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Mr. Chairman and members of this distinguished subcommittee, on behalf of the Blinded Veterans Association (BVA), I want to express our appreciation for your invitation to present our views on H.R.2792 The Disabled Veterans Service Dog and Health Care Act of 2001, currently pending before the subcommittee. I want to commend you, Mr. Chairman, for introducing this important legislation. We in BVA feel especially qualified to comment on the importance of the role of service dogs in assisting severely disabled veterans. Service dogs help veterans in coping with their disabilities and achieving successful reintegration into their communities.

Section 2 of H.R.2792 would amend section 1714 authorizing the Secretary of the Department of Veterans Affairs (VA) to provide service dogs to disabled veterans with spinal cord injury or disease or other chronic impairments that result in limited mobility as well as service dogs for the hearing impaired. We are especially pleased that this bill makes all veterans enrolled in VA Health Care eligible for these dogs. In our view, eligibility for prosthetics services based on enrollment was one of the fundamental elements of the Eligibility Reform Act that contributed significantly to the transformation of the VA Health Care system. The removal of complex and unnecessary eligibility criteria for the provision of vital prosthetics services has substantially improved access for disabled veterans to needed services.

As I mentioned above, Mr. Chairman, BVA feels especially qualified to comment on this provision of your bill because VA has possessed the authority to provide guide dogs to blinded veterans for many years. The value of guide dogs for enabling people who are severely visually impaired or blind to overcome the problems associated with safe and independent mobility has been well documented and widely accepted by the general public. Guide dogs are permitted access everywhere, affording visually impaired individuals the opportunity for full participation in their communities.

Despite the fact that guide dogs afford the fastest, safest, and most efficient means of travel for people who are blind, a very small percentage of people who are blind use guide dogs. The use of a guide dog is a personal decision, which is influenced by many factors. The utilization of guide dogs by blinded veterans reflects the general blind population, which is less than four percent. Consequently, the impact on VA is minimal. This is especially true in that the guide dog schools do not charge a fee for the dogs, and generally will pay for the transportation to and from the school.

As you may know, VA Blind Rehabilitation Service (BRS) only trains blinded veterans in the use of the long cane for safe and independent travel. Whether a veteran chooses to apply for a guide dog is a very personal decision. Long cane travel is quite stressful, as you might imagine, requiring intense concentration and skill. Some blinded veterans never develop enough confidence in the skills with the cane and turn to a guide dog. The guide dog enables the person to travel more quickly, safely, and efficiently than when using a cane. The choice therefore between the cane and a guide dog depends primarily on the individuals independent travel needs, confidence, and comfort level when using the long cane

BVA believes a very similar experience will result from providing VA the authority to provide service dogs to certain disabled veterans. The service dogs, while not as common and widely accepted as the guide dog, clearly provide the same kinds of benefits. Mr. Chairman, the most difficult aspect of accepting and adjusting to a disability is coping with the loss of independence. Becoming dependent on others to perform basic activities of daily living, which are normally taken for granted, is the single most difficult aspect of disability to cope with. Restoring ones independence is essential to rehabilitation and fundamental to this process is the integration of prosthetic devices, sensory aids, appliances, and now service dogs. It has been clearly demonstrated that using service dogs enhance the quality of life characterized by restored self-esteem, confidence, and worth. Concurrently, the utilization of the service dog substantially reduces dependence on paid personal care assistants. Without question, Mr. Chairman, the VA should be authorized to provide service dogs to those disabled veterans who have a demonstrated need and can benefit from the use of a service dog. Similar to guide dogs, we would not expect that a substantial percentage of disabled veterans would require or benefit from a service dog. Regulations should be specific as to under what conditions a service dog is necessary. Guide dogs and service dogs alike are not intended to be companions, pets, or attack dogs.

SECTION 3

BVA strongly supports Section 3 of this bill, which requires VA to maintain its capacity to provide specialized treatment and rehabilitation for disabled veterans. This requirement was originally established with the adoption of the eligibility reform Act of 1996. This act not only required VA to maintain such capacity, it also required VA to submit a report to congress annually known as the Capacity Report (CR).

The ERA only required VA to maintain national capacity in the Special-Disabilities Programs. Sec. 3 of H.R. 2792 requires not only maintenance of National but Network Capacity as well. We believe this is essential to assuring disabled veterans equitable access to these vital services. The importance of this requirement is exemplified by a situation that occurred more than two years ago. One VAMC hosting a blind Rehabilitation Center (BRC) arbitrarily closed fifteen beds dedicated to the delivery of comprehensive residential blind rehabilitation. They also eliminated the professional positions dedicated to provide that service. In an effort however, to comply with ERA, another fifteen-bed BRC was established in another Network. While strong arguments can be made for the need for the new BRC, the loss of the fifteen beds at the original VAMC has only resulted in longer waiting lists and times for admission. Consequently, blinded veterans are either being denied or at the very least delayed access to essential

specialized rehabilitative services. The Special-Disabilities Programs are regional in nature, making it extremely important to maintain a national balance affording equity of access for disabled veterans.

While BVA supports this provision in H.R. 2792, we have several concerns regarding its depth and scope. Specifically, the method utilized to measure capacity is problematic. We believe it is not enough to only measure number of veterans treated and the dollars spent. Certain Special-Disabilities programs such as blind rehabilitation and spinal cord injury/disease are carried out in residential settings. Therefore, they require a certain number of beds dedicated to the provision of these very specialized services along with a specific number of Full-Time Employee Equivalent (FTEE) professionally educated and trained to deliver these services. It follows, therefore, if these beds and essential FTEE are not counted, preserved, and protected, VA certainly cannot maintain its capacity.

There are those who would argue that the Special-Disabilities Programs should mirror the shift from inpatient service delivery to outpatient settings. In our view, the need for acute care provided on an inpatient basis will always exist as will the need for inpatient residential rehabilitative service for severely disabled veterans. The comprehensive benefits realized in the inpatient programs cannot be duplicated on an ambulatory basis. There is no question, in some instances, outpatient services may be indicated and appropriate, but this does not negate the need for the residential training programs. It is imperative, therefore, that beds and FTEE be integral elements of any methodology for measuring capacity.

VA will argue they have treated more blinded veterans than ever before and spent more dollars providing this treatment. This is the basic argument employed against counting beds and FTEE. The fundamental flaw with this argument in our view is the increases in numbers of blinded veterans receiving treatment in the BRC's is due primarily to substantially reduced lengths of stays. Limiting the programs enables VA to pump an increasing number of blinded veterans through the program, inflating the numbers treated and reducing the cost per blinded veteran. We are deeply concerned that quality of care is being compromised to achieve artificially high numbers. Some BRC's have gone so far as to introduce shortened programs (1 or 2 weeks) in an effort to inflate the numbers treated as well as game the Veterans Equitable Resource Allocation (VERA) model. Under VERA, blinded veterans who are admitted to a BRC and spend at least one night qualify their host Network for reimbursement at the high or complex rate. Mr. Chairman, these short programs are not residential blind rehabilitation, and only serve to improperly utilize beds dedicated for the comprehensive program.

The CR clearly has been a numbers game. It does not address quality issues and accountability. Therefore, we strongly believe that maintenance of capacity must be included as a performance measure in the facility and Network Directors Performance contracts. They have vigorously resisted this in the past, insisting that they only be required to monitor these programs. Monitoring is not the same as measure and they must be held accountable. We strongly encourage the inclusion in H.R. 2792 such requirements.

BVA is also deeply concerned that the outpatient programs currently in operation in VA Blind Rehabilitation Service (BRS) be included in the maintenance of capacity requirement.

Specifically, I am referring to the Visual Impairment Service Team (VIST) Coordinators and the Blind Rehabilitation Outpatient Specialist (BROS) positions. The VIST Coordinators are the case managers responsible for assuring the delivery of comprehensive service to all blinded veterans in their respective areas. They serve as the access point for blinded veterans into the system and for referral to the BRC's. The BROS are the professionals charged with providing blind rehabilitation services to blinded veterans unable to attend the BRC program. Both positions are very vulnerable in the de-centralized management environment employed by the Veterans Health Administration (VHA). When vacancies occur, field managers either attempt to eliminate, or drastically alter the position descriptions, usually assigning collateral duties. This latter tactic prevents those professionals from meeting the demand for care and specialized rehabilitative services. Additionally, local management frequently attempts to fill these crucial positions with unqualified individuals. Therefore, we believe very strongly the full-time VIST coordinators and BROS must be counted if capacity is to be maintained.

BVA also firmly supports the requirement that VA continue providing the CR to Congress for the next three fiscal years. Although BVA has complained that data used for the CR's provided over the past several years has been flawed, we fervently believe, without the reporting requirement, the Special-Disabilities Programs would have possibly been damaged beyond repair. We believe it imperative that the focus on these specialized programs must be continued.

Mr. Chairman, on a personal note, I have had the honor of chairing the Federal Advisory Committee on Prosthetics and Special-Disabilities Programs for the past several years and I know first hand that our committee has failed to agree with VA's assertion that they have been maintaining capacity. Each year of the CR, we have reported the data utilized has been flawed, highlighting the limitations of VHA Information Management systems. Clearly uniform national standards for coding and costing must be implemented if valid and reliable data is to be generated for reporting purposes. The Advisory Committee, in its most recent meeting held at the end of May, strongly recommended the continuation of the CR reporting requirement and will certainly appreciate your efforts to that end.

SECTION 4

BVA supports Section 4 of this bill that would implement the Department of Housing & Urban Development (HUD) low-income index for establishing thresholds for veteran's health care eligibility means tests. We believe this is a more equitable method for conducting means testing of veterans and allows for variability in cost of living in certain areas of the country. Veterans burdened by a substantially higher cost of living associated with certain areas, should not be penalized, and required to utilize their limited resources to pay for care from VA. We appreciate your inclusion of this provision in the bill.

SECTION 5

Mr. Chairman, BVA is deeply concerned by this section of the legislation. We opposed this provision in the last session of Congress and feel compelled to do the same this time. Converting VA into a payer for veteran's health care rather than a provider is disturbing at the

very least. The provision seems to be a cost avoidance measure and certainly not in the best interest of disabled veterans.

BVA is painfully aware of the financial constraints under which VA must operate its health care system, but question the wisdom of turning veterans over to non-VA providers which would insist that veterans rely on their own insurance or Medicare. Proper management of veteran's care utilizing this model seems problematic at best.

This provision requires that all payments by VA for deductibles, co-pays etc. must be made from the Medical Care Cost fund (MCCF) at the local level. As you know, these are receipts collected from third party payers and retained at the local facility. Although these funds are used to offset the cost of providing care to certain Non Service-Connected (NSC) veterans, or for the care provided for treatment of NSC conditions, it is also available to enhance the overall capacity to provide service at any given facility for all veterans including those with Service Connected (SC) disabilities. Therefore, the proposed pilot projects contemplated under this provision would avoid costs by providing care in non-VA facilities. Potentially, this could result in reduced capacity and quality of care of SC disabled veterans. Fundamental to maintaining quality is maintaining a sufficient workload at facilities, assuring professional opportunities for learning, education, and the acquisition and maintenance of skills and expertise necessary for the provision of high quality services. This is particularly important in specialty areas. VA cannot provide specialized services without the availability of the full array of medical and ancillary services necessary to support the Special-Disabilities Programs.

We are also very concerned this approach to service delivery sets a precedent that can be perceived as the first step towards vouchering out all VA health care. We also believe this approach would not be in the best interest of disabled veterans. VA possesses a long history of experience, expertise, and knowledge in providing specialized health care and rehabilitative services rarely available in the community. The drive to reduce the cost associated with the delivery of VA health care should not result in disabled veterans being forced out of the system especially designed to address their unique and special needs.

SECTION 6

Mr. Chairman, BVA also has reservations to Section 6 of this bill. Requiring all contract or fee basis treatment to be provided through managed care programs raises serious concerns. Managed care programs do not offer all the specialized services that might be required by disabled veterans nor make appropriate referrals to VA providers who do indeed possess this expertise. Again, is cost avoidance warranted at the risk of disabled veterans not receiving essential service in a timely manner?

SECTION 7

BVA supports this provision. The families of severely disabled veterans who have suffered for years, or are burdened by catastrophic illness or disease, deserve all the bereavement counseling assistance VA can provide. Typically, family members are the primary care givers and, in many cases, devote much of their adult lives caring for veterans. Without this devoted

care, the burden would fall to VA. Clearly, VA should provide counseling to support and assist these devoted Americans in coping with their loss.

SECTION 8

BVA supports this provision of H.R. 2792.

CONCLUSION

Again, Mr. Chairman, BVA appreciates the opportunity to appear this afternoon to share our comments on H.R. 2792 and commend you and the subcommittee for introducing this important legislation. As always, I would be pleased to respond to any questions you or other members might have.