

**Statement of
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Chief
Eastern Blind Rehabilitation Center
Before the
Committee on Veterans' Affairs
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Mr. Chairman and Members of the Committee:

It is an honor to speak with you today in my role as Chief of the Eastern Blind Rehabilitation Center, which is housed at the West Haven Campus of the Connecticut VA Healthcare System.

In 1969, the Eastern Blind Rehabilitation Center (EBRC) became the second VA Blind Center to serve blinded veterans. Today, our 34-bed EBRC serves 16 states and 6 VISNs in its catchment area. We have 27 on-board blind rehabilitation instructors, many of them cross-trained, and full-time nursing coverage. We reorganized the EBRC eight years ago from skill-specific teams into interdisciplinary treatment teams to improve continuity of care and better utilize time and staff. Last year we served 258 inpatients at the EBRC.

We have three Blind Rehabilitation Outpatient Specialists (BROS) stationed in Boston, West Haven, and Baltimore, who provide local outpatient blind rehabilitation training to veterans in our catchment area. Our Regional Consultant coordinates and oversees service delivery of our 42 full and part-time Visual Impairment Service Team (VIST) Coordinators, who identify blinded veterans and serve as case managers for this population. We pride ourselves in our dedicated staff, strong programs, and strong leadership in providing excellence of care for blinded veterans, in the most appropriate modes possible. Last week at the EBRC, we celebrated our 35th anniversary with some of those veterans. Our history has been one of steady improvements and enhancements to services for vision-impaired veterans.

Through early 1970s, the EBRC served a veteran population that included many young, totally blinded Vietnam veterans. Low Vision programs, electronic aids, and computers were all but non-existent or experimental. The standard length of stay was four months. Mobility, Braille, adjustment, and pre-vocational counseling took the bulk of the time. By the late 1970's, the EBRC veteran population, technology, and blind rehabilitation began to change. Vietnam veterans returned for refresher courses and to attempt state-of-the-art technology, such as the now defunct Sonic Guide for mobility. Low Vision used the first Closed Circuit Televisions (CCTVs). Our researcher worked with a private inventor named Kurzweil to develop an experimental, room-sized machine, which recognized and spoke written text. Its miniaturized descendants reside in most of today's screen-reading and voice-activated computer technology. In the 1980s, more specialized optical aids were available in Low Vision, and training increased. Braille was taught for labeling, not reading, and new cassette recorders were used for note taking.

In the 1990s, our Mobility program modified techniques for wheelchair and mobility-challenged veterans, and our Living Skills program increased touch-typing instruction. This better prepared the many veterans who wanted to continue on to the Computer Access Training (CAT) Program. The average age of our blinded veterans continued to increase, and more female veterans appeared. Most were blinded due to diseases related to aging, such as diabetic retinopathy. More had severe physical impairments and many exhibited decreased memory or cognitive functioning. We increased nursing staff to ensure 24/7 skilled coverage. Electronic or computerized aids for the blind increased, and the EBRC began to evaluate and prescribe the most promising of the devices. By 1993, we created a department devoted solely to this specialty.

In 2000, the EBRC became the first Blind Center in the United States to receive full accreditation from the Council for Accreditation of Rehabilitation Facilities (CARF). We also earned full accreditation, with no recommendations, again in 2003.

In the past three years, we have reduced our average daily cost by almost \$2,000. Our average length of stay at the EBRC is five weeks, and our wait list is now down to an average of 125 days for our Regular Program. Through a series of

initiatives, including out-sourcing CAT for qualified applicants, the wait time for admission for our CAT Program has been reduced from 443 days two years ago to its current 149 days.

Our CAT staff is evaluating a digital recorder that will record instruction and download it directly into a computer. One of our CAT staff is experimenting with a technique to telecommute with a student; the potential is great for future instruction of veterans who might stay at home for this training. The same student has also learned to communicate with his daughter living in Israel by using voice e-mail on his adapted computer.

In the past three years, the EBRC has experienced an unprecedented shift in its veteran population. Never before have we experienced the age disparity of our inpatient population. Many veterans are now in their 80's and 90's, but we are also seeing the youngest in 25 years, many of them recent active duty veterans blinded by unusual accidental causes, rather than actual military conflict. As a result, our inpatient programs have again become more individualized, and our lengths of stay have varied depending on patient needs. Our staff is challenged to provide rehabilitation training to both old and young veterans, who have extremely differing needs and abilities.

We have refocused our local outpatient treatment to improve service delivery. In 2001, the EBRC created an Outpatient Treatment Team, which included the VIST Coordinator and BROS, and added a staff Optometrist and Chief. We shortened outpatient waits and treatment length by assigning a Low Vision specialist to patients who only needed Low Vision evaluation and training. Some veterans are tracked directly into outpatient Low Vision training, some into more expanded BROS training to obviate the need for inpatient training, and some for admission into the EBRC. This has improved wait times and case closure for the BROS veterans. We also now "fast-track" some veterans in an intense, one-week training curriculum to expedite training in mobility, low vision, and rehabilitation. Currently the team is exploring a 1-2 week modified day program that would allow veterans to participate in the group atmosphere of the inpatient program, which often facilitates adjustment skills and improved morale.

We are also proud of our participation in the initial development and follow-up of research projects conducted by the Atlanta Rehabilitation Research and Development

Department. These two historic projects developed criteria to evaluate the effectiveness of blind rehabilitation training and to create benchmarks in various VA and non-VA settings. Beginning in 1997, the EBRC began using these criteria to evaluate our student population and our program in three major areas: demographics, patient satisfaction, and change in functional independence following rehabilitation. One example of changes we have made from application of the criteria involves a modification to our training curriculum based on results of the Atlanta Functional Change Scores. Seeing a drop in our scores in Low Vision tasks in 1999, the EBRC modified and increased its training in mid-distance viewing tasks, and in 2001, ambitiously began a staff cross-training initiative in Low Vision where staffing and training hours were inadequate. Our scores in these areas improved noticeably. Our cross-training now has expanded to other skill areas. We now have five cross-trained staff in Low Vision, five in Manual Skills, and two in Living Skills, as well as five staff who have dual degrees in Orientation and Mobility, and Blind Rehabilitation Teaching.

Quality, veteran choice, continuity of care, and increased independence for each blinded veteran continue to be our foundation and guide our future. At the EBRC, we will continue to explore and evaluate training alternatives and best practices for our ever-changing veteran population. Mr. Chairman, this concludes my statement, and I will now be happy to answer any questions you might have.