimately, the service member-patient must return to active duty or begin the process of returning to civilian life. Those who do not return to active duty must make an adjustment back to living in the civilian world. Negotiating the transition from a military paradigm to a civilian paradigm and from a person without disability to one with disability are two of many important transitions the service member-to-citizen makes. Nationally, there are many nonmedical programs for those injured during military service that support veterans and their families with recovery, transition to civilian life, education, and employment. Federal and state government programs are supplemented by more than a thousand private-sector, community, volunteer, and faith-based initiatives that help injured service members and their families (United States, 2007). In the New England region, a veteran and his or her family can turn to Northeast Passage’s PATH program to seek assistance with transitioning home and reclaiming wellbeing.

**Foundations of the PATH Model**

Northeast Passage, founded in 1990, is a nationally recognized leader in the provision of innovative therapeutic recreation services. Northeast Passage (NEP) delivers disability-related health promotion and adapted sports programs throughout New England. Promoting Access, Transition and Health (PATH) is one of three core services provided by NEP. PATH is a treatment model designed to support veterans with a variety of disabilities in attaining and maintaining personal health and wellness. The program utilizes a multifaceted approach that combines education, application, and psychosocial support systems to address the individualized needs of each veteran. Licensed and certified recreation therapists (CTRS/L) utilize purposeful recreation strategies relevant to the veteran’s life to achieve personal goals related to health and wellness, and to decrease secondary conditions connected to disability. The PATH model operates within the framework of the World Health Organization’s International Classification of Functioning (ICF). PATH is also aligned with our national health agenda, Healthy People 2010 and, now, Healthy People 2020. Finally, the model is rooted in self-efficacy theory (Bandura, 1986).

**PATH and the ICF**

The ICF provides a mechanism for the classification of human functioning and disability across various health domains (WHO, 2002). The ICF, similar to recreation therapy, looks at health through the lens of individual circumstances across physical, social, cognitive, emotional and environmental domains (Porter & Burlingame, 2006). This vantage point underscores the central understanding that health status is quite personal and cannot be fully understood or addressed within a single construct, such as the absence of disease. The ICF allows the clinician to assess health through both function and disability as well as through contextual factors, classified as environmental and personal (WHO). For example, the PATH therapist assesses how an individual’s functional capacity interacts with his/her environment. Identifying the barriers and facilitators to effective daily functioning within
home and community environments is a key treatment focus in the PATH model (Sable & Gravink, 2005). Prior to the ICF, it was difficult to codify and systematically address the importance these contextual factors have on one’s health. The ICF framework acknowledges that one’s environment and one’s personal circumstances are highly relevant to attaining and maintaining health. Within this framework, the PATH therapist is provided with the necessary scaffolding to identify and address these important elements of health and wellbeing. The inclusion of a classification system that recognizes the importance of environmental factors on daily function is an important innovation within the ICF (WHO, 2002). To illustrate, a referral for PATH intervention services typically results in eight to 10 treatment sessions in the veteran’s home environment over the course of a calendar year. This timeframe of service is purposeful. Recognizing that the environmental conditions of the northeast region of the country change dramatically from season to season, the PATH therapist works with the veteran over the course of these seasonal challenges in an effort to identify and address the different barriers to participation that arise out of the natural environment.

Within the ICF framework, critical attention is paid to how disability affects a person’s ability to perform in given life tasks. The PATH therapist aims the intervention at the level of activity and participation and addresses performance facilitators and barriers that arise out of the veteran’s own environment. Further, the PATH therapist addresses the personal circumstances that impact treatment outcomes. The ICF provides a valuable framework upon which to build an approach to treatment. It is a framework that elevates the importance of the person’s environment and other psychosocial factors as key determinants of health and wellbeing. Under the ICF classification paradigm, and given the holistic philosophy that underpins the recreation therapy profession (Austin, 2009; Shank & Coyle, 2002), the skilled recreation therapist is well positioned to be an effective agent in moving persons with disabilities along the continuum to optimal health.

PATH and Healthy People 2020

When veterans with disabilities return to civilian life, they join the ranks of America’s 49.7 million citizens with disabilities (Waldrop & Stern, 2003). As part of this transition, they are subject to a variety of governmental policies and practices aimed at assisting persons with disabilities. Among the more progressive health initiatives with respect to disability is our national health agenda, Healthy People 2020 (U.S. Department of Health and Human Services, n.d.). HP2020 has identified three areas for public health action that are specific to people with disabilities. They are: (1) improving conditions of daily life; (2) addressing inequities in resource distribution; and (3) raising awareness, expanding the knowledge base, of determinants of health among people with disabilities (U.S. Department of Health and Human Services, para 10). HP2020 also makes use of the ICF framework targeting key contextual factors that influence health disparities between those with and without disability. Specifically, in HP2020,
the first principle is to “improve the conditions of daily life by: Encouraging communities to be accessible so all can live in, move through, and interact with their environment” (U.S. Department of Health and Human Services, para 10). The inclusion of social determinants of health is new to Healthy People 2020 and includes a new focus on the community itself as a key determinant of health and wellbeing. Further, HP2020 calls for “Improving the conditions in which people live, learn, work, and play and addressing the interrelationship between these conditions...[to] create a healthier population and a healthier workforce” (U.S. Department of Health and Human Services, para 10). The PATH model is, in large part, built upon the belief that health and wellness interventions for persons with disabilities should be delivered in the community setting (Bocarro & Sable, 2003; Sable & Gravink, 2005). In providing services in the community, intended outcomes of the PATH intervention are aligned with the following disability and health (DH) summary objectives identified in HP2020:

**Environment**

*DH–8:* (Developmental) Reduce the proportion of people with disabilities who report physical or program barriers to local health and wellness programs.

*DH–9:* (Developmental) Reduce the proportion of people with disabilities who encounter barriers to participating in home, school, work, or community activities.

*DH–10:* (Developmental) Reduce the proportion of people with disabilities who report barriers to obtaining the assistive devices, service animals, technology services, and the accessible technologies that they need.

**Activities and Participation**

*DH–13:* (Developmental) Increase the proportion of people with disabilities who participate in social, spiritual, recreational, community, and civic activities to the degree that they wish.

*DH–17:* Increase the proportion of adults with disabilities who report sufficient social and emotional support. (U.S. Department of Health and Human Services, pp 55-57)

While the PATH model is aligned with international (WHO and the ICF) and national (HP 2020) efforts to broaden our collective understanding of what constitutes health, it is equally important to recognize that each individual is ultimately the critical factor in whether health outcomes are valued and attained. Even the best intervention plan is unlikely to be successful without the individual’s meaningful engagement in his/her care (Kilo & Wasson, 2010).

**PATH and Self-efficacy Theory**

The PATH model features the individual as a central actor in determining his/her own health and wellbeing. Concepts of person-centered care and the promotion of self-management of illness or disability are central to the PATH intervention. Empowering the individual to act in his/her own self-interests toward health promotion is a guiding tenet of PATH. This approach to treatment is conceptually based in self-efficacy.
theory (Sable & Gravink, 2005). Distilled to its essence, Bandura’s theory of self-efficacy suggests that “what people believe affects what they do” (Evans, 1989, p. 83). From this vantage point, the CTRS understands the importance of not only supporting veterans to develop skills and competencies for success, but facilitating the instillation of a strong self-belief in his/her own ability to successfully use the skills learned.

To develop a strong sense of personal efficacy in the face of illness or injury, it is necessary to assist the veteran to adopt health-promoting behaviors and to mitigate any risky or unhealthy behaviors or habits. According to Bandura (1986), in attempting to raise a person’s perception of self-efficacy, it is critical to instill a sense of personal capacity to exert control over one’s life circumstances. However, one’s beliefs typically take shape through the successful exercise of personal agency. Having the confidence to attempt new experiences is requisite but insufficient. Throughout the therapeutic process, the PATH therapist acknowledges that the perception of self-efficacy alone is not enough to produce adequate or high level performance if antecedent skill development is lacking or absent. This is a primary reason why teaching veterans functional skills is critical to the long-term exercise of personal agency (Bandura). The CTRS utilizes the four strategies of Bandura’s (1986) theory to enhance self-efficacy as he/she, (1) offers veterans the opportunity to engage in mastery experiences, (2) acts as a source of modeling, (3) incorporates social persuasion through positive encouragement for effort made and reassurance of capacity to perform, and (4) provides judgment and guidance on the individual’s physiological status in relationship to his/her personal capacities and vulnerabilities (Evans, 1989, italics added). Ultimately, the PATH therapist strives to facilitate two types of outcomes. One is to teach the veteran the skills necessary to achieve his/her goals for a healthy and engaged life, and the other is to enhance the veteran’s sense of self-efficacy so he/she can use those skills successfully.

Lastly, Bandura’s theory is useful in that it recognizes the importance of the social support system as an additional agent in developing a positive sense of self-efficacy (Bandura, 1986). Bandura asserts that social supports have the potential to buffer against a variety of stressors. However, it is critically important that these social supports encourage and move a person toward positive health behaviors rather than detrimental ones. Inaccurate perceptions of ability, fear, or other negative beliefs can compromise the veteran’s ability to take full advantage of rehabilitative services, particularly if such inaccuracies or fears are echoed from within the veteran’s social support network (Evans, 1989). To address this phenomenon, the PATH therapist also works with the veteran’s direct social support network. The PATH intervention is therefore designed to support these relationships through the development of skills, attitudes and beliefs that enhance the quality of these relationships (Bocarro & Sable, 2003).

**The PATH Model in the Veteran’s Administration Health Care System**

As we move globally to a broader, more encompassing understanding of health, the military’s approach to the
treatment of wounded servicemen and women is also evolving, philosophically and practically. A more holistic and person-centered paradigm is emerging. In 2007, the President’s Commission on Care for America’s Returning Wounded Warriors called for a patient-centered recovery plan that should identify patient goals along a continuum from post-acute care to outpatient treatment through a return to active duty or to the home community (United States, 2007). The PATH model is a clear example of this valued and personalized approach to the rehabilitation needs of service members as they adjust to life beyond active duty and in the presence of acquired disability.

**Interface with VA Health Care System.** Third-party payers are beginning to recognize and respond to the need for person-centered health promotion models that emphasize prevention and self-management and reduce health care utilization and expenditures for individuals with disabilities (Bodenheimer, Lorig, Holman, & Grumbach, 2002; Gordon & Galloway, 2008; Kilo & Wasson, 2010). While recreation therapists are well positioned to take an active role in extending health promotion services beyond the hospital and into community settings, our continued viability is contingent upon establishing reliable referral and funding streams to support the provision of services. Establishing strong relationships with third-party payers is a critical avenue of collaboration. Northeast Passage (PATH program) and the Manchester Veteran’s Administration Medical Center (herein referred to as the VA) is an example of such a partnership. The PATH model presented here has been modified to more directly align with the needs of veterans, as such, it differs from the previous iterations of the model presented in the literature (Bocarro & Sable, 2003; Sable & Bocarro, 2004; Sable, Craig, & Lee, 2000; Sable & Gravink, 1999; Sable & Gravink, 2002; Sable & Gravink, 2005).

**Populations served.** Veterans are defined as servicemen and women from the U.S. Army, Air Force, Coast Guard, Marine Corps, and Navy, who are no longer classified as active duty personnel because they have been discharged from the military. The three-year, fee-based contract with the Manchester VA is designed to support veterans across two major cost centers in attaining and maintaining personal health and wellness through in-home/community recreation therapy services. The first cost center comprises veterans from past conflicts, such as the first Gulf War, Vietnam, and Korea, who are aging with or into disability. This population includes veterans who have sustained, and are aging with, combat-related traumatic injuries such as brain injury, spinal cord injury, amputation, and other orthopedic injuries. The second major cost center of the VA, and primary focus of this article, comprises veterans from OEF, OIF, and OND who have sustained severe combat injuries such as traumatic brain injury, spinal cord injury, amputation, blast injuries, gunshot wounds, fractures, and burns and present with concomitant post-traumatic stress disorder (PTSD). In order to be eligible for PATH services, veterans from this second cost center must have a primary diagnosis of physical disability, must be followed by a primary care physician through the VA, and must be actively receiving health care services through the VA’s Outpatient Therapy Department.
or Spinal Cord Injury Clinic. It is important to note that servicemen and women are not eligible for VA services, PATH or otherwise, until they have been discharged from active duty.

According to the National Organization on Disability (NOD), there are approximately 12,000 to 15,000 seriously wounded veterans attempting to achieve independence and begin new lives in the wake of their disability and discharge from military service (Glazer, 2010). These veterans are markedly different from veterans of previous wars. They are surviving more serious wounds than veterans of earlier wars, and they are an older demographic with an average age of 28 versus 19 from the Vietnam era (70% are married and 65% have children under the age of 18). Perhaps the most telling demographic relates to the percentage of veterans who have PTSD or TBI as a component of their disability. Approximately 40% of veterans have PTSD as their primary disability and 20% have traumatic brain injury as their primary disability (Glazer). These veterans experience higher rates of marital problems, unemployment, suicide, and drug and alcohol abuse than their veteran peers who do not present with PTSD. The implications of this trend are significant as PTSD symptoms can undermine the veteran’s ability to make a successful transition to a civilian life with disability. This is a distinct generation of veterans with disabilities for whom few community-based health promotion service models exist.

To date, 15 veterans who sustained combat-related disabilities in post-September 11th conflicts have successfully completed the PATH program. In order to illustrate ways in which the PATH intervention supports the “new wounds, new needs, and new demographics of veterans” (Glazer, 2010, p. 5), a single case example of a veteran who completed the PATH program is presented here and woven throughout the description of the PATH intervention that follows. A pseudonym is used to protect his identity.

Dan is a 23-year-old male recently discharged from the Army due to an improvised explosive device incident in OIF that resulted in mild traumatic brain injury, fractures in both of his legs, and a secondary diagnosis of PTSD. He moved to New England as part of his rehabilitation program, which includes a veteran employment support program. He is employed full-time. Dan lives alone in a moderate-sized city in New Hampshire. He is single and has a long-term girlfriend who visits him from his home state for a few months out of the year. He does not have any children. Dan has a high school education and is currently enrolled in a community college under the G.I. Bill. He plans to enroll in a four-year college upon conclusion of his associate’s degree. Dan receives primary care and PTSD counseling services through the VA’s Outpatient Therapy Department.

PATH therapists. The PATH-VA contract reflects a one-year period of intervention with a CTRS/L. Since PATH therapists are not VA employees, they must obtain special clearances to utilize the electronic health data management
system. In order to be granted remote access to veteran medical records, PATH therapists are required to participate in an intensive training process through the VA, which includes the General Employee Privacy Awareness Training program and the Information Security and Privacy Awareness Training program. These training programs consist of annual security background checks, reviews of HIPPA regulations, training in the use of the electronic medical records system, and access to restricted-use computers for retrieving and inputting data into the medical record.

Referral and intervention protocol. Figure 1 provides a description of the referral process and intervention protocol for the PATH-VA contract. Referrals to the PATH program come from a variety of sources, including case managers, nurse practitioners, registered nurses, and physical or occupational therapists, all actively working with or treating the veteran through the VA Outpatient Therapy Department or SCI Clinic. All PATH referrals must be approved and signed off by the veteran’s primary care physician (PCP), who then posts the order to the electronic medical record. Currently, CTRSs are not a part of the treatment team in either department, but CTRSs from the inpatient Rehabilitation Unit keep PATH therapists apprised of referrals that appear in the medical records system. On a weekly basis, the PATH therapist reviews all referrals in the system and has seven days to set-up an in-home appointment, where he or she will conduct an initial intake interview and assessment. In order to maintain continuity in the referral process, PATH therapists conduct bi-annual in-service trainings on the intervention for the medical and therapy staff of the SCI Clinic and Outpatient Therapy departments.

Dan was referred to PATH by his PCP in the Outpatient Therapy Department where he was receiving PT and mental health counseling for his PTSD diagnosis. According to treatment team notes obtained from the medical record, Dan exhibited physical limitations in balance, strength, and endurance; however, he was independent in ambulation and did not require the use of a wheelchair or walking device. He demonstrated cognitive deficits, including a decreased ability to concentrate and focus on specific tasks. He reported anxiety and sleep disturbance, which he attributed to the pain he experienced from his constant headaches and leg fractures. Since Dan’s family and friends live out of state, his primary social support system consisted of coworkers and veteran peers whom he met at the VA.

Assessment and treatment plan. During the first in-home session, the PATH therapist conducts a comprehensive intake interview and assessment examining a number of areas, including the veteran’s “current level of physical, social and community engagement; past, present and potential interests for involvement; perceived and real barriers to participation; personal network and support systems; knowledge of accessible resources; and risk factors with potentially negative health impacts” (Sable & Gravink, 2005, p. 83). Additional
Veteran referred to PATH program by medical/therapy staff of VA Outpatient Department or SCI Clinic

CTRS receives order via electronic medical record (EMR). Schedules in-home evaluation in 7 days.

Within 30 days, CTRS completes evaluation including the following:

| Standardized health-related quality of life instruments (pre-test) | Collaborative development of treatment plan focused on veteran’s goals in areas of need. |

Goals addressed in 8-10 home/community based sessions lasting 2-8 hours. Treatment areas include:

- Individual Fitness
- Wellness Education
- Advanced Functional Skills
- Community Engagement
- Recreation Skill Development
- Peer Networking and Resource Development

Using EMR via remote access, the CTRS:

- Post results of initial intake interview
- Posts assessment and treatment plan information
- Completes progress notes for each session
- Assign appropriate CPT codes for reimbursement

CTRS conducts a discharge meeting with veteran, makes appropriate referrals and recommendations, administers standardized health-related quality of life instruments (post-test), and posts discharge summary to EMR.

**Figure 1.** PATH Referral and Intervention Protocol

health outcome data are collected from all veterans referred to PATH using standardized instruments in order to determine baseline measurements of quality of life, health-related quality of life, generalized self-efficacy, and pain level. These instruments include the Flanagan-16 Quality of Life Scale (Flanagan, 1982), the EuroQol 5-D Health Related Quality of Life Scale (EuroQol Group, 1990), the General Self-Efficacy Scale (Schwarzer & Jerusalem, 1995) and a pain scale that asks participants to rank their pain level on a scale of 1-10. In order to track the impact of the PATH intervention on these health outcomes across the length of treatment, the standardized instruments are administered again in a post-test format during the discharge session at the conclusion of the intervention. These instruments serve three purposes in the PATH intervention, they are: (1) a benchmark for the veteran to inform his/her treatment plan; (2) a post-test measure to reflect the veteran’s outcomes as a result of the PATH intervention; and (3) a measure of efficacy of the PATH intervention for each individual veteran case.

The results of the intake interview, assessment, and standardized pre-test instruments are summarized and presented to the veteran during the second in-home session, where the CTRS and the veteran set goals and objectives for the PATH intervention and determine the number of sessions necessary to meet the identified goals.

Dan’s initial assessment resulted in a treatment plan that focused on four main areas of need: (1) recreation skill development in cycling, waterskiing, snowboarding, kayaking, golf, target shooting, sled hockey, and physical fitness with an emphasis on adaptive equipment use; (2) stress management sessions geared toward pain and anxiety management; (3) socialization through formal peer mentoring opportunities; and (4) community resource awareness to facilitate independent recreation participation. When asked to identify how the CTRS could most effectively meet his needs, he commented that he needed someone to “motivate him” to re-engage in his previous recreational interests and community activities. Family education was not an emphasis of Dan’s treatment plan because they live out of state; however, his girlfriend was active in his treatment when she was visiting.

Implementation of the PATH intervention to address unique veteran needs. The PATH intervention is designed to help newly injured veterans adjust to and cope with the variety of physical, emotional, cognitive, social and cultural challenges associated with the sudden acquisition of a disabling condition and resulting discharge from the military community. The intervention is based on a minimum of eight to 10 in-home and/or community visits with the CTRS/L. The average travel and direct intervention time per session ranges from two to eight hours. Based on each veteran’s goals and needs, he or she may be involved in six health promoting treatment areas, including: (1) an individualized fitness program developed in the home or a community
facility; (2) wellness education sessions comprised of nutrition, stress management, coping skills, fatigue, and/or pain management; (3) advanced functional skill development including mobility in the community and transfers to/from adaptive recreation equipment; (4) community engagement; (5) peer networking and community resource development; and (6) individual/family recreation skill development. For a thorough explanation of each treatment component, see Sable and Gravink (2005).

The personal relationship between the CTRS/L and the veteran is critical to building the trust needed to influence healthy behaviors and community engagement. The CTRS/L tailors the intervention to each veteran’s needs and employs various strategies to promote independence in physical, cognitive, emotional, and social functioning (Sable & Gravink, 2005).

The PATH therapist delivered Dan’s intervention through a variety of instructional formats. Dan participated in one-to-one, in-home/community skill development sessions, was referred to group skill development sessions with Northeast Passage Staff and his veteran peers, and received relevant community resources through email and telephone communication.

The PATH intervention assists veterans with their transition to life with a disability by engaging them in health promoting activities that foster success. The perception of forward progress in recreation and community activities is critical to the veteran’s sense of control over his or her specific health issues related disability. Consistent with Bandura’s (1986) self-efficacy theory, the PATH therapist supports the veteran to develop health promotion skills and facilitates strong beliefs in his or her own ability to successfully utilize the skills learned.

Dan’s treatment plan included his engagement in a variety of meaningful recreation and social activities aimed at fostering mastery experiences. Through basic and advanced skill instruction and adaptive equipment use, Dan was able to demonstrate total independence in his chosen recreational activities. He commented that it was through his recreation successes that he recognized he “could do things again” and perhaps had something to “give back” to others. This realization ultimately led him to volunteer with a local youth services organization.

PATH’s wellness education component further assists veterans as they negotiate the transition to disability. Typical education topics include the importance of nutrition and the role of healthy life habits in reducing secondary conditions of disability. Due to the high incidence of PTSD and anxiety among current veterans, the PATH therapist also introduces cognitive-behavioral coping strategies to manage and cope with issues such as pain, fatigue, anger, anxiety, and/or sleep disturbance.

Dan exhibited a high level of anxiety as a result of chronic pain associated with his headaches and
leg fractures. He reported that he had problems with sleep, which often left him feeling fatigued and irritable during the day. The CTRS capitalized on Dan’s interest in physical activities by introducing him to stress reduction modalities such as adapted fitness/exercise and boxing. He responded well to both modalities, reporting a sense of “release” after each activity. He valued the stress reduction benefits so much that, upon concluding the PATH program, he obtained a boxing membership at his local Police Academy and continued his physical fitness routine at the community fitness facility.

In an effort to help veterans recognize that they are not alone in their adjustment to disability, the PATH therapist incorporates formal and informal peer mentoring activities. Consistent with Bandura’s (1986) notion of “social persuasion” in self-efficacy theory, the inclusion of others with similar experiences provides the veteran with positive encouragement, feedback and support to persevere in the face of adverse conditions.

Dan benefited from the formal peer mentoring opportunities incorporated into his treatment plan. He especially enjoyed participating in target shooting sessions at the range with his veteran peers who also had disabilities. Dan further engaged in group-based skill development sessions in waterskiing, kayaking, and golf with other veterans, and participated in one-to-one adapted snowboarding lessons with an instructor who was also a veteran. These peer mentoring opportunities positively impacted Dan’s level of social engagement and helped him recognize that he was not alone in his recovery.

**Discharge and evaluation.**
At the conclusion of the PATH intervention, the PATH therapist administers the standardized health outcome measurements in a post-test format to the veteran. The post-test scores are used in conjunction with the outcomes of the treatment plan to comprise the veteran’s discharge summary. The discharge summary outlines the veteran’s progress toward, and attainment of, treatment goals and objectives, documents TR services rendered, and provides recommendations to foster further health-related gains. The PATH therapist reviews the discharge summary with the veteran and outlines the PATH follow-up protocol, which includes one follow-up phone call conducted at three-month, six-month, and one-year post-discharge time intervals. The veteran is also instructed to contact the PATH therapist as needed beyond these formal follow-up calls.

In order to facilitate the transition from military to civilian life, the PATH therapist provides the veteran with relevant community resources to assist with continued independent participation upon discharge from the PATH program. Veterans are invited to continue accessing Northeast Passage resources as a community member. These resources include seasonal and ongoing adapted sports and recreational opportunities, an extensive database of community-based adaptive programs, an adaptive equipment rental program, and practitioner expertise to assist with
problem solving (Sable & Gravink, 2005).

In addition to connecting the veteran with community resources during the discharge session, the PATH therapist also provides support in navigating complex and often fragmented services provided through the VA system. Due to the stigma associated with a PTSD diagnosis and/or other mental health conditions, current veterans are often reluctant to advocate for mental health services within the VA system (Glazer, 2010). In response to this trend, the PATH therapist encourages the veteran to take advantage of specialized mental health services through the VA, which include resources such as a 24-hour call center, substance abuse programs, and mental health support groups.

Dan’s discharge summary reflected attainment of all his treatment goals. He participated in numerous leisure education and skill development sessions in adaptive waterskiing, kayaking, snowboarding, cycling, target shooting, and physical fitness. Due to scheduling conflicts, Dan was unable to meet his sled hockey goal; however, he indicated he was aware that he could independently participate as a member of the Northeast Passage (NEP) sled hockey team. Dan additionally met his stress management goal through participation in boxing and gym workouts, which he viewed as beneficial stress release modalities. He further met his goal of connecting with veteran peers who had experienced similar combat and health-related challenges.

To assist in Dan’s transition to civilian life, the PATH therapist provided him with several recreation-based community resources. He was added to NEP’s mailing database and received quarterly newsletters, announcements about upcoming adapted sport and recreation events, and access to the adapted equipment rental program. In the winter months, Dan was connected with a regional adapted ski program for snowboarding lessons. Since his discharge from PATH, Dan independently returned to the ski program, signed up for a NEP waterskiing event, and organized additional target shooting sessions and kayaking sessions with veteran peers. Recently, he contacted his PATH therapist to inquire about vacation resources for a summer trip he is planning with his girlfriend. Dan was independently accessing veteran benefits and services provided through the VA and further benefited from the veteran employment resources offered through the VA.

**Documentation and reimbursement.** For each veteran served, the PATH therapist completes documentation by utilizing the VA’s electronic medical record via remote access. The documentation includes an initial intake and assessment summary report, treatment plan, progress notes per treatment session, and a discharge summary at the conclusion of the intervention. In order to obtain reimbursement for PATH services, the CTRS/L additionally enters CPT billing codes into the medical record upon conclusion of the treatment session.
The most frequently utilized CPT billing codes include: therapeutic procedure, aquatic therapy, therapeutic activities, development of cognitive skills, wheelchair management/propulsion, and community/work reintegration.

The primary CPT billing codes utilized during Dan’s treatment program included therapeutic procedure, therapeutic activities, and community/work reintegration.

**Discussion**

There are compelling reasons for recreation therapists to explore treatment interventions for service members returning from post-September 11th conflicts. The myriad battlefield-associated traumas that can exist long after the service member returns home are complex and do not lend themselves to rapid resolution. Multiple transitions must be addressed by our returning service men and women. These transitions are occurring in the face of broad and sweeping changes in the U.S. Healthcare system itself that add yet another layer of complexity to the rehabilitation process. While medical care in the U.S. is often excellent, it is oriented to acute care. As such, gaps in care exist and problems persist in the areas of continuity of care, care transitions and patient self-management (Glazer, 2010; Kilo & Wasson, 2010; United States, 2007). Health promotion programs that address long-term wellness for persons with disabilities are very much needed (Rimmer & Rowland, 2007).

The National Organization on Disability (NOD), in cooperation with the U.S. Army, has been working to address career planning, mentoring, education, and work initiatives to assist veterans in developing the self-sufficiency to transition to productive and valued members of their civilian communities. The NOD program exemplifies a leading model of transition by valuing proactive solutions, a holistic approach, a long-term view for services, and an emphasis on outcomes that are data-driven (Glazer, 2010). The PATH model presented here has been evolving over the past decade in response to similar goals.

The PATH model is a proactive approach to treatment focused on timely intervention that is specifically tailored to the individual veteran. Referral pathways are varied so that any health care provider with whom the veteran has contact, who sees a need for PATH, can initiate a consult. The PATH model uses a holistic approach to treatment seeking to involve any and all significant others in the treatment paradigm, as appropriate. The PATH model is individualized and person-centered. The PATH therapist meets with the veteran face-to-face over several months, in their home and within their chosen communities. In this way, services can be precisely tailored to address the goals and desires of the individual and his or her family, and can also directly address any environmental barriers or facilitators to successful participation. This “real time, real place” aspect of the PATH model is a critical component in the model’s success. The PATH therapist uses a data-driven approach to treatment employing the clinical process (APIE) and utilizing both standardized and non-standardized measures of efficacy. Lastly, the model is cost-effective.
and replicable. The NOD’s Wounded Warriors Career demonstration projects cite an annualized cost of $3,000 to $4,000 dollars per veteran as a significant cost savings for the military. The cost of the PATH intervention, which includes eight to 10 visits during the course of one year, is approximately $2,000. It is replicable in that a qualified CTRS with the requisite skill, knowledge, abilities, clearance and access to the veteran population could employ the PATH model. Successful replication of the PATH model necessitates the alignment of several considerations. Ideally, the therapist has a clinical background in rehabilitation and expertise in delivering services in a community setting. An understanding of the challenges inherent in the delivery of recreation therapy services in a variety of community-based settings (urban vs. rural, for example), as well as adroitness in the delivery of services, is essential. The therapist will need access to a variety of adaptive equipment and assistive technology to address the multiple interests of a diverse clientele. The therapist also needs access to the VA system to arrange a contract for both funding and referral; this element is critical to the long term viability of the service.

The groundswell of attention to uncover effective programs and interventions to assist people with disabilities to live fulfilling lives is in part driven by the circumstances facing wounded military personnel as they rejoin civilian life. This trend is evidenced in recent calls for a more effective, efficient and consumer-focused approach to the health care for our wounded veterans (United States, 2007). In addressing this need, continued research on the efficacy of the PATH model is warranted with veterans from post September 11th conflicts and veterans from previous conflicts who are aging with/into disability. Future research may employ an experimental design to assess whether the PATH intervention can impact health-related quality of life, health care utilization and cost containment, readmission rates, treatment compliance, and patient satisfaction. Future qualitative research may be valuable to understand how the PATH intervention may impact the phenomenon of veteran “transitions,” including the two critical transitions outlined in this article. After more than a decade of development, the PATH model is one example of a PATH-way home for our veterans.

References


