



Department of Texas
VETERANS OF FOREIGN WARS
of the **UNITED STATES**

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**DEPARTMENT OF TEXAS VETERANS OF FOREIGN WARS
POSITION ON CARES**

**WE APPRECIATE HAVING THE OPPORTUNITY TO TESTIFY
BEFORE THE CARES COMMISSION CONCERNING OUR
FEELINGS ABOUT THE VETERANS HEALTH CARE ISSUE
IN THE STATE OF TEXAS.**

**AS WE APPROACH THE FINALIZATION OF THE CARES
PROCESS, WE IN TEXAS WHO ARE CONCERNED WITH
VETERANS, ARE CONCERNED THAT THE HEALTH CARE
NEEDED BY THE VETERANS OF TEXAS WILL NOT BE
TAKEN CARE OF. WE APPLAUD THE CARES COMMITTEE,
FOR WANTING TO PROVIDE MORE OUTPATIENT CLINICS
THROUGHOUT TEXAS, SO OUR VETERANS WON'T HAVE
TO TRAVEL AS FAR TO RECEIVE OUTPATIENT CARE. WE
APPLAUD THE CARES COMMITTEE, FOR TAKING AN**

HONEST LOOK AT MANY OF THE FACILITIES THROUGHOUT THE UNITED STATES, AND MAKING RECOMMENDATIONS, TO THE SECRETARY, OF WAYS TO ENHANCE THE FUTURE CARE FOR VETERANS AND SAVE MONEY TO THE VA SYSTEM AND TAXPAYERS. WE HOWEVER ARE AFRAID THAT THE PROPOSALS IN TEXAS WHICH WOULD CLOSE THE BIG SPRINGS HOSPITAL AND THE WACO HOSPITAL WILL BE DETRIMENTAL TO THE HEALTH CARE THAT IS NOW BEING PROVIDED TO TEXAS VETERANS.

TEXAS IS ONE OF THE FEW STATES THAT HAS A GROWING VETERANS POPULATION. WE ARE THE ONLY LARGE STATE WITH MORE POST-KOREAN VETERANS, THAN PRE-KOREAN VETERANS. BECAUSE OF THIS, TEXAS VETERANS WILL NEED HEALTH CARE FOR MANY YEARS TO COME. MANY OF OUR VETERANS ARE YOUNGER VETERANS AND THEY WILL NEED HEALTH CARE FOR MANY YEARS TO COME AS WELL. ONE OTHER PROBLEM

THAT WE FACE IN TEXAS IS THE LARGE SIZE OF OUR STATE. WE DON'T HAVE THE LUXURY OF MANY OF THE NORTHEASTERN STATES, TO HAVE ALL OUR VETERANS WITHIN A 200 MILE RADIUS OF ANY PLACE IN THE STATE. CLOSURE OF THE BIG SPRINGS HOSPITAL WILL MAKE VETERANS OF THAT AREA HAVE TO TRAVEL OVER 300 MILES TO THE NEAREST VA HOSPITAL. FROM THE VALLEY AREA OF TEXAS, IT IS OVER 200 MILES TO SAN ANTONIO. THESE ARE PROBLEMS THAT OUR VETERANS HAVE ENDURED FOR MANY, MANY, YEARS. THE PROPOSED CONSTRUCTION OF A NEW HOSPITAL IN MIDLAND / ODESSA WOULD TRULY HELP THE VETERANS OF THAT AREA IF IT IS COMPLETED. WE WOULD ASK THAT THE COMMISSION PLEASE LOOK INTO OUR STATES RAPIDLY GROWING VETERAN POPULATION BEFORE MAKING ANY DECISIONS THAT WOULD ADVERSELY AFFECT OUR RETURNING VETERANS FROM CONFLICTS AROUND THE WORLD & TAKE INTO ACCOUNT THE

FUTURE NEEDS OF OUR AMERICAN DEFENDERS, BEFORE CLOSING ANY HOSPITALS. WE CANNOT ACCURATELY PROJECT THE FUTURE VETERAN'S NEEDS WITH FLOW CHARTS. WE DO NOT KNOW WHERE WE WILL HAVE TO DEFEND OUR GREAT NATION IN OUR FIGHT AGAINST TERRORISM OR FUTURE WARS, OVER THE NEXT 20 YEARS. TO DO THIS WOULD BE A TRAVESTY OF OUR OBLIGATION & NEED TO TAKE CARE OF OUR VETERAN POPULATION. WITHOUT AMERICA'S VETERANS, THERE WOULD BE NO AMERICA! WE ASK THE COMMISSION TO PLEASE CONSIDER ALL THE FACTS, NOT MERELY PROJECTED NUMBERS BASED ON A MULTI PAGE FLOW CHART, AND NUMBERS THAT HAVE BEEN INFLUENCED BY RESTRICTING WHO THE VA TREATS & ENROLLS BEFORE MAKING A FINAL ASSESMENT. THE GRAPH SHOWING ENROLLMENT TRENDS WAS ON THE INCREASE FROM 2001 THROUGH THE BEGINNING OF 2003 WHEN THE VA ASKED VSOS TO HELP ENROLL NEW ELIGIBLE VETERANS. THIS

TIME PERIOD WAS WHEN VSO'S WERE ACTIVELY HELPING GET VETERANS IN NEED, ENROLLED. THEN SUDDENLY, IN 2003, ENROLLMENT DECLINES, AS WE WERE TOLD THE VA WAS NOT ACCEPTING NEW ENROLLEES. WE AS VSO'S, KNOW THERE ARE MORE VETERANS IN NEED OF FUTURE CARE, THAT ARE NOT CURRENTLY ENROLLED. WE KNOW THERE MUST BE CHANGE TO ASSURE COST- EFFECTIVENESS, BUT LET'S NOT DO IT AT THE EXPENSE OF OUR COUNTRIES DEFENDERS.

WE MUST GO BACK TO THE GAO'S ORIGINAL CHARGE FOR THE REASONING BEHIND THE COMMISION. THE GAO CHARGED THEIR HIGHEST WEIGHTED PRIORITY WAS TO THE ONE-VA CUSTOMER SERVICE AREA. 0.56 POINTS OUT OF A 1 POINT WEIGHT, WAS WARRANTED TO

- 1. INCREASE CUSTOMER SERVICE**
- 2. INCREASE QUALITY OF SERVICE**

3. DECREASE WAITING TIME

4. INCREASE BENEFIT OR SERVICE PROVIDED

5. INCREASE THE NUMBER OF CUSTOMERS.

OVER HALF OF THE CHARGE ON A SCALE OF 1 POINT, WAS ISSUED AS ABOVE. WE REALLY NEED TO THINK ABOUT IF THIS IS ACTUALLY HAPPENING, OR GOING TO SOME LOWER PRIORITY ON THIS ONE POINT SCALE.

FINALLY, LET'S UTILIZE VETERAN'S SERVICE ORGANIZATIONS, THEIR KNOWLEDGE AND NEEDS OF THEIR OWN AREAS, ALONG WITH VA REPRESENTATIVES AND DIRECTORS OF HOSPITALS, TO ALLOW THEM TO JOINTLY COME UP WITH A SOLUTION FOR COST CUTTING AND EFFECTIVENESS OF EACH UNIT. THE VETERANS RECEIVING CARE AT A HOSPITAL OR OPC COULD GIVE A GREAT INSIGHT AS TO WAYS TO SAVE MONEY, AS WELL AS TO GET BETTER SERVICE. NO ONE ASKS THESE QUESTIONS EXCEPT IN SURVEYS FILED OUT AT THE HOSPITAL THEY ARE TREATED AT, AND MOST FEEL

THEIR LEVEL OF CARE WILL DIMINISH IF THEY ANSWER TRUTHFULLY. WE FEEL THIS WOULD BE A BETTER SOLUTION FOR PLANNING, RATHER THAN SPENDING MONEY FOR UNREALISTIC, PRE-PROGRAMMED STATISTICS, FOR OUR VETERANS FUTURE NEEDS.

WE STAND READY TO SUPPORT AND HELP THE CARES COMMISSION IN MAKING THE PROPER RECCOMMENDATIONS TO THE SECRETARY, SO THAT THE HEALTH CARE PROVIDED TO TEXAS VETERANS IS IMPROVED IN THE FUTURE.

THANKS, ONCE AGAIN, FOR ALL THE COMMISION HAS DONE TO ACHIEVE ITS GOAL, AS A COMMISSION. WE HOPE THIS TESTIMONY ON OUR POSITION, HAS GIVEN SOME INSIGHT AS WHERE THE VETERANS OF OUR GREAT STATE AND NATION STAND ON THIS ISSUE.

BLINDED VETERANS ASSOCIATION VISN 17 CARES INPUT

Stakeholder Assessment of the Re-location of the Blind Rehabilitation Center

This document is a combined effort of both the South Texas Regional Group of the Blinded Veterans Association and the North Texas Regional Group of the Blinded Veterans Association. The purpose of this document is to advise VISN management of our position on the relocation of the Waco BRC. We have joined together to strongly advocate that the BRC be retained as a 15 bed facility and that the program be relocated to the Dallas VA. In the paragraphs below we state our case.

As the stakeholders in VISN17, the Blinded Veterans Association (BVA) presents input only after making a careful and measured analysis.

We have three major considerations when we put forth our suggestions:

What will afford the best possible treatment for the most blinded veterans in the VISN?

What are the future trends that might affect treatment of blinded veterans?

What are the best uses of the available resources for the treatment of blinded veterans?

What are the best possible treatment alternatives for the most blinded veterans in the VISN?

Presently there is a 15-bed Blind Rehabilitation Center (BRC) at the Waco campus of the Central Texas Health Care System. The facility has been in existence since 1979. It began as a Clinic and changed to a Center function in the 1990's. Like all other BRCs it has found its patient population for the most part aging and there has been a dramatic drop in the length of training time. Training time nation wide once was in the range of 16 weeks. This has dropped to 4 to 6 weeks for an average program today.

The Waco BRC serves only a select and limited portion of the blinded veteran population. Many veterans choose not to attend due to health, family or other concerns.

Since the 1998 change in the law governing outpatient issuance of prosthetics there has been a steady increase of local service provision in the North and South Texas Health Care Systems. Unfortunately for the blinded veterans in

Central Texas, that VHCS has been very slow to initiate even the most basic of local services.

We strongly endorse local services. We think they represent the present and growing future need of blinded veterans. Having stated this, we recognize that there is a need for hospital-based care for the training of some of our veterans. We do not discount the need for a BRC in VISN 17. In order to afford our visually impaired and blinded veterans the best possible care and service within the VISN, a combination of local service working in conjunction with a well supported and fully staffed BRC will be required.

What are the future trends that might affect treatment of blinded veterans?

We have been informed that Central Texas is considering going from a 15 bed BRC to a 34 bed BRC with the impending closure of the Waco campus. This deeply concerns us for a number of reasons:

1. The number of veterans on the Waco BRC waiting list has been steadily dropping. This is an indication that a decreasing pool of applicants exists within the VISN.
2. The move to double the bed count seems linked to the current VERA reimbursement. VERA is the model of the moment, but there may well be changes in the future. The BVA is working at the national level to institute intermediate level VERA funding. This would provide local stations funds to treat blinded veterans in their local communities. The BVA feels this is extremely important. It is projected that in FY 05 there will be funding for training veterans locally. This may present a monetary disincentive for other VISNs to refer to the expanded 34-bed unit. Could VISN 17 alone be expected to fill 34 beds? Our present demographics and rate of referrals would suggest that this would not be feasible.
3. We recommend that VISN management gather and analyze the data generated by the Waco BRC. The Past performance indicates that Central Texas has never been able to generate adequate applications to fill even a 15-bed program. A review of the data from the last 10 years will reveal the sources which generated the majority of applications to the Waco BRC. Historically Central Texas has not produced large number of referrals to the Waco BRC. Until fairly recently, south Texas provided the bulk of applications to the Waco BRC. North and south Texas have led the VISN in the development of effective local services. It is noteworthy that in Central Texas even the prospect of their veterans being trained close to home has not seemed to entice blinded veterans to attend in great numbers. In south Texas the numbers appear to be declining based on what we observe as health and age issues and the fact that many blinded individuals have already attended the BRC.

4. The BVA has observed a move towards the implementation of new modes of care. The Visual Impairment Services Outpatient Program (VISOR), a lodger type program in the Lebanon VAMC shows that short focus programs are a cost effective, efficient way to get outstanding results in limited, intense training periods. This is an example of another level of care that could be used in the VISN versus more hospital based inpatient beds.
5. We are also favorably impressed with the risk management model of service delivery established in south Texas. We are attaching a copy of this model for VISN review.
6. If the new Medicare Bill that includes funds for Vision Rehabilitation (currently in Senate – House review committee) is adopted by the full Congress there will be alternative services to siphon blinded veterans away from traditional VA hospital based blind rehabilitation services. This would not bode well for an expanded BRC. We suggest this is not the time to construct a new facility.
7. We ask what roll will a BRC play in the future. World War II veterans will unfortunately not be available to fill the beds. There will be the need to tap a new generation of veterans. This new generation will have different expectations than the past generation. They will demand more timely services and will be accustomed to medical services focused on an outpatient basis close to their homes. This is what they are being taught by our present health care system. It is possible for a hospital based system to survive these expectations, but services will need to be close to the home area for the vast majority of veterans.
8. The VISN has informed us that in ten years two thirds of the workload for the VISN will be in the Dallas – Fort Worth area. If this is true then the future of the BRC is where the future blinded veterans are.

What are the best uses of the resources at hand for the treatment of blinded veterans?

We believe strongly in the concept of "leave no blinded veteran behind." The BVA has been told that Central Texas is preparing plans for a massive outlay of funds to construct a new BRC. The purpose of CARES is supposed to be to address over capacity in fixed facilities! As taxpayers, we strongly question the need and wisdom to incur this type of construction and relocation cost when there may be building capacity within the VISN. We believe that the monies planned to construct a new BRC would be more wisely spend to provide a continuum of care and services to all the veterans in VISN 17.

In our recommendations of sites for a BRC, we would select the Dallas campus. Unlike the decision to build a new facility on the Temple campus, we base our decision on the facts and merits of such a move. This is how we view the factors:

The Case against Leaving the Blind Center in Central Texas:

1. Central Texas management in recent times has provided minimal ancillary staffing for the blind rehabilitation program. One of our major concerns is that Central Texas VA management has never seemed to have the commitment to provide adequate resources for a properly run BRC.
2. Temple is not close to a major veteran population and future projections do not indicate that it will be in the foreseeable future. Although Central Texas is likely to grow in population, this growth is not projected to produce a large number of new veterans.
3. The Temple – Belton area is a major population center, but lacks the trappings of a major city. The airport is adequate at best, not a major hub. The downtown area in Temple lacks major transit assets for training. Our assessment of the City of Temple as a training site for visually impaired and blinded veterans is that it is seriously limited.
4. It is not clear to the BVA what type of space would be allocated for a Blind Center. New construction of a facility modeled on the Hines BRC seems unwarranted from a financial standpoint and contrary to sound business practices. Thus far, the management of Central Texas has made no attempt to communicate with or partner with, nor have they sought any input from the stakeholders concerning the location or size of the proposed new BRC.
5. Historically we have not been impressed with the support of the existing BRC in Waco by central Texas management. They have allowed the BRC to remain in an inadequate building. They have allowed staffing levels to decrease, especially nursing. Some of the decrease in referrals to the BRC has been the direct result of management refusing to adequately staff the center. The BVA has tried for years to persuade Central Texas management to separate the BRC from the in-patient psychiatric patients housed upstairs in the BRC. Even though Waco has many available empty buildings and frequent promises were made, nothing was ever done. Past performance has not shown us a management committed to a first class BRC. Why the sudden interest now? We would hope it is not just a means to reap VERA funds.
6. While both north and south Texas have implemented the use of the Scrip Talk and insulin pins, Central Texas has shown little interest and less initiative. Management has allowed veterans to remain at risk in spite of requests by the BVA for corrective action.

The Case for the BRC to be relocated to the Dallas Facility in North Texas:

1. **Welfare of the Veterans:** The Dallas facility is a modern, progressive up to date medical center. We feel that it is superior based on size and range of services. We have been impressed with the progressive leadership of the Dallas VAMC. We observe a real commitment to serving all visually impaired veterans. The provision of local services has long been supported and implemented.
2. VISN projections indicate that two thirds of the VISN's workload will be in the Dallas – Fort Worth area in ten years. This means that this area is a major hub of veterans, both now and more so in the future. This is seen by the BVA as a major plus in considering future sites for care and specialty programs. We would feel comfortable recommending veterans attend a BRC located in North Texas. The same cannot be said about central Texas.
3. A transit system (rail) runs in front of the Dallas facility. Dallas has a major airport and a smaller downtown airport. The conjunction of these three assets as well as accessibility by bus favors Dallas as a BRC location.
4. The Dallas area offers the opportunity for veterans attending the BRC to take part in many events and activities as part of their transition into community integration. A major city may also offer many volunteers and sponsors of recreation and special events. Central Texas is very lacking in this area.
5. The Dallas management has shown a long sustained commitment to have a BRC located there. We are favorably impressed by this desire to provide for blinded veterans, which existed before the onset of the VERA allocation model! The progressive management in North Texas and their sound support of local services to blinded veterans indicates a high probability of proper support and management of a BRC.

Conclusion: Based upon the projection of workload in the future also concerns based on the past history of minimal support for the BRC in Central Texas, as well as the comparative advantages offered by Dallas when compared to Temple, we feel that there is a need to put the facilities where the veterans are (and where they are projected to be in the future), in this case Dallas, not Central Texas.

We ask that the VISN conduct an analysis of the present and historical data before finalizing any decision regarding the relocation of the Waco BRC. This is an opportunity to partner with the stakeholders in developing a plan that will meet the needs of blinded veterans in VISN17 while at the same time reflecting sound business practices.

The BVA requests that the management of Central Texas produce hard data to show why the expansion of the BRC if moved to Temple is needed. Our first

reaction to expansion is that we are at the threshold of the expansion of outpatient services. This is certainly the word from the Secretary. VERA is being modified to comply with this. We see a potential reduction of BRC inpatients if the new Low Vision services portion of the Medicare Bill is passed.

Based upon the foregoing, which is predicated upon all available information at our disposal and our past experience with the management of Central Texas VHCS, the Blinded Veterans Association strongly recommends and urges that the BRC be relocated to Dallas and that the current 15 bed configuration be retained with sufficient support and staff to treat, train and care for the majority of visually impaired veterans, without undue delay, that seek admittance to the facility.

Respectfully submitted:

Attachment: South Texas Risk Management Model

South Texas Risk Management Model
Decision making based on clinical indicators

Services for Blinded Veterans In South Texas

Introduction

The Visual Impairment Services Team (VIST) Coordinator is in place to provide services to all the blinded veterans identified in the assigned geographic area. This responsibility includes both newly identified patients and those established with the program. Veterans are identified with varying levels of residual vision and often medical and physical issues. There are also likely to be psychosocial considerations and the need for positive intervention. Vision loss usually causes changes in family dynamics. Often the family is anxious to have the veteran's abilities restored as soon as possible. All newly identified VIST veterans are seeking hope.

For veterans who live alone it is likely that there is an immediate need to ensure proper medication management. There may be a wide array of other immediate critical needs depending on the veterans living circumstances and support network. These immediate needs are the early focus of intervention with the goal of stabilization.

The VIST Coordinator has to develop an intervention plan based on the individual veterans circumstances. Clinical decisions have to be made. Referrals may need to be accomplished. Once the veteran is stabilized the VIST Coordinator can turn attention to the task of more long term planning. Many variables are interwoven into the development of any long-term treatment plan.

South Texas Veterans Health Care System (STVHCS) VIST Program RISK Management Service Model

Blind Rehabilitation Services within the Department of Veterans Affairs (VA) has in the past been based on the model developed during World War II at Valley Forge and Avon Old Farms. This model was refined and expanded post war at Hines VA in Chicago. The model has evolved into a chain of hospital based blind rehabilitation centers (BRC) around the country.

In this model a newly blinded individual would be immersed in a total rehabilitation atmosphere at a BRC. This system was and is highly

South Texas Risk Management Model
Decision making based on clinical indicators

effective for newly blinded service personnel. Post Viet Nam a new phenomenon began to shape the features of blind rehabilitation services – the graying of our nations veterans. The bulk of World War II veterans attending VA blind rehabilitation centers were losing their sight due to eye conditions such as age related macular degeneration, diabetic retinopathy, and end stage glaucoma.

Several other aspects of sight loss intervention evolved in this post Viet Nam time frame. Historically there were limited optical devices to offer blind individuals. The first electro-optical device, a Closed Circuit Television became available. This device offered a practical way for an individual to access print for a prolonged period of time with a device that was easily used and highly effective.

Post Viet Nam also saw a growth of community services as an outgrowth of the "Great Society" social services initiative of the 1960s. Many of the services and devices now readily available to the visually impaired did not exist when the VA developed the residential model of treatment.

Within the VA other models of quasi-residential treatment have also evolved over the years. There are now VICTORS programs and a VISOR model. Even in the BRC, the time a veteran is considered to require inpatient care has drastically dropped from 16-18 weeks to some 4-5 weeks. Some of this may not be due to just clinical indicators but also to changes in funding (VERA) incentives.

In the late 1990s and early in this century the trend towards an older population has increased and will continue to do so. It is not uncommon to find a veteran well into their ninth decade attending a BRC.

BRC's have limitations and are not equipped to provide the following:

1. Intervention immediately if immediate intervention is needed.
2. Meet the needs of those who are classified as severely visually impaired – but not legally blind.
3. Address the needs of those who are not in stable health (precluding BRC training) or address the needs of veterans who for some other reason do not attend a BRC.