

BLINDED VETERANS ASSOCIATION (BVA)

TESTIMONY ON GAO REPORT 04-949

Before the U. S. House of Representatives

Committee On Veterans Affairs

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Presented by Thomas H. Miller, BVA Executive Director

Mr. Chairman and members of this distinguished Committee, on behalf of the Blinded Veterans Association (BVA), I want to express our sincere appreciation to you for conducting this hearing to address what we believe to be very serious problems with VA Blind Rehabilitation Service (BRS) and the manner in which BRS delivers blind rehabilitation services to America's blinded veterans. Before commenting specifically on "GAO Report 04-949 VA Health Care: VA Needs To Improve The Accuracy Of Reported Wait Times For Blind Rehabilitation Services," I especially wish to thank Chairman Simmons and Senator Graham for requesting that GAO determine the accuracy of reported average wait times for admission to one of the ten VA Blind Rehabilitation Centers (BRCs). As you know, BVA has expressed strong concern for a number of years over the rapidly growing waiting lists and particularly the unconscionably long wait times to access the VA BRC program. I must say that the GAO report reveals nothing that BVA did not already know. Hopefully its findings reinforce our arguments for substantial changes in the leadership and culture within BRS, the manner in which these essential services are delivered and the critical need for more stringent accountability at all levels of BRS.

Mr. Chairman, BVA wholeheartedly concurs with the two principal recommendations made by GAO regarding the reported accuracy of wait times for admission to blind rehabilitation services. In our view, it is absolutely critical that the Secretary of Veterans Affairs as well as the Under Secretary for Health take an active leadership role if the necessary changes are to be fully implemented. VA BRS has existed for 56 years and has long been recognized as the premier provider of comprehensive residential blind rehabilitation services. Unquestionably, BVA continues to believe that this reputation remains intact. The reputation certainly has been challenged, however, as a result of the decentralized decision-making authority system of health care management currently in place, as well as the manner in which resources are distributed to the Veterans Integrated Service Networks (VISNs) and ultimately to the facility level. Further compromising these practices, as it relates to the delivery of blind rehabilitation services, has been the insufficient budget the Veterans Health Administration (VHA) has received in recent years.

Background

Mr. Chairman, there are a few fundamental concepts that must be clarified in order to fully appreciate the concerns BVA has over wait times and length of wait lists. In its report, GAO describes VA blind rehabilitation Services as the means by which legally blind veteran acquires the skills necessary to maximize his/her independent functioning. The report goes on to say that VA provides these services almost exclusively in residential BRCs. While we

certainly do not disagree with this description, we believe it does not go far enough in emphasizing the importance of the residential program. The reader of this report could be left with the impression that the BRC is not the most effective model for service delivery. It is absolutely essential to understand that the overarching purpose of the comprehensive residential BRC program is to assist the severely visually impaired veteran with acceptance of and adjustment to vision loss. Without question, acquisition of essential adaptive skills is an integral piece of the process, but not the end in and of itself. Unless these veterans are able to accept themselves as people who are blind, they will never fully utilize acquired skills or strive for independence. It has been clearly demonstrated over the past 56 years that the comprehensive residential training environment facilitates the process of acceptance, adjustment, and skill acquisition. Any criticism BVA may have for long wait times or lists should in no way be construed as minimizing the importance of or need for the comprehensive residential BRCs.

The other fundamental reality is the increased prevalence of severe visual impairment and blindness associated with aging. It is well documented that aging is the single best predictor of visual impairment and blindness. Given the aging of our veteran population, it is not surprising that the numbers of visually impaired and blind veterans are growing just as rapidly. It follows that there will be an increased demand for VA blind rehabilitation services. Access to essential services is the crucial issue and, regardless of the accuracy of wait time reporting, there is no question that those times will be long, given the numbers of veterans applying for these vital services.

In response to specific findings of GAO contained in the report, BVA is appalled that VA BRCs appear to be unable to accurately and consistently report wait times. There appears to be no excuse for failure to uniformly comply with relatively clear policy from the BRS Program Office in VACO as to how to determine wait times. This is not "Rocket Science". This pitiful failure demonstrates BVA's long-standing concerns over lack of leadership, oversight, and accountability. Until Dr. Lucille Beck was appointed Chief Consultant for the Rehabilitation Strategic Healthcare Group (SHG), a significant void existed in terms of leadership from the program office. Her dynamic leadership has clearly resulted in substantial progress to enhance timely access to appropriate models of service delivery.

Mr. Chairman, in fairness and as partial explanation for the failures in leadership, the program office has absolutely no "line authority" over the BRCs in the field. It is extremely difficult for the Director of BRS to be held responsible for the system-wide program in the absence of line authority. Undeniably, this is the real test of leadership (the ability to influence subordinates and all levels of management to do the right thing).

The next level of responsibility within BRS consists of positions classified as Regional Consultants. There is one such position stationed at each of the five large BRCs. Two of the five positions are currently vacant, and one of the two vacancies is currently open to applicants. These are unusual positions in that those occupying them, according to the position description, spend 75 percent of their time as the representative of the Director of BRS in the field. Unfortunately, however, these individuals have no real authority and are easily ignored when making recommendations during site visits at VA facilities within their areas of responsibility. If desperately needed oversight by the VACO Program Office is to be accomplished, the Regional Consultant positions must be strengthened.

The two other essential professional positions intimately involved in the delivery of comprehensive services to America's blinded veterans are the Visual Impairment Service

Team (VIST) Coordinators and Blind Rehabilitation Outpatient Specialists (BROS). Here again, the Director of BRS has no line authority. Mr. Chairman, if VA is to provide uniform, appropriate and timely service, the classification and recruitment authority for key positions within the special disabilities programs must be re-centralized and the Program Director must, at the very least, have concurrence on the selection of any BRC Chief, Regional Consultant, Full-Time VIST Coordinator or BROS.

Finally, if wait times are to be consistently and accurately reported, accountability must be enforced. Since the program office has no line authority, accountability must begin with the Under Secretary for Health (USH) and move through the Deputy Under Secretary for Operations and Management, to the VISN Directors, and ultimately to the local Facility Directors. Clearly, that is the chain of command responsible for the performance of the Chiefs of the BRCs, full-time VIST Coordinators, and BROS. BVA fully concurs that clear policies and procedures must be established and implemented regarding the accurate reporting of wait times. Without accountability, however, compliance, as demonstrated by the GAO study, will not occur.

Additional Factors Affecting Wait Times

Mr. Chairman, BVA also offers some additional factors that have a direct impact on wait times. These factors must be addressed if significant improvements are to be realized. Without a doubt, BRS must become more accurate in reporting the length of time required to enter BRCs. Unfortunately, however, the GAO report does not shed light on what the real wait times are. No doubt, given the increased demand for service mentioned above, they are quite long. We submit, Mr. Chairman, that these lengthy wait times may not be necessary. There are several contributing factors that GAO did not address in its study of the accuracy of wait time reporting.

First, we question whether all of the veterans being referred to the BRC, and currently on waiting lists, truly need the residential program. Many have had previous training in a BRC and are only referred back in order to obtain a particular piece of adaptive equipment, or receive some remedial training. We contend that many of those individuals could have their needs met through greater utilization of local resources, both within VA as well as outside the system.

Second, to this end, BRS has already taken aggressive steps to refer blinded veterans to qualified local resources, where they exist, for Computer Access Training (CAT). Until this month, these veterans were being forced to attend one of the BRCs in order to receive this training or any necessary upgrades in equipment. We applaud this initiative and believe it will substantially reduce the wait lists and times, freeing up residential beds currently dedicated to the CAT program. Because of the increased demand for CAT training, residential beds previously dedicated to the basic adjustment to blindness program were being shifted to the CAT program. Consequently, the wait for the residential program was made longer. In our view, the basic program must have priority for these beds.

A third factor affecting wait times has been the inability of BRCs to operate all the authorized beds due to staffing shortages. Several BRCs with vacancies in blind rehabilitation specialist positions have not been allowed to fill those vacancies and have therefore not been able to operate all their beds. Admitting a visually impaired or blinded veteran into a BRC without sufficient staff to provide essential instruction only makes an individual's

rehabilitation program unnecessarily longer, thus increasing wait times for those still on the waiting lists. BVA is very concerned that, in an effort to keep the wait lists and times down, facility managers place increasing demands on BRC staff to shorten the length of stay for each veteran in the program. Quality will certainly suffer if veterans are not provided sufficient time in the program to a) make the appropriate adjustment to their vision loss, and b) obtain proficiency with the newly acquired adaptive skills.

The fourth factor that could have a substantial impact on wait times is the influx of casualties from Iraq and Afghanistan. Fortunately, the numbers are small at this time but, given the level and nature of the insurgency, eye casualties may increase. Newly visually impaired and blinded servicemen/women will definitely require the basic comprehensive residential program. As you can imagine, adjustment issues for young individuals, blinded traumatically, are significant. There is no question that the therapeutic environment provided by the comprehensive residential BRC is absolutely crucial if these veterans are to successfully adjust to their visual impairments. In order for these individuals to complete a beneficial course in blind rehabilitation training, the length of the program will necessarily be much longer than the average length of stay currently reported by the BRCs. The needs of a young, suddenly traumatically blinded person are much more extensive than those of elderly, medically compromised veterans possessing residual vision that can be improved with the prescription of and training with optical low vision aids. For example, Mr. Chairman, when I underwent my own blind rehabilitation training following med evacuation from Vietnam, the average length of stay in a BRC at that time was eighteen weeks. I submit that we needed every bit of that time. The average is now approximately six weeks. Therefore, the longer the program, the more slowly the beds are turned over and those on the waiting lists must wait longer. Pressure by network and facility managers to reduce length of stay must not be tolerated.

Mr. Chairman, BVA believes that a partial solution to wait times is assuring that visually impaired and blinded veterans are referred to the most appropriate level of rehabilitative care to meet individual needs. This solution may or may not involve the BRC.

This partial solution relates to the BVA response to the second portion of the GAO report on VA BRS. Again, Mr. Chairman, we concur wholeheartedly with the GAO recommendation that the USH issue a standard of care policy for VA to provide a broad array of inpatient and outpatient vision rehabilitation care for legally blind veterans across the entire system.

On a positive note, VA BRS has recently forwarded two proposals for approval by the USH that BVA believes will change the prevailing culture of BRS and substantially improve access to quality blinds rehabilitation services. Specifically, there are three initiatives BVA strongly supports that we believe will assist in achieving the goal of increased timely access to essential services.

First, the Visual Impairment Advisory Board (VIAB), a multi-disciplinary group appointed by Dr. Thomas Garthwaite (USH at the time), was charged with exploring more effective methods of integrating BRS into the network system of health care delivery. BVA has been an active member of VIAB and is represented on its executive council. VIAB has forwarded to the Health Committee of the National Leadership Board (NLB) a comprehensive recommendation calling for VA to provide a full continuum of vision rehabilitation care across the entire VA Healthcare system. The Health Committee received the proposal favorably and requested that a GAP analysis be conducted to determine what resources

currently exist within VA and what resources will be necessary to fulfill the requirement to provide the full continuum. The Gap Analysis has just been completed and is being carefully reviewed by VIAB prior to submission to the Health Committee. Mr. Chairman, BVA believes it is imperative that the NLB and the USH expeditiously approve this proposal and mandate the implementation of the full continuum. We also believe that the proposal should be included in network strategic plans as well as in the performance measures for Network and Facility Directors. As mentioned above, accountability will be absolutely essential if the implementation is to be successfully achieved as a National System Priority. Of course, the initiative will also satisfy the GAO recommendation.

A second initiative, which BVA believes is an essential companion to the Continuum of Vision Rehabilitation care, is modification of the Veterans Equitable Resource Allocation (VERA) model of resource allocation to the Networks. Under the current VERA methodology, there is no incentive for facility managers to develop capacity for the delivery of outpatient blind rehabilitation services, or for that matter to contract for such services in the local community. Over the years, the BRS culture has trained facility managers to refer all legally blinded veterans to the BRC for training. We contend that, for a variety of valid reasons, many veterans are either unable to leave home for an extended period to receive these services, or in fact do not require the residential environment of the BRC to obtain necessary services. This is particularly true for our older veterans who now have spouses that are either disabled or have serious medical conditions. These conditions often obligate the blinded veteran to remain home as the primary caregiver. Working closely with the Chief Financial Office of VHA, BRS has submitted a proposed change in VERA that, in our view, would more equitably allocate funds for the provision of services, both inpatient and outpatient, for the legally blind veteran population enrolled in the VA Healthcare system. Again, this proposal has been referred to the Finance Committee of the NLB. We urge expeditious approval by the NLB and the USH. The new allocation should enable and provide incentives for local facilities to successfully comply with the provision of a full continuum of vision rehabilitation care. Contained within the proposal is an element that may prove controversial. In order for the recommended change in VERA for legally blind veterans to be fully implemented in Fiscal Year 2005, funding must be provided through Special Purpose funds for the first three years before the change can stand on its own. We urge this committee to strongly encourage the USH to provide such Special Purpose funds.

The third initiative that will assist in reducing both wait times and lists is expansion of the current bed capacity in BRCs. This initiative is currently under consideration at two facilities: the BRC at the West Palm Beach, Florida, VA Medical Center and the BRC at the Waco, Texas, VAMC. Additionally, the CARES plan approved by Secretary Principi earlier this year calls for establishing two more comprehensive residential BRCs to be constructed at the VAMCs in Biloxi, Mississippi and Long Beach, California.

Ultimately, however, BVA believes that expansion of VA's capacity to provide vision rehabilitation services on an outpatient basis is the real solution to wait times and lists. To their credit, some facilities have already recognized this reality on their own and have taken steps to provide more services through outpatient models of service delivery. The bottom line is that all of the GAO recommendations for improving vision rehabilitation services for legally blinded veterans can be implemented through approval of the two VIAB proposals by the USH. Such approval will set in motion VA's increased and enhanced capacity to provide the appropriate vision rehabilitation services in the right place at the right time.

Mr. Chairman, if the goal recommended by GAO is to be achieved, there will need to be strong leadership from the highest levels of VHA, the BRS Program Office, and all management elements in the VISNs. BVA is encouraged by the selection of a new, dynamic leader for the BRS Program Office. We hope and pray that he fully recovers from his recent medical problem. Additionally, we believe a dramatic change in BRS culture is required for these new proposals to succeed.

Finally, Mr. Chairman, I wish to express our sincere appreciation for your invitation to participate in this hearing this morning. We are especially grateful that Chairman Simmons and Senator Graham have requested that GAO examine the long wait times involved in receiving VA blind rehabilitation services. As always, I would be pleased to respond to any questions you or the Committee members might have